

THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

Special Issue: Assessment Intervention Sessions

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This Issue

We are delighted to present the first Special Issue of the *TA Connection* about Assessment Intervention Sessions (AIS), coedited by J.D. Smith and Raja David. Although we worked together as editors, I (J.D.) want to make sure credit is given where credit is due: Raja David proposed a Special Issue about AIS nearly nine months ago.

Like many TA practitioners, he noted the challenge of learning and conducting AIS. Despite the many examples of AIS in the literature and the writings of Steve Finn and colleagues about the topic (e.g., Finn, 2007; Tharinger et al., 2009), Raja wanted a resource of AIS examples in the published literature that is comprehensive and provides a brief description of the session. He also simply wanted more examples of AIS, both successful and challenging, for TA practitioners to make use of and learn from. From this desire, Raja envisioned this Special Issue, and we solicited contributions from the TA community.

The Special Issue begins with a piece by Steve Finn that provides the history of AIS in TA and also his current thinking, much of which has not appeared in print before. Steve mentions the inspiration of Connie Fischer's work in his developing AIS. He notes the challenges of AIS, including the need for assessors to be comfortable creating emotional distress in the client and helping them manage it; the importance of having established a safe and trusting relationship with the client earlier in the TA; and choosing an appropriately intense target for the AIS. Next, Steve introduces a way to broadly characterize clients' difficulties and design effective AIS

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for each type of client. These “typologies” that he describes have been used routinely in Steve’s supervision and advanced training in the Therapeutic Assessment Institute for several years and are very useful for understanding clients and linking to the activities of the AIS. This is the first time they appear in print. After going into significant detail about the two types of clients (over- and underdefended) and providing case examples of each using the kinds of AIS that are most useful, Steve talks briefly about what to do when the AIS doesn’t go as planned. Maintaining a stance that adheres to the Core Values of TA (Finn, 2009), even a so-called “failed” AIS can be useful for the assessor and client alike.

In the next contribution, Raja David and Mark Bertucci conducted a review of the TA literature to locate examples of AIS. An impressive 31 articles were identified that included at least one AIS resulting in a total of 49 example sessions. They consisted of 28 examples with children, 5 with adolescents, 13 with adults, and 3 with adult romantic couples. The majority of the articles, with some exceptions, describe in-depth case studies that provide significant detail about the case and the AIS. Raja and Mark provide a brief description of each AIS so the reader can identify a potential resource that can then be accessed in full text. Despite the 49 examples in the current literature, the authors noted types of AIS, including those that do not go as planned, that would be useful. Frequent updates will have to be made to this list because more examples are soon to appear in the literature (stay

tuned for more details about these upcoming publications!).

The next two columns in the Special Issue are case studies that focus on the AIS. First, Jason Turret presents the case of Rita, a 30-year-old woman struggling with the correlates of an underlying depression. In the AIS a series of TAT cards was used to elicit her underlying feelings that she had become adept at distancing herself from others but had in fact been coming out to them as angry and irritable. Through the AIS, Jason carefully helped Rita experience her feelings of being judged and neglected and learn that others were willing and able to help and support her.

Second, Deborah Tharinger and Judith Wan present the case of Mary, a 15-year-old who was a talented actress living in a complex family situation that fueled Mary’s anger that she directed toward her mother. In the Family AIS, Mary and her parents participated in a Consensus TAT and a series of constructed vignettes that were aimed at bringing into the room the family dynamics having to do with communication and differing perspectives. The detailed presentation of this session underscores the potential power of a Family AIS or systemic AIS.

“The Summit”

From September 17th through 20th the Board of the TAI met near Black Mountain, North Carolina. Through our recent venture with the Foundation for Excellence in Mental Health Care, the board was invited to hold a summit at the home of Don Cooper and Lisbeth Riis-Cooper. Don and Lisbeth are the founders of CooperRiis, a hea-

ling community for adults in western North Carolina (for more information about the wonderful therapeutic work they do, visit their website: www.cooperriis.org/). The 17 members of the TAI Board met for three and a half days to discuss the short- and long-term plan for TA and the activities of the TAI. Integral to our planning was our nonprofit status and ability to raise funds to grow TA around the world. Don, Lisbeth, and Virgil Stucker, the executive director of CooperRiis, offered their wisdom about growing a nonprofit organization in mental health care. Don and Lisbeth were tremendously gracious hosts and made sure that we had time to socialize, enjoy the beautiful surroundings of their home (see the photo on page 26), and the local offerings, including bluegrass music and barbecue. The time was well spent and allowed us the space to “think big” about TA and the direction we are heading during the next decade and beyond. Our initiatives will be shared in the newsletter as they are realized. Training future generations of TA practitioners, branding TA to improve marketing and increase demand, and conducting high-quality research are among our top priorities as an organization. There are many exciting developments on the horizon.

Skills Training Workshop

It's time to mark your calendars for the next big training. The TAI will be hosting a three-day workshop June 2–4, 2016, in Austin, Texas, titled “Skills Training in Therapeutic Assess-

ment: Taking Your TA Skills to the Next Level.” This workshop, co-chaired by Dale Rudin and Pamela Schaber, is designed for professionals with prior training in TA (e.g., the immersion course, multiple workshops) who desire more hands-on training in TA skills. The workshop time will comprise didactic presentations, viewing of new and old-favorite training videos and materials, and structured role plays, all under the guidance and support of the TAI faculty. The workshop will provide 18 hours of CE credit. The venue is the beautiful Westin Austin at the Domain (11301 Domain Drive), where we have negotiated a group rate and have secured a room block. There will also be a group dinner on Friday evening for interested attendees. The flyer and registration form for this workshop will soon be available on the TA website. Early registration will be due on May 1, 2016, and space is limited.

Free TA Webinar by Steve Finn

On December 10, 2015, 1:00–3:00 PM EST, the American Psychological Association and the Society for Personality Assessment will present a *free* webinar by Steve Finn titled, “How Therapeutic Assessment Works: Theory and Techniques.” Registration is free and can be completed through this webpage: <http://apaonlineacademy.bizvision.com/product/13344>.

The Therapeutic Assessment Fund

The TAI has partnered with the Foundation for Excellence in Mental Health Care to form the Therapeutic Assessment Fund.

This fund will support scholarships to trainings in TA, development of training materials, and research on TA. Please consider contributing so we will be able to continue to spread TA and provide the best available mental health services to the clients we serve. All donations are tax deductible. The website for the fund appears on page 9.

Future Issues of the TA Connection

As always, I would love to hear your feedback and suggestions for the newsletter. If you have conducted an exemplary or interesting TA case, want to write about some aspect of TA, or there is a topic you would like to see appear in an upcoming issue, please let me know. There is a standing invitation to anyone who is interested in submitting a column. Email me at jd.smith@northwestern.edu with your ideas and I would be more than happy to help in whatever way I can. A warm thank you to the contributors in this issue: Steve Finn, Raja David, Mark Bertucci, Jason Turret, Deborah Tharinger, and Judy Wan, as well as our wonderful associate editors.

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

The History of and Recent Thoughts About Assessment Intervention Sessions in Therapeutic Assessment

*By Stephen E. Finn, Ph.D.
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The Development of Assessment Intervention Sessions

As I explained in my 2007 book, *In Our Clients' Shoes*, Assessment Intervention Sessions (AIS) were one of the later additions to the semi-structured Therapeutic Assessment (TA) model. I started experimenting with these sessions in the early 1990s while searching for ways to make psychological assessment more therapeutic. I had three concerns/insights/goals in mind at the time.

The Primacy of Experience Over Explanation

I invented TA by creatively experimenting with clients during assessments and watching myself on videotapes afterward to see what worked. I became more and more convinced that the best way to help clients develop new ways of thinking and being was through “bottom-up” memorable experiences during an assessment, rather than through a “top-down” explanation at the end. I knew from my own familiarity with, and training in, Gestalt therapy how life-changing vivid, unanticipated experiences could be. And

I became fascinated by Chapter 4 (“Assessing Process”) in Connie Fischer’s (1985/1994) book, where she described using tests as windows into clients’ “experiencing” (p. 87). It was clear from her examples that clients could arrive at startling insights when assessors helped them observe and understand how their test comportment related to their habitual ways of being in the world.

The Challenge of Self-Verification

As I became clearer about the implications of Swann’s (1997) *self-verification theory* for psychological assessment, I kept being struck by a dilemma I experienced frequently in assessments I was doing: I often understood more about clients at the end of an assessment than they were able to hear and take in. Several memorable assessments convinced me that it rarely is helpful to tell clients information that is Level 3 (i.e., very incongruent with their existing ideas about themselves and the world), and that it could be dangerous if I tried to leverage such information using my authority and clients’ developing trust in me. Several clients came close to having disintegration experiences, which I thankfully was able to help them avoid. But I kept asking myself, How could I

help make Level 3 information more accessible to clients before a Summary/Discussion session? One day I had a useful “vision” of finding ways to let clients “trip over” some experience on the path to the assessment feedback, which I could help them notice and analyze. This gave me the idea of refining Fischer’s procedures to focus on *particular* moments of experiencing rather than those that just happened to occur naturally during the administration of relevant tests. In an important discussion over dinner one year at the annual meeting of the Society for Personality Assessment, Connie Fischer and I talked about the possibility of finding clients’ “tipping points” and targeting those in sessions just preceding assessment feedback. I understood those “tipping points” to be situations in which clients’ dilemmas of change were most apparent, and I coined the term “Assessment Intervention Sessions” (AIS).

Increasing the Efficacy of Brief Assessments

When I opened the Center for Therapeutic Assessment in Austin in September 1993, I had a flood of referrals for brief, inexpensive adult Therapeutic Assessments, many of which involved an initial interview

during which I gathered assessment questions, completion of the MMPI-2 by the client, a consultation with the referring therapist, a 60-minute Summary/Discussion session that included the client and therapist, and preparation of a two-page feedback letter. This short format precluded much collaboration with the client, except in the initial and Summary/Discussion sessions. Thus, I began introducing one-hour AIS, many using the Bender Gestalt Test (beloved by Connie Fischer), the TAT, or other picture story tests as a way to help clients discover things I believed I understood from their MMPI-2 profiles. I became very skilled at using the MMPI-2 to identify split-off affect states that were related to clients' dilemmas of change and then targeting those emotions in experiential sessions. The efficacy of my brief assessments increased dramatically, and I estimate that between 1993 and 2000 I conducted more than 500 of this type of short, MMPI-2-based TAs. I published a small book during this time (Finn, 1996a) in which I described this approach, but minus the AIS step because I was not yet ready to write about the AIS. As you can imagine, practice makes perfect, and I got clearer and clearer about the underlying structure of the AIS, which I presented at a conference in 1993 (Finn, 1993) and wrote about for the first time in a chapter with Hale Martin in 1997 (Finn & Martin, 1997). Teaching this structure to students in my assessment course at the University of Texas helped me refine it further, and I began successfully introducing role plays of AIS in TA workshops I was doing at the time. I also began experimenting with, and teaching about, the AIS with

couples' and child/family assessments. This led to a chapter about using the Consensus Rorschach as an AIS with couples (Finn, 2007) and an article about family sessions as AIS with children and adolescents, written with my friend and colleague, Deborah Tharinger (Tharinger, et al., 2008).

