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THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

Introduction

By J.D. Smith, Ph.D.
Northwestern University

My warmest greetings to dear friends and colleagues. As I write this, we are well into 2015, and I am aware of my tardiness in delivering the first issue of the year. I believe, however, that the slight delay is well worth it: The very well written and engaging contributions in this issue are sure to be of interest to you. A preview:

This Issue

In this issue's research column, Wendy Eichler provides a brief overview and some additional comments about a paper that was recently published in the *Journal of Personality Assessment*, written by myself, Wendy, Kaila Norman, and Steve Smith. The study examined the effectiveness of using a brief Collaborative/Therapeutic Assessment (C/TA) model for midtherapy assessment consultation. Although the study was relatively small, the daily symptom measures allowed for powerful tests of effects for the clients as a whole and for the individual clients. The results suggested that the majority of clients experienced significant symptom improvement that coincided with initiation of the C/TA. The average group effect was also promising. Wendy also discusses the potential mechanisms responsible for the observed effects and some directions for future research based on this small pragmatic study.

Next, Lionel Chudzik approaches the Teaching and Training column from a different perspective compared to those of previous issues. Rather than our usual approach of how we can teach and train others in the use of TA, Lionel discusses how learning, using, and receiving supervision in TA taught him many lessons about his work with convicted sex offenders. For Lionel, the practice and challenges of TA with these clients were firmly rooted in his past experiences. Supervision with Steve Finn and Lionel's openness to the process of self-exploration and vulnerability with scary clients helped him realize his full potential to connect to the dark parts of his clients' experiences. Lionel's experience is common

In this issue:

for TA practitioners and is a reminder of the power of the approach and the power of we human beings to effect change in those we work with.

Barton Evans then presents an interpersonal approach to understanding the humanness of PTSD. Barton's extensive work with combat veterans and his immersion in the works of interpersonal theorists, such as Harry Stack Sullivan, is clearly evident in his writing. Whether in the context of TA or psychotherapy, anyone working with clients with PTSD and many other forms of trauma will find Barton's metaphors and phrasings useful while connecting and humanizing their experiences and ongoing challenges. Despite the interpersonal approach that Barton describes, the methods and techniques are not in disagreement with what is considered evidence-based practices such as prolonged-exposure and cognitive-processing therapies.

Exciting News

On behalf of the Therapeutic Assessment Institute, Steve Finn announces a newly developed collaboration with the Foundation for Excellence in Mental Health Care, a non-profit philanthropic foundation that helps promising mental health care programs raise funds for a variety of activities including research, training, and dissemination. This partnership has the potential to open many doors for TA that could usher in a time of tremendous growth for our community and increase access to TA for families, children, adolescents, and adults.

Upcoming TA Trainings

The list of upcoming training opportunities in TA reflect the global presence of the model. Trainings are scheduled in Italy, France, the Netherlands, and Japan. Sounds to me like a great opportunity to travel and keep abreast of the state of the science in TA. Trainings in the United States are still being developed and scheduled. Stay tuned for announcements in the next issue of the *TA Connection*.

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 with your ideas. A warm thank you to the contributors in this issue: Wendy Eichler, Barton Evans and Lionel Chudzik. And a thank you to my associate editors for their assistance.

Please email questions or comments on this column to J.D. Smith at jd.smith@northwestern.edu

A Real-World Study of Collaborative/ Therapeutic Assessment as Midtherapy Consultation

By Wendy C. Eichler, M.A.

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Clinicians are often divided (perhaps this is self-imposed) into those who do assessment and those who do not. However, clients may experience greater benefits from receiving both psychotherapy and assessment. Finn (2011) has observed that when working with challenging clients, asking a colleague to provide midtherapy assessment has informed and supported the therapeutic work. However, the potential therapeutic benefits of consultation between a psychotherapist and a separate assessment professional have not been empirically investigated. Most of the research in this area is limited to assessors collaborating with school personnel (e.g., Noell et al., 2005) or in medical settings (e.g., Pace, Chaney, Mullins, & Olson, 1995; Smith, Finn, Swain, & Handler, 2010). From an empirical standpoint, it is unknown to what extent psychological assessment could be helpful as a midtherapy consultation tool even though this common practice in the community conforms to the recommendation that competent psychologists seek consultation when indicated (see Kaslow, 2004).

Therapists might initially consult with assessors at the beginning of treatment to answer diagnostic referral questions or determine an appropriate treatment plan. However, as treatment progresses, an assessment may provide opportunities to identify new courses of action, help the client see him or herself in a new way, and serve as a catalyst for deepening the therapeutic work. As noted by Finn (2011), assessment consultation may be well suited for challenging therapies—for example, cases in which the therapeutic relationship is strained, progress has stalled, or treatment failure is looming—the origins of which are generally multifaceted (Shimokawa, Lambert, & Smart, 2010) and often linked to the therapist's case conceptualization (e.g., Clark, 1999; Lambert, 2010). Collaborative and therapeutic approaches to psychological assessment (C/TA; see Finn, Fischer, & Handler, 2012) were designed to assist with case conceptualization, reduce client resistance, enhance the therapeutic alliance, and improve various clinical outcomes (Finn & Tonsager, 1997; Meyer et al., 2001). As such, C/TA seems well suited for use in a midtherapy consultation.

