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THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

# Fresh Perspectives on TA

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Greetings, friends and colleagues. This issue marks the beginning of the fourth volume of the *TA Connection.* The past three volumes (six issues) contained columns about a wide range of topics and from many different authors. I think I can speak for the TA community when I express my sincere gratitude for the contributions of these authors. It is always exciting and a true pleasure for me to read the columns that are submitted and then to see the final products after feedback and suggestions from myself and my distinguished associate editors. In this issue, we are given a glimpse into some fresh perspectives on TA that have not yet been covered in the newsletter.

## *This Issue*

In the first column, Deborah Tharinger provides a synopsis of two papers that will be appearing in the *Journal of Personality Assessment* in 2016. The two articles, by Smith and Egan and by de Saeger, Bartak, Eder, and Kamphuis, report the findings of qualitative research projects on the experience of delivering TA (from the perspective of graduate trainees) and participating in a TA (from the perspective of adult clients). These are two voices in the TA experience that are currently underrepresented in the empirical literature. Deborah weaves together the findings of the two studies in a way that illuminates the ways TA affects trainees and clients. The results are both inspiring and interesting.

In the second column, Dale Rudin discusses the assessment of adult clients presenting with symptoms of an autism spectrum disorder. She provides case examples to illustrate the ways in which assessors can distinguish symptoms that are or are not truly representative of this diagnostic cluster. Further, Dale provides some thoughts about how the TA model and core values help assessors more accurately assess and diagnose clients that are thought to have autism. The growing appreciation of the ways autism spectrum disorders manifest, and the rapidly increasing rates of diagnosis (and perhaps an increase in its prevalence as well) make this a very timely article.

In the third column, Donna Kelley describes her experiences as a trainee of TA. This perspective is one that all of us at some level or point in time can

## *In this issue:*

relate to. Donna describes the consultation she has been receiving from Dale Rudin about TA and how it has improved her grasp of the model and her work with clients more generally. She presents snippets of a TA and how she discussed this case with Dale in consultation. I found Donna's description of her anxieties, excitement, challenges, and triumphs to be very normalizing and at the same time, inspiring. I hope you will have similar positive feelings as you read her story and feel energized to more deeply build your TA skills.

Last, many of you likely have heard of the passing of Leonard Handler in January. Len was a luminary in the field of collaborative and therapeutic assessment whose teaching, writing, and clinical supervision shaped a generation of clinical psychologists and inspired some of the steps and techniques that are now formally part of the TA model. Steve Finn and I further discuss the impact that Len had on TA and on the personal growth of countless assessment psychologists.

### *A Special Thank You to Constance Fischer*

We are honored and delighted to announce that the Therapeutic Assessment Institute has received a generous donation from Dr. Constance Fischer to support its work. Among other things, the TAI Board has established a scholarship fund to TAI trainings for participants who might otherwise not be able to attend. For example, for the TA Skills Training in June, four deserving people received full or partial scholarships to the training. As we announce each future training, we will give instructions about how to apply for scholarships. Although they will be limited in number, we feel these grants are a wonderful way to honor the pioneering and important work of Connie Fischer and to carry her ideas and vision forward.

### *Upcoming Special Sections in the Journal of Personality Assessment*

I am very pleased to announce two upcoming special sections that will soon be published in the *Journal of Personality Assessment* for which I had the pleasure of serving as guest editor. Both sections contain articles relevant to, or explicitly about, TA. The first special section titled "Cultural Considerations in Collaborative and Therapeutic Assessment" was developed as a symposium presented at the 2015 meeting of the Society for Personality Assessment held in Brooklyn, New York. The published special section contains an introduction by me; four articles authored by Filippo Aschieri, Lionel Chudzik, Barton Evans, and Francesca Fantini; and a comment from Bruce Smith.

The other special section is titled "Teaching, Training, and Supervision in Personality and Psychological Assessment." This section contains an introduction, seven articles, and two comments. Two articles are directly relevant to TA. The first is the Smith and Egan study that Deborah Tharinger discusses in her column in this issue of the *TA Connection,* and the other is a discussion of assessment consultation groups and other continuing education methods for professional psychologists that is coauthored by Barton Evans and Stephen Finn. The remaining articles in the special section concern teaching methods for undergraduates, models and approaches for teaching graduate and postdoctoral trainees, a survey of current assessment teaching in doctoral programs, and a survey of assessment supervisory practices and methods. This is a very exciting collection of articles that covers the developmental span of training in assessment. The two forthcoming comments are authored by Katherine Nordal and Elena Eisman from the American Psychological Association Practice Organization and Nadine Kaslow from Emory University School of Medicine.

This special section is being dedicated to Leonard Handler for his many contributions to the field and in particular his commitment and enthusiasm for training assessment psychologists. Len inspired many of us who practice and research TA, myself included, as his last graduate student at the University of Tennessee.

The complete bibliographies of these two special sections are provided on page 27 in the Recent Publications section.

### *2nd International Collaborative/ Therapeutic Assessment Conference*

We at the Therapeutic Assessment Institute (TAI) are delighted to announce that we have finalized the dates for the 2nd International Collaborative/ Therapeutic Assessment Conference, which will be held September 22 and 23, 2017, in Austin, Texas. Building on the wonderful experiences and top-notch presentations of the inaugural conference back in 2014, we will again hold the meeting at

the beautiful AT&T Executive Education and Conference Center in downtown Austin, which is close to the University of Texas, 6th Street, and other Austin attractions that make the city such a fun destination.

As with the inaugural conference, we will be offering pre-conference workshops on Thursday, September 21, and two days of scientific sessions (Friday and Saturday). The format of the scientific presentations will include large-group plenary sessions, symposia, paper and case presentations, and panel discussions. We have also made some changes to the schedule based on attendees' feedback in 2014. Namely, presenters will be given more time and we will have a happy hour on Friday evening to facilitate socializing and getting to know one another.

For those of you who are interested in conducting a workshop, proposals will be due March 1, 2017. Proposals for presenting in the scientific sessions will be due May 1, 2017. A registration pamphlet will be distributed early in 2017, and more specifics will be provided in the next issue of the newsletter. I will again be serving as the program chair, so please feel free to email me directly with any questions about the conference.

### *Skills Training Workshop*

The TAI will be hosting a three-day workshop June 2–4, 2016, in Austin, Texas, titled "Skills Training in Therapeutic Assessment: 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., immersion course, multiple workshops) who desire more hands-on training in TA skills. For those interested in getting to know TA for the first time, the first day will be a full-day introductory workshop that will serve as preparation for the following two days. The workshop will provide 18 hours of CE credit (6 per day) and will be held at the beautiful Westin Austin at the Domain (11301 Domain Drive).

### *Steve Finn's TA Webinar*

In December 2015 the American Psychological Association and the Society for Personality Assessment jointly sponsored a webinar by Steve Finn titled "How Therapeutic Assessment Works: Theory and Techniques." The webinar is now archived and free to view through the APA Online Academy.

### *Donate to TA*

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. Information about the website for the fund appears on page 9.

### *Future Issues of the TA Connection*

I would love to hear your feedback and gather your suggestions for the newsletter. Many of the topics covered in the newsletter have come from your suggestions, and I hope to continue to provide information that is useful to our readers. If you have conducted an exemplary or interesting TA case, want to write about some aspect of TA, or have a suggestion for 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 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: Deborah Tharinger, Dale Rudin, Donna Kelley, and Stephen Finn, as well as our wonderful associate editors.

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

# Learning/Practicing and Participating in a Therapeutic Assessment

## What We Can Learn from the Voices of Psychology Graduate Students and Clients

***By Deborah J. Tharinger, Ph.D.***
***University of Texas at Austin***

In this column I introduce you to two new studies published in the *Journal of Personality Assessment* that examine Therapeutic Assessment (TA) from a qualitative methodology and analysis perspective. The first study will inform us about the experience of psychology graduate students learning TA and their interest in pursuing TA in the future. The second will inform us about clients' views of what they gained from participating in a TA and what surprised them. But first I ask you to reflect on your own experiences of being introduced to TA.

### *Reflecting on First Exposure to TA*

As a psychologist or psychologist in training who values and practices TA, do you remember the first time you were exposed to TA and what you experienced? Was it when you read Stephen Finn's book *In Our Clients' Shoes* (Finn, 2007*)* or an article about TA? Was it when you attended your first workshop or presentation about TA given by Finn, one of his colleagues from the Therapeutic Assessment Institute, or someone else with expertise in TA? Or was it when you were taking a graduate course that comprehensively taught TA or provided one or two lectures about it?

Before your introduction to TA, had you been discouraged about traditional models of psychological assessment? Did you find yourself less and less invested in learning or practicing psychological assessment? In contrast, through your exposure to TA, did you experience being drawn to and excited about the potential of practicing TA or renewing your work in assessment through a TA lens? Were you attracted to being able to use your "testing" skills as well as your therapy skills in a collaborative process designed to address clients' assessment questions? Were you excited about giving feedback matched to your clients' capacity to sequentially absorb the information, organized by their assessment questions? And did your initial enthusiasm carry over to your first TA case? That is, were your expectations confirmed?