Recent Thoughts About AIS

I have previously written about the goals and logical steps underlying an AIS (Finn, 2007), but I list them again in Figure 1 to give a common reference. Next I will highlight certain points that have become clearer to me in recent years.

A Successful AIS Begins with a Good Case Conceptualization

I previously wrote that the first steps in an AIS are to "select a focus" for the intervention and "imagine how to elicit the problem behavior in vivo" (Finn, 2007, p. 87). This is true, but both of these steps depend on a good case conceptualization. This is achieved by carefully reviewing and integrating the standardized test results, background information, discussions with the client, observations, and information that came out in Extended Inquiries to answer the questions listed in Figure 2. Even partial or tentative answers to these questions can greatly help the assessor choose a focus and decide how to move ahead with the AIS. J.D. Smith and I have developed a set of worksheets (part of an eventual TA training manual) that walks assessors through these questions and helps in the planning of AIS (Smith & Finn, 2011) that we would be happy to share.

The Assessor Needs to Be Comfortable Creating Emotional Distress in the Client and Helping Manage Intense Emotions

When thinking of ways to elicit problem behaviors or emotional distress in an AIS, assessors will be hampered if they are themselves fearful of the emotions they hope to bring in, or if they are so defended against their own aggression that they never want to "hurt" a client—even if doing so would greatly help the client have a better life. To some extent, getting comfortable with this aspect of the AIS depends on the assessor's own emotional security and resilience (achieved by many of us through good supervision and/or personal psychotherapy). But I also find that my own emotional holding capacity can vary from time to time, depending on what is going on in my life. In the months after my partner, Jim, died in 2012, I found it difficult to sit with clients' grief or sadness because I was stretched to the limit in managing my own. This was a sign to me to get more emotional support for myself, to decline to work with certain types of clients, and to have compassion for myself and choose less emotionally arousing activities for AIS sessions.

A Successful AIS Depends Greatly on Trust and Alliance Built in the Earlier Part of the Assessment

During an AIS we ask clients to sail away from the shores of their existing ways of thinking and being to explore new lands. I have come to believe that one of the most essential elements in clients being willing to undertake such a potentially dangerous journey is their trust in us as "navigators." At the risk of

sounding mystical, I believe clients sense to what extent we truly have their best interests in mind versus to what extent we may be attempting to meet some egocentric need to feel successful or effective. And they can tell whether we ourselves are terrified of the uncharted emotional waters we have invited them to traverse. In the language of attachment theory, clients cannot

assessor from the very first contacts on the phone and in the initial session. These factors are equally important, if not more important, for the AIS.

A Common Empathic Error Is to Choose Too Difficult a Target for the AIS

Of course, all of us who practice TA hope that our assessments will benefit our clients. In my

self-narrative and how much disintegration would be produced if such a shift occurred. We see a certain piece of awareness as Level 3 information, but in fact, it is Level 5 or even 10. Sometimes this empathic error stems from a lack of appreciation of the client's social context and how difficult it would be for the client to become more aware because it would wreak havoc on her

Figure 1

Basic Steps in Conducting Assessment Interventions

1. Plan beforehand:
 - How can you elicit the problem behavior in vivo?
 - Choose an assessment question that will best explain why you are conducting this session.
2. Observe and name the problem behavior:
 - Ask the client how she thinks about/describes it.
 - Adopt the client's words.
 - Draw connections to how the problem shows up outside the assessment.
 - Draw connections to the client's assessment questions.
3. Explore the context leading to the problem behavior:
 - When did it start? What adaptive functions does the behavior serve or did it serve in the past? What costs are there?
 - What factors are necessary and sufficient to produce the problem?
 - What elicits it? What reinforces/maintains it?
4. Imagine solutions to the problem behavior in vivo:
 - How can the context be changed in a session to block maladaptive solutions or elicit more adaptive strategies?
 - First ask the client what thoughts she has.
5. Test out the proposed solutions in vivo:
 - Ask the client to observe the results, then add your observations.
6. Keep revising proposed solutions until the client feels some success in implementing more adaptive behaviors.
7. Discuss how to implement solutions outside of sessions:
 - Do "thought experiments" about how different contexts might affect the new behavior.
 - Envision further refinements.
 - Make a plan to try the new solution in the life context.
 - Ask the client to report back about what happened.

engage their "exploratory system" (to be curious about and learn new ways of looking at themselves and the world) when their "attachment system" is activated and they do not feel safe and secure. In TA we pay a great deal of attention to the alliance between client and

experience, this desire leads some of us to choose overly ambitious targets for an AIS, and then to feel like a failure when the client doesn't show the kind of emotional breakthrough we anticipated. We may often fail to realize how big a shift we are trying to create in the client's

primary relationships.

So I now encourage people in planning the AIS to think about what is "low-hanging fruit," especially given what has come out in the previous sessions. In my experience clients often "signal" us when they are ready to face their "tipping points," and this

readiness depends not only on the alliance they feel with us, but also on what kinds of supports they have outside the assessment. I try to remember that huge changes can result from helping clients *understand* their own dilemmas of change and feel more compassion for themselves, even if they don't make major life changes based on what they learn. I remember a 68-year-old woman who became aware through an AIS of how unsupported she felt in her marriage, in spite of years of couples' therapy with her husband. At the end of the session she said aloud, "OK, so I see how I've been trying to ignore how little I get from my husband, and that this has been greatly affecting my health. I don't think I'm going to leave him at this point in my life, because it would just be too hard. But now I can face the reality of what's not there and decide how I'm going to manage that in a different way."

Two Main Types of Assessment Intervention Sessions

There is a concept I have found to be useful in planning and conducting AIS that I have elaborated on with close col-

leagues in the Therapeutic Assessment Institute but have not yet published. I'm excited to write about this here for the first time. In short, when thinking about potential assessment interventions I now distinguish between "underdefended" and "overdefended" clients. Let me first describe these two groups of clients and then discuss how to work with them in AIS.

Distinguishing Underdefended and Overdefended Clients

Underdefended clients are those whose main problems-in-living result from affective flooding caused by inadequate ways of coping. These clients ask assessment questions concerning the breakthrough of problematic emotions, such as "Why do I always lose my temper with my children?" "Why do I feel like I'm going to fall apart if I leave my house?" "Why am I so anxious all the time?" and "What can I do when I start crying and can't stop?" Clients in this group can show either internalizing or externalizing problematic behaviors. The key distinction is that they are mainly curious about, and focused on, how to control their emotional over-

whelm, which sometimes is the result of their having given up previously successful methods of coping that were too costly (e.g., alcohol, drug use). Alternatively, some of these clients never developed adequate ways of managing painful affect states and have histories of serious psychopathology. Clients with unresolved or preoccupied attachment are overrepresented in this group, as are clients in Cell A of my 5-fold table of MMPI-Rorschach cross-classification (Finn, 1996b). Quite frankly, people in this group were not commonly seen at the Center for Therapeutic Assessment in its early years and thus are underrepresented in published case studies describing AIS.

In contrast, **overdefended clients** have problems-in-living as a result of "overly active" coping mechanisms that have become very costly and/or have led to the client having little access to emotions. Examples of typical assessment questions are "Why can't I cry?" "Why do I always space out, and what can I do about that?" "What can I do to manage my extreme perfect-

Figure 2

Questions to Be Addressed During Case Conceptualization That Help in Planning the Assessment Intervention Session

- 1) What are the necessary and sufficient conditions to elicit the problematic experience/behavior the client is most curious about?
- 2) How does the problem-in-living currently serve or protect the client or how did it do so in the past?
- 3) In which contexts is the problem better, or does it even disappear?
- 4) How close is the client to understanding her dilemma of change at this point in the assessment?
- 5) What information from the assessment is the client likely to find most threatening or anxiety arousing?
- 6) Which new understandings/insights/emotional experiences might have the most impact if the client can integrate them into a new narrative? In other words, what are the "tipping points" in the client's current narrative?
- 7) How much flexibility and resilience does the client have at this point in the assessment to handle emotionally challenging situations?
- 8) How able is the client to make use of the assessor for emotional support and protection against disintegration?

ionism?” and “What will happen if I stop using marijuana?” Again, these clients can show internalizing or externalizing problems; the defining feature is that the major focus of their curiosity is on the costs of their characteristic methods of coping and what they can do instead. In my experience, people with dismissing attachment status (George & West, 2012) are overrepresented in this group, as are clients in Cell B of my MMPI-Rorschach classification (Finn, 1996b). Many of the published case studies of AIS with adult clients concern individuals in this group.

As the reader might imagine, some clients have problems-in-living related to both overactive *and* inadequate coping mechanisms (e.g., clients with borderline personality disorder), and it can then be an art to decide how to focus an AIS. (In fact, one may elect to do several AIS with different targets.) Also, both groups of clients often show underlying problems with emotional regulation on the Rorschach (e.g., $CF + C > FC$ on the RCS, and high $(CF + C)/C$ on the R-PAS). However, the underdefended clients have negative D and AdjD (RCS) or low MC-PPD (R-PAS) scores, and the overdefended clients generally have the opposite. Also, overdefended clients typically show robust evidence of other psychological coping mechanisms in their Rorschach protocols, such as high $\Lambda/F\%$, low Affective Ratio/8910%, or high $AB + Art + Ay$.

Planning and Conducting Assessment Intervention Sessions

Underdefended clients. Before undertaking an AIS with this type of client, an assessor needs

to know ways of helping clients regulate emotional flooding, either when alone or interpersonally. I have found that many of the techniques taught to clients in Dialectical Behavior Therapy (DBT) are extremely useful, such as distraction and self-soothing skills (Linehan, 2014). Also, “grounding” techniques developed for use with traumatized and dissociative clients are invaluable, such as Rothstein’s (2000) Directed Awareness paradigm.

Because the assessment questions of these clients are directed to understanding and dealing with emotional flooding, the problem behavior the assessor tries to bring in the room in the AIS is emotional overwhelm. This is generally accomplished by exposing the client to stimuli or situations that will arouse strong feelings, such as highly emotional TAT cards, difficult family photographs, past medical records, or a difficult interpersonal situation. Typically, standardized tests or previous interviews with the client help the assessor choose the stimuli that are likely to be most overwhelming and help the assessor assess how fragile the client is. In part, the assessor learns if the client has already developed some successful ways of managing emotional flooding. Once the client is starting to experience emotionally flooding, the assessor then helps regulate the client interpersonally and either reminds the client of existing healthy strategies or teaches new adaptive ways of handling difficult emotions, until the client’s affect is successfully regulated.

A chapter by Overton (2012) includes an excellent example of an AIS with an underdefended client. The client was a 35-year-old woman with a history of

terrible abuse and neglect. She found herself unable to move forward in her life because she was constantly flooded with flashbacks and emotions about her past abuse. As might be anticipated, the client had numerous intrusions of traumatic content during the Rorschach administration—giving her a Trauma Content Index of .74 (Kamphuis, Kugeares, & Finn, 2000)—and she was highly distressed by these images. This experience gave Overton an idea of how to focus the assessment intervention. In the subsequent session, she invited the client to take the Rorschach again, but to use a form of directed attention (another coping mechanism taught in many schools of psychotherapy) to see if she could avoid focusing on the traumatic images in the Rorschach. Instead the client was to concentrate on “what was there on the card” and to put any traumatic images out of her mind. With practice the client was able to do this, and was relieved and elated. She then was able to successfully use the newly learned coping strategy in her life outside the assessment room, with the result that her flashbacks and overwhelm greatly decreased. If needed, another strategy with this type of client is to make black and white photocopies of the colored Rorschach cards to see if this keeps the client from flooding affectively (cf. Peters, Handler, White, & Winkel, 2008), and then to help the client “ignore color” in her daily environment.