Given this reasoning, my colleagues and I (J.D. Smith, Kaila Norman, and Steve Smith) evaluated a critical aspect of the treatment utility of assessment: consultation to therapists during an ongoing psychotherapy. The complete article associated with this study appeared in Volume 92, Issue 3, of the *Journal of Personality Assessment* (Smith, Eichler, Norman, & Smith, 2015). We conducted a replicated single-case experiment with 10 participants to examine the effectiveness of C/TA for reducing clients' symptomatic distress and improving the processes and outcomes of ongoing psychotherapy. Recruitment targeted the psychotherapists, who were asked to identify a particular client from their psychotherapy practice who might be interested in, and might also benefit from, participating in an assessment and receiving feedback as an adjunct to their therapy. We hypothesized that participation in a midtherapy C/TA would (a) reduce clients' self-reports of symptomatic distress, collected using an Internet-based reporting system, and (b) improve therapy process variables that are instrumental to client change, such as the working alliance and other aspects of the psychotherapist–client relationship.

Previous research has suggested that symptom improvement, as reported by adult clients, coincides with the onset of C/TA (e.g., Aschieri & Smith, 2012; J. D. Smith & George, 2012) and that the psychotherapist–client dyad experiences improvements in therapeutic process variables, such as the working alliance (Ackerman, Hilsenroth, Baity, & Blagys, 2000). To increase the generalizability and ecological validity of our findings, we took a pragmatic approach to the conduct of this study. It

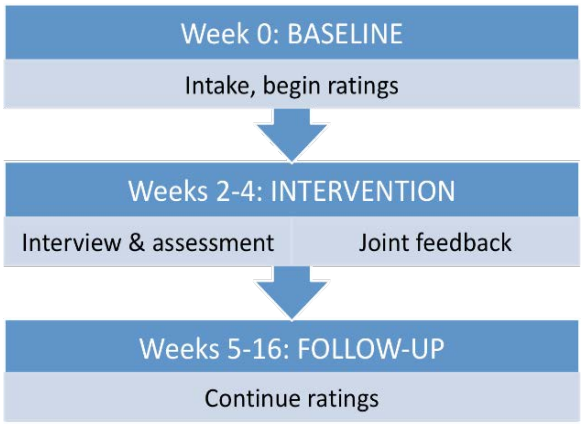
included setting broad participant eligibility criteria, using an individually tailored intervention protocol and a client-centered outcome assessment strategy, and using a study design that is compatible with the demands of real-world professional practice.

Study Overview

The inclusion criteria simply required the participant to be in ongoing psychotherapy with the same therapist for at least 10 sessions, that the therapist be a licensed doctoral-level psychologist, and that both the therapist and the client agreed that an assessment might be useful for informing treatment. After screening for eligibility, 11 dyads completed the intake session and received the C/TA. After enrollment, one participant was found to have substantial cognitive limitations that prohibited completion of the assessments and was thus excluded from all analyses and reported results. The majority of the remaining 10 clients were female (70%) and the overall average age was 33.9 years. Formal diagnostic im-pressions were not collected at intake, but reported concerns primarily consisted of general mood and adjustment issues.

The study followed a rep-licated single-case design with three phases: baseline, inter-vention, and follow-up (see Figure 1). This is the same design Smith and colleagues used in previous studies of TA effectiveness (e.g., Smith, Handler, & Nash, 2010). Following enrollment, each client received an initial intake with a research assistant who explained the study procedures, gained informed consent, gathered relevant background information, and explored the client's treatment goals in psycho-therapy. On the basis of this interview, a research assistant, in collaboration with the principal investigator, designed brief, idiographic outcome indices that the client was then asked to complete on a daily basis beginning the day of the intake, which marked the beginning of the baseline phase. The clients also completed ratings of each psychotherapy session throughout the three phases of the study. All outcome measures were administered via a secure web-based survey. After a minimum 2-week baseline phase, which provided the necessary number of daily reports for valid and reliable analysis, clients met with the assessment clinician to begin the C/TA intervention. The assessment clinician was blind to the specific daily idiographic outcome ratings that clients completed. Clients continued to complete the daily ratings throughout the C/TA and for approximately 2 months afterward.

Figure 1. *Study Design*



The C/TA intervention consisted of an initial interview during which the client posed assessment questions, one to two test administration sessions, and a joint feedback session with the client and psychotherapist. All clients completed the Rorschach Inkblot Method (Exner, 2003) and the Personality Assessment Inventory (Morey, 1991). Additional tests were administered when the client's assessment questions indicated a need to assess for cognitive impairments or other psychopathology, for example. The focus of the joint feedback session, which occurred in the psychotherapist's office, was on addressing the assessment questions posed by the client and therapist at the beginning of the assessment. The feedback followed the evidence-based procedures described by Finn and colleagues (Finn, 2007; Smith & Finn, 2014; Tharinger et al., 2008). At the end, the therapist and client were presented with a technical assessment report and a personalized letter, respecttively (see Finn, 2007). Psychotherapy continued throughout the study pro-cedures and the C/TA.

Results and Discussion

We used multiple methods to evaluate the effectiveness of using C/TA midtherapy. The daily measures were evaluated for significant imp-rovements idiographically (i.e., we looked at the significance of change for each individual client) and nomothetically (i.e., we calculated the average effect for the 10 clients). We examined a change in the level and the slope of symptom severity between the baseline phase and the remainder of the study period. Our results indicated that participation in a mid-therapy consultation using C/TA coincided with a significant reduction in clients' symptomatic distress and a significant change in the trajectory as well. In total, six of the clients showed significant imp-rovements at the idiographic level, while the overall effect of the intervention was a medium effect of .50, which means that symptom levels were reduced by one standard deviation after onset of the C/TA, compared with baseline levels. In addition, we found statistically significant increases in

the therapist–client working alliance in this study—mainly in the area of agreement about the tasks of therapy—indicating some malleability in the therapeutic relationship as a result of the C/TA intervention.