### *Smith and Egan Study*

I think each of us has our own story of entering the world of TA. But what do we know about the impact of initial exposure to TA? A recent study by Smith and Egan (2015) in the *Journal of Personality Assessment* informs us about this question. The study was embedded in a graduate course in personality assessment taught from a TA approach by the first author (Smith). Ten students were enrolled in the course, which included the requirement to conduct a brief TA case. Following the completion of the course, the students responded, through writing, to the following questions:

1. What was your experience of conducting the assessment with your client?

2. What was the most important thing you learned about the assessment process through this project?

3. What did you find most helpful to you about the project

in your learning of assessment and psychotherapy more generally?

4. What areas of the project do you feel you did well in? Why?

5. What areas do you see as needing improvement? Why?

A qualitative coding system using a directed content analysis approach was developed and used to code the trainees' responses. The system was based on the course objectives, the core values of TA (humility, respect, compassion, collaboration, openness, and curiosity (Finn, 2009), and the Assessment Questionnaire, Version 2 (AQ 2; Finn, Schroeder, & Tonsager, 2000). I will return to the results and implications after asking you to reflect on your clients' experiences of TA and introducing a second study.

### *Reflecting on Your Clients' Experiences of TA*

As a psychologist or psychologist in training who values and practices TA, what have you imagined that your clients experienced when they participated in and collaborated with you on a TA, and how did you know? Did they spontaneously tell you along the way or at the end? Did you ask them to complete a measure about their experiences at the end of the TA? Did you follow up with them at the end of the TA or several months later by phone or mail to see what stayed with them from their experience with TA? Maybe you didn't know anything from your clients directly, but had your own sense of their experience.

Did you think that your clients felt respected and valued by you and that they thought you were genuinely curious about and open to their concerns? Did you believe they felt they were in a collaborative role with you and that their input was important and taken into account? Did you sense that your clients trusted you and felt you could empathize with their challenges and hold compassion for them? Did you feel they learned new things about themselves that would lead to positive changes in their lives? If your clients were in therapy and stuck, or beginning therapy, did you think their experience of TA would enhance their subsequent progress?

### *De Saeger, Bartak, Eder, and Kamphuis Study*

A second study, conducted in The Netherlands by De Saeger, Bartak, Eder, and Kamphuis (2015) and published in the *Journal of Personality Assessment,* investigated clients' experiences of TA. This study was a follow-up to a randomized clinical trial (RCT) that compared TA with an alternate motivational intervention (De Saeger et al., 2014). Following the RCT and treatment that followed in both conditions, the first author (De Saeger) completed semistructured interviews with 10 clients who had participated in the TA condition. They were interviewed by phone using the following questions and probes:

1. Can you tell me what has most stuck with you from the TA sessions? When you look back to the TA sessions, what was most important to you? What did TA bring you? (When the participant mentions benefit, follow up with, ... in which way do you think the TA has been helpful? When a participant mentions several aspects, ... what do you think was the most important aspect, and follow through on this aspect first).

2. Was there anything that surprised you about the TA sessions? Was it at all in some aspects different from what you have experienced before in previous psychotherapy or mental health–related sessions? If yes, how was that for you? Can you tell me anything about important moments during the TA sessions?

3. Were there any aspects of TA that you experienced as unpleasant? If yes, can you say more?

The interview data were analyzed using guidelines provided by the Consensual Qualitative Research paradigm (Hill, 2012). I will return to the results and implications of this study shortly, after looking at the results from the first study.

### *Back to the Smith and Egan Study*

In the first study, the first author (Smith) found himself in a unique position, being asked to teach a graduate course in personality assessment, a once-proud clinical endeavor that had fallen from grace and was not highly respected or valued by his graduate students at that time because faculty did not seem to

endorse its relevance. Smith saw an opportunity and agreed to teach the course if he could approach it from the principles, procedures, and techniques of the TA model. These were covered in the course via readings, lecture, and the use of videotaped sessions of the instructor conducting a TA with an adult client. The course culminated with each trainee conducting a brief TA with a volunteer graduate student from another program. In addition to providing a different experience for the students learning assessment, Smith also saw the research potential. By structuring the evaluation form to focus on the trainees' TA case, Smith had the opportunity to capture, in their words, their experience with conducting a TA and their perceived future interest in pursuing TA training and practice. (It is important to note that the volunteer graduate students who were recipients of a TA also were asked to complete a brief assessment form to address their expectations for the assessment and what they found valuable and not valuable. However, only five returned the forms, and although analyzed in the article by Smith and Egan, those findings are not included here.)

### *Results*

The results from the trainees' responses to the evaluation form indicated high acceptability of TA. Trainees described TA as a powerful clinical tool that facilitates the therapeutic alliance, emphasizes collaboration from the beginning with the codevelopment of assessment questions, and allows clients to be understood at a deep, therapeutic level. The trainees indicated that they incorporated the core values of TA (e.g., having respect for their clients) and also conveyed feelings of competence in particular skills and techniques (e.g., conducting the clinical interview, codeveloping assessment questions, collaborating with their clients, and providing feedback). In addition, they described TA as rewarding, enjoyable, and helpful.

Significant for the future practice of assessment and the appeal of TA, the analysis indicated a shift in trainees' view of assessment from dehumanizing, hierarchical, and pathologizing, per trainees' reports at the beginning of the course, to collaborative and therapeutic at the end of the course. In addition, trainees expressed the sentiment that TA was congruent with their personal and professional values and how they want to function as clinicians. And finally, trainees expressed an intention or desire to continue using or learning about TA.

### *Back to the De Saeger, Bartak, Eder, and Kamphuis Study*

In the second study, De Saeger and her colleagues also found themselves uniquely positioned to conduct a study about the experience of TA, in this case clients' experience of participating in a TA. Following the RCT study and treatment, clients who had received a TA were invited to participate in semistructured interviews (see above) designed to assess their in-depth perspective of participating in a TA. Ten completed the interview.

### *Results*

The results revealed four core content domains as being of great importance to the clients. First, *the quality of their relationship with the TA assessor* was key. Clients emphasized positive feelings about the assessor, such as the assessor being warm, kind, and pleasant. In addition, they described active collaboration with the assessor, feelings of equality with the assessor, and positive validation from the assessor. Second, *new insight into personal dynamics* was central. Clients indicated that they had gained new, deeper, more focused insights into, and attitudes about, their own personal dynamics. Third, clients spoke of gaining a *sense of empowerment* from the TA experience and indicated that it enhanced their readiness to begin treatment. Finally, clients emphasized the importance of the *validation of self*. Receiving validating feedback from the assessor in assessment sessions *and* in the feedback sessions was emphasized. When asked about surprising experiences, clients indicated feeling like an equal and an essential collaborator, both of which were new to them in comparison with their previous experience with mental health providers.

### *Synthesis of the Two Studies*

When I looked across the two studies, two things stood out to me. First, I learned that graduate

student trainees who were having their first exposure to TA expressed themselves not unlike, and in fact very similar to, what so many of us have experienced when introduced to TA. The findings across the participants indicate positive feelings toward TA, an appreciation for the collaborative and therapeutic nature of TA, the experience of it being useful to clients, and the fit of TA and its core values with their own personal and professional values.

I also learned that clients who were diagnosed with personality disorders were touched by their experience with TA. They valued their relationship with their assessor, experienced being treated as equals and collaborators, felt validated, reached new understandings of their own dynamics, and were eager to begin treatment. It is easy to see these clients as the recipients of the core values of TA. These findings are also reflective of what many of us want for our own clients and strive to provide.

Second, I learned that both studies were studies of opportunity. That is, something else (a graduate course or an RCT) was in place and the qualitative research component was added on to it. This point is important not only for the results obtained from these two studies, but for encouraging others, researchers *and* clinicians, to do the same. Researchers who are studying the efficacy of TA in a group comparison or pre–post design, or through a case study, can easily add a qualitative component that will contribute to what we know about the experiences of the people participating in a TA, through their own voices. In addition, clinicians practicing TA can do the same, that is, collect qualitative information from their clients through written means or through an interview format, when possible, with a trained interviewer other than the assessor. In addition, reflecting the work of Smith and Egan (2015), teachers of courses or workshops in TA are encouraged to take the opportunity to assess the experience of their students, again either in a written format or, if there are resources, in an interview format.

In closing, the findings from these two studies leave me encouraged that future psychologists exposed to TA in graduate school will seek out additional training and hopefully choose to practice and teach TA. This result would help ensure that more clients will have the opportunity to benefit from TA and that additional students will be exposed to TA in graduate school. The findings also add to the growing evidence that clients are benefiting greatly from TA, and their own voices affirm this. I encourage you to read these two articles and consider how you can be part of continuing efforts to understand and promote the appeal and power of TA.

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## 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. Donations are tax deductible and can be given in any amount through the *Foundation for Excellence in Mental Health Care* website: http://www.mentalhealthexcellence.org/projects/therapeutic-assessment-fund/

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### *Author*

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

# The Use of Clinical Judgment in the Assessment of Autism Spectrum Disorders in Adults

***By Dale Rudin, Ph.D.***
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Often, people who are interested in getting assessed come into our consultation rooms because they are struggling in their daily lives. They want to understand why they are having so much difficulty. The recent increase in the rate that symptoms associated with autism spectrum disorders (ASD) are recognized and the publicity surrounding the disorder have led people to think they might have an ASD when they are experiencing symptoms that include (a) difficulties

in social relationships, (b) problems maintaining a job, (c) discomfort with understanding/expressing emotions, (d) sensory sensitivities, and/or (e) problems with understanding others. They long for an explanation so they can better understand themselves and be able to explain themselves to others. These symptoms may be consistent with other diagnostic criteria, so it is important to know how to differentiate among the different diagnoses that share common symptoms. As a diagnostic category becomes popularized, there is some risk of overdiagnosis. Through the use of good clinical judgment, reliable and valid assessment tools, and a collaborative approach, an accurate diagnosis that helps people better understand themselves can be made.