Overdefended clients. If you first learn to work with underdefended clients and how to help them manage affective overwhelm, you will be well prepared for working with overdefended clients. Even though these latter clients are focused on the costs of

current strategies for managing affective overwhelm, they too can become emotionally flooded during the AIS if they experiment with setting aside this familiar strategy. If one can manage it, however, the goal is to stop the AIS before affective overwhelm occurs, but to stir up enough distress that it activates the problematic coping strategy.

There is a video I show frequently in workshops that demonstrates an AIS with this second type of client. “Jack” was a 46-year-old man referred for a TA by his couples’ therapist, who was concerned that Jack’s typical way of managing painful feelings—with blatant denial and unrealistic optimism—was contributing to his wife’s depression. The client’s tendency to use primitive denial was verified by his MMPI-2 profile, which showed elevations on L and Scale 3. However, subclinical elevations on Scales 2, 7, and 8 also gave information about Jack’s dilemma of change: If he gave up his denial so he could show more empathy for his wife, he would likely face his own underlying depression that he was successfully holding off by seeing every glass as “half full.”

At the beginning of the AIS I told Jack I wanted to explore something I thought might help his marriage. My target was to elicit his denial so that we could observe it, discuss it, and understand it, but I did not say this to him. I then gave Jack three TAT cards: 3BM (figure kneeling on floor), 13MF (man in foreground with woman on bed), and 8BM (boy in foreground with surgery in background). I thought these cards would stir up painful affect states, and I asked him to tell me stories that fit the cards. As I expected, Jack’s stories initially dealt with the painful situations in the cards but then had rapid and unrealistic happy endings. (The woman on the bed in Card 13MF was very sick with a virus, but was given “an antidote” that revived her and relieved her husband’s anxiety.) With me leading in half-steps, Jack was able to acknowledge that the happy endings in his stories reflected his general view of life (“Most problems are solvable”). He could also see how this optimistic worldview caused conflict between him and his wife. But as he had told me in our initial session, the philosophy he learned while growing up was to “look on the bright side,” and

this had worked well for him so far, except in his relationship with his wife. What else could he do?

I then asked Jack if he was willing to try an experiment. I suggested he try telling a story without a happy ending, and I gave him another dysphoric TAT card, 3GF (despondent woman in doorway). Jack struggled to tell an appropriately painful story, at times touching into painful emotion but repeatedly backing away. I interrupted a series of coping strategies, including intellectualization and the usual denial, and redirected Jack to tell the painful story he had in his mind. As he did this, he gradually became aware of growing physical and emotional discomfort and said he felt anxious and nauseous. I immediately stopped Jack before he got flooded, and we discussed what he had experienced and learned. He quickly understood that his usual way of “putting happy endings” on things in life was a way to avoid incredibly uncomfortable feelings, and that his intolerance for these feelings was why he couldn’t listen to his wife’s depression without trying to cheer her up. Jack left with a

Contribute to the Therapeutic Assessment Fund

The newly established **Therapeutic Assessment Fund** will help support scholarships to our more costly TA trainings and research studies and the development of training materials and web resources about TA.

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good initial understanding of his dilemma of change, and this eventually led to a more comprehensive couples' assessment for him and his wife, a successful Summary/Discussion session, and Jack's going into individual psychotherapy after the assessment to explore a highly traumatic childhood. Years later I heard from Jack that the AIS had been a turning point for him in understanding himself and his marriage.

Summary. I hope these two examples are helpful for distinguishing these two types of assessment interventions. In brief, the assessor asks herself if the client's main focus/concern is (1) the breakthrough of painful affect, or (2) a problematic way of defending against dissociated affect states. With the former, the assessor uses the AIS to flood the client and then teaches adaptive ways of handling painful affect. With the latter, the assessor stirs up enough painful affect to elicit the usual coping strategy, then explores the costs and benefits of the defense and perhaps what other alternative ways of coping might be.

Closing: When the AIS Does Not Go As Planned

Before ending, I think it is important to underscore something that may not be clear from the published AIS case examples: *Often, even with the best case conceptualization and planning, an AIS does not unfold as planned!* This does not mean that the AIS has "failed," and in fact it may lead to even greater understanding of the client. For example, I can think of numerous clients who surprised me by giving more adaptive responses to potentially problematic situations in an AIS than I had expected, given their test results.

Later it became clear that this was the result of the client having changed during the course of an extended TA, so the test results from 4–6 weeks earlier were no longer an accurate reflection of the client's current functioning.

The key to handling these and other surprising events during an AIS is to return to the core values of TA and to be curious, humble, and collaborative. For example, in one published case example of an individual AIS with an adolescent (Tharinger, Gentry, & Finn, 2013), the teen did not show the expected problem behavior the assessor hoped to elicit, perhaps because the affectively arousing stimulus was not intense enough. However, the assessor stayed calm and decided to discuss the original plan for the AIS with the adolescent, who then confirmed the case conceptualization and went on to give other important background information. In the end, the "failed" AIS served all its intended goals in terms of helping the assessor get more in the client's shoes and preparing the client for the upcoming Summary/Discussion session.

In addition, it is good to be humble about what we are able to achieve in an AIS with certain types of clients. In my mind, an AIS is successful if (1) it leads to some shift in the client's awareness, even if it means Level 2 information becomes Level 1; (2) it clarifies and gives more information about a previously held hypothesis the assessor had on the basis of the test findings; or (3) the assessor learns more about the client's capacity to assimilate Level 2 or Level 3 findings and her characteristic defenses when she reaches the edge of that capacity. Each of these pieces of information can

greatly increase the therapeutic impact of the Summary/Discussion session.

In closing, I acknowledge that the AIS is perhaps the most difficult step in TA to learn. But I think it becomes easier if one can "take the pressure off" to achieve a certain outcome and think of the session as an opportunity to collaborate with the client while conducting an experiment whose outcome will always be valuable, even if it is different than originally anticipated. This frees us up to be curious and present with the client, which in my mind are the most essential therapeutic elements in the TA model.

References

- Finn, S. E. (1993). *Using "softer" tests to demonstrate MMPI-2 findings to clients*. Paper presented at the 28th Annual Symposium on Recent Developments in the use of the MMPI, MMPI-2, and MMPI-A, St. Petersburg Beach, FL.
- Finn, S. E. (1996a). *A manual for using the MMPI-2 as a therapeutic intervention*. Minneapolis, MN: University of Minnesota Press.
- Finn, S. E. (1996b). Assessment feedback integrating MMPI-2 and Rorschach findings. *Journal of Personality Assessment*, 67, 543–557.
- Finn, S. E. (2007). *In our clients' shoes: Theory and techniques of Therapeutic Assessment*. Mahwah, NJ: Erlbaum.
- Finn, S. E., & Martin, H. (1997). Therapeutic Assessment with the MMPI-2 in managed health care. In J. N. Butcher (Ed.), *Objective psychological assessment in managed health care: A practitioner's guide* (pp. 131–152). New York, NY: Oxford University Press.

Fischer, C. T. (1985/1994). *Individualizing psychological assessment*. Mahwah, NJ: Erlbaum.

George, C., & West, M. (2012). *The Adult Attachment Projective Picture System: Attachment theory and assessment in adults*. New York, NY: Guilford.

Kamphuis, J. H., Kugeares, S. L., & Finn, S. E. (2000). Rorschach correlates of sexual abuse: Trauma content and aggression indices. *Journal of Personality Assessment*, 75, 212–224.

Linehan, M. M. (2014). *DBT skills training manual, second edition*. New York, NY: Guilford.

Overton, C. G. (2012). Therapeutic Assessment of severe abuse: A woman living with her past. In S. E. Finn, C. T. Fischer, & L. Handler (Eds.), *Collaborative/Therapeutic Assessment: A casebook and guide* (pp. 199–224). Hoboken, NJ: John Wiley & Sons, Inc.

Peters, E. J., Handler, L., White, K. G., & Winkel, J. D. (2008). “Am I going crazy, doc?”: A self psychology approach to Therapeutic Assessment. *Journal of Personality Assessment*, 90, 421–434.

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York, NY: W.W Norton & Co.

Smith, J. D., & Finn, S. E. (2011). *Learning and practicing Therapeutic Assessment: A workbook for developing basic and advanced skills*. Preliminary copies available from the Therapeutic Assessment Institute, Austin, TX [email: sefinn@mail.utexas.edu or jd.smith@northwestern.edu].

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

Tharinger, D. J., Finn, S. E., Austin, C., Gentry, L., Bailey, E., Parton, V., & Fisher, M. (2008). Family sessions in psychological assessment with children: Goals, techniques, and clinical utility. *Journal of Personality Assessment*, 90, 547–558.

Tharinger, D. J., Gentry, L., & Finn, S. E. (2013). Therapeutic Assessment with adolescents and their parents: A comprehensive model. In D. Saklofske, C. R. Reynolds, & V. L. Schwann (Eds.), *Oxford Press handbook of psychological assessment of children and adolescents* (pp. 385–

422). New York, NY: Oxford University Press.

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Tapping Into the TA Well

Examples of Assessment Intervention Sessions in the Literature

By Raja M. David, Psy.D., & Mark Bertucci
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As those who have conducted an Assessment Intervention Session (AIS) can attest, it is often one of the

most challenging and rewarding aspects of conducting a TA. The challenge stems from the fact that a good AIS requires us to tap into our clinical wisdom, our understanding of our client, and our creativity. Curiosity about how to foster creativity in ourselves and others was the impetus for this article. We

wondered about the different types of AIS that have been tried and presented in the literature. The result of our curiosity is the heart of this article. Tables 1–4 identify articles where one can find examples of an AIS. We hope these tables will be useful for those wishing to identify an approach to an AIS with a current TA client. Equally, we hope that seeing the different types of AIS in the literature may lead to new creative interventions. We preface by providing a brief overview of our process of identifying articles and our observations regarding what we noticed in the tables.

Process

The initial step in finding articles involved a literature search. As the foundation for our search, we used the reference list that Raja received during his TA Immersion Training in Austin. We then reviewed all the *TA Connections* published to date (including this issue), with an eye on the Recent Literature section in each. Once we felt we had all the potential articles that might include a description of an AIS, we began reviewing them.

At that point in the process we consulted with Steve Finn about our article. He provided the following definition, which we adopted: “In TA, an Assessment Intervention Session is a pre-planned session that occurs after the initial case conceptualization and before feedback, to explore the case conceptualization, help clients become aware of potential Level 3 information, explore recommendations, provide clients with vivid memorable experiences related to the case conceptualization, and generally prepare clients for feedback.” (S. Finn, personal communication, September 14, 2015).