The results should be considered cautiously given the study design limitations; for example, causality cannot be determined, because the effects found in this study could be a result of the ongoing therapy. Inclusion of a control group would add to the internal validity of the findings. However, it is worth exploring some possible reasons why C/TA could have contributed to the promising results we found. Several possible mechanisms of action in the application of C/TA may be responsible. For example, the literature suggests that simply receiving feedback is sufficient for improving client outcomes (Poston & Hanson, 2010). In addition, the therapist being present for feedback and receiving information may have led to a revision of the case conceptualization, which may change the course of therapy and the resulting therapeutic outcomes. Another possibility is that the feedback session itself, in which the assessor helps facilitate a discussion about the answers to the client's and therapist's questions, is a significant catalytic experience for both the therapist and the client. This therapeutic feedback session may provide a unique opportunity for the therapist and the client to understand the client in a new light. It is possible that the client's experience of being understood by the assessor may reduce distress, and the therapist's empathy for the client increases. Although the mechanism of action cannot be determined from the current study design, the results lay the groundwork for many future studies to explore this topic further.

In terms of the positive change in therapist–client working alliance in this study, one hypothesis to be explored is whether the C/TA intervention facilitated this change. Perhaps C/TA helps therapists increase their level of attunement with their clients through the process of attaining new information and thus considering a revised case conceptualization. Or, perhaps the tasks of therapy become more well defined as a result of the process of drafting specific questions to be addressed in an assessment and gathering relevant data. Again, these hypotheses are ripe for exploration in future research.

Given this study's pragmatic methodology, the practicalities involved in the process of consultation with therapists in ongoing treatment deserve mention as well. First, we found that many therapists were interested in having their client receive assessment, but for various reasons the dyads were not able to participate in the opportunity. One reason was the scheduling difficulties involved in simply adding another commitment to the involved parties' already-busy schedules. In addition, several of the treatments had ended before the study was initiated. As is often found in general outpatient settings, client drop-out and ending a treatment prematurely is not uncommon, for a variety of reasons. Therefore, it seems important that therapist–client dyads interested in pursuing a midtherapy C/TA consultation be apprised of the duration of the process and know to what extent they can commit to it. Alternatively, methods that have been used to track the progress of psychotherapy and to predict premature termination (Lambert, 2010) could be used to identify cases at risk for treatment failure, and a C/TA could be initiated to prevent this occurrence. Either way, it is clear that this area of clinical practice is ripe for empirical study and that C/TA is well positioned to be the model of choice.

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Loneliness, Fear, and Violence

What I Learned from Encountering Evil Through Therapeutic Assessment

By Lionel Chudzik, Ph.D.

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I am a clinical psychologist from Normandy, France. Nearly all my work consists of providing mandatory psychotherapy to convicted sex offenders in the highest security level prison in France. I have worked with men and women who committed sexual offenses against children, men, or women (even a ship one time!) who have killed (most often another man) or who have tortured others short or long term. My goal is to help them through psychotherapy.

A Strange Familiarity

When people ask me why I work with these clients I usually reply that I grew up in several countries in Africa during civil wars and, in my opinion, this experience must have a link with my current job. While thinking of my earliest memories from Africa, these images come to mind: a false memory of a gardener lying dead in my garden after an attack from outside the walls of our estate (my parents told me a long time after that the attack was real, but not the death of the gardener); a dead child lying in the middle of the road, white liquid flowing from his head; an open meat market and giant black men with long knives and the blood in the street; I remember very well the township in the south of Luanda that I crossed every morning to go to school.

My way to cope with those memories was to think, think, think about what I saw during my days, what I understood, and trying to find explanations or reasons. I started to cultivate my own loneliness. It wasn't easy to be a sensitive boy in this world, but I did my best to understand the things that happened around me. And I grew up, still thinking. I had a difficult time making friends during my childhood and adolescence, and I didn't stop thinking. During my late adolescence, my thinking all the time revealed itself in a mysterious look on my face, which attracted girls, yet I didn't even notice them. I continued to think. I never stopped. I found psychology and became addicted to books and theories. They simply helped me think even more, to cogitate about the things I had seen and lived. I felt less lonely among those books and theories, and I became a very good student.

One day during my internship I met my first juvenile delinquent. I felt comfortable with him, as if I knew something about him. I asked to meet more juvenile delinquents. I started to work in the various programs for this population. Every time, I felt this strange familiarity when in contact with them. I worked with juvenile offenders for 6 years and wrote a doctoral thesis about this topic. But I remember still feeling unsatisfied by my work. At this time, I believed too much in what I was reading and my approach was too theoretically grounded, too intellectualized. My life pushed me to move from Paris to Normandy, where I began to work for a public hospital. I was quickly asked to also provide services in a prison. I accepted and again felt this strange familiarity. I have always had compassion for these men, my clients. They liked me a lot, I was doing a great job ... and then I met Steve Finn.

TA, Evil, and Me

I started to implement the principles of Therapeutic Assessment (TA) in prison. TA is a strange thing. It's like playing the piano or guitar. It seems easy at the beginning, you can be satisfied with playing a few chords, but the more you learn it, the more you realize how much you still have to grow. Clearly, the most important part of TA is the relationship with the client. Steve asked me to forget all my theories and to use the client himself as a theory and to really listen to him, without the filter of the theories. This ended up being my first lesson from TA: I often use theories as defenses. Perhaps some of my colleagues do as well. Steve asked me to stop thinking and to start feeling. And

I looked at myself: Why did I think so much when I was young? Where does this familiarity with criminals come from?

