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THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

Venturing Out

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A very warm greeting to you all, but especially everyone in places where fall is setting in. Here in Chicago the nights are chilly and mornings are crisp with the feel and smells of the changing season.

It has been a pleasure to put together this issue of the *TA Connection.* I was able to work with some wonderful new contributors and learn about some topics in TA that I was not familiar with before. I am sure you too will find this issue to be very informative and interesting. I titled my intro to this issue "Venturing Out" because each contribution in some ways expands or pulls TA into new places. I hope this thread is evident across the three main columns of this issue.

This Issue

This issue's Research column is a bit more of a theoretical paper on the ways developmental science informs the way we practice TA. Coauthors Mike Troy and Julie Robinson draw on years of direct clinical experience with youth and a broad command of the developmental psychology literature to describe the way empirical research has found its way into TA and how it can guide the way clinicians practice TA. Mike and Julie review some of the key concepts in the literature, such as normative developmental milestones, attachment theory, developmental neurobiology, developmental psychopathology, and quantum superposition (are you as intrigued as I am?). They end the column with three case examples to illustrate some common issues encountered when working with children and adolescents in TA. These cases are used to bring the research to life. This column only scratches the surface of what could easily be expanded into a first-rate scholarly publication. But I don't want to twist the authors' arms too much.

In this issue:

The Clinical column this month describes the use of TA in the context of infant mental health. This is a new frontier for TA and the authors, Natalie Gart and Marian Williams, clearly make the case that the TA approach aligns with current best practices in this specialty field. This column builds upon a peer reviewed journal article by co-authors Natalie, Marian, and Irina Zamora that appeared in *Infant Mental Health Journal* earlier this year (titled Parallel Models of Assessment: Infant Mental Health and Therapeutic Assessment Models Intersect Through Early Childhood Case Studies). Thank you for pioneering the expansion of TA into this exciting and important area of mental health care.

For our Training column, Hale Martin takes us to Brazil! First, Hale describes the history of collaboration between TA and the vibrant assessment community in Brazil led by Anna Elisa Villemor-Amaral, who coauthored the column with colleagues Erika Tiemi Kato Okino and Sonia Regina Pasian. Hale then takes us on his journey to present on TA and conduct a training in Florianópolis at the 2016 congress of the Brazilian Society of Rorschach and Projective Methods. Hale's hosts then describe their experience of the presentation and training in TA from their perspective. The challenges and rewards of cross-cultural training are made clear, as are the commitment and excitement that that collaboration has generated. As TA spreads around the world (even more than it already has) we will continue to see the wonderful relationships and experiences that result.

Also in this issue are two reviews of TA-related resources. Stephen Finn reviews and discusses a recently published collection of Connie Fischer's seminal works. Steve describes how many of the chapters and articles contained in the collection were instrumental to the current theory and steps on the TA model. The second review, by Christopher Hopwood, is of the APA Psychotherapy Series video on Therapeutic Assessment with Adults. Steve Finn was invited for this prestigious APA series and completed the filming in the summer of 2015. Chris's review describes the format of the video, the case that Steve conducted, and how this can be a useful resource for anyone interested in TA, from students to seasoned practitioners of the model.

Steve Finn Receives Award from APA's Division 12

It is my pleasure to announce that Steve Finn will receive the award for Distinguished Contributions to Assessment Psychology from Section IX (Assessment) of Division 12 (Clinical Psychology) of the American Psychological Association. He will accept the award and give an address at the APA Convention in August 3-6, 2017 in Washington, D.C. Please join me in congratulating Steve for this well-deserved honor!