As most people know, there has been an enormous increase in the incidence of autism. The Centers for Disease Control and Prevention has indicated that the prevalence of the disorder in the United States is about 1 in 68 births, about 1% of the world population has an ASD, and the prevalence of reported ASD diagnoses increased by 6% to 15% each year between 2002 and 2010. During the past two decades, there has been an increase in awareness, screening, and assessment of children with autism. But what about those born prior to this increased awareness? What about the adults who have a number of life problems and wonder whether they might be autistic? Because of my background in special education, my interest in families who have a child with a disability, and my knowledge of autism, I have received a number of referrals from individuals or referring professionals who believe they or their client may have Asperger's or high functioning autism. Presently, in the *DSM-5* the diagnostic category is labeled ASD. I have chosen to use the older term *high functioning autism* and *Asperger's disorder* in this article because, generally speaking, my referrals specifically use these terms. I suspect in a few years the *DSM-5* nomenclature, ASD, will become commonplace.

In this article I discuss four cases and demonstrate how collaboration and the values of Therapeutic Assessment (TA) can assist with making an accurate diagnosis. Before discussing the cases and principles it is probably important to highlight significant aspects of the diagnostic criteria for ASD. The *DSM-5* states that a person diagnosed with an ASD must have "persistent deficits in social communication and social interaction across multiple contexts." Examples of these deficits may include difficulty with social–emotional reciprocity, nonverbal communication, and developing and maintaining relationships. The diagnostic criteria also include "restricted, repetitive patterns of behavior, interests or activities," manifested in at least two ways, including stereotyped or repetitive movements, rigidity and insistence on routines, highly restricted interests that are abnormal in intensity, and/or difficulty with sensory input.

What is critical, especially in the diagnosis of ASD in adults, is that these symptoms must be present in childhood and that the "symptoms cause clinically significant impairment in social, occupational or important areas of functioning." ASD is a developmental disorder and unless there is a history of difficulties in these areas, the diagnosis should not be made. However, because of previous difficulty in diagnosing children who are high functioning, some adults may have escaped the diagnosis but have suffered the symptoms for many years.

## Assessment Cases

### *Social Awkwardness, Lack of Friends, and Anxiety Are Not Enough to Make a Diagnosis: The Case of Taylor*

About six years ago, I got a call from a person who wanted to schedule an assessment. When Taylor originally left his message I couldn't tell if the person calling was a man or a woman. The voice sounded very feminine. I returned the call and we scheduled to meet a few weeks later. When Taylor walked into the room, I again thought I was talking with a woman. He sat down and we began to talk about why he wanted the assessment. There were a number of things in his life that he didn't really understand. He could make friends, but the friendships didn't last long. He didn't understand why he had never been in a romantic relationship. He was very socially anxious. He said he had been doing research on the Internet to determine what might be wrong with him. He found that many of his difficulties were similar to those of people who had Asperger's disorder.

It was clear that Taylor was in a lot of pain. He was lonely and wanted to understand why he was so alone. One of the first things Taylor said to me was that in trying to determine if he had Asperger's disorder, he thought back to how he was with his friends and other people. He described being ridiculed and treated with impatience by his teachers. He grew up in a small town in the South where differences were not tolerated. He said he enjoyed playing with dolls and dressing up. He described himself as being a whiney kid whom peers made fun of. He said he loved to play pretend games and that comforted him a lot.

As an adult he sought treatment at a counseling center that served the LGBTQ community. He said he was extremely anxious and was dealing with a lot of

frustration and anger. He felt he was transgendered and was unable to explore this further because when he took hormones he became violently ill. He said, "I still feel female but I'm not willing to put myself through that kind of torture again." Taylor said the first time he thought he might have Asperger's disorder was when a psychologist suggested it to him to explain why he was so anxious and struggled with keeping friends.

At the end of the first session I was certain that he did not have an ASD. He made good eye contact and conversed in a very natural, reciprocal way. There was an effortless give and take of information between us. His tone of voice had typical inflections and a natural cadence. His developmental history included pretend play and the ability to take other people's perspective. He never complained of sensory issues, repetitive, or rigid behavior. He remarked on thinking back about his friends. The bottom line was he was unhappy and wanted an explanation for it. I didn't see any need to wait to share my thoughts with him. I explained why, even after meeting him just one time, I did not think he had Asperger's. We talked about how being transgendered may have affected his interactions with others, his anxiety, and insecurity. He wanted to come back and talk more about this possibility, and we continued to work together for several more sessions. The issue of Asperger's did not come up again, and he seemed satisfied that he had gained a new understanding of himself and his struggles.

### *Even If Self-Reports Are Positive for the Diagnosis, It May Mean Something Else: The Case of Adriana*

Adriana, a 28-year-old former dancer who was in and out of recovery, was involved with a man with Asperger's. She was certain that she too must have Asperger's because of how similar she was to John, her boyfriend, who had been diagnosed with Asperger's as a teenager. She was hard to follow, very anxious, and lived at home with her aging parents. She described herself as disorganized and needing structure. Her father accompanied her to the initial session and talked about how his daughter had been in and out of treatment programs, and they were worried that she would not be able to live independently once they passed away. At her initial session we generated questions for the TA that we were beginning. Her first question was, "Do I have an autism spectrum disorder or, if not, what's wrong with me?" She said, "It's the only thing that seems to fit with all my little things." Her list of "little things" included "getting really obsessive about things, like this Asperger thing," being "bad with time," "not [being] good at the social aspect [of work]," having "had major [educational] issues as a child," and being able to "understand complex ideas but sometimes have trouble with simple things."

In our first session I understood that she had suffered her whole life with feeling like an outsider. She had attended boarding school, where she got in trouble for drugs and alcohol. She was committed to dancing from an early age and it was the one thing that sustained her. She described several traumatic events in her childhood. In her adulthood, she was raped twice. She said she didn't get along with her mother because she was very cold. She desperately wanted an explanation for why she was so unhappy and unsuccessful.

We did a complete battery of tests. Because Adrianna was convinced that she had Asperger's disorder, I decided to ask her and her parents to complete the Social Responsiveness Scale-2 (SRS-2). This is a 65-item questionnaire that measures various dimensions of interpersonal behavior, communication, and repetitive/stereotypic behavior characteristic of ASDs. Although Adrianna's self-report fell within the severely autistic range on all the subscales, the only elevated subscale in both of her parents' results was a mild elevation in Social Motivation. This gave us a chance to talk about the discrepancy between her and her parents' scores. We puzzled together what her understanding of that might be. Adrianna analyzed this in a way that reflected her ability to take perspective and illustrate that she had a theory of mind.

Throughout the assessment, she wanted to know if I thought she was on the spectrum. I was honest even though I knew that she could leave the assessment midway through, if I did not agree with her, as she had done several times before with other clinicians when she wasn't feeling understood. I said I knew that figuring out why she struggled so much throughout her life was very important to her. But I didn't think she was on the spectrum. I explained why: (a) she was relational in a give-and-take way, (b) she didn't suffer from any sort of pragmatic language problem, (c) she was emotional and able to explain what she was feeling, (d) she struggled in relationships and said some inappropriate things but felt she knew the social rules but didn't like following them, (e) she was able to analyze her relationship with her mother in an in-depth way, (f) she was a gifted dancer (i.e., she was not motorically awkward), (g) she didn't have any sensory disturbances, and (h) her Rorschach was not consistent with that of a person with an ASD. Throughout the assessment we agreed that both of us would keep an open mind until all the data were in.

In the end, she understood and accepted why I did not diagnose her with an ASD.

### *An Accurate Diagnosis Can Be Very Comforting, or Yes, Folks With Autism Can Be Lonely: The Case of Donald*

Donald, age 44, came in to see me because his supervisor was retiring and she suggested he call me. He asked for an appointment and said he thought he should come in because his supervisor had told him to do so. He had his master's degree in library science and had an undergraduate degree in physics. He had an odd speech pattern, was extremely polite, and complained of being lonely. He said he needed to deal with some work issues. He did not come in for an assessment but kept wondering why he felt so sad.

In the first session he shared how difficult work was because he kept getting more and more responsibilities. He felt that things were no longer peaceful there and that at times he felt like, "God, I could just kill someone." When he got anxious, he made catlike noises that disturbed other workers. He shared how he used to like his job but now he wasn't sure about it. He needed the job but the changes were making him very anxious. He wondered what his world would be like if he did something else. He talked in a very dysfluent manner and used a lot of excess words to fill the spaces as he gathered his thoughts. He was one of the most sincere, kind, and polite people I had ever met. He was odd but very likeable. At varying points in that first session I wondered if he were intellectually impaired.