TA is very effective with my clients. With time and experience and the help and the support of the TA Institute, I witnessed good results. I was proud of the questions I gathered from my clients, and everything was fine. I struggled a bit with the question my clients most frequently asked me: "Why did I do that?" That is, why had they committed the act(s) that landed them in prison? It's a tricky question because at the end of a TA, during a summary and discussion session, you can't say, "because you were depressed," or "because you have a personality disorder," or "you use so much denial and splitting that you need to project your own feelings onto others." In this situation all these answers make no sense. While I struggled with the difficulty of providing answers to this question, I started to realize what the expression *in our clients' shoes* means. To answer the question my clients posed to me, I had to put myself in the clients' shoes. It's not easy. But imagine how difficult it becomes when your client is a convicted murderer or the guy who tortured another human being all night. Or the man who had sex with an 8-year-old boy. As I realized what I needed to do, my question became, "Do I really want to put myself in their shoes?"

At that point I began to understand something that is very important to me now. The link between growing up in Africa and my job: I was attracted by the trauma. Africa traumatized me. This is most likely evident to you, but for me it was Level 3 information, and I clearly was not aware of it at the time. With time I came to understand this strange familiarity I felt with the sexual deviants and prisoners. Once I appreciated that a part of me felt understood by them, I was able to understand them. Steve taught me later that this process is called *right-brain to right-brain connection*. But I wondered where the resonance came from. Why did I feel so connected with these criminals?

In the Shoes of Evil

One day at the hospital a psychiatrist asked me to meet a recently admitted patient. He was there because a judge had determined that he was not responsible for his crime because he had schizophrenia. The patient's rap sheet was impressive. He had robbed a bank, taken hostages, committed violent assaults, and abused substances. The psychiatrist asked me to meet with the patient in an isolation room with two male nurses. I refused and finally was able to meet the patient alone in an office of the unit. Then I asked Steve for supervision.

The assessment went well. The client explained to me that just prior to his last infraction he had been alone in his apartment and was severely anxious, even panicked. His mother came once a day to leave food on the table while he was in bed. On that day he had closed all the shutters in order to prevent people from hurting him. On the day of the crime he felt so alone he decided to go away. He left the apartment, then went out on the street, where he stopped the first car that came past and took the driver hostage. They spent the whole night talking together in the car.

His MMPI-2 showed a 9684 code type and a T-score of 30 on Scale 2. This code type suggested paranoid thinking and grandiosity to cover up inner insecurity; difficulties expressing anger in an adequate way; feelings of being unfairly treated and persecuted; alternate overcontrol of emotions and excitation, irritability, and fear of inadequacy. His Rorschach had 20 responses, a Lambda of 1.00, a Coping Deficit Index of 4, only one H (human) response, a SumC' of 4, and a Morbid content score of 3. He scored 16 on the Psychopathy Checklist-Revised, which is below the cutoff for psychopathy.

Steve said two things about these results. First, he asked if I thought the patient took pleasure in his criminal acts. I said, "No," but Steve asked me to ask my client. So I did. He looked at me and said, "You know, it was like an orgasm," and he described the moment when he was waiting for the police outside of the bank. His plan was to commit suicide "by cop" as he had seen on a television show, meaning that he would act in a way that gave the police no option but to shoot and kill him. He said that his anxiety was spent because he had already gotten the money and the fear was not there yet. In this moment he felt all-powerful. I was surprised by his response because I think of myself as very good with the MMPI-2 and I thought I understood the 9684 code type.

The second hint that Steve gave was to ask me to explore my client's experience of loneliness. Our case conceptualization was that my client was traumatized by loneliness. This made sense to me immediately and made me think a lot.

Steve and I began to think about loneliness as a trigger for the patient, and I started to think about loneliness. We planned an assessment intervention session during which he would be asked to tell stories to TAT cards and then link his stories to his internal experience of depression and loneliness.

During this particular TA, something interesting happened. I had several nightmares during the time frame in which I conducted the TA, all of them focused on violence, fear, and loneliness. I connected these nightmares to my work with my client, and they taught me about my blind spots and what is behind the theories.

Evil Inner World

As a transtheoretical approach, TA cuts across theoretical divisions by pulling from many common factors that have an evidence base. This allows an assessor to work from whatever theoretical orientation they are most comfortable with. It also provides a wonderful opportunity to model and elicit openness and curiosity in supervision. By starting from the student's current orientation toward understanding human beings, the supervisor is able to gently elicit in the supervisees a curious, collaborative stance. This can be accomplished through discussion about questions such as "What do you think makes people tick?" and "How do you think people change?" By explicitly viewing the student's current manner of understanding people as worthy of interest and curiosity, the supervisor sets the stage for collaboration and respect in the supervisory relationship.

This client taught me about the inner world of many of my clients. This world is empty and dark, while our inner world is full of attachment figures, for better or for worse. Psychology doesn't have many theories about loneliness, but I remembered some from my past reading, especially what Fromm-Reichman (1959/1990) called *real loneliness.* Real loneliness is not communicable and is simply terrifying. I remembered what Winnicott (1965/2007) said about the capacity of being alone in the presence of someone else. I also recalled what Piaget wrote about the co-construction of meaning with peers (Piaget, 1966/2000).

I remembered at this point the work of Spitz (1945) regarding "hospitalism." He showed the deep and physical impact of loneliness on human infants. He wrote that during the first month after separation from the caregiver, the child is demanding, grasping everyone within his reach. After 2 months, he begins to refuse contact from others. After 3 months he adopts the typical position of lying on his belly, motionless. After 4 months he loses facial expression. I also remembered what Winnicott (1965/2007) said, that the capacity to be alone and to enjoy the aloneness is possible if the person has internalized a good object that is able to soothe him.