Steve also provided us with synopses of different articles that contain an AIS, a resource he shares at trainings. Steve’s document helped confirm our selection of articles and shares some similarities with this article. However, the focus of each is slightly different in that our goal was to find what actually has been tried with regard to different types of AIS, with less focus on the client’s issues or the resolution.

Having adopted Steve’s definition of an AIS meant that we had a narrow scope with regard to including articles. We reviewed but did not include some articles that predated the TA model and described approaches such as a consensus Rorschach. There were also more recent articles, some of which used the term *AIS*, but these were not retained because they did not completely align with the definition provided

by Steve (e.g., the AIS came before, as opposed to after, the case conceptualization).

Observations

What is most noteworthy is that many of the AIS in the articles (15 out of 31) used storytelling cards (e.g., TAT cards) in some capacity. This was particularly true for the cases involving adults, in which 8 of the 12 AIS included storytelling cards. In contrast, the AIS in the child and adolescent articles were more likely to have used a different approach, perhaps speaking to the need for playfulness and creativity when working with children in stuck families.

Raja noted that across all the articles, examples of AIS in the age range of 15 to 23 were absent. It would be useful if examples with those ages were added to the literature. For example, it might be helpful to review an AIS with an older adolescent, with an eye on how the AIS might be connected to individuation. In addition, the emerging adulthood years often are a time when clients are beginning to make sense of the impact of their upbringing on who they are and exploring that impact in an AIS might make for an interesting and informative read and inspiration.

Mark also noted that, from his perspective as a student, more examples of when an AIS does not work as planned would be helpful. Even with a strong conceptualization of the client’s difficulties and careful planning of an AIS, it is possible that the session may not bring out a *client’s problem-in-living*, or it may even lead to a rupture in the therapeutic alliance. Budding clinicians and TA students could benefit from learning about how such situations were navigated.

Last, we noted that the majority of these examples are found in the *Journal of Personality Assessment* or in books. While not all journals publish case studies, it may be useful to target other publications to expose TA to new audiences.

In summary, we see this article as a resource for those seeking to further explore ways of conducting an AIS to meet their clients’ needs in unique and creative ways.

The findings of the review are presented in a series of tables that include child (Table 1), adolescent (Table 2), adult (Table 3), and couples (Table 4) AIS. The tables are included at the end of this issue of the *TA Connection*, in an Appendix.

References

- Aschieri, F., Fantini, F., & Bertrando, P. (2012). Therapeutic Assessment with children in family therapy. *Australian and New Zealand Journal of Family Therapy*, 33(4), 285–298.
- Austin, C., Krumholz, L., & Tharinger, D. (2012). Therapeutic Assessment with an adolescent: Choosing connections over substances. *Journal of Personality Assessment*, 94(6), 571–585.
- Fantini, F., Aschieri, F., & Bertrando, P. (2013). "Is our daughter crazy or bad?" A case study of Therapeutic Assessment with children. *Contemporary Family Therapy*, 35, 731–744.
- Finn, S. E. (2003). Therapeutic Assessment of a man with "ADD." *Journal of Personality Assessment*, 80(2), 115–129.
- Finn, S. E. (2007). *In our clients' shoes: Theory and techniques of Therapeutic Assessment*. Mahwah, NJ: Earlbaum.
- Finn, S. E. (2012a). Implications of recent research in neurobiology for psychological assessment. *Journal of Personality Assessment*, 94(5), 440–449.
- Finn, S. E. (2012b). Therapeutic Assessment with a couple in crisis: Undoing problematic projective identification via the Consensus Rorschach. In S. E. Finn, C. T. Fischer, & L. Handler (Eds.), *Collaborative / Therapeutic Assessment: A casebook and guide* (pp. 379–400). Hoboken, NJ: John Wiley & Sons, Inc.
- Finn, S. E., & Chudzik, L. (2013). L'Évaluation Thérapeutique pour enfant: théorie, procédures et illustration. [Therapeutic Assessment with children: Theory, techniques, and case example.] *Neuropsychiatrie de l'Enfance et de l'Adolescence*, 61, 166–175. (English translation available from Stephen Finn.)
- Finn, S. E., & Kamphuis, J. H. (2006). Therapeutic Assessment with the MMPI-2. In J. N. Butcher (Ed.), *MMPI-2: A practitioner's guide* (pp. 165–191). Washington, DC: APA Books.
- Finn, S. E., & Martin, H. (1997). Therapeutic Assessment with the MMPI-2 in managed health care. In J. N. Butcher (Ed.), *Objective psychological assessment in managed health care: A practitioner's guide* (pp. 131–152). New York, NY: Oxford University Press.
- Finn, S. E., & Martin, H. (2013). Therapeutic Assessment: Using psychological testing as brief therapy. In K. F. Geisinger, B. A. Bracken, J. F. Carlson, J. I. C. Hansen, N. R. Kuncel, S. P. Reise, & M. C. Rodriguez (Eds.), *APA handbook of testing and assessment in psychology, Vol. 2: Testing and assessment in clinical and counseling psychology* (pp. 453–465). Washington, DC: APA Books.
- Fischer, C. T., & Finn, S. E. (2014). Developing the life meaning of psychological test data: Collaborative and therapeutic approaches. In R. P. Archer & S. R. Smith (Eds.), *Personality assessment, 2nd edition* (pp. 401–431). New York, NY: Routledge.
- Frackowiak, M. (2012). Therapeutic Assessment with an adolescent: An adopted teenager comes to feel understood. In S. E. Finn, C. T. Fischer, & L. Handler (Eds.), *Collaborative / Therapeutic Assessment: A casebook and guide* (pp. 225–242). New York, NY: Wiley.
- Guerrero, B., Lipkind, J., & Rosenberg, A. (2011). Why did she put nail polish in my drink? Applying the Therapeutic Assessment model with an African American foster child in a community mental health setting. *Journal of Personality Assessment*, 93, 7–15.
- Hamilton, A. M., Fowler, J. L., Hersh, B., Hall, C., Finn, S. E., Tharinger, D. J., . . . Arora, P. (2009). Why won't my parents help me? Therapeutic Assessment of a child and her family. *Journal of Personality Assessment*, 91(2), 108–120.
- Haydel, M. E., Mercer, B. L., & Rosenblatt, E. (2011). Training assessors in Therapeutic Assessment. *Journal of Personality Assessment*, 93, 16–22.
- Hinrichs, J. (2015). Inpatient Therapeutic Assessment with narcissistic personality disorder. *Journal of Personality Assessment*, 1–13. Available ahead of print.
- Kamphuis, J. H., & de Saeger, H. (2012). Using Therapeutic Assessment to explore emotional constriction: A creative professional in crisis. In S. E. Finn, C. T. Fischer, & L. Handler (Eds.), *Collaborative / Therapeutic Assessment: A casebook and guide* (pp. 133–156). Hoboken, NJ: John Wiley & Sons, Inc.
- Martin, H., & Jacklin, E. (2012). Therapeutic Assessment involving multiple life issues: Coming to terms with problems of health, culture, and learning. In S. E. Finn, C. T. Fischer, & L. Handler (Eds.), *Collaborative / Therapeutic Assessment: A casebook and guide* (pp. 157–178). Hoboken, NJ: John Wiley & Sons, Inc.
- Overton, C. G. (2012). Therapeutic Assessment of severe abuse: A woman living with her past. In S. E. Finn, C. T. Fischer, & L. Handler (Eds.), *Collaborative / Therapeutic Assessment: A casebook and guide* (pp. 199–224). Hoboken, NJ: John Wiley & Sons, Inc.

Smith, J. D., Finn, S. E., Swain, N. F., & Handler, L. (2010). Therapeutic Assessment of families in healthcare settings: A case presentation of the model's application. *Families, Systems, & Health, 28*(4), 369–386.

Smith, J. D., Nicholas, C. R., Handler, L., & Nash, M. R. (2011). Examining the potential impact of a family session in Therapeutic Assessment: A single-case experiment. *Journal of Personality Assessment, 93*(3), 204–212.

Smith, J. D., Wolf, N. J., Handler, L., & Nash, M. R. (2009). Testing the effectiveness of family Therapeutic Assessment: A case study using a time-series design. *Journal of Personality Assessment, 91*, 518–536.

Smith, J. D., & George, C. (2012). Therapeutic Assessment case study: Treatment of a woman diagnosed with metastatic cancer and attachment trauma. *Journal of Personality Assessment, 94*(4), 331–344.

Tharinger, D. J., Christopher, G., & Matson, M. (2011). Play, creative expression, and playfulness in Therapeutic Assessment with children. In S. W. Russ & L. N. Niec (Eds.), *Play in clinical practice: Evidence-based approaches* (pp. 109–145). New York, NY: Guilford.

Tharinger, D. J., Finn, S. E., Austin, C., Gentry, L., Bailey, E., Parton, V., & Fisher, M. (2008). Family sessions in psychological assessment with children: Goals, techniques, and clinical utility. *Journal of Personality Assessment, 90*(6), 547–558.

Tharinger, D. J., Finn, S. E., Wilkinson, A. D., & Schaber, P. M. (2007). Therapeutic Assessment with a child as a family intervention: Clinical protocol and a research case study. *Psychology in the Schools, 44*(3), 293–309.

Tharinger, D. J., Fisher, M. E., & Gerber, B. (2012). Therapeutic Assessment with a 10-year-old boy and his parents: The pain under the disrespect. In S. E. Finn, C. T. Fischer, & L. Handler (Eds.), *A guide to Collaborative/Therapeutic Assessment* (pp. 311–333). New York, NY: Wiley.

Tharinger, D. J., Gentry, L., & Finn, S. E. (2013). Therapeutic Assessment with adolescents and their parents: A comprehensive model. In D. Saklofske, V. Schwane, & C. Reynolds (Eds.), *Oxford Press handbook of psychological assessment of children and adolescents* (pp. 385–422). New York, NY: Oxford University Press.

Tharinger, D. J., & Wan, J. (2015). Case of an adolescent and her parents: The Family Assessment Intervention session. *TA Connection, 3*(2), 18–22.

Turret, J. (2015). Assessment Intervention: A doctoral student's perspective. *TA Connection, 3*(2), 15–17.

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Assessment Intervention

A Doctoral Student's Perspective

By Jason M. Turret, M.A.
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Rita, a 30-year-old married female of mixed race, was self-referred for a psychological assessment. I met her at the Professional Psychology Clinic (PPC), which is the training center for the Graduate School of Professional Psychology at the University of Denver. Rita was seen during my second year of graduate training, and Hale Martin, Ph.D., supervised her case. In addition to supervision by Dr. Martin, Steve Finn (2007) provided important theory and techniques that helped guide this Therapeutic Assessment (TA).

Rita had had only one prior encounter with a therapist, which she described as a bad and invalidating experience. This previous encounter reinforced her resolve made in childhood to keep her feelings, particularly her sadness, hidden. To others, Rita simply appeared angry and irritable; she explained that she frequently lost her temper with friends, family, and her husband, which ultimately left her feeling ashamed of her behavior. Rita was aware that life had been difficult for her, but she was seeking a psychological evaluation because she was interested in receiving a mental health

diagnosis. Since she had felt invalidated during her one previous therapy experience, she was hopeful that a psychological evaluation would give her more specific and accurate information about her distress.