During that first session he gave me background information and shared what was in his heart and mind. His father had died when Donald was 21. He felt his dad had loved him but was disappointed that he wasn't a star athlete. He wondered what it would have been like if he had siblings. He wished he could have been an uncle. He commented that all his grandparents were gone. Even though he lived on his own, far away from his mother, he was frightened about what would happen when his mother died. He wished he could be a teenager again. He said that as a child he didn't talk until he was 4 years old, wasn't very sociable, and that doctors had told his mom that he wouldn't amount to anything. He was proud that he overcame the odds and did very well in school.

During the next couple of sessions it was clear how profoundly lonely he was. He wished for a family and comforted himself by fantasizing about having more friends and family. He poignantly said, "If I were normal, I'd have kids by now." This was a theme that kept coming up. I knew through my interactions with him that Donald was on the autism spectrum. Why? (a) He had a developmental history of delays in the language and social domains; (b) he was extremely naïve about the social world and used what felt like cognitively learned patterns of interaction to relate to others, so his social interactions were stilted and not very reciprocal; (c) he comforted himself by repetitively rocking while making sounds; (d) he did not have an awareness of how his behavior affected others; and (e) his speech had an unnatural prosody—odd intonation and tone of voice.

I made a decision to share my diagnostic impressions with him after meeting with Donald and his supervisor, Ada. Ada was worried that when she retired, there might not be another supervisor who would be sympathetic to Donald. She thought if Donald were given a psychiatric diagnosis, he would be protected by the Americans With Disabilities Act. I also thought that an accurate diagnosis would help him make sense out of his life and his disappointments.

When I shared my diagnostic impressions with Donald, he was relieved. It allowed him to stop blaming himself for not having a family. We worked to get him in touch with an agency that served adults with autism. He participated in a social group that he enjoyed, made friends, and had social outings to attend. I also suggested that he participate in the Big Brother, Big Sister Organization. They paired him with a little brother that was on the spectrum, and he became part of his little brother's family. Last I heard, his mother had passed away, and he had bought a house and was living with a younger man.

### *Odd Facial Expressions, Being an Engineer, and Lack of Affect Are Not Sufficient for the Diagnosis: The Case of Jeffrey*

Jeffrey was referred because the residential treatment center staff where his daughter was hospitalized suggested he talk with me to find out how he may be negatively affecting the emotional life of his daughter. The service providers in the treatment facility said they thought he might have Asperger's disorder or high functioning autism. As we talked I noticed that he made eye contact in a very intense way—looking straight at me. It almost felt as if he were looking through me, without showing any facial expression. He talked about his job as an engineer at a small computer software company. He supervised other people and enjoyed this part of his job. He talked about his daughter and how hard it was for him that she was so far away from home. He said how upset he was about this, but his facial expression never changed.

We decided to do a brief assessment using the MMPI-2 and the Rorschach to focus on his two concerns:

What kind of influence have I had on my daughter's condition? Do I have an autism spectrum disorder? There were very few elevations on his MMPI-2. His low scores on Scale 5 (T = 30), Amorality (Ma1 = 35) and Emotional Alienation (Sc2) were indicative of someone who is rigid, moralistic, and practical minded—not unlike people with autism. However, the scores that you would expect to be elevated in someone with an ASD, including Clinical Scales 2 and 0, Social Discomfort (SOD), and the PSY-5 Introversion scale, were not elevated (Ozonoff, Garcia, Clark, & Lainhart, 2005). Jeffrey's Rorschach painted a picture of someone who minimized his dependency needs, was able to cooperate with others, focused on the facts, and had less stress than you might think, given the family situation. His responses were indicative of someone who is not in touch with his emotional life and does not always focus on the complexities of life.

When I interacted with Jeffrey, it felt like I was talking with someone who had autism. Our conversation felt stilted, and his lack of emotional responsiveness or affect was consistent with someone who has an ASD. However, I did not diagnose him with an ASD because he did not report any developmental difficulties. In addition, he talked about having a wide network of friends, and he did not indicate that he had any restricted, repetitive patterns of behavior, interests, or activities. Talking about the diagnosis allowed us to focus on his limited emotional responsiveness, why that might be part of who he is, and how it would affect his daughter.

### *Assessment Tools Specifically Focusing on Autism That Assist in Making the Diagnosis*

While I hope I have made a case for using clinical judgment in discerning an ASD diagnosis, there are several assessment tools that are useful when it is difficult to rule out the diagnosis through a clinical interview and developmental history. The Autism Diagnostic Observation Schedule-2 (ADOS -2) is often considered to be the "gold standard" observational tool for diagnosing an ASD. It is a semistructured, standardized assessment of communication, social interaction, play/imaginative use of materials, and restricted and repetitive behaviors (Lord et al., 2012). It has four modules and a Toddler Module. The activities and interview questions in Module 4 were developed for use with older adolescents and adults who have fluent language skills and who have a level of independence in daily living skills. It provides a structured yet flexible way to interact with, and obtain information about, the client in a variety of areas, including communication, emotional awareness, conversation, and social difficulties.

The Social Responsiveness Scale, Second Edition (SRS-2), is a 65-item objective measure of symptoms associated with autism. There are different forms of the measure: the Pre-School Form for ages 2½ to 4 ½ and the School-Age Form for ages 4 to 18 are intended for completion by a teacher or parent. The Adult Form, for ages 19 and up, is a self-report form. A parent, friend, or relative of the person being assessed may also complete this form. The areas it addresses are social awareness, social cognition, social communication, social motivation, and restricted interests and repetitive behavior (Constantino & Gruber, 2012).

It is important to be aware of several online self-report questionnaires because a person who is wondering if he/she might have a diagnosis of an ASD might have already taken these tests. The questionnaires also can reveal good information that can serve as a springboard for further exploration by the assessor. The Ritvo Autism Asperger Diagnostic Scale-Revised (RAADS-R) is an 80-question scale that was designed as a screening tool (Ritvo et al., 2011). Although this tool was designed to be administered by a clinician, it is readily available online for anyone who is interested.

Another readily available online tool is the Baron-Cohen et al. (2005) diagnostic system, the Adult Asperger's Assessment (AAA): A Diagnostic Method. This system was based on the *DSM-IV* criteria for Asperger's syndrome. Although the criteria have changed with the *DSM-V,* it is still available online. The related questionnaires are the Autism Spectrum Quotient (ASQ) and the Empathy Quotient (EQ). If they are used in an interactive manner, the answers to the items can provide good information.

A new self-report measure, the Adult Repetitive Behaviours Questionnaire-2 (RBQ-2A; Barrett et al. 2015), explores restricted and repetitive behaviors. This measure gives the assessor a series of questions that address this part of the diagnosis, which might be overlooked, dismissed, or confusing to assess.

### *Conclusion*

In this age of evidence-based assessment and treatment, I hope I have made a case for trusting and developing your clinical judgment in diagnosing people with an ASD. The cases demonstrate the importance of tailoring the assessment protocol to the individual and keeping the values of TA at heart. If we are truly being collaborative, it is critical to use our best clinical

judgment to focus on the client's needs and assessment questions. Through collaboration we can understand our clients better and decrease the possibility of a misdiagnosis of autism.

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# Therapeutic Assessment
## An Experience with Consultation

***By Donna Kelley, IHM, Psy.D.***
***Immaculata University***

As I listened to Stephen Finn's description and history of the Therapeutic Assessment (TA) model during the 2010 Society for Personality Assessment (SPA) annual meeting, I was inspired by his passion and zeal. I left his presentation determined to learn and use this assessment method. Little did I realize where this journey would take me and the amazing people I would meet along the way. Later that day I purchased *In Our Clients' Shoes* (Finn, 2007) and over the years attended several TA workshops, including Countertransference and Trauma: Therapeutic Use of Self with Clients in C/TA, Working with Shame in Psychotherapy & Psychological Assessment, Introduction to the Therapeutic Assessment, and the Therapeutic Assessment Conference. I also read articles about TA, spoke enthusiastically about the model in the personality assessment classes I teach at Immaculata University, and attempted to use it in my private practice. Yet I sensed there were key components missing from my training in the TA model but could not identify them.

I discovered the missing pieces during the 2015 TA Immersion Course in Austin, Texas. What an incredible experience! Meeting other participants interested in TA from several countries and states was enriching in itself. In addition, the TA faculty were dedicated, affirming, and down to earth. It was refreshing to spend five days with such a caring and empathetic group. The warm and relaxed learning environment made it easy to be myself.

Throughout the week I discovered the elements I was missing in my attempts to teach TA to myself. TA is a collaborative process that requires interpersonal connection. You can't do it alone, and now I believe you can't learn it on your own. Although I read about it and listened to lectures about the model, it came alive in the presence of other professionals who love it. For example, I had "head knowledge" of the six TA steps, but I did not know the goals or the role of each step. Through lectures, role plays, and discussions, I came to understand the significance of establishing a collaborative environment, developing assessment questions, collecting background information, and meta-processing.

The most beneficial, yet stressful, facet of the week was the small group role-play sessions. In this group a bond developed between the leaders, Dale Rudin and Hale Martin, and the other members of the group. I felt free to practice what was taught during the lectures and receive feedback from the group, as well as offer it to them. It made the lectures come alive and helped me flesh out TA concepts. For example, learning the importance of using assessment to access split-off affect was a new idea, and it intrigued me to think of assessment in this manner. The role plays provided an avenue to see how this occurred, making the process clearer. Dale was a great actress (she depicted a client who was emotionally avoidant and interpersonally detached), keeping the atmosphere light and the group laughing.