What we are talking about in this case is extreme loneliness that resembles what we know about isolation in jail or prison that leads to psychosis. But Sullivan's (1953) writing on malevolent transformation is most on my mind. Malevolent transformation occurs when parents use repressive authority, rejection, and humiliation. Children anticipate this and feel that their needs for affection will bring more anxiety. The child then considers these needs as weakness and begins to transform them into cruelty and exploitation of others. When you don't have anyone to protect you, you have to protect yourself. This malevolent transformation is always rooted in deep loneliness. This extreme loneliness occurs when you are alone inside with no internalized references that you can draw upon to soothe yourself. Likewise there is no internal secure base or haven of safety, to borrow from the attachment literature. The world becomes dangerous because you don't expect anything good from your environment and you have to be suspicious of others. When the world is terrifying, one will do whatever it takes to find a way to survive. And loneliness and helplessness could lead someone to violence and sometimes to rage.

This particular client drove me to this place. Loneliness, helplessness, and violence were the contents of my nightmares. My client helped me consider the emotional part of my experience in Africa that I had intellectualized for a very long time. He also helped me understand that my theories were deficient when it came to explaining this experience. Kohut (1972/2011) approached this experience through the concept of "narcissistic rage," and I have quoted Sullivan, Winnicott, and Spitz. These authors helped us understand the inner world of my clients in certain ways, mostly intellectually, but only TA led me so close to my client's inner world and experiences, that I felt scared.

Conclusion

I want to thank Steve for asking me to be a part of a symposium at the 2015 meeting of the Society for Personality Assessment, where I first considered these feelings and presented this paper. It really pushed me to think. I learned that I had my own experiences of fear and loneliness—that Africa had affected me deeply because nobody was there to make sense of the world for me and I was therefore obliged to do it alone. I learned to soothe myself when I feared for my life by engrossing myself in books and theories. After the TA with this client, I understood where my strange feelings of familiarity came from. They are derived from the mutual experience of feeling the fear of being deeply alone. My inner world had some parts that overlapped with my clients' inner world. As a psychologist, I often meet people who are not well understood because they are not normally seen in treatment. I learned that I need to take care of myself when treating these clients because being attracted to trauma could lead us to be traumatized again and again if we stay alone with what we hear and feel in our work. And I learned something important for all my future clients: Never neglect the experience of extreme loneliness.

Acknowledgments

I thank all the faculty of the Therapeutic Assessment Institute for the support and stimulation they gave me, especially Stephen Finn for much more than I can possibly say here; Barton Evans for introducing me to the work of H. S. Sullivan; J.D. Smith for his precious comments; and Filippo Aschieri for all our intellectual exchanges.

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PTSD as a Human Experience

An Interpersonal Approach

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DISCLAIMER:

The opinions expressed in this article are those of Dr. Evans alone and not those of the trauma survivors or the Veterans Administration (VA). The VA does not endorse, and is not responsible for, the content of this article.

Assessment and treatment of psychological trauma has become a ubiquitous part of modern mental health practice, with high incidence among specific populations such as combat trauma survivors, torture survivors, survivors of violence and child maltreatment, and accident and disaster victims. Assessment of psychological trauma is now considered an essential element of an initial assessment of individuals seeking mental health care (see the APA trauma guidelines). While evidence-based cognitive behavioral therapies such as prolonged-exposure therapy (PET) and cognitive processing therapy (CPT) are frequently seen as preferred best-practices treatments for PTSD, Steenkamp and Litz's (2013, p. 51) review of outcome studies for PET and CPT VA PTSD treatment approaches indicates that "current treatment best practices aimed at ensuring that trauma survivors access, complete, and benefit from PTSD care remain far from ideal." Indeed, leading trauma experts, such as van der Kolk (1994), have questioned whether such cognitively based treatments are suitable, when research shows PTSD to be so deeply rooted in the nonverbal areas of the brain.

One way of thinking about this evidence is to suggest that there is still "room at the table" for considering new ways of thinking and approaches to PTSD. As suggested by Cloitre et al. (2006), focusing on the interpersonal aspects of PTSD may offer another avenue of support for trauma survivors. Interpersonal therapy for depression (see Klerman & Weissman, 1994) is another evidence-based treatment (EBT) that has shown efficacy with a variety of disorders, including a promising pilot study with PTSD (see Bleiberg & Markowitz, 2005). Although what many of the current manualized EBT approaches share in common is generally good and replicable reduction of positive symptoms of PTSD, to my way of thinking, the addition of what I call an *experience near* understanding of the adaptive value of PTSD symptoms can deepen interpersonal connection with trauma survivors. The treatment outcome studies–based work of Carl Rogers (1961), arguably the original proponent of EBT, have shown us that respect, acceptance, genuineness, and empathy are critical components of psychotherapy outcome. On the basis of Roger's work and subsequent research (e.g. Lambert & Barley, 2001) supporting it, we have learned that the interpersonal process between psychologist and client that is a main curative component is the quality of the therapeutic relationship. This article is an initial exploration of an avenue for an "experience-near" understanding of the experience of the trauma survivors.

Harry Stack Sullivan's (1953) interpersonal theory was an important, if unacknowledged, contributor to modern thinking about the human experience of overwhelming shock and horror. Central to Sullivan's thinking is the inextricable connection between humans, what he calls both the *theory of tenderness* and *theory of anxiety,* which presaged Bowlby's attachment theory (see Evans, 1996). Sullivan's *one genus hypothesis*, "We are simply more human than not," focused on common human processes, and Sullivan came up with the term *problems in living* to describe the difficulties with self and others rather than use the term *mental illness* or *mental disorder*. Sullivan leveled a powerful critique of the Kraepelinian model of psychiatry with its emphasis on distinguishing between "normal" and "sick/disordered" functioning, which increased the power differential between doctor and patient and exacerbated the already-potent social stigma of being labeled with a mental

disorder (see Szasz, 1960). As such, both medical diagnostic symptoms of PTSD in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) and modern EBT practice rely on this system, sharing some of the problems inherent with the Kraepelinian model, especially if it is not balanced with an empathic understanding of what function these symptoms serve.