Therapeutic Assessment Immersion Course 2017

The TAI will be hosting a Therapeutic Assessment Immersion Course, January 18–22, 2017, in Austin, Texas. This workshop, co-chaired by Marita Frackowiak and Pamela Schaber, is intended for early and seasoned TA trainees. All the steps of the TA model are covered in depth during the 5 days through lectures and video examples from real cases. The Immersion Course is unique in its use of role plays: Attendees choose to focus on one kind of client (adult, child and family, or adolescent and family) throughout the week and practice role-playing the steps of TA in a small, supportive group format with TAI faculty leaders. The same case is followed through the 5 days, which gives attendees a "first person" experience of a full TA. The course will provide 35 hours of CE credit (7 per day) and will be held at the beautiful Westin Austin at the Domain (11301 Domain Drive). A flyer for the course is included as the final page of this issue of the newsletter and can also be found at:
www.therapeuticassessment.com

TA at the Annual Meeting of the Society for Personality Assessment

This year's annual meeting of SPA is in beautiful San Francisco at the Marriott Marquis, March 15–19, 2017. TA will be there in full force with four preconference workshops (see page 28 in the Upcoming Training in TA section) related to TA and a number of presentations in the scientific portion of the program. Hale Martin and I will again co-facilitate the Collaborative/ Therapeutic Assessment Interest Group lunchtime meeting. SPA is a great opportunity to learn about TA and, of course, to socialize with others in this warm and welcoming community that we are all a part of.

2nd International Collaborative/ Therapeutic Assessment Conference

As I mentioned in the last issue of the TA Connection, the Therapeutic Assessment Institute

(TAI) is 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. The inaugural conference back in 2014 was a great success and we heard overwhelmingly positive feedback about continuing to have conferences devoted to TA. We will again hold the meeting at the well appointed 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. Your feedback in 2014 guided some changes to the schedule. Namely, presenters will be given more time for each presentation, 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 specifics will continue to be provided in the newsletter. I will again serve as the program chair, so please feel free to email me directly with any questions about the conference. We look forward to seeing you all there!

Special Section in the Journal of Personality Assessment on Cultural Considerations in Therapeutic Assessment

An update: In the last issue, I announced that the *Journal of Personality Assessment* would soon be publishing a special section titled Cultural Considerations in Collaborative and Therapeutic Assessment. This is now published and appears in Volume 98, Issue 6, of the journal. The 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. Please check out these fantastic contributions to the TA literature.

Special Section in the Journal of Personality Assessment on Teaching, Training, and Supervision in Psychological and Personality Assessment

I also mentioned that there was also to be an upcoming special section in the *Journal of Personality Assessment* titled, Teaching, Training, and Supervision in Personality and Psychological Assessment. All contributions to this section are now accepted and most are available online. The print version of this special section is set for early 2017 (Issue 1 or 2 of Volume 99). The section contains an introduction written by me, seven articles, and two comments. The complete bibliography for the section appears on page 27 in the Recent Publications section. Two articles are directly relevant to TA. The first is the Smith and Egan study and the other is coauthored by Barton Evans and Stephen Finn and discusses continuing education methods for professional psychologists. 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 very exciting collection of articles covers the developmental span of training in assessment. The two comments are authored by Katherine Nordal and Elena Eisman from the American Psychological Association Practice Organization and Nadine Kaslow and Glenn Egan from Emory University School of Medicine. They focus on the implications of the special section articles for healthcare and competency, respectively.

This special section is 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. Len's contributions to the field of clinical and assessment psychology were many. As such, it is no surprise that the Board of Trustees of the Society for Personality Assessment has chosen to honor Len in the 2017 Marguerite R. Hertz Memorial Lecture at the 2017 convention in San Francisco. Both Steve Finn and I have been invited to present alongside other esteemed colleagues and Len's wife, Barbara. It is sure to be a moving and joyful time.

Donate to TA

The TAI is now a nonprofit organization and is able to accept tax-deductible donations. These funds 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 11.

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: Mike Troy, Julie Robinson, Natalie Gart, Marian Williams, Hale Martin, Anna Elisa Villemor-Amaral, Erika Tiemi Kato Okino, and Sonia Regina Pasian, Stephen Finn, and Christopher Hopwood, as well as our wonderful associate editors for their guidance and feedback to the authors.

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

A Developmental Perspective on Therapeutic Assessment

By Michael F. Troy, Ph.D., & Julie A. Robinson, Ph.D.