During the initial interview, we worked collaboratively to formulate questions for the TA. Together, we came up with the following questions:

1. Am I depressed?
2. Can I live a normal life?

Rita explained that her life had not felt "normal" because she did not complete college, had difficulty maintaining employment, and her relationships were somewhat volatile. To Rita, a normal life meant more stability and joy.

Assessment Findings

During a period of several weeks, Rita completed the MMPI-2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), the Rorschach Inkblot Method (Exner, 2003), and a modified version of the Early Memories Procedure (EMP; Bruhn, 1985). Her MMPI-2 showed a 2*346 code type. This code type suggested a severe depression (T -score > 90), low self-esteem, difficulty expressing anger in a

modulated way, and feeling unfairly treated. Notably, her profile suggested that although she tends to cover up the struggles, difficulties, and stresses in her life, she likely feels worse than her appearance would suggest.

On the Rorschach, she received the following scores: $R = 31$, $\Lambda = 0.41$, $DEPI = 6$, $S-CON = 8$, $D = -3$, and $C = 1$. In addition, she had three Morbid special scores and a Trauma Symptom Inventory of 0.29. On Card 2 she saw "a dead cow with hearts and blood right here from the head. It almost looks like it's seeping." I recalled my graduate professors who taught me the interpretive trick of placing the words "I am" in front of morbid responses to get a sense of how clients feel about themselves. I began to get a better sense of what it was like to "be in her shoes" and feel hurt, damaged, and in a great deal of pain.

To save time, instead of completing the EMP as outlined by Bruhn (1985), Rita completed a modified version of the EMP. In this modified version, Rita was instructed to write about her early memories in free response form in between our testing sessions. As I reviewed her responses in between our testing

appointments, I noticed that her early memories were of being lonely and sad because her parents spent much of their time working and little time caring for Rita during her formative years. Her memories revealed that she was not vitalized or validated by her parents, and lacking their emotional support and attention, she felt unprotected.

At the start of our next testing session, Rita and I reviewed her memories together. We talked about how throughout her childhood she felt mistreated, judged, and neglected by her family, but while discussing this with me, she expressed little emotion. She was stoic while she told me that this task was very difficult for her because she felt an immense amount of pressure and little support and attention from her family. Her presentation and affect were consistent with the testing results, which strengthened our hypothesis that Rita tended to feel numb and avoid her emotions rather than identify them and cope with them.

Case Conceptualization

In this issue of the *TA Connection*, Finn wrote that a successful Assessment Intervention Session (AIS) is dependent upon on a good case conceptualization, which is achieved by integrating the standardized test results, background information, discussions with the client, observations, and information that came out in Extended Inquires. After reviewing and integrating all these data, Dr. Martin and I conceptualized that Rita had been experiencing severe depression that she had hidden from others and from herself. Growing up in a neglectful environment, Rita had enormous struggles with minimal help and support from others, and her interactions with her

parents left her feeling misunderstood, judged, and invalidated. She began to organize herself around the concept that others cannot help and support her and are not willing to do so, and this belief became her expectation for current interactions and relationships. We hypothesized that this was at the root of her depression. We also posited that Rita learned to distance herself from her emotional experiences because her parents never helped her develop the skills needed to identify and cope with her emotions.

Assessment Intervention Session

Our plan for the AIS was to try to elicit an emotional response from Rita and then help her tolerate her emotions in the room. Specifically, we wanted to bring Rita's depression into the room and identify it, explore it, and understand what was underneath it, which we hypothesized was a longing to be supported and accepted by another. We anticipated that this would be a very powerful experience for her in that she had learned to distance herself from her emotional experience. We also recognized that it was necessary that this intervention be executed carefully, because Rita's previous therapy experience had left her feeling even more invalidated. I wanted to ensure that this pattern of feeling invalidated did not repeat itself during the AIS.

Using the Thematic Apperception Test (TAT; Murray, 1943), I selected cards indicative of depression and sadness, with the intent of eliciting the desired emotional response. As we suspected she would, when Rita shared stories that were distressing, she displayed a very restricted range of affect. After she had composed several stories

based upon the cards she had reviewed, I suggested that she was holding back some painful feelings. Her story on Card 4 stood out to me because it included themes that were consistent with our conceptualization of her. On this card, she told the following story about a woman who was longing to be recognized and supported:

A woman is at a restaurant with her husband. She looks at him longingly, hoping and trying to get attention. He continues to be distracted by other things and refuses to talk to her about what she wants to talk about. She realizes that he can't do it, he can't talk to her. So they finish their lunch at the restaurant and go home. She feels frustration, sometimes anger. And hopelessness.

I asked Rita to create a different story about Card 4 and this time allow herself to really feel the feelings that came to her as she described the story. My goal was to bring some of these painful feelings into the room and help her process these emotions while helping her finally feel validated. Rita surprised me by sharing a more positive story:

There are two people at a restaurant, and the woman looks to get her husband's attention. He turns to her and they talk and they spend quality time together and she feels really good about it. They eat their lunch and they go home. She is thinking that she is having a really good day, and she feels loved.

After Rita shared this story, I reflected to her that the woman in this story felt loved and supported. As Rita nodded, her tears finally came. While she

cried, I sat with her and we processed her pain together. She explained that similar to the woman in her new story, she had been longing to feel supported by another individual. I was able to validate the suffering and pain that Rita was experiencing, and she was able to have a new experience of feeling supported and understood by a person, instead of feeling judged and neglected.

Our sessions that led to this intervention were critical to the success of the process. Throughout the TA, I was able to create rapport, trust, and understanding to orchestrate this powerful assessment intervention, during which Rita told me how depressed she really was and tearfully processed her pain with me in a deeply therapeutic way. More important, this intervention helped Rita learn and accept that others are willing to help her and support her.

Concluding Thoughts

Our AIS had a powerful impact on the rest of the assessment. When Rita arrived for the Summary/Discussion session, she looked like a different person. She appeared brighter, and she spoke with excitement and optimism. She did not look like the woman who saw a dead cow that was seeping blood on the Rorschach.

During our Summary/Discussion session, Rita shared that her initial intention for the assessment was to merely go through the motions of testing while feeling numb, and ultimately receive a mental health diagnosis. We were able to discuss how this assessment was a powerful experience for her because she allowed herself to release some strong feelings while she retold her story about a wife who

finally felt supported and loved by her husband. In this Summary/Discussion session, we collaboratively processed our AIS. We talked about how during that session we were able to process her pain together, and for the first time in a very long time, she felt supported and understood instead of feeling judged and neglected. Rita was able to integrate her feelings instead of distancing herself from them, and she was able to see how beneficial this process was for her.

Rita shared that it was so moving and meaningful for her to personally experience an actual human being tell her, in a gentle and caring tone, "Rita, you are in a lot of pain." She said that hearing this simple statement made her feel deeply understood, validated, and connected to me. I shared with Rita that I was hopeful that she would experience that same feeling more frequently in her life. I wondered if Rita's assessment would have been yet another invalidating experience if she had completed a traditional assessment and not a TA with a meaningful AIS.

References

- Bruhn, A. (1985). Using early memories as a projective technique: The cognitive perceptual method. *Journal of Personality Assessment*, 49(6), 587–597.
- Butcher, J. N., Dahlstrom, W. G., Graham, J. R., Tellegen, A., & Kaemmer, B. (1989). *MMPI-2: Minnesota Multiphasic Personality Inventory-2: Manual for administration and scoring*. Minneapolis, MN: University of Minnesota Press.
- Exner, J. E., Jr. (2003). *The Rorschach: A comprehensive system* (4th ed.). New York, NY: Wiley.

Finn, S. E. (2007). *In our clients' shoes: Theory and techniques of Therapeutic Assessment*. Mahwah, NJ: Erlbaum.

Murray, H. A. (1943). *Thematic Apperception Test manual*. Cambridge, MA: Harvard University Press.

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Case of an Adolescent and Her Parents

The Family Assessment Intervention Session

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Background Information

At the time of the TA, Mary was a 15-year-old Caucasian female who was a freshman at a public high school. She was a good student and a talented actress who performed in musicals and plays. Because of school demands and rigorous performance rehearsals, her days were often very long and busy and required much coordination from her parents to meet her scheduling needs. Mary lived with her biological parents, who were in their 50s and 60s, and with her twin brother, who was developmentally disabled. Mary had a long history of anxiety and peer difficulties that seemed to have peaked at the end of eighth grade and followed her into high school. She also struggled with early pediatric pain that had gone undiagnosed and not understood through much of her childhood and early adolescence.

Tom (Mary's father) was an attorney and the breadwinner of the family, and Susan (Mary's mother) was also an attorney who was no longer working and was a full-time stay-at-home mother. The parents had a strained romantic relationship but shared common intellectual interests that fostered a friendship and partnership that was functional for the family. The parents also had multiple chronic medical conditions and strong family histories of depression, and both of them had received treatment for their own depression in the past. While Tom worked long hours at a job that underappreciated his work and was described as distant from active parenting, Susan was the hub of the family who organized, mobilized, and oversaw each member of the family, making sure they met expectations and fulfilled responsibilities.

Prior to the TA, Susan had been in her own therapy. It was her individual therapist who had recommended

that she and her family participate in a TA to address the escalating difficulties between her and her daughter. At the time, the Therapeutic Assessment Project at the University of Texas at Austin, under the direction of Dr. Deborah Tharinger, had informed the local clinical community that they were offering free TAs to adolescents and their families in exchange for the families' participation in a research component studying the process and outcome of TA with adolescents. Mary and her family were deemed a good referral to the project, and they agreed to participate and granted consent and assent. The Comprehensive Model of TA with Adolescents was used and involved two assessors—one who worked primarily with the adolescent and the other with the parents, although in many sessions both assessors were involved, including in the Family Assessment Intervention Session (AIS).

According to the mother's therapist who had made the referral, Mary had become increasingly angry toward her mother about the various situations that upset her at school and at home. At the same time, mixed with the anger, verbal diatribes, threats of running away, and frequent arguments, Mary was also very dependent and anxious when her mother did not attempt to soothe and comfort her when she experienced distress or when her attempts were unsuccessful. Mary's increasing angry demands of her parents, especially of her mother, and her more pronounced shifts in moods were becoming overwhelming for her entire family. This background information was very useful when later planning the Family AIS.