I also discovered other important aspects of TA that my own attempts to learn it had left me lacking, including the extended inquiry (EI), case conceptualization, and Assessment Intervention Sessions (AIS). Each skill was taught through lecture, role plays, and/or videos. This repetition helped solidify the techniques and clear up confusion. As the week progressed, my love for, and belief in, TA deepened. At the conclusion of the week, I felt sad to leave, grateful for the experience, and excited to use the skills. Truly, it was the most enriching training that I had ever attended.

During the Immersion Course, I wondered if TA might help a particular client I had reached an impasse with. We were both frustrated—he with his lack of "progress" and me with his inability to move beyond anger. My hope was the collaborative process might empower him and provide direction for further work. Before leaving Austin, I spoke with Steve Finn about ways to continue my training. One thing he suggested was conducting a TA with a consultant. This seemed like a perfect idea and to my delight, the client consented to the assessment. Even better, Dale Rudin graciously agreed to be my consultant. Thus, motivated and anxious, I began a new stage in my TA training.

I tried to enter the consultative process without expectations and an openness to whatever might transpire. It turned out to be a powerful and broadening experience. Dale was a wonderful mentor throughout the assessment process. We set up regular meeting times through Skype or by phone and reviewed my videos either together or separately. She was always pleasant, patient, and positive, walking me through each step and tolerating my mishaps. It was helpful to have a guide who kept me focused on each step. What follows is a reflection on my experience of completing a TA under the watchful eye of a TA consultant.

### *A Case Illustration*

Mario, a never-married, 40-year-old Caucasian male with a history of bipolar and trauma, was self-referred. He reported several past hospitalizations for psychotic episodes and had been stabilized on medication for the past eight years. His main complaints were depression, anger, interpersonal conflicts, and poor self-image. At the time of the assessment, we had been working together for four years. After explaining the TA process, I helped Mario develop these assessment questions:

1. How does my anger, resentment, and frustration get played out?
2. How can I engage the process of getting rid of this anger and resentment?
3. Why is it hard for me to jump in and get started at the beginning of therapy?
4. Do I want to make progress? If so, what would help me make more progress in therapy and how will I know that I am making progress?
5. At times, why do I get stuck in the thought that nothing will ever change?
6. How can I be so positive with others and not with myself?

Dale reviewed the questions and offered suggestions for collecting additional background information about Mario's anger. We then moved into the standardized testing portion of the assessment. Mario completed a tailored sentence completion focusing on anger, the MMPI-2, MCMI-III, and the Rorschach. The first profile Dale and I reviewed was his MMPI-2, and we were not surprised that he responded defensively. Although his code type was a 3*487, there were several significant scores, suggesting a mixed pattern of symptoms: Scale 3 (91*T*), Scale 4 (84*T*) Scale 8 (84*T*), Scale 7 (81*T*), Scale 2 (72*T*), Scale 6 (72*T*), and Scale 1 (68*T*). When Dale looked at the profile, she gently stated, "He is really suffering." When I heard the compassion in her voice, I was moved with emotion. This was the first powerful moment of the consultation process. I sat with her statement and the compassion I heard in her voice for a long time. Suddenly, I realized that I had lost compassion and empathy for Mario. I could only feel frustration at his anger and annoyance at his need to push me away. As I held his profile in my hands, I began to see him differently. Here was a person who was really suffering and wanted relief. My perception of him changed, and since that day, I can empathize with him even on his "bad" days. For this, I am indebted to Dale.

Before administering the Rorschach, Dale and I discussed the pros and cons of its use with a client I had, and would continue to see, in individual psychotherapy. Since patients will be more open and less defended in their responses with their own therapist as the administrator (Finn, 2011), I was hesitant, but I also believed it would supply valuable insights; therefore, I chose to use it. Although Mario gave only 16 responses, it was a heavy and intense session. His responses contained descriptions such as a scary face (Card I), a heavy and frightened person (Card 1), and a bat with opened wings, to whom he cautioned, "Bat, you don't want to be that open" (Card V). To Card II, he gave the following response:

*So, at a deeper level, it looks like two people pressing hands together. It is almost a perfect fit. They are applying force. These heads are red showing anger. What is underneath? I am seeing under the black, red which isn't obvious at first. I am seeing a lot of red. The black looks like the body to me. I am seeing blood that is splattered, but it is a great struggle.*

During a consultation session with Dale, we spoke at length about this response. We began to understand Mario's split-off affect at a deeper level. To us the black represented his anger and he used it as a cover for his other feelings. Under the black (anger) was red, which symbolized potential split-off feelings, such as sadness, fear, and loneliness. These emotions appeared in Mario's other responses as well. From this analogy, my understanding of Mario became clearer.

In our next session I conducted the EI of the Rorschach, and Mario allowed himself to be more vulnerable. One of the responses I chose to ask about was to Card VI (Response 9). In his initial Rorschach, Mario gave this response:

*I think this is some sort of figure. A male figure standing on what looks like some sort of elevated rock and he has spikes in each side of his neck like shards, not arrows. His arms are outstretched like this (demonstrates) and hands look like spears, spearheads. Through him there is a dart sort of.*

*What do you call it? I see some dark connected thing that is visible through the back and connects him, anchors him, to the rock that he is standing on. From the front something is coming out, not sure what.*

During the EI, after Mario read this response, he stared at the card and repeated, "So violent … the violence is striking. This is me." It triggered a childhood memory of fighting with a younger brother. When his brother began to cry, his father blamed Mario for the fight, mocking and humiliating him. He was left feeling helpless, hopeless, alone, hurt, and sad. He likened it to shards going through his neck and felt like he was being tortured.

Following this reflection, we reviewed Response 13 on Card IX:

*It looks like someone caught behind two rocks. What I am seeing is the person's face, the eyes but I can't see the expression. It looks like they are caught, a blank stare. It looks very confining. They can barely move. The eyes look pessimistic. What comes from the face is a cloud, a nebulous place. It is red. The rocks look like helmets, the rocks that are keeping the person confined.*

After he read his response, he repeated the phrases "closed in space," "blank stare," and "covered with a mask." He also added, "The red are the feelings." He then gave the following response:

*A blank stare, that is how I present myself so I do not get ridiculed…no feelings and no emotions, just blank. I put on sunglasses and go behind a rock and peek out so no one can see what is going on inside. I am always ready to be hurt. That is how I was when I was younger. My parents would threaten to put me out on the street if I messed up. I was scared. Who would take care of me? Now I am afraid that if I mess up, I will be said good-bye to and left on my own. It doesn't make sense I know. It is illogical. Here is another illogical thing. When I get frustrated, I want to do something to get back at you and so I frustrate you. It doesn't seem fair that I am the only one frustrated so I want you to be frustrated also. I know it is illogical but that is what I do.*

At the end of this session, Mario remarked, "I think we are going in the right direction." I couldn't help but agree. I was struck and moved by Mario's insights. Just as Dale and I expected, Mario had a tremensdous amount of painful emotion beneath the surface of his anger. The extended inquiry process helped me further my understanding of his pain, and my compassion and empathy for him deepened. His responses provided an image of the defenses he uses against humiliation and rejection, such as running behind a "rock" or putting on "sunglasses." I could identify moments when these occurred in his therapy sessions. My perception of his intense shame also became more vivid, and my sensitivity to it increased

In our next consultation, Dale and I discussed these responses and my understanding of Mario. I then worked on my case conceptualization of him in relation to his assessment questions. After scoring his Rorschach, I interpreted his scores with caution, as recommended by Stephen Finn, when testing your own clients (Finn, 2011). In spite of this, his Structural Summary fit my experience of him. Based on his scores, he appears to have sufficient resources available (EA = 13); however, he is unable to use them (EB = 7:6). He also is likely to experience episodes of strong emotion, including depression (DEPI = 5 and CDI = 1), expresses them intensely (FC: CF + C = 2:5), and probably feels badly about himself (FD = 3, V = 1). Although he may be interested in others, he tends to be cautious and guarded (T = 0, HVI = Positive) and relates to people in an aggressive manner (COP-0, AG = 5). Furthermore, his anger and oppositional tendencies are negatively affecting his interpersonal relationships (S = 4). My case conceptualization was coming together. I could see how Mario's anger had served him by protecting him from the painful split-off feelings of sadness and hurt.

Dale was wonderful in clarifying questions related to split-off affect and half steps. I also consulted with Dale on the AIS, and she walked me through the steps of this process. For me this was the most challenging part of the TA and the one I was most anxious about attempting. Dale eased me with her affirmation of my skills and alliance with Mario.

For the AIS, I chose cards from the Roberts Apperception Test (Roberts & Gruber, 2005) to see if I could elicit Mario's split-off affect and help him begin to understand how his anger protected him from profound sadness and hurt. Mario responded beautifully. Two of his stories that were most meaningful for his TA were to Cards 6B and 12B. Below is a summary of his story to Card 6B:

*There is a boy with his hands in his pocket trying to protect something. The other two boys are asking him for it and acting all haughty. He doesn't want to give it away but the boys kept it up. In the end, he gives them his gum and left sad. He wanted the gum.*

When Mario looked at Card 12B, he appeared sad and said, "This is my life." He then went on to tell the following story.