Like everyone else, trauma survivors are sensitive about being labeled as "crazy" and frequently do not find "civilians" able to relate to their traumatic combat experiences. Further, by definition, these traumatized clients have had past experiences of powerlessness and emotional flooding that have hurt them, and talking about trauma is an emotionally arousing and anxiety-producing experience. Individuals with PTSD approach treatment in a state of confusion and distress about their experience. Over the years, I have begun to understand their experiences in a new light, something that I call an *experience-near approach to psychological trauma*. This has allowed me to provide a "person-centric" approach that optimizes empathy magnification and diffuses the stigma of mental illness and diagnostic depersonalization so commonly experienced by trauma survivors.

Indeed, this experience-near approach to PTSD is a natural fit for Therapeutic Assessment (TA) because it matches the core elements of TA. As Finn (2007) has so elegantly pointed out, TA is client-centric, diffuses the stigma of diagnostic depersonalization, and changes the client's narrative from a disorder to a normal reaction to overwhelming life experience. The main goal of TA is to help clients understand themselves better and improve their lives, as opposed to "cure" or reduction of symptoms. Clients and therapeutic assessors become collaborators in this search for understanding. Assessment and psychotherapy in general by its nature provokes anxiety in the client (and the assessor), which must be addressed if therapeutic change is to move forward (Cohen, 1952; Fromm-Reichmann, 1949). By definition, traumatized clients have felt powerlessness and have been flooded with terror; TA procedures reduce retraumatization by an assessment by emphasizing emotional attunement over "getting the data" and by clients' increasing feeling of control in most aspects of the assessment. TA starts with clients and their experience, and an experience-near approach to psychological trauma helps frame their trauma as a human experience, which shifts the focus from vulnerability to posttraumatic resilience (Southwick et al., 2015).

This approach begins by reframing the meaning of psychological trauma and PTSD from a medical diagnosis to a normal reaction to overwhelming life experiences. Jeffrey Jay (1991) characterized the horrific experiences and memories of psychological trauma as "*Terrible Knowledge,"* a term that focuses attention on the meaning of the survivor's experience. Almost always these traumatic experiences change the person and disrupt almost everything they believed about life. With combat trauma survivors, for example, I ask the question, "In your worst experience or nightmare before the military, could you possibly imagine what you saw and felt in Vietnam?" Usually the veteran says that he or she could not begin to imagine the horrors of war. I share with the veteran my belief that most of us live in a bubble in which the horror and evil that exist in the world are kept out, if we are lucky. In exposure to war or other trauma, a hole is blown in the bubble, forcing us to see the evil that is, and always has been, around us. We humans are changed by this experience in a powerful way and are alienated from the lives we had before, and we may live alone with our memories and meaning of these traumas, the Terrible Knowledge of what we experienced. I then ask if he or she knew that his or her experiences are universal, experienced by nearly everyone who encounters Terrible Knowledge. Very often the trauma survivor is surprised by this new way of thinking and is open to hearing more.

I next ask trauma survivors what they understand about their hypervigilance, startle reaction, focus problems, and the like. Usually they will describe examples of their experience, though generally with no sense of the function these symptoms have played for them. I will ask a series of questions such as, "You know we shrinks call this *hyperarousal*, but this really should be called *staying alive.*" To help, for example, the Vietnam veteran understand the survival value of hypervigilance, I will ask, "So how important was it for you to be alert to danger and on guard all the time during Vietnam?" About startle reactions, I ask, "How important was it for you to respond to every sound and dive for cover at anything that sounds like a mortar, shot, or rocket?" With regard to the nearly ubiquitous sleep problems that trauma survivors have, I inquire, "When does bad stuff happen usually?" to get at the frequency with which

mortar, rocket, and sapper attacks occur at night and then follow up with "OK, now how important was it to sleep with 'one ear open' when you were in the combat zone?" In terms of concentration problems, I will ask, "When you are walking through the bush, how much can you afford to have a narrow focus, say on the trail ahead of you, or have a moment for a private thought without maintaining a broad focus on what's going on around you?" With regard to irritability, I pose the question, "When you are attacked, how important is it for you to go from zero to full-tilt boogie, from at rest to high aggression, rock and roll mode? What is the emotion you are feeling at these times? Do you have time to think about what you are doing or were you trained to 'get on it' before your conscious mind knows what you are doing?"

This inquiry helps trauma survivors become aware that what they thought were symptoms of a mental disorder are in reality completely adaptive responses in the context of their traumatic experiences. Very frequently I hear, "You mean I'm not crazy, doc?" We then discuss how these "symptoms" were comprehensible human survival reactions that made it possible for them to sit across from me today. I also share what we know about extended exposure to highly dangerous situations. The brain undergoes changes (see Bremner, 2006; Vasterling & Brewin, 2005) that continue a person's sensitivity to danger long after leaving the dangerous combat zone. In a very real way, "staying alive" patterns are very much battle scars in the same way as a bullet or mortar fragment wound is.

van der Kolk's (1987) concept of the biphasic response of psychological trauma is useful for understanding the function of reexperiencing symptoms and numbing/avoidant symptoms of PTSD. He observed that trauma survivors are usually predominantly in one or the other of these symptom clusters, but rarely both at the same time. To my way of thinking, these symptom clusters are expressions of two powerful human motivations: our human need to understand our experience and our need to avoid pain, which we share with all other animals. With this in mind, I reframe reexperiencing symptoms such as intrusive memories, nightmares, flashbacks, and traumatic triggers and related panic as "Trying to Comprehend the Incomprehensible" and avoidance and numbing symptoms as "Escaping the Pain of Memory."