Therapeutic Assessment Is Inherently Developmental

Like others in the Therapeutic Assessment (TA) community, our TA work is informed by our formative clinical training. For us, this includes a background in developmental and neuro-developmental psychology and in developmental psychopathology. These skills have provided us with a sound base from which to study and practice TA. We also have been struck by the extent to which we have found these theoretical approaches embedded within TA theory and practice. We believe that TA is an inherently developmental clinical model. And while this assertion reflects the excellent work that has been done to apply the TA approach in stage-appropriate ways with children and adolescents (e.g., Mercer, 2011; Smith, 2010; Tharinger, Gentry, & Finn, 2013), we suggest that TA is developmental in a more general and fundamental way as well. In highlighting both the implicit and explicit ways in which we find this to be true, we hope to contribute to the continuing evolution of the TA approach as it applies across the lifespan.

Among the many contributions of the TA approach has been a thoughtful and respectful focus on the client's subjective experience. The ability, for example, to develop therapeutic questions that are relevant and meaningful to the client's life is essential to the process. In our own work, we have found that a clear understanding of general developmental principles is critically important to our TA work with children, adolescents, and their parents. Core developmental constructs, such as developmental salience, transformation, and coherence across stages, have been especially helpful. We also maintain that understanding developmental milestones of infancy, early childhood, middle childhood, and adolescence is critical to the effective application of TA across the developmental spectrum. Although a general understanding of child and adolescent development may allow for effective TA, specific knowledge and awareness of developmental principles will enhance the clinician's ability to more fully join with the child or teen in the exploration of their concerns, from their own point of view. Similarly, we believe that if clinicians have a developmentally informed understanding of the child's worries, hopes, and attributions, they will encourage developmentally

relevant TA questions and design effective assessment intervention sessions. They will also be able to more fully appreciate and help clarify the parents' concerns for their child, which are often (and reasonably) developmentally based.

In describing TA as developmental, we refer to the way it looks to the past to help understand the present and anticipate the future. The past is relevant not because it ascribes fault, but because it explains and shows us where strengths and resources may lie. It reveals and highlights a variety of possible future trajectories and focuses on those that are most hopeful in suggesting positive outcomes (Yates, Burt, & Troy, 2011). The TA clinician joins the client for a relatively brief part of his or her life, but does so with an eye on the past, focus on the future, and with the goal of promoting a positive and healing ongoing trajectory.

A developmental perspective helps us organize and reflect back to our clients and their families the complexity of their lives in ways that are recognizable but not overwhelming. This allows us to "join with the client" (child or adolescent and family) and facilitate effective TA. Further, a developmental perspective rooted in normative child and adolescent development is essential to being able to fully explore and understand the client's concerns, as well as those of their parents. It helps us, for example, understand the frustration of a 16-year-old whose parents have set an 8 p.m. curfew on weekends, as well as the anxiety that may be motivating the parents to set a curfew that is out of the norm. As Tharinger, Christopher, and Matson (2011) point out, we're trying to guide parents in shifting their attitudes toward, and interactions with, their child in a way that will foster not only the child's development, but also the development of the entire family.

Attachment Theory

Attachment theory includes an emphasis on the development of internal working models of interpersonal and emotional functioning, which are established very early in life (before representational memories) and carried forward across later developmental stages (Sroufe, Egeland, Carlson, & Collins, 2005). Consequently, it is not surprising to find attachment theory frequently emphasized in TA case formulations, regardless of the age of the client. In seeking to understand the quality of the attachment history, the TA clinician hopes to understand the client's ability to expect, seek, and accept resources that might be used over time in the service of healthier life adjustment, and in this way to more effectively "step into our client's shoes." For instance, we saw a 12-year-old and her mother in our clinic whose TA illustrated the value of understanding early attachment. The 12-year-old, who presented as very emotionally and behaviorally dysregulated, was seen by her mother as "crazy." It ultimately became important to carefully revisit what was occurring for the child's mother at the time our client was an infant. At that time, the mother was married to an abusive and drug-addicted spouse, and she was already caring for five other children. When we asked the mother to recall the child's first year, she admitted that she truly could not recall the 12-year-old's infancy because of the trauma and stress she, herself, was experiencing at the time.