*The husband is standing over his wife after beating her. He looks all powerful with his hands on his hips and he is saying to her, "See who is the boss? Keep it up and I will*

*throw you out on the street." The wife is crying and scared. She is diminished. The little boy is peering over the chair terrified and crying quietly. He is scared that he will be next. He then runs to his room and hides under his magic carpet.*

At that moment, the sadness in the room was poignant. When I asked Mario what he was feeling, he responded, "I feel frustrated," illustrating how anger is so much easier for him to verbalize and express than sadness. After a failed attempt at a half step, I shared, "I feel so sad!" He appeared bewildered and remarked, "I think we are on to something." As I reflected on the AIS in light of Mario's case conceptualization, my understanding of him became clearer. His need to deprive himself of his wants by giving in to the wishes of others, I saw as an attempt to avoid rejection. I also remembered instances in therapy when he appeared scared and shamed like a child who hid under his magic carpet to avoid facing deeper feelings. I also could sense a positive change occurring in our therapeutic relationship. Mario's trust in me was increasing and his resistance was decreasing. On the other hand, my empathy was deepening.

At this point in the TA, I had a good understanding of Mario and his test data. This was the result of my close work with Dale and frequent review of his assessment questions. Consequently, I felt comfortable with the amount of data and was able to connect it to my client in an understandable way. When I wrote my responses to his questions, I found it much easier than when I write the results section of a traditional psychological report. As a result, the feedback session with Mario went smoothly. In fact, by this point, Mario had a clear sense of his own answers to his TA questions. As such, he responded favorably to the formal feedback sessions. At the end of it, he expressed gratitude and was looking forward to receiving his letter.

Before I wrote the letter, Dale clarified the "warm" features of a TA letter, as well as the introduction and the conclusion. She also reviewed my first draft and provided suggestions for the finished product. With her help, it developed into a warm, respectful, and sensitive letter. After Mario received it, he arrived at a therapy session with his letter in hand. He exclaimed, "You are really into this. It is so clear and the suggestions are useful and practical. I never had anything like it." When I asked him what part of the letter he liked best, he remarked the initial sentences, acknowledging how much I enjoyed working with him. He also expressed appreciation for my comments about what I learned from him. He was beaming.

## Conclusions

In retrospect, conducting my first TA in consultation with Dale was a powerful and invaluable experience. Engaging in the collaborative process with an expert made my book knowledge and training come alive. It kept me focused on each part of the TA process, making me less likely to forget anything. In all honesty, Dale's insights enriched this process tremendously and also changed Mario's course of therapy.

When I met with Mario for a follow-up session eight weeks later, we reviewed the suggestions provided in his letter, and he was amazed at his progress with them. This was a significant improvement in Mario's willingness to complete recommendations. He continues to bring his letter to therapy and reads it in between sessions. With many thanks to TA and my consultation with Dale, my client is in a good place in therapy. While the training I received in the Immersion Course provided me with skills and understanding of the TA process, consultation offered me an opportunity for hands-on training with an expert. It was an incredible and powerful experience for me both personally and professionally. My trust in Dale and the TA process mirrored my client's trust in me and the therapy process. This trust and Dale's guidance helped me reach a new understanding of my client and thereby changed his course of therapy. I wholeheartedly recommend the use of consultation to those interested in deepening their TA skills! I see it as a vital part of practicing TA.

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# Leonard Handler's Enduring Contributions to Therapeutic Assessment

***By Stephen E. Finn, Ph.D. and J.D. Smith, Ph.D.***

This past February, the Therapeutic Assessment Institute reported the passing of Leonard Handler, one of the pioneers of Collaborative/Therapeutic Assessment (C/TA). At that time, we promised we would be finding ways to honor Len and his work, and this article is a first step in that regard. As a close colleague of Len's (SF) and his last Ph.D. student (JDS), we first summarize Len's contributions to TA and then describe his personal impact on each of us individually. It's worth mentioning that Len's work and impact on the field of psychology are much larger than we can summarize in this brief account. We focus on his work and its effects related directly to C/TA.

### *A Brief Overview of Len's Life and Career*

Len was born on September 6, 1936, in a poor section of Brooklyn, New York, to parents who were immigrants from Eastern Europe. As he described in a published autobiography (Handler, 2005), he was an indifferent student in elementary and high school, who eventually made his way to Brooklyn College, where he became fascinated with psychology. He earned a master's degree at City University of New York and eventually entered the Ph.D. program in clinical psychology at Michigan State University in 1958. As part of his fellowship to MSU, he worked and lived

at Battle Creek Veteran's Administration Hospital. All the other staff would go home at 4:30, but because Len was lonely, he would go on the hospital wards and spend time with patients. There he found evidence of something he had read in one of Harry Stack Sullivan's (1953) books: "We are all more simply human than otherwise" (p. 16). As many of you know, this belief is a core principal of Therapeutic Assessment (Finn, 2009). Years later Len cited his experiences at the Battle Creek VA as having been fundamental in the development of his own ideas about psychological assessment. In his second year of the doctoral program, Len tested clients at the Dearborn VA Hospital outpatient clinic and there earned the title of the "slowest assessor," because he spent a great deal of time collaborating with his clients, testing the limits, and interviewing them about their lives. He began to feel that the traditional division between assessment and psychotherapy was artificial and made no sense.

While in graduate school, Len met and married Barbara Handler, who remained his loving and supportive companion until he died. Those of us close to Len know how much he relied on Barbara and how much she organized and enriched his life. Some might also recall that she regularly accompanied Len to the Society for Personality Assessment's annual meeting. The photo of Len and Barbara that appears with this article was taken at the dinner celebrating his receipt of the Bruno Klopfer Award in New Orleans, Louisiana, in March 2008.

In 1964, after receiving his Ph.D., Len joined the faculty of the University of Tennessee at Knoxville, where he spent his entire academic career (42 years, plus three as emeritus). He was beloved as a professor, served as director of the Psychological Clinic, and chaired more than 75 dissertation committees and served on more than 200. Len published four books on clinical psychology and psychological assessment and authored more than 100 journal articles and book chapters. He was president of the Society for Personality Assessment (SPA) from 2003 to 2005 and won the 2008 Bruno Klopfer Award for Distinguished Lifetime Contribution to Personality Assessment. He was also honored in 2008 with the Toy Caldwell-Colbert Award for Distinguished Educator in Clinical Psychology from the Society for Clinical Psychology—Division 12 of the American Psychological Association, in large part for his dedication and contributions to the teaching and supervision of psychological assessment. In addition, Len always maintained a private practice, where he conducted psychotherapy and psychological assessment with children, adults, and families. Len was truly an amazing scholar, teacher, and clinician, and many people benefited from his warmth, wisdom, and expertise.

### *Len's Contributions to Collaborative / Therapeutic Assessment*

Len brought to his practice and teaching of psychological assessment (a) a belief in the value and wisdom of the client, (b) a remarkable sense of empathy and caring, (c) a willingness to "break rules" when it made sense to experiment with nontraditional ways of using tests, (d) a great sense of creativity and playfulness, and (e) a belief in the therapeutic power of psychological tests. His publications and presentations attest to the fact that he was collaborating with clients and having profound therapeutic effects long before the terms *collaborative assessment* or *therapeutic assessment* came into being. For example, in one paper presentation at SPA (Handler, 1988), Len described how he used Klopfer's "Testing of the Limits" procedure for the Rorschach with the WISC and the WAIS. This was one example of a set of techniques Len eventually called the *extended inquiry*—a phrase that is now part of the standard terminology in TA.

Len was particularly interested in projective drawing techniques, and both his first (Handler & Reyher, 1964) and one of his last publications, an edited book about the topic (Handler & Thomas, 2013), concerned this area of assessment. He developed a remarkable projective drawing and storytelling task called the "Fantasy Animal Drawing and Storytelling Technique" that he used primarily with children. His chapter in the C/TA casebook

(Handler, 2012) is a remarkable account of his sensitive and therapeutic use of this procedure, and some of the same material is narrated in Len's lecture in a DVD series published by SPA, called "Pioneers of Therapeutic Assessment" (Handler, 2009). In the recorded lecture, Len tells the story of how he happened upon this technique. The story embodies his giftedness as a clinician and the creativity and sensitivity he brought to his work with children. Interestingly, Len credited Connie Fischer and Steve Finn with "discovering" his work at the SPA annual meeting and telling him that he was doing "therapeutic assessment." He became an important and vibrant member of the C/TA community in the last 15 or so years of his career, coediting the C/TA case book (Finn, Fischer, & Handler, 2012); publishing an important chapter (Handler, 2006) about his many ways of using tests therapeutically with children, adolescents, and their families; publishing one of the few chapters about collaborative supervision in assessment (a reflection of C/TA values applied to the supervisor-supervisee; Handler, 2008); and coauthoring a number of journal articles and chapters about C/TA with his graduate students. During his career, Len also developed innovative and interesting ways of using psychological tests with couples and families. You probably have heard about the consensus Rorschach, which he wrote about (Handler, 1997), but have you ever thought of doing a consensus WAIS? Len did, and would tell amazing stories of what he learned about couples through this procedure, and, more important, what couples learned about themselves.