Assessment Questions Addressed in the Family Assessment Intervention Session

Two assessment questions were the focus of the Family AIS. The first was generated with the whole family present and although agreed upon by all, was driven by the mother: *"How can we help Mary develop self-soothing and self-control when she is feeling anxious, so she can rely more on herself? How can we help Mary decrease her expectation and demands that others need to*

rescue her from situations when she is feeling anxious and overwhelmed?” The second question was generated by the adolescent in an individual session with one of the assessors and was private to her, as per the adolescent model of TA. *“How can my mom and I better listen to each other and respect each other when we communicate? (She keeps calling me manipulative—makes me sound evil.)”*

Assessment Findings and Case Conceptualization

From discussions, observations, testing, and extended inquiries, the assessors learned that Mary was easily stressed and emotionally activated by complex and demanding activities and that she did not have an internalized safe base to self-soothe. In addition, she did not find either of her parents reliably emotionally present, and she was self-critical and blamed herself for many things that were not in her control. Her responses to the administered tests (MMPI-A, Rorschach, Early Memories Procedure (EMP), individualized sentence completion), as well as parent-completed behavioral rating scales, yielded convergent information about symptoms, thinking patterns, and ways of relating that were indicative of depression or a mood disorder. Her MMPI-A profile indicated that she was depressed and experienced loss of appetite, low energy level, and sleep difficulties along with feelings of irritability, guilt, and pessimism and uncertainty about the future. On her sentence completion items, she provided direct responses stating that she felt unwanted and unloved and that she almost always felt stressed and overwhelmed. Her EMP stories were full of loss, anxiety, and threat and were notably self-critical and shaming. The extended inquiry of critical MMPI-A items helped the assessors further understand the impact of her undiagnosed childhood chronic pain on her sense of helplessness in getting her needs met. The assessors learned that emotional awareness and attunement to her own feelings overwhelmed and even challenged her cognitively, at times even impairing her thinking, concentration, and decision-making abilities.

Each family member completed the Adult Attachment Projective (AAP), and the parents also completed the MMPI-2, with the hope that findings would provide insight into how the parents' personalities and styles of relating contributed to their parenting of and relationship with Mary, specific to the assessment questions. Results of the parents' MMPI-2s indicated that both Susan and Tom experienced depression and health concerns, which affirmed the assessors' experience of the parents as depleted, exhausted, and overwhelmed.

The AAP results revealed that both Mary and her father were Preoccupied in their attachment status and Susan was Dismissive. Mary and Tom's Preoccupied attachment status explained their tendencies to get caught up in “thought circles,” going back and forth in their minds about problems, while Susan's Dismissive status explained her tendency to problem solve, move forward, and accomplish tasks while minimizing emotions. These findings corresponded well to the assessors' experience of the family and greatly informed the case conceptualization of why the mother-daughter relationship was so difficult. The family's attachment findings also were central to planning for the Family AIS and addressing the family-related assessment questions.

From these results, the assessors hypothesized that Mary did not know how to regroup and self-soothe when her feelings of helplessness, shame, and self-criticism were aroused. Instead, Mary screamed and raged at her family (especially her mother), with the hopes of getting help and her needs met. Unfortunately, the way in which she demanded attention and comfort was difficult for her parents, especially for her mother, in that their natural ways of relating did not fit Mary's ways of relating. Specifically, Mary's need for approval and reassurance greatly conflicted with her mother's tendency to minimize emotions and problems. In addition, her father's distant parenting made it difficult for him to be responsive to Mary's problems. So, when they did not provide her with the emotional support she desired, Mary felt even more rejected, anxious, hopeless, and depressed.

Family Assessment Intervention Session

Following separate check-ins with the parents and with Mary to inquire about reactions to the previous session and how the week had gone, we all met together and the assessors introduced the purpose of the Family AIS. We indicated that we planned to try some new activities with them that would encourage interactions and that would help inform their assessment questions. They seemed agreeable. We introduced the storytelling task and our desire that they work together on creating a story they could agree about. We used the child TAT instructions and asked them to work and think out loud as much as possible and to let us know what they noticed and what it was like to work together. The first TAT card we used was the one of the young barefoot boy sitting in front of a cabin by himself (13B). Tom immediately said it was from Kentucky and reminded him of some of his relatives and of poverty. He later said that the boy is thinking about how to get out of these circumstances.

Mary saw the boy as sad and alone and that he went outside to be by himself. Mom said the boy was thinking about his day and all the things he would get done—he was planning. This was a good warm-up to seeing their different takes, both intellectually and emotionally, to the card. The differences in their responses were so glaring to the assessors and the family members that we just sat with the differences and didn't ask them to come up with a common story. We thought we would try that on the next card, depending on their responses.

The second TAT card we used was the one with an empty boat near a lake with trees surrounding it (12BG). Mary described an abandoned boat in a meadow, whereas both her parents saw springtime and the opportunity to be outside, perhaps to have a picnic or go on a boat ride. After the assessors highlighted the contrasting affective states between the two stories and encouraged them to come up with one common story, Mary first disingenuously moved to describing a similar upbeat scene. However, with support and permission from one of the assessors to expand on her original story, she continued to describe the scene as an abandoned boat that was alone and sad and yet somehow peaceful. In hearing this, her father was able to align with his daughter's depressive projections and see the scene as she described, whereas her mother was not able to tolerate and accept Mary's negative affective projections. Agreement was not reached, though at the end Tom and Mary seemed content with Mary's story and mom seemed stirred up and uncomfortable.

At this time, Tom asked for a break. During the break, Susan voiced to one of the assessors that she was very upset that Mary had been speaking in a baby voice in the session thus far and that she was so aligned with her father, even leaning on his lap during the session. The assessor validated Susan's frustrations but also highlighted the emotionally activating nature of the materials and the fact that the clinic setting was a safe space for Mary to demonstrate her emotional immaturity. By way of contrast, the assessors stated that had this been a different social situation, such as an extended family holiday dinner, Susan would and should be able to intervene and correct her daughter about her immature behavior. Following this brief check-in, Susan seemed more present for the rest of the session.

When we all got back together, we moved on to the second activity involving the constructed vignettes because we felt we had accomplished what we had needed with the two TAT cards and did not need to use additional ones. We had developed five vignettes

that closely related to the challenges Mary experienced in her family but because of time constraints, we chose two: one about an abundance of homework and one about feeling pain. In the first vignette, the scenario described a girl arriving home upset because she had an enormous amount of homework. Mary read verbatim from a card with the vignette written out and used a very high-pitched voice and exaggerated speech. "My teacher is so unfair! She doesn't know what she is doing and so she assigned us a ridiculous amount of homework to do! It will be impossible for me to finish all this work because there's so much of it! I don't know what to do!" With the goal of engaging Tom more and giving him a more parental role within the family, he was encouraged to respond first (which Susan was all for—she said she dealt with this issue all the time with Mary, and it was his turn). Incorporating the feedback from the first portion of the session (the TAT cards), Tom noted Mary's feelings of being upset and overwhelmed with homework and then offered to help. When asked about her father's response, Mary reported that it was helpful and supportive. It was a good moment between Mary and her father. Tom expressed that he thought he had done well, although Susan rolled her eyes a bit, suggesting that he had gotten off easy.

We then turned to the second scenario about a girl who had joint pain, and we directed the responding at mom. Mary read the vignette verbatim, again in a very high-pitched exaggerated voice, "I don't feel good—my body and joints have been aching all day. It hurts it hurts it hurts. I can't do anything today because of it. I have all this homework to do but it hurts! Ughh!" Though mom tried to be responsive and emotionally attuned, she seemed genuinely stuck and lacked the words (except to say "I'm sorry") and delivery style to convey empathy and compassion for Mary's joint pain in this scenario. Observing mom's difficulty in responding and emotionally supporting Mary with her feelings and experiences, one of the assessors gently leaned over to Susan and whispered ideas of what to say in her ear as she spoke. Susan's voice softened and her pace of delivery slowed as she conveyed empathy, understanding, and compassion for her daughter's pain, using both the assessor's whispered ideas and also adding her own words. The assessor complimented Susan for providing support and holding Mary's painful feelings, and Mary appropriately accepted comfort and support from her mother. The dialogue follows, picking up right after Mary read the vignette:

MOM: I'm sorry. I'm sorry the whole body hurts.

MARY: I don't like it when you say it that way. I think you need to be more sincere.

ASSESSOR ASKS FOR TIME OUT AND SUGGESTS THEY START AGAIN.

MOM: I'm sorry. What part of your body hurts?

MARY: Everywhere.

MOM: Well, I'm sorry.

AT THIS POINT ONE OF THE ASSESSORS WHISPERS ADDITIONAL RESPONSES INTO THE MOTHER'S EAR, WHICH SHE REPEATS.

ASSESSOR, THEN MOM: It must be hard to have so much of your body hurt, and I know it's been going on for a long time.

MOM: Sorry, sweetie.

ASSESSOR, THEN MOM: It must be so frustrating to deal with this all the time. Forever.

MOM: And nobody is able to see that it's hurting. Nobody sees—I'm sorry. I love you. I'm sorry you feel bad.

ASSESSOR ASKS FOR TIME OUT AND SUGGESTS THEY LOOK AT WHAT JUST HAPPENED.

ASSESSOR: How are you feeling? What was mom saying?

MARY: She was agreeing with me. And she was showing more sympathy and understanding and that it's OK for me to hurt and that someone understands, and then she was taking the time to let me know she understands instead of just jumping to "you need to do this and you need to do that to make it better, and then you can complain." Because that's what she does. Normally.

MOM: That's it. That's what I do. I say, "Sorry—have you taken your medicine?" It's like it's one word, one breath. "What have you done to take care of it?"

OTHER ASSESSOR, SPEAKING TO MARY: And this time she acknowledged that it must be so hard to feel pain and not have people see it. It felt more genuine to you and you felt more heard.

MARY: Yes, that's right.

ASSESSOR: Well—I'm glad we could do this together. This is just some practice, and it's not a cure-all.

MOM: But it's trying to be there, to listen, to actually be there instead of moving directly into the solutions.

OTHER ASSESSOR, SPEAKING TO MARY: It's not going to be overnight. If your parents are trying something different, you need to try a different way of receiving it.

MARY: I will.

All the family members seemed to have a good experience and appreciated the Family AIS. Susan reported to the assessors on the way out that they needed more of what they had just experienced and asked if we all could continue to work together. The assessors encouraged them to consider working with the mom's therapist or finding a family therapist who could continue this work with them.

Following the session the two assessors discussed their experience. They were pleased with how well the session had gone and how effective the two activities had been together. They were also impressed with how well the test findings and case conceptualization were predictive of what happened in the session.

Concluding Thoughts: How the Family Assessment Intervention Session Affected the Rest of the Assessment

The Individual and Family Summary/Discussion sessions and the Follow-up session six weeks later completed the TA. It is hard to isolate how one session affects later sessions because the effect is cumulative from the first session to the last. However, we were fortunate to have research interviews following each session and draw from Mary's interviews to capture the impact of the Family AIS on the rest of the assessment.

At the conclusion of the TA, when asked about how things had been different in her family, Mary reported that things were overall calmer and that there was less fighting and less conflict at home. She reported that her relationship with her mother was "a little better" because they were "more patient and understanding with each other," but that her relationship with her father had not changed as much as she would like because his work schedule hadn't changed. Furthermore, when asked what she learned about her family that she didn't know from before the TA, Mary reported that she realized her family was not "lovey dovey all the time" but that they were trying to "share [their] emotions better and more with each other in a more understanding way." Specifically, she reported that her mother "has not been as abrupt in responding to [her] and has been listening to [her] more" and that they have overall been "listening to each other more rather than yelling and screaming."