Developmental Neurobiology

In his 2012 article, "Implications of Recent Research in Neurobiology for Psychological Assessment," Steve Finn describes the emerging emphasis on developmental neurobiology in TA theory. He points out the recent convergence in the science and theory of attachment, infant neurodevelopment, neurobiology, psychopathology, and therapy that is dramatically influencing the way clinicians think about their clients, whether child or adult. He notes Allan Schore's research highlighting the growing evidence that emotional consequences of insecure attachment experiences most heavily affect functioning in the right hemisphere, where the reciprocal connections between the limbic and subcortical areas process much of affectively based attachment experience (Schore, 2009). Consequently, Finn points out, many of the client's emotional experiences are unconscious and not primarily accessible through language. He also postulates that performance-based tasks, such as the Rorschach and TAT, commonly used in TA, allow us to mine emotionally arousing material that is more likely to reside in the right hemisphere. He points to meta-analytic studies (e.g., Diener, Hilsenroth, & Weinburger, 2007) that suggest clients make greater progress when clinicians provide an environment that heightens emotional experience, expression, and attunement. Here we see how a developmental perspective allows us to draw on neurodevelopmental science in the service of a deeper, more empathic and effective therapeutic relationship with our clients.

Developmental Psychopathology

Perhaps nowhere has developmental theory had a more profound effect on clinical thinking than in the area of developmental psychopathology. During the past 30 years it has fundamentally changed how we understand clinical processes and disorders as they

unfold and occur across the lifespan. We find this way of thinking about the clinical enterprise quite consistent with the TA approach. We highlight several core developmental psychopathology principles here, confident that their relevance to TA in general will be self-evident, especially in regard to case formulation.

Sroufe and Rutter (1984) defined the domain of developmental psychopathology as "*the study of the origins and course of individual patterns of behavioral maladaptation*, whatever the age of onset, whatever the causes, whatever the transformations in behavioral manifestation, and however complex the course of the developmental pattern may be" (p. 18, italics in original). This broad description takes into account the development of both typical functioning and psychopathology, as well as the relations between patterns of adjustment and maladjustment (Cicchetti, 1984).

Psychopathology, then, might be understood as a developmental distortion, or a form of unsuccessful adaptation. More specifically, Mash and Dozois (1996) characterize psychopathology in children as an adaptational failure that "may involve deviation from age-appropriate norms, exaggeration or diminishment of normal developmental expressions, interference in normal developmental progress, failure to master age-salient developmental tasks, and/or failure to develop a specific function or regulatory mechanism" (p. 5). This way of thinking about clinical problems in terms of difficulties of *a particular child at a particular point in time,* can help us make the connection between normal and abnormal development understandable for ourselves and for our clients.

Another way of thinking about the connection between normal and abnormal development is to examine the notion of *process*. Sroufe and Rutter's (1984) original definition of developmental psychopathology suggests that adaptation (or maladaptation) is an ongoing activity, with transformations of patterns of thinking, feeling, and behaving at various developmental stages. So we can think about disorders as "successions of deviations over time," with small problems leading to larger problems, or different problems, and so on (Cummings, Davies, & Davies, 2000); children's psychopathology, then, does not emerge all of a sudden or out of the blue, but rather unfolds over time. Early experience has special significance because it provides the foundation on which all subsequent adaptations are constructed (Sroufe, Egeland, & Kreutzer, 1990). Competence begets competence and maladaptation begets maladaptation because both are developmentally grounded in prior experience (Yates et al., 2011).