As an introduction to discussing intrusive, reexperiencing symptoms, I ask combat veterans to reflect with me on how much time they have spent on trying to understand horrific, overwhelming experiences they saw in combat. I then ask if any of what they saw makes any sense to them, no matter how hard they have tried. Not infrequently I will hear about innocent children, women, and men being killed or the look on a buddy's face at the moment of his death from shrapnel wounds. I then ask if it is possible that the traumatic experience makes no sense and that is what is traumatic about it. I share my belief that part of being human is to make sense out of, or derive meaning from, what we do and see. There is fundamental damage to the integrity of our meaning of what it is like to be a human with other humans, and this damage never truly leaves us.

Next, I offer that I have come up with only one clear idea about the meaning of these experiences: It is always better to survive. This discussion often brings up powerful experiences of a combat veteran's survivor's guilt, questions about why he survived when his buddy or the 10-year-old Vietnamese boy did not. I put forward the idea that there is no real answer to this question and that the veteran is trying to "Comprehend the Incomprehensible." I say that while my suggestion may be "thin soup," I believe that real meaning comes out of these terrible experiences when we embrace the question of what does it mean to have survived. Now that we have our life, what is it that we have chosen to do with it? Frequently this leads to an exploration of how the trauma survivor has lived her life after the trauma, along with things undone, done poorly, and most important, done well. I often hear how trauma survivors have had a deeper understanding of how precious life is and how this helped him be a better parent, worker, or marital partner as a result of understanding the fragility of life. We will also discuss how the knowledge of combat trauma has contributed to the veteran's role as protector of his family and community. I will often say in these instances that keeping traumatic experiences in mind provides a special understanding of the danger of the world. I may share how powerful research (Janoff-Bulman, 1992) has shown that trauma victims who "blame themselves" for what happens to them are often engaging in preparatory recognition of dangerous situations so that they and those they love are safer from the vulnerability to the evil of the world around them.

Another aspect of working to "Comprehend the Incomprehensible" involves traumatic experiences that disrupt the veteran's deeply held sense of personal morality and spirituality, a concept often referred to as *moral injury* (see Litz et. al., 2009; Shay & Parson, 1994). In such instances, trauma survivors are racked with overwhelming guilt for having engaged wittingly or unwittingly in an act so horrible they are unable to forgive themselves—for example, killing a child during combat. Frequently, loved ones, friends, and therapists have counseled the veteran to forgive himself and let go of the past. Often, to the veteran's great surprise, such well-meaning sympathy only makes him feel wretched, confused, and isolated. I will often say to the veteran that there is only one thing worse than feeling the unbearable guilt for his actions, and that is feeling nothing at all. We will then discuss the difference between feeling unrelenting guilt and maintaining moral integrity through remembrance and bearing witness to the terrible acts of war, speaking of the veteran's unwillingness to "forgive and forget" as an act of moral courage. In the words of Deepak Chopra (2001), "We can become living memorials to tragedy by restoring the power of life."

Finally, to understand avoidance and numbing symptoms of PTSD, I reconceptualize them for trauma survivors as "Escaping the Pain of Memory." We discuss how avoiding activities that trigger memories and associated painful feelings are part of our natural human motivation to avoid and escape painful experience, something we share in common with all animals. Because we are social animals, "Escaping the Pain of Memory" usually involves avoiding social interaction. Social avoidance is frequently exacerbated by the trauma survivor's feelings of guilt and unworthiness to be part of the human group or even to be alive, referred to as *posttraumatic guilt.* The increasing avoidance of life situations, especially social interaction, frequently leads to a diminished interest in pleasurable, life-affirming activities. "Escaping the Pain of Memory" can lead to a depressive disengagement from life and can block the veteran's connection to future hopes, aspirations, and connections to others. In its most extreme form, past traumatic memories can be so dissociated that the veteran lives in a world where past, present, and future remain disconnected and a confused, befuddled, and bewildered state of mind predominates. We know that PTSD has the most chronic and intractable course when the "Escaping the Pain of Memory" symptom cluster of PTSD is the principal mode of dealing with Terrible Knowledge (see Feeny et al., 2000 and Litz, 1992).

A second element of "Escaping the Pain of Memory" involves how emotional numbing can be a highly adaptive protective process for trauma survivors. We talk about the normal human reaction to sudden, horrific, and tragic loss. I will ask combat veterans, "In the heat of combat, did you have time to wail and mourn the loss of your buddy?" We discuss how the normal human grief reaction is similar to depression, with deep sadness, lowered energy, and a turning inward rather than an aggressive, adrenalized focus on externalized danger so essential in the heat of battle. As a result, as exposure to casualties and other horrors mount, the veteran learns to respond with "don't get close so you don't feel loss." Much like avoidant aspects of "Escaping the Pain of Memory," emotional numbing powerfully generalizes to noncombat and postmilitary situations, further robbing the veteran of his or her empathic connection to others and to her or his internal self. Frequently, trauma survivors share how inhuman and "dead inside" they feel, when they cannot cry or feel much of anything at the funerals of loved ones or at the emotional struggles of their children. Helping trauma survivors see that their reactions are an adaptive response to the nearly incomprehensible suffering of trauma can be a first step to engaging in the courageous and painful process of learning to remember their experiences in a different way and regain lost humanity.

A third and someone different aspect of posttraumatic avoidance is trauma survivors' reluctance, or even unwillingness, to speak about their traumatic experiences. Although this behavior can be a way to manage painful memories, I have come to see this somewhat differently for many trauma survivors. Not infrequently trauma survivors share with me that they can really never talk about what happened to them with anyone other than fellow trauma survivors. Many trauma survivors are able to share excruciatingly painful memories of their experiences with other trauma survivors, but they are unable to speak about them with their partners, parents, or friends. In this way we have reframed this dilemma of avoiding conversations as the need to protect others from seeing the "terrible pictures" in the trauma survivors' minds. Many trauma survivors are powerfully motivated to defend and protect others, often at considerable cost to themselves. Acknowledging their motivation for not

sharing this information even to spouses can be a powerful way to empathically connect with trauma survivors, reaffirming their good judgment in doing so.