At the Follow-up interview, Mary reported that her family had “overcome obstacles” and that they were “much calmer and more cooperative” and that they “respected each other more.” She continued to report an improvement in her and her mother’s relationship but still little improvement in her relationship with her father, which she attributed to his continued busy work schedule. When asked how she had interacted differently with her family as a result of the assessment, she described an interaction effect in which changes she made in her behaviors in turn influenced her parents to respond differently to her, and vice versa. She reported that she was more “understanding and loving toward [her parents]” and that she “realized that [when her parents] didn’t understand what she was going through [she] tried to help them understand [her] better.” When asked how the Family AIS helped her, Mary reported that it helped generate new ideas of how she and her mother could get along better, which was at the crux of their family difficulties. When asked what she learned about her parents, she reported that her parents “were really trying hard to help [her] and that they really did care” and that because of that they were more “emotionally connected.”

Authors



Deborah J. Tharinger, Ph.D., is a professor in the Department of Educational Psychology at the University of Texas at Austin and a licensed psychologist in Texas. She is the former director of the Therapeutic Assessment Project, a research program at UT. She

has practiced, researched, published, and taught extensively about the models of Therapeutic Assessment with children and adolescents. Dr. Tharinger is also a founding member of the Therapeutic Assessment Institute in Austin. Currently she lives in Santa Fe, New Mexico, close to her 94-year-old mother and her sister.



Judith Wan, Ph.D., is a licensed psychologist and has a private practice in Pasadena, California. She specializes in conducting therapy and psychological assessments with children and adolescents. She has conducted and researched Therapeutic Assessment with adolescents.

Please email questions or comments about this column to Deborah Tharinger at dtharinger@mail.utexas.edu

Remembering Deb Parker

By Stephen E. Finn

On May 2, 2015, we lost a beloved member of our TA community, Deborah Wynne Parker, from Toronto, Canada. After coming to TA sessions at the SPA annual meeting, Deb attended the very first TA Immersion Course in 2010 and immediately became part of a monthly TA phone consultation group I led. She was a loyal group member, often adding gentle, wise comments to our case discussions and presenting about her thoughtful, empathic work with adolescents and families at the Willow Centre in Toronto. Deb also took part in the TA Advanced Training in Austin in October 2011, and, when in remission from her colon cancer, she attended the Level 1 Crisi Wartegg System training in Austin in June 2014.

When I think of Deb, I think of her optimism and her passion for life, which she expressed through her dedication to her clients and through travel, biking, hiking, and enjoying good food. I spoke with Deb shortly after she was diagnosed with cancer and was impressed by how she had researched treatments and put together a program that combined Western medicine with alternative approaches. We were all overjoyed when it seemed Deb had licked the cancer, and concerned a year later when we heard it had reappeared. I had the good fortune to speak with Deb several months before her death; she was as optimistic as ever, but also told me that she was not afraid to die and was grateful for a rich, wonderful life full of people who loved her. I remember thinking at the time, “Oh, dear friend, how could anyone not love you?!”

The Therapeutic Assessment Institute has established a scholarship fund in Deb’s name to provide financial assistance to people who could not otherwise attend TA trainings. Tax deductible donations to this fund can be made online through the Therapeutic Assessment Fund at the Foundation for Mental Health Excellence webpage: <http://www.mentalhealthexcellence.org/projects/therapeuticassessment-fund/>. Donations can also be made in Deb’s name to the Willow Centre Child and Family Foundation, 45 Sheppard Ave E. #202, Toronto, ON M2N 6K6, Canada.



Photo Album



Above: Members of the European Center for Therapeutic Assessment participated in the Advanced Training in TA, September 28–October 3, 2015, in Milan, Italy. From left: Cristina Corvi, Francesca Fantini, Erica Dell'Acqua, Alessandra Chinaglia, Camillo Caputo, Steve Finn, Adriano (the doorman at the CEAT), Patrizia Bevilacqua, Cristina Augello, Filippo Aschieri. Missing: Elisa Castiglioni.



Above: The breathtaking panorama from the Cooper residence, where the TAI met for “the Summit” in September 2015.



Left: Attendees at a TA workshop in Belgium (summer 2015), conducted by Steve Finn and Hilde De Saeger, look on intently.

Right: Filippo Aschieri and attendees of a Therapeutic Assessment training enjoy dinner out in Monterey, Mexico, November 2015.





Above: Members of the TAI toured the CooperRiis healing community farm near Mill Springs, NC. Pictured from left (back row) Don Cooper (CooperRiis Founder), Jan Henk Kamphuis, Lisbeth Riis-Cooper (CooperRiis Founder), Steve Finn, Lena Lillieroth, Hilde De Saeger, J.D. Smith, Pamela Schaber, Deborah Tharinger, Hale Martin, Barton Evans; (middle row) Diane Engelman, Noriko Nakamura, Melissa Lehman, Dale Rudin; (front row) Filippo Aschieri, Francesca Fantini, Lionel Chudzik, and Marita Frackowiak.

Recent Publications in Therapeutic/Collaborative Assessment

- Aschieri, F., de Saeger, H., & Durosini, I. L'évaluation thérapeutique et collaborative: preuves empiriques [Therapeutic/Collaborative Assessment: Empirical studies]. *Pratiques Psychologiques*.
- Chudzik, L. (2015). Évaluation thérapeutique et obligation de soins [Therapeutic Assessment and mandatory treatment]. *Pratiques Psychologiques*. doi: 10.1016/j.prps.2015.09.005
- Engelman, D. H., Allyn, J. B., Crisi, A., Finn, S. E., Fischer, C. T., & Nakamura, N. (in press). "Why am I so stuck?": A Collaborative/Therapeutic Assessment case discussion. *Journal of Personality Assessment*.
- Finn, S. E. Therapeutic Assessment with couples. *Pratiques Psychologiques*. doi: 10.1016/j.prps.2015.09.008
- Finn, S. E. (in press). Using Therapeutic Assessment in psychological assessments required for sex reassignment surgery. In V. Brabender & J. L. Mihura (Eds.), *Handbook of gender and sexuality in psychological assessment*. New York, NY: Routledge.
- Frackowiak, M., Fantini, F., & Aschieri, F. L'évaluation thérapeutique: description de quatre modèles [Therapeutic Assessment: Description of four models]. *Pratiques Psychologiques*. doi: 10.1016/j.prps.2015.09.006
- Hinrichs, J. (2015). Inpatient Therapeutic Assessment with narcissistic personality disorder. *Journal of Personality Assessment*, 1–13. doi:10.1080/00223891.2015.1075997
- Hobza, C., & Macdonald, H. (in press). Using Collaborative/Therapeutic Assessment in a psycho-educational context. In R. Valle & J. Klimo (Eds.), *The changing faces of therapy: Evolving perspectives in clinical practice and assessment*. Alameda, CA: Argosy University Press.
- Krishnamurthy, R., Finn, S. E., & Aschieri, F. (in press). Therapeutic Assessment in clinical and counseling psychology practice. In U. Kumar (Ed.), *Personality assessment: The way forward*. United Kingdom: John Wiley and Sons, Inc.
- Miller-Matero, L. R., & Cano, A. (2015). Encouraging couples to change: A motivational assessment to promote well-being in people with chronic pain and their partners. *Pain Medicine*, 16(2), 348–355. doi:10.1111/pme.12600
- Punzi, E. H. (2015). Neuropsychological assessment in substance abuse treatment: Focusing on the effects of substances and on neuropsychological assessment as a collaborative process. *Smith College Studies in Social Work*, 85(2), 128–145.
- Smith, J. D., & Egan, K. N. (2015). Trainee and client experiences of Therapeutic Assessment in a required graduate course: A qualitative analysis. *Journal of Personality Assessment*, 1–10. doi:10.1080/00223891.2015.1077336

Upcoming Trainings in Therapeutic Assessment

**April 29, 2016, 10:00–17:00; April 30, 9:00–17:00;
May 1, 9:00–16:00: Tokyo, Japan**

Title: "Live Therapeutic Assessment of an Adult Client"

Presenter: Stephen E. Finn

Sponsor: Asian Center for Therapeutic Assessment

Information: www.asiancta.com

June 2–4, 2016: Austin, TX

Title: "Skills Training in Therapeutic Assessment: Taking Your Therapeutic Assessment Skills to the Next Level"

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

Sponsor: Therapeutic Assessment Institute and the Society for Personality Assessment

Information: www.therapeuticassessment.com

April 12, 2016, 9:00–17:00: Östersund, Sweden

Title: Therapeutic Assessment of Children: Moving from Curiosity to Understanding.

Presenter: Marita Frackowiak

Languages: English

Information: marita.frackowiak@gmail.com

April 13, 2016, 9:00–17:00: Stockholm, Sweden

Title: Therapeutic Assessment of Children: Using Psychological Testing to Change the Family Story

Presenter: Marita Frackowiak

Languages: English

Information: marita.frackowiak@gmail.com

**April 14, 2016, 8:30–17:00; April 15, 8:30–17:00;
April 16, 8:30–3:30: Stockholm, Sweden**

Title: Skills Training in Therapeutic Assessment of Children, Adolescents, and Families

Presenter: Marita Frackowiak

Languages: English

Information: marita.frackowiak@gmail.com

August 11, 2016, 8:30–17:00; August 12, 8:30–17:00: Helsinki, Finland

Title: Therapeutic Assessment of Children: Using Psychological Testing to Change the Family Story

Presenter: Marita Frackowiak

Sponsor: HUCH–Child Psychiatry, Helsinki University Central Hospital

Languages: English

Information: marita.frackowiak@gmail.com

Dates to be announced, Monterrey, Mexico

Title: Skills Training in Therapeutic Assessment of Children, Adolescents, and Families

Presenter: Marita Frackowiak

Languages: English with Spanish translation

Information: marita.frackowiak@gmail.com

Table 1			
<i>Family AIS with Child Clients</i>			
Article	Client Characteristics	Primary Difficulties	Description of AIS
Aschieri, Fantini, & Bertrando, 2012	8-year-old girl	separation anxiety	The parents engaged in puppet play with their daughter. The session was videotaped and reviewed with the parents during the following session to help them identify ways they could improve connection and communication with their child.
Fantini, Aschieiri, & Bertrando, 2013	4-year-old girl	angry outbursts, early neurological issues (tremors)	While together in one room, the child completed projective drawings to help her parents understand and respond to her sadness.
Finn & Chudzik, 2013	7-year-old boy	enuresis, nightmares, anxiety	The child and extended family members collaboratively planned a memorial service for the child's deceased uncle.
Guerrero, Lipkind, & Rosenberg, 2011	11-year-old girl	atypical, oppositional, and angry behaviors; learning issues	The child and caregivers engaged in a card game and a consensus storytelling task using TAT cards and Robert's Apperception Test cards to highlight family dynamics.
Hamilton et al., 2009	8-year-old girl	attention seeking, dramatic behaviors, peer relationship difficulties	The parents engaged in client-centered play with the child, with an emphasis on mirroring affect and being nonjudgmental.
Haydel, Mercer, & Rosenblatt, 2011	6-year-old boy	academic underachievement, emotional and behavioral dysregulation	A Family AIS with the mother and child was conducted with two parts. First, the child engaged in semistructured play, and the mother was able to join the assessors in validating her son. Next, parent coaching was provided to help the mother and son see they could persevere through his difficult homework.
Smith, Finn, Swain, & Handler, 2010	11-year-old boy	somatic symptoms, situational stress and anxiety.	The Early Memory Procedure and Robert's Apperception Test cards were used to bring into the room how the family communicated about emotions and the child's tendency to avoid emotions.
Smith, Nicholas, Handler, & Nash, 2011	12-year-old boy	parental concerns about potential academic underperformance; issues with peers and low self-esteem	The child's IQ scores, drawings, and Bender-Gestalt were used to help the father obtain a more realistic view of his son's intellectual abilities and understand how to support him. The child also learned how to slow down his work process.