For the TA clinician this perspective promotes curiosity about the narrative within which the client's current concern is embedded, including within the family and cultural context, and over time. We believe that often it is differences in this larger narrative (How did this problem come to be? When did it begin? What does it mean for the future?) that are most important to understand, most likely to be the source of conflict within families, and may often underlie the deeper fears, sense of damage, and source of shame of our clients. TA, with its emphasis on understanding the client's story and its integration of verbal and nonverbal/conscious and unconscious processes is powerfully situated to address the client's questions from a developmental psychopathology perspective. As noted earlier, a developmental perspective is a fundamentally hopeful perspective because it recognizes that both adaptation and maladaptation reflect the same basic, lawful developmental principles. Consequently, and consistent with Therapeutic Assessment, it values the capacity for change. The developmental psychopathology model is clearly consistent with Steve Finn's description of "dilemmas of change," which is based on Papp's (1983) description. Finn (2007) notes that behavioral patterns that are adaptive at one point in time may become the source of problems at a later point in time and in different contexts. We have found a developmental psychopathology perspective helpful in generating approaches to address these dilemmas.

Adolescent Collaborative Assessment: It's Like Quantum Superposition

Assessment with adolescents poses especially important considerations in regard to the developmental task of identity formation and, in turn, important implications for diagnostic formulation during assessment feedback. More specifically, the language and narrative used to communicate assessment findings to adolescents has more than descriptive importance. It may, to a considerable and differentiated extent, influence the formation of self-identity.

From a pediatric perspective, adolescence is often seen as a late stage in the larger developmental arc from infancy to adulthood. From an adult clinical perspective, it is generally seen as the starting point of adult development. Both these perspectives tend to underappreciate the full and distinctive arc of adolescent development itself. In terms of both psychological and neurological development, adolescence is a time of rapid change and transformation with important implications throughout the lifespan. For example, adolescents at risk for major

psychopathology may accelerate into significant and disabling symptoms. For those at risk for maladaptive personality patterns, adolescence represents a period of consolidating symptom patterns, especially those most relevant to interpersonal functioning. These transitions occur against the backdrop of an increased sense of self-awareness and a heightened sensitivity to how they are perceived by others.

The diagnostic formulation presented to the adolescent client is not simply a matter of sharing ideas. It has important implications for the developing self-concept of the adolescent client. We use, by way of analogy, the quantum construct of superposition to describe this clinical phenomenon. Quantum superposition is a conceptualization of how certain subatomic particles can exist in multiple states at the same time, until they are observed, at which point they collapse into a single state. In a similar manner, the very act of observing (and describing) the complex system of the developing adolescent's personality functioning may cause shifting diagnostic probabilities to collapse into a single, enduring reality. For example, we recently worked with a 17-year-old girl leaving soon for college. We learned over time that she was extremely wedded to her conceptualization of herself as "unique" because of her depression and anxiety. While we recognized the importance of the teen's need to view herself in terms of her uniqueness, we worked to help her see that she could retain this uniqueness without holding onto psychiatric symptoms.

Case Examples and Summary

We recognize and recommend the extensive and growing literature on the use of TA with children and adolescents. Our intent in writing this article from a more general developmental perspective is to help build out the conceptual framework within which these research and case study articles are considered. In the end, it will be our ability to focus on TA with youth and families through a developmental lens that matters most. Consequently, we close with three brief case examples broadly representative of three points along the developmental continuum in hopes of demonstrating this broad developmental approach we have described in this article thus far.

Martha, 4 years old. Martha is a 4.25-year-old child with a history of feeding difficulties that had been assessed and addressed since infancy with a number of different interventions. Parents had enrolled Martha in an early childhood special education class 4.5 days per week, private preschool during the other half of 3 of the days, private speech/language, school-based speech/language, and occupational therapy at two different sites. One of the parents' questions for this assessment was, "What, if any, interventions should we add to guarantee she is ready for kindergarten?"

In this case, the parents were overly focused on Martha's cognitive development and academic readiness, but they seemed to be ignoring issues related to the child's social and emotional development. When asked about play and peer relationships, they really couldn't tell us much. They admitted that she doesn't play "in the neighborhood" because she's never home. Between structured school settings and her numerous therapies, the child did not have much time for free play, creativity, and using her imagination. By gently reviewing with the parents the key developmental tasks of this age, including the critical importance of play, imagination, and creativity, we were able to help them revise their question to what interventions could be removed to allow Martha to have more free time.