In closing, I have found considerable value in reframing psychiatric symptoms of PTSD into experience-near statements regarding the adaptive value of trauma survivors' often bewildering experiences. There is no doubt that the diagnostic accuracy and acumen of the DSM 5 and IV Expert Panels based on strong research from the National Center for PTSD and others have advanced our understanding of the sequelae of psychological trauma. It is then up to us as clinicians to find ways to translate this knowledge to trauma survivors in order to get "in our clients' shoes" (see Finn 2007).

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The Foundation for Excellence in Mental Health Care Adopts Therapeutic Assessment as One of Its Causes

By Stephen E. Finn, Ph.D.

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A recent development could affect all of us in the Therapeutic Assessment community for years to come! Members of the Therapeutic Assessment Institute have long recognized the need for training materials, financially accessible TA trainings for students and new professionals, and more research about TA. Now an eminent group of philanthropic advisors has decided to help us. *The Foundation for Excellence in Mental Health Care* is an international community foundation (think of United Way) that helps raise funds for innovative, effective programs addressing mental health needs of clients and their families. The core values of the *Foundation for Excellence* overlap a great deal with those of Therapeutic Assessment, and after more than a year of discussion, the Therapeutic Assessment Institute was invited to become a sponsored project of the Foundation. The newly established **Therapeutic Assessment Fund** will help raise money for research studies, training videos, and web resources about TA, and we also hope to offer scholarships to our more costly TA trainings (e.g., the TA Immersion Course). Donations to the Therapeutic Assessment Fund are completely tax deductible as charitable donations, and they can be given in any amount at the *Foundation for Excellence* website: http://www.mentalhealthexcellence.org/projects/therapeutic-assessment-fund/

While you are on the website, take a look at some of the other projects/methods sponsored by the Foundation. They include "Open Dialogue," an innovative approach to treating early psychosis, developed in Finland; the "Hearing Voices Network," which provides support groups around the world to individuals who hear voices; and "Families Healing Together," which provides online training materials and support to families with loved ones with acute mental health needs.

We are proud and excited to be adopted by the *Foundation for Excellence* in Mental Health Care!

Upcoming Trainings in Therapeutic Assessment

June 25, 2015, 13:00–18:00; June 26–27, 2015, 19:30–18:00, Milan, Italy

Title: L'Assessment Terapeutico di famiglie con bambini: Sedute dal vivo [Live Therapeutic Assessment of a Child and Family] (all sessions in Italian)
Presenters: Stephen E. Finn, Francesca Fantini, Filippo Aschieri
Sponsor: European Center for Therapeutic Assessment and Alta Scuola di Psicologia Agostino Gemelli, Catholic University of the Sacred Heart
Information: http://asag.unicatt.it/asag-assessment-terapeutico-di-famiglie-con-bambini-dal-vivo-programma-didattico

September 3, 2015, 8:30–17:00, Paris, France

Title: Introduction to Therapeutic Assessment (in English and French)
Presenters: Marita Frackowiak, Lionel Chudzik
Sponsor: École de Psychologues Praticiens
Information: www.psycho-prat.fr

September 4–5, 2015, 8:30–17:00, Paris, France

Title: Therapeutic Assessment with Children and Families (in English and French)
Presenters: Marita Frackowiak, Lionel Chudzik
Sponsor: École de Psychologues Praticiens
Information: www.psycho-prat.fr

October 8, 2015, 10:00–17:00, The Netherlands

Title: Therapeutic Assessment with Adolescents
Presenters: Stephen E. Finn, Jan Henk Kamphuis, Hilde De Saeger
Sponsor: The Viersprong Clinic
Information: www.deviersprong.com

October 9, 2015, 9:30–12:30, The Netherlands

Title: Working with Shame in Psychological Assessment
Presenters: Stephen E. Finn, Jan Henk Kamphuis, Hilde De Saeger
Sponsor: The Viersprong Clinic
Information: www.deviersprong.com

October 9, 2015, 13:30–17:30, The Netherlands

Title: Building a Strong Alliance in Psychological Assessment
Presenters: Stephen E. Finn, Jan Henk Kamphuis, Hilde De Saeger
Sponsor: The Viersprong Clinic
Information: www.deviersprong.com

November 21, 2015, 9:00–18:00, Tokyo, Japan

Title: Introduction to Therapeutic Assessment
Presenter: Stephen E. Finn, Noriko Nakamura
Sponsor: Asian Center for Therapeutic Assessment
Information: www.asiancta.com

November 22, 2015, 9:00–18:00, Tokyo, Japan

Title: Therapeutic Assessment with Children
Presenter: Stephen E. Finn
Sponsor: Asian Center for Therapeutic Assessment
Information: www.asiancta.com

November 23, 2015, 9:00–17:00, Tokyo, Japan

Title: Building a Strong Alliance in the Initial Session of Adult and Adolescent Assessments
Presenters: Stephen E. Finn, Noriko Nakamura
Sponsor: Asian Center for Therapeutic Assessment
Information: www.asiancta.com

Recent Publications in Therapeutic/Collaborative Assessment

Aschieri, F., Fantini, F., & Smith, J. D. (in press). Collaborative/Therapeutic Assessment: Procedures to enhance client outcomes. In S. Maltzman (Ed.), *Oxford handbook of treatment processes and outcomes in counseling psychology*. New York, NY: Oxford University Press.

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