### *Personal Recollections*

***Steve Finn.*** I heard Len speak in the mid-1990s at an SPA annual meeting about his assessment work with children, and I immediately sought him out. He was very touched by my interest, and we immediately began to correspond and talk by phone about our respective experiences with the therapeutic power of assessment. At Len's invitation, I began to visit Knoxville in the early 2000s to give presentations to his students at the University of Tennessee, about TA. Len was an incredibly gracious promoter of my work, saying that I had "more good ideas" than he had ever seen. His humble encouragement meant a great deal to me in that I was receiving very mixed reactions to my ideas at the time. When I was struggling with self-doubt or anxiety, I would call Len and would always feel better afterwards. And whenever I could, I would ask him to tell me stories about his work with clients. I listened with rapt attention and always came away with new ideas.

I remember one time Len told me about working with a client who had become emotionally overwhelmed and had given highly thought-disordered responses to Cards VIII, IX, and X of the Rorschach. Len was very concerned, took a break, and made black and white photocopies of these brightly colored blots. He then re-administered the cards to his client, who gave good responses. They then had a very productive and frank conversation about how the client's thinking "was way out there" when he was emotionally flooded. I remember marveling at Len's courage and

creative thinking, and then using the same procedure that same week with a client, to great benefit.

Len and I began to present together at meetings of SPA and of the International Society for Rorschach and Projective Methods, and he never failed to produce a thoughtful, wise, moving, and creative paper. I miss him terribly and still find myself asking, "What would Len do here?" when I have a particularly difficult clinical case. Len's contributions to TA, both direct and indirect, are too numerous to list in this brief account. I look forward to seeing his work studied and recognized in these years after his death.

The above picture was taken at the XVIII International Congress on Rorschach and Projective Methods in Barcelona, Spain, 2005, when Len presented in a symposium with (front row, from left) Marita Frackowiak, Caroline Purves, Connie Fischer, Diane Engelman, and (back row from left) Irving Weiner, Len Handler, Judith Zamorsky, Dorit Noy-Sharav, Steve Finn, and J.B. Allyn.

***J.D. Smith.*** My first experience with Dr. Handler was in a course called Interviewing and Observation that he taught to all incoming clinical psychology Ph.D. students in their first year in the program at the University of Tennessee. I remember the seven of us graduate students anxiously sitting and watching a recording of one of us conducting an interview with an undergraduate volunteer while Dr. Handler, patiently laid back in his chair, slowly rubbing his hands in a repetitive, self-soothing motion. It seemed clear that our neophyte clinical skills and no doubt countless mistakes were slightly uncomfortable for everyone in the room. He would periodically pause the video-recording and ask us to ponder dynamics between interviewer and interviewee or to consider what the client was "really communicating," comments that were usually well beyond our current understanding. We sat there in awe of his observational skill and clinical intuition.

This awe was magnified 100-fold the following year when we again had Dr. Handler for the advanced course in psychological assessment during which we learned the Rorschach, Thematic Apperception Test, and drawing techniques, and how to integrate test results, conceptualize the client, and write an integrated report. Students were asked to bring in test materials and we would sit and interpret them, blind to any information at all about the client who had been assessed. When it was my turn to present my materials, I recall Dr. Handler examining the responses and test results and offering a very specific account of this man's childhood experiences. The client had reported most of the information to me during the initial interview and during testing sessions when I had conducted extended inquiries. However, there was a good deal of details about his childhood experiences, particularly with his parents and peers, that Dr. Handler proposed through his evaluation of the materials. I recall thinking at the time that these pieces of my client's life were plausible—that is, they were a cohesive narrative that seemed to make sense to me—but it was not until the assessment feedback session, when my client spontaneously confirmed nearly all of Dr. Handler's interpretations as we discussed the results, that I came to believe in the power of assessment and to recognize and appreciate Dr. Handler's clinical aptitude.

It was in this course that Dr. Handler introduced me to Therapeutic Assessment and to Steve Finn, who gave a full-day introductory workshop at the Tennessee Psychological Association meeting in Nashville that same semester (Len was the program chair and had invited Steve). After Steve's workshop, because of the many stories that Dr. Handler shared with us about his own therapeutic assessment work with clients in the course, and my own dabbling with these techniques, I decided I wanted to do research on Therapeutic Assessment and learn how to practice the model. First, I had to convince Dr. Handler to take me on as an advisee even though he had stopped accepting students three years prior in preparation for retirement from academia. I approached him with my desire to do my dissertation on Therapeutic Assessment, and to my delight he agreed without hesitation.

The picture above of Len and me was taken at the 2011 SPA meeting held in Boston.

I had a unique relationship with Dr. Handler because he was emeritus or retired the entire time I was his student. He had no other students on campus, no research lab, and a new office that he shared with another emeritus professor that he never used. So when I would need to meet with him, I would go to his home or to his therapy office. We often had two- to three-hour meetings during which he would read my work as I waited, scribbling edits and suggestions on printed copies of my manuscript or dissertation drafts. I would read or work patiently until he asked a question or was ready to go over the document with me. We had to discuss the edits immediately because I couldn't read his writing very well and he would forget what he had been thinking if we had to return to it later. Often as Dr. Handler worked on my paper, Barbara would come by to steal me to help her with something around the house, like changing a high-up light bulb or carrying enormous bags of bird feed from the car to the back deck, which Len wasn't able to do because of knee problems and a period of recovery from knee replacement surgery. Barbara admitted to me once that she planned trips to the garden center on the Sundays that I was scheduled to meet with Dr. Handler.

Through our time together I came to know Len more and more and to appreciate his caring, his playfulness and creativity, and his sensitivity. His mentorship was exactly what I needed as a young researcher and clinician. He inspired me to be bold in my academic pursuits, and at the same time he taught me how to be the kind of mentor that I wanted to someday become. My story of being inspired, mentored, and prepared for life, as much as for professional practice in psychology, is not unique. He left an indelible impression on generations of psychologists through his personal relationships with them and through his many academic contributions. I am grateful to have known him the way I did and for his influence on me personally and professionally.

### *Legacy*

Despite having been a humble, deferent, and unassuming man, Len's contributions, influence, and impact on C/TA were sizeable and enduring. His writings and presentations affected many psychologists who now advance research and clinical training on C/TA and who use these techniques to their clients' benefit every day. Even if Len's work isn't explicitly cited, his thinking about the ways to use psychological assessment therapeutically and his creativity that spawned techniques such as the extended inquiry or the Fantasy Animal Technique will continue to shape the C/TA paradigm. We hope you consider reading some of his work and/or watching the SPA DVD to experience Len's inspiring work firsthand.

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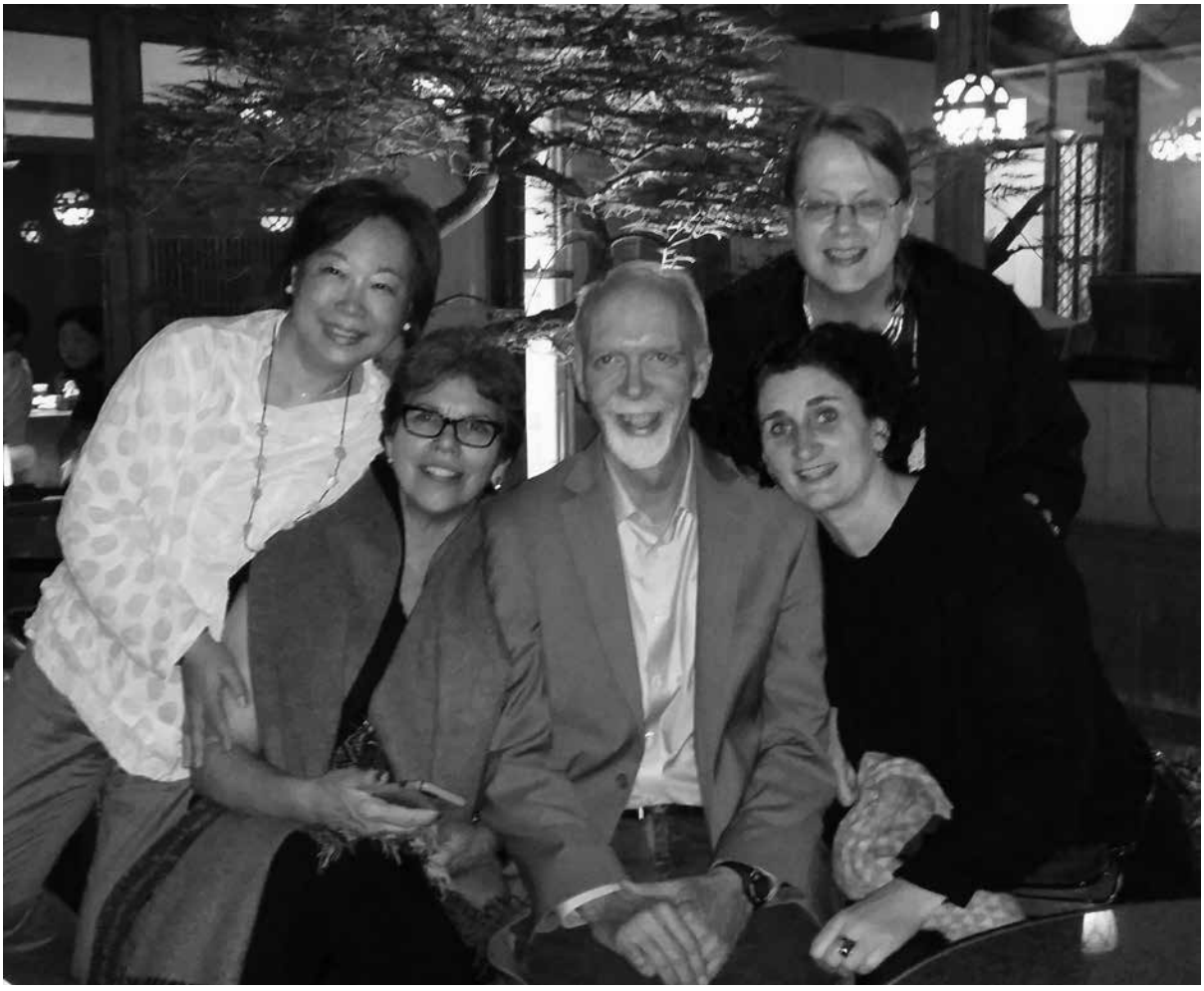
# Photo Album

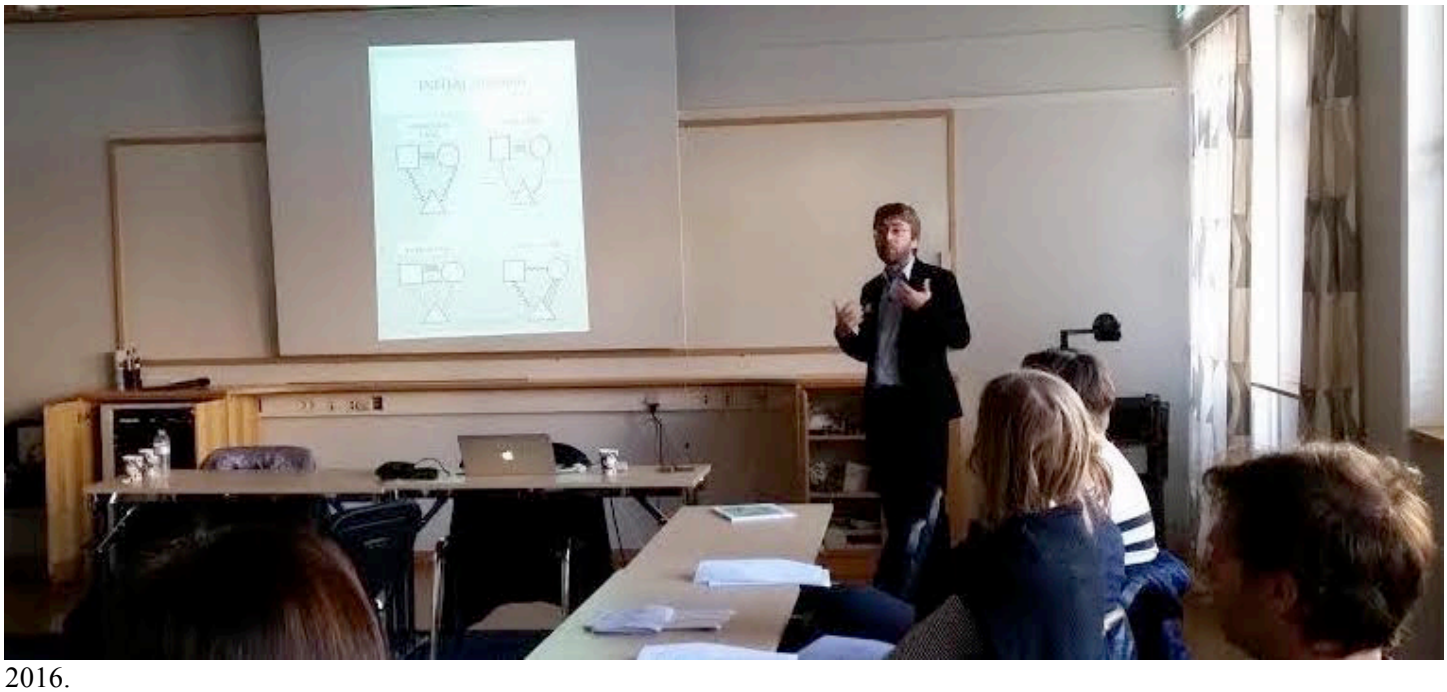


Left: (From left) Noriko Nakamura, Dale Rudin, Stephen Finn, Hilde De Saeger, and Lena Lillieroth in Japan to conduct trainings at the Asian-Pacific Center for Therapeutic Assessment, May 2016.

Right: Marita Frackowiak presents about initial sessions in Therapeutic Assessment at a workshop in Sweden, April 2016.

Above: Members of the Asian-Pacific Center for Therapeutic Assessment at an in-house training in Tokyo, Japan, May 2016. From left: Shin-ichi Nakamura, Sho Yabugaki, Mitsue Tomura, Naoko Nishiyama, Hisako Nakagawa, and Sachiyo Mizuno.

Below: Lionel Chudzik presents at a training about Therapeutic Assessment for children and families in Sweden, April



2016.

# Recent Publications in Therapeutic/Collaborative Assessment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### *Special Section on Cultural Considerations in Collaborative and Therapeutic Assessment*

Aschieri, F. (2016). Shame as a cultural artifact: A call for self-awareness and reflexivity in personality assessment. *Journal of Personality Assessment*, 1–9. doi:10.1080/00223891.2016.1146289. Available ahead of print.

Chudzik, L. (in press). Therapeutic Assessment of a violent criminal offender: Managing the cultural narrative of evil. *Journal of Personality Assessment*.

Evans, B. F. (in press). What torture survivors teach assessors about being more fully human. *Journal of Personality Assessment*.

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Smith, B. L. (in press). Context matters: Commentary on papers by Aschieri, Chudzik, Evans, and Fantini. *Journal of Personality Assessment*.

Smith, J. D. (in press). Introduction to the special section on cultural considerations in collaborative and Therapeutic Assessment. *Journal of Personality Assessment*.

### *Special Section on Teaching, Training, and Supervision in Personality and Psychological Assessment*

Evans, B. F., & Finn, S. E. (in press). Training and consultation in psychological assessment with professional psychologists: Suggestions for enhancing the profession and individual practices. *Journal of Personality Assessment*.

Hopwood, C. J., & Blais, M. A. (in press). Model-based approaches to teaching and practicing personality assessment. *Journal of Personality Assessment*.

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# Upcoming Trainings in Therapeutic Assessment

**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
Language: English
Information: www.therapeuticassessment.com

**June 18, 2016: Milan Italy**
Title: Come rendere i test vivi e relazionali: le techniche dell'inchiesta estesa [How to make tests alive and relational: The method of the extended inquiry]
Presenters: Stephen E. Finn and members of the European Center for Therapeutic Assessment
Sponsor: European Center for Therapeutic Assessment, Catholic University of the Sacred Heart, Milan
Language: Italian
Information: segretaria.ceat@unicatt.it

**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
Language: English
Information: marita.frackowiak@gmail.com

**October 13–15, 2016: Uppsala, Sweden**
Title: Working with Shame in Psychological Assessment and Psychotherapy
Presenter: Stephen E. Finn
Sponsor: Therapeutic Assessment Institute
Language: English
Information: llillieroth@gmail.com

**October 21–22, 2016: Milan, Italy**
Title: Introduction to Therapeutic Assessment with Couples
Presenters: Stephen E. Finn and members of the European Center for Therapeutic Assessment
Sponsor: European Center for Therapeutic Assessment, Catholic University of the Sacred Heart, Milan
Language: Italian
Information: segretaria.ceat@unicatt.it

**November 18, 2016: Tokyo, Japan**
Title: Introduction to Therapeutic Assessment: Using Psychological Testing as Brief Psychotherapy
Presenters: Stephen E. Finn, Noriko Nakamura, and members of the Asian-Pacific Center for Therapeutic Assessment
Sponsor: Asian-Pacific Center for Therapeutic Assessment
Languages: English and Japanese
Information: asiancta@gmail.com

**November 19–20, 2016: Tokyo, Japan**
Title: Planning and Conducting Assessment Intervention Sessions in Therapeutic Assessment
Presenters: Stephen E. Finn, Noriko Nakamura, and members of the Asian-Pacific Center for Therapeutic Assessment
Sponsor: Asian-Pacific Center for Therapeutic Assessment
Languages: English and Japanese
Information: asiancta@gmail.com

**November 23, 2016: Kyoto, Japan**
Title: Introduction to Therapeutic Assessment: Using Psychological Testing as Brief Psychotherapy
Presenters: Stephen E. Finn, Noriko Nakamura, and members of the Asian-Pacific Center for Therapeutic Assessment
Sponsor: Asian-Pacific Center for Therapeutic Assessment
Languages: English and Japanese
Information: asiancta@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

**June 2017: Milan, Italy**
Title: Live Therapeutic Assessment of a Couple
Presenters: Filippo Aschieri, Francesca Fantini, and Stephen E. Finn
Sponsor: European Center for Therapeutic Assessment, Catholic University of the Sacred Heart, Milan

Language: Italian
Information: segretaria.ceat@unicatt.it

**September 21–23, 2017: Austin, TX, USA**
Title: 2nd International Collaborative/Therapeutic Assessment Conference
Chair: J.D. Smith
Sponsor: Therapeutic Assessment Institute
Information forthcoming.