This example highlights the importance of the assessor understanding normative child development, specifically, helping the parents learn that they were actually enhancing their child's functioning by not focusing solely on her academic development. By facilitating this shift in the parents' understanding, we believe we likely helped create a more relaxed and enjoyable atmosphere, grounded in appropriate developmental expectations, for both Martha and her parents.

John, 10 years old. John is a 10-year-old boy with normal-range intellectual skills, but he has a history of expressive and receptive language difficulties and had been diagnosed with a reading disability. Parents have been very proactive in getting John extra tutoring, but he had become increasingly frustrated and almost phobic about school. He was showing signs and reporting symptoms of depression and anxiety. In spite of the fact that he was a very outgoing boy with a strong network of friends, he was becoming increasingly socially withdrawn. He lacked energy and sometimes told his parents he wanted to quit school.

In this case, John and his parents were asking questions that seemed to be developmentally appropriate. His parents wanted to know, "How can we reduce John's frustration with school?" and John's question was, "Why do I feel bored all of the time?"

The challenge was helping parents think about the factors that have an impact on a 10-year-old boy's self-concept and that help build healthy self-esteem.

By encouraging John and his parents to think about other important domains of development (besides academics) for a boy his age, including the salience of other skills such as athleticism, social competence, and ability to manage peer and sibling conflict without physical aggression, they became less pessimistic about how John was functioning overall. And by helping them shift their focus, it allowed John to recognize the areas in which he actually was doing quite well, as he was a very good athlete with good friends and opportunities for leadership because of his athletic interest and ability. Shifting the focus from what he is "bad at" to what he enjoys learning about was also helpful. He had lost sight of his interest in learning because he had begun to see school only as a chore.

This case provides an illustration of the ways in which relatively small changes at one point in development may improve the developmental trajectory going forward. In helping this family appreciate John's strong functioning in areas outside of the classroom, we hoped to establish improved self-esteem and, consequently, a stronger base from which to negotiate later developmental tasks and demands.

Cam, 14 years old. Cam was a 14-year-old boy referred by his pediatrician for help in managing his misophonia. Misophonia is hypersensitivity to selective soft sounds and other background noise. Symptoms and triggers are unique to each individual. Exposure to a trigger sound results in an immediate negative emotional response. In this case, Cam was extremely bothered by the sound of others chewing gum or food, the sound of his mother's voice (and the voices of certain other females), and a variety of other sounds, including the use of pencils. Cam had been fairly masterful in engineering an environment that minimized his exposure to these sounds as much as possible. He hadn't eaten dinner with the family in 5 years, often asked his mother not to talk to him, and carried pens to hand out at school to classmates who were using pencils. He also spent most of his time at home in the basement. Surprisingly, he was a very competitive football player and denied feeling bothered by noises when he was playing. In fact, parents described him as an unusually aggressive player who often had injuries because he tended to go "all out."

Parents came in with the primary presenting question, "How can we help Cam better manage his hearing sensitivities?" Cam's question was similar: "How can I get people to understand my hearing sensitivity?"

This was a situation in which parents were so "caught in the trenches" dealing with Cam's irritability on a day-to-day basis that they had lost perspective. They were not looking ahead to how Cam would successfully master the developmental tasks that were on the horizon for him. By helping parents think about what they wanted for Cam as a 15-year-old, as a 17-year-old, and as a college student, it became apparent to them that unless Cam was able to tolerate being with peers while they were eating, he would miss out on a lot of age-appropriate activities, such as pizza parties after a football game. Cam was not learning how to handle frustration and solve conflict with siblings, because he would avoid them. We gradually helped parents shape their assessment question from "How can we help those in Cam's environment reduce Cam's discomfort whenever possible?" to "How can we help Cam manage his hearing sensitivity, as well as the broader issue of anxiety, so that he can return to a more adaptive lifestyle that allows him to be successful academically?"

While not wanting to invalidate Cam's hearing sensitivities, we did feel that this was a young man whose very identity seemed to be defined by disorder (in this case, misophonia). Cam seemed to be at great risk for entering late adolescence and young adulthood with a defining sense of himself as a person with a debilitating disorder. In the TA feedback session it was critical to help reframe his self-perception away from that of being a damaged person toward that of a young man with significant strengths and resources. We hoped that this would allow him to accept support and education in managing auditory sensitivity and anxiety without being defined by these problems.

Summary

Across all domains of development, certain universal principles hold. Systems move from a broad, global state toward increasing differentiation and integration. The quality with which tasks and issues of early stages are resolved is of great importance because it forms the foundation upon which later stages are built. Consequently, we believe that by any measure the theory and practice of TA is on a robust and resilient developmental trajectory. In increasingly sophisticated ways, TA is encouraging us to engage our clients from a stance of respect and humility and to foster change that is meaningful and enduring.

In this article we have viewed TA through a general developmental lens with the intent of offering a complementary perspective to that of the foundational

work of Steve Finn and the other TA pioneers, as well as that of the many TA clinicians and researchers who have contributed to the varied and impressive literature addressing the use of TA with children and adolescents.

References

Cicchetti, D. (1984). The emergence of developmental psychopathology. *Child Development*, *55,* 1–7.

Cummings, E. M., Davies, P. T. & Campbell, S. B. (2009). *Developmental psychopathology and family process.* New York, NY: Guilford Press.

Diener, M. J., Hilsenroth, M. J., & Weinberger, J. (2007). Therapist affect focus and patient outcomes in psychodynamic psychotherapy: A meta-analysis. *American Journal of Psychiatry, 164,* 936–941.

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

Finn, S. E. (2012). Implications of recent research in neurobiology for psychological assessment. *Journal of Personality Assessment, 94,* 440–449.

Mash, E. J., & Dozois, D. J. A. (1996). Child psychopathology: A developmental-systems perspective. In E. J. Mash & R. A. Barkley (Eds.), *Child psychopathology* (pp. 3–60). New York, NY: Guilford Press.

Mercer, B.L. (2011). Psychological assessment of children in a community mental health clinic. *Journal of Personality Assessment*, *93,* 1–6.

Papp, P. (1983). *The process of change*. New York, NY: Guilford.

Schore, A. N. (2009). Right brain affect regulation: An essential mechanism of development, trauma, dissociation, and psychotherapy. In D. Fosha, M. Solomon, & D. Siegel (Eds.), *The healing power of emotions: Integrating relationships, body, and mind. A dialogue among scientists and clinicians* (pp. 112–144). New York, NY: Norton.

Smith, J. D. (2010). Therapeutic Assessment with children and families: Current evidence and future directions. *Emotional and Behavioral Disorders in Youth,* Spring, 39–43.

Sroufe, L. A., Egeland, B., Carlson, A., & Collins, W. A. (2005). *The development of the person: The Minnesota study of risk and adaptation from birth to adulthood.* New York, NY: Guilford Publications.

Sroufe, L. A., Egeland, B., & Kreutzer, T. (1990). The fate of early experience following developmental change: Longitudinal approaches to individual adaptation in childhood. *Child Development*, *61,* 1363–1373.

Sroufe, L. A., & Rutter, M. (1984). The domain of developmental psychopathology. *Child Development, 55,* 17–29.

Tharinger, D. J., Christopher, G., & Matson, M. (2011). Play, playfulness, and creative expression in therapeutic assessment with children. In S. W. Russ & L. N. Niec (Eds.), *An evidence-based approach to play in intervention and prevention: Integrating developmental and clinical science.* New York, NY: Guilford.

Tharinger, D. J., Gentry, L. B., & Finn, S. E. (2013). Therapeutic Assessment with adolescents and their parents: A comprehensive model. In D. H. Saklofske, C. R. Reynolds, & V. Schwean (Eds.), *The Oxford Handbook of Child Psychological Assessment* (pp 1–37). New York, NY: Oxford University Press.

Yates, T. M., Burt, K. B., & Troy, M. F. (2011). A developmental approach to clinical research, classification & practice. In D. Cicchetti & G. Roisman (Eds.), *Minnesota Symposium on Child Psychology: The origins and organization of adaptation and maladaptation*, Volume 36. New York, NY: Wiley.

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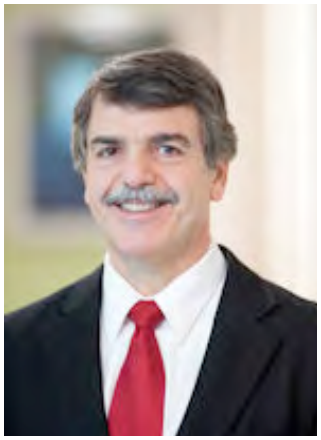

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Considering the Opportunity for Therapeutic Assessment: Values and Practices in Pediatric Primary Care

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One of the very first lessons I learned in graduate school was that regardless of theoretical orientation, population, or setting, the therapeutic relationship is the foundation of any successful intervention. Therapeutic Assessment's (TA) core values of collaboration, respect, humility, compassion, openness, and curiosity (Finn, 2009) highlight the importance of the relationship as a necessary component to foster growth through assessment. No one understands this more than those in the world of infant mental health, where Donald Winnecott's famous saying, "there is no such thing as an infant" (1960, p. 587) has become a mantra, highlighting the idea that a baby cannot exist without the context of its caregivers and their relationship. TA's emphasis on the relationship between assessor and client creates the supportive holding environment necessary to explore and enhance understanding within the relationship between the caregiver and his/her young child. Thus, as the assessor supports the caregiver and the child, the caregiver becomes more able to empathically respond to the child.

Recently, together with my mentors, Drs. Marian Williams and Irina Zamora, I compared TA's values and practices to best practices in assessment of infants and young children (Gart, Williams & Zamora, 2016). When examined side by side, the relational commonalities between the two became even clearer. Several commonalities were highlighted, including the importance of collaboration, active participation of the family, empowering caregivers, developing and revising family stories, increasing parents' understanding of their child, reducing isolation, and increasing hope. My mentors and I learned there is great opportunity for the marriage of TA practices with best practice in infant and early childhood assessment and intervention.

Ample evidence supports the value of TA with children as an intervention to increase parental understanding and empathy and to shift family expectations (Smith, Finn, Swain, & Handler, 2010; Tharinger et

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al., 2009). At the heart of TA is putting the pieces together and telling the child's and family's story in a way that is accessible, meaningful, dynamic, and supports positive change. Arguably, anyone would benefit from this type of collaboration and meaning making. As much as 40% of children and adolescents are estimated to experience behavioral issues that do not meet diagnostic criteria for behavioral health disorders (Oppenheim et al., p. 125). In this light, it would be valuable to apply the aforementioned core values of TA to population-level, prevention-oriented care.

For infants and young children, this level of care occurs in pediatric primary care. Several programs have moved in this direction. For example, Healthy Steps for Young Children (HS) is a program designed to enhance pediatric primary care experiences for children, birth to 3 years old, and their families, by including a developmental specialist in well-child visits with pediatricians (Zuckerman, Kaplan-Sanoff, Parker, & Young, 1997). HS uses a relationship-based approach that emphasizes the pediatric primary care setting as an important context in which families can get information and support to care for their young children and where questions and concerns can be addressed in a familiar, nonstigmatized and accessible setting (Buchholtz & Talmi, 2012). Much like TA, Buchholtz and Talmi emphasize how HS capitalizes on "using 'teachable moments,' developing strong and collaborative relationships with families and providing anticipatory guidance in promoting child development" (p. 431).

Programs such as HS provide an opportunity to incorporate the values and practices of TA to reach a more widespread population and set the stage for parents to trust and collaborate with helping professionals to further understand their child