Table 1 continued			
<i>Family AIS with Child Clients</i>			
Article	Client Characteristics	Primary Difficulties	Description of AIS
Smith, Wolf, Handler, & Nash, 2009	9-year-old boy	aggressive behaviors at home only	Two Family AIS occurred during which each parent individually interacted with the child while the other parent and assessors were behind a one-way mirror. During the first session, the parents were coached on how to talk to their son about a recent conflict so they could validate his feelings and own their roles in his escalating behaviors. During the second AIS the Squiggle Game was used to improve communication and positive feelings in the family.
Tharinger et al., 2008	8-year-old boy	depression; anger management problems	The parents were taught the “sportscasting technique,” and they enthusiastically narrated their son’s actions, which enabled the boy to have an experience of being understood and validated.
Tharinger et al., 2008	10-year-old boy	feelings of inadequacy; depression	The assessor first taught the mother and stepfather about empathic listening, and it was practiced via role play. The child was then brought into the room, with the goal of having the parents use this technique with him. However, he struggled with being the focus of attention, and instead he “coached” one of the assessors in additional role plays with the parents. Despite the boy’s reluctance, the parents were able to empathically label his actions and feelings.
Tharinger et al., 2008	9-year-old boy	possible ADHD; anger	The father and son engaged in semistructured play using Legos, which helped the father see the importance of collaboratively connecting with his son through activities.
Tharinger et al., 2008	8-year-old boy	anger, separation anxiety, OCD symptoms	The child and parents completed family drawings and then family sculptures, which helped the parents see that when their son was angry, he needed support and help with his emotional regulation.
Tharinger et al., 2008	12-year-old girl	temper tantrums	A family reenactment of the girl’s anger outbursts was facilitated, during which the daughter was placed in the mother’s role. The parents were able to see that the child felt unwanted, which was connected to their ambivalence about having her.

Table 1 continued			
<i>Family AIS with Child Clients</i>			
Article	Client Characteristics	Primary Difficulties	Description of AIS
Tharinger et al., 2008	8-year-old boy	withdrawal behaviors and excessive sleepiness at home only	The boy and his parents participated in a consensus Rorschach, which helped the parents see that when they were in conflict, the boy reacted by withdrawing and getting sleepy.
Tharinger, Christopher, & Matson, 2011	9-year-old boy	parents were divorcing and child was angry, oppositional, and engaging in self-harming behaviors.	The mother and child produced family drawings and comic strips and engaged in family sculpture to help experience and address the dynamics that occurred when they were in conflict.
Tharinger, Finn, Wilkinson, & Schaber, 2007	11-year-old girl	noncompliant, angry; concerns about ADHD and bipolar disorder	An interactive board game was used with the grandparents and the child to give the family an opportunity to experience positive family connections and play.
Tharinger, Fisher, & Gerber, 2012	10-year-old girl	disrespectful, struggles with emotion regulation	The family engaged in nondirective play, with an emphasis on letting the girl have more control and limiting the influence of the stepfather.
The following examples have only a brief description of the AIS in the article; as per the lead author, they were not designed to be case studies.			
Tharinger et al., 2008	6-year-old boy	anxiety	A Family AIS was conducted during which it became apparent that the boy's anxiety was connected to being tormented by his siblings.
Tharinger et al., 2008	no age or gender listed	child's behaviors served to divert attention away from marital conflict	The family was asked to discuss spending a monetary windfall, which led to the parents fighting and the child's behaviors worsening.
Tharinger et al., 2008	no age or gender listed	holding anger for the family	The family members were asked to discuss how anger is managed, which revealed a family value about never expressing anger.
Tharinger et al., 2008	male child with no age identified	misbehavior to obtain maternal attention	The mother and son were asked to play a board game, with the assessor offering parental coaching, but the mother's depression affected her ability to sustain effort.

Table 1 continued			
<i>Family AIS with Child Clients</i>			
Article	Client Characteristics	Primary Difficulties	Description of AIS
Tharinger et al., 2008	8-year-old female	difficulties with parent–child interactions	During a Family AIS, the assessor created a positive relational experience so the parents could gain hope about their daughter and their relationships.
Tharinger et al., 2008	male child with no age identified	autism	The child’s caregivers (grandmother and aunt) played with the child, with parental coaching from the assessor, to reinforce how to engage with the boy.
Tharinger et al., 2008	8-year-old girl	psychosis	The parents and the child were first asked to sort different words into categories (e.g., real, scary), and then the parents were coached on how to interview the child about elves (auditory hallucinations) she was seeing at school, to gain an understanding of the child’s thought disturbance.
Tharinger et al., 2008	7-year-old girl	anger problems	The family was asked to demonstrate what happened the last time the child “raged” and how everyone handled it, to help the parents see how they contributed to the girl’s anger.
Tharinger et al., 2008	8-year-old girl	excessive demands for attention	The girl’s parents were guided in providing positive, focused attention to see the effect on their daughter and then were able to implement the strategy at home almost immediately.
Tharinger et al., 2008	11-year-old girl	poor follow through; anger, depression	Family drawings and sculptures were used to bring into the room the family dynamics when there was conflict. During the AIS, the parents were unable to see their role in the arguments, and the daughter was overwhelmed. By the following session the father had gained some awareness of how his anger affected the client.

Table 2

Adolescent AIS

Article	Client Characteristics	Primary Difficulties	Description of AIS
Austin, Krumholz, & Tharinger, 2012	13-year-old boy	drug use, relationship difficulties	An Adolescent AIS was conducted using Robert's Apperception Test cards, with an emphasis on helping the client recognize how he was avoiding emotions. A Family AIS was conducted with the teen and father, during which they created consensus stories for the Adolescent Apperception Test cards and then created a collage, which helped the father see how limits could be set with his son.
Frackowiak, 2012	14-year-old girl	oppositional and angry behavior, aggression	The mother and daughter engaged in a consensus storytelling task using Robert's Apperception Test cards, with a particular emphasis on staying with and validating painful emotions.
Tharinger et al., 2008	14-year-old girl	severe depression	During a Family AIS, the girl and her parents participated in a consensus TAT, targeting the parents' difficulties staying with their daughter's difficult feelings.
Tharinger, Gentry, & Finn, 2013	13-year-old boy	drug use, poor relationships; anxiety, depression	During an Adolescent AIS, the assessors used a memory for words test and TAT cards to explore the connection between being emotionally aroused and the client's tendency to space out. During a Family AIS, the mother and son engaged in a storytelling task using TAT cards to address the mother's discomfort with difficult feelings and its effects on their relationship.
Tharinger & Wan, 2015	15-year-old girl	anxiety, dependency, anger, argumentative behavior at home	The client and her parents engaged in two activities as part of a Family AIS. Initially, they completed consensus TAT stories to bring into the room their different ways of seeing themselves and the world. Next, the girl read vignettes that the assessors had written based upon the family's conflicts. The mother was guided in how to respond to her daughter in a way that was beneficial and that deescalated the argument.

Table 3

Adult AIS

Article	Client Characteristics	Primary Difficulties	Description of AIS
Finn, 2003	28-year-old man	possible ADD; romantic relationship problems	Number recall tests similar to the Wechsler Digit Span subtest and select TAT cards were used to help the client see how, when he became emotionally overwhelmed, his concentration and attention were affected.
Finn, 2007	24-year-old man	low self-esteem, achievement issues	The Bender Gestalt was used, emphasizing copying and immediate recall, to develop insight into the effects of the client's pattern of underperforming or wanting to give up because of self-denigration.
Finn, 2012a	27-year-old man	sexual compulsive behavior	TAT cards were used to give the client an opportunity to experience negative emotions in session and gain insight into his compulsive need to act out sexually in response to those emotions.
Finn & Kamphuis, 2006	45-year-old woman	depression, dissociation	TAT cards were used to bring into the room feelings of abandonment and resultant dissociation, which were then processed in the session to develop new experiences and insight.
Finn & Martin, 1997	35-year-old woman	anger, premature termination of therapy	TAT cards were used to induce feelings of frustration and the client's pattern of overcontrolling her anger because she feared hurting others. The client was then able to develop new stories that entailed assertive communication.
Finn & Martin, 2013	26-year-old woman	childhood trauma, current alliance issues with therapist	TAT, Adolescent Apperception cards, and Family Apperception Test cards were used to evoke an increasingly intensive emotional reaction, in the hope of increasing the client's ability to control the pace of emotional experiencing in a therapy session.
Fischer & Finn, 2014	adult man, age unknown	anger and emotional abuse toward supervisees at work	To bring the client's anger into the room, WAIS-III Block Design was used to intentionally deceive the client into believing he should be able to complete the 9-block pattern with only 7 blocks. The client expressed his anger with this impossible task and the assessors' role. The client and assessor then discussed more adaptive ways of expressing anger with his work staff.

Table 3

Adult AIS

Article	Client Characteristics	Primary Difficulties	Description of AIS
Hinrichs, 2015	55-year-old-man	sedative dependence, narcissistic traits	The assessor asked the client to interpret his own test data, claiming he had nothing more to add, with the intention of bringing into the room the client's independent style and tendency to constrict affect.
Kamphuis & de Saeger, 2012	37-year-old man	work issues, unhappiness	Card 1 of the TAT was the main focus, with an emphasis on having the client better understand his difficulties in accessing his feelings in the moment and being assertive.
Martin & Jacklin, 2012	27-year-old man	possible learning disability, relationship issues	TAT cards were used to help the client develop ways of expressing needs and expectations in relationships that were being affected by his feelings of loss and abandonment.
Overton, 2012	35-year-old woman	experienced chronic childhood abuse	The Rorschach was given a second time with special instructions to help determine the client's ability to separate her previous traumatic experiences from present-moment attention and awareness.
Smith & George, 2012	52-year-old woman	depression and anxiety related to cancer diagnosis; unresolved attachment status	A personalized Sentence Completion Test was used in what is referred to as a <i>low-intensity assessment intervention session</i> designed to help the client begin to see the connection between her trauma and her current difficulties.
Turret, 2015	30-year-old woman	anger, depression, difficulty maintaining employment, volatile relationships	TAT cards were used to help the client have an experience of feeling supported, and not judged, for expressing her emotional pain.

Table 4***Couples AIS***

Article	Client Characteristics	Primary Difficulties	Description of AIS
Finn, 2007	heterosexual couple in their mid-40s	physical fights with each other	A consensus Rorschach was used to help illuminate the husband's guarded distress and develop ways to support his emotional needs.
Finn, 2007	gay male couple in their late 30s	ineffective conflict resolution	A consensus Rorschach was conducted to help the couple understand the way their "pursuer-avoider" dynamic escalated their conflicts.
Finn, 2012b	heterosexual couple	wife's chronic pain and grief	A consensus Rorschach was used to address the couple's interactions concerning the wife's chronic pain and develop more effective support from the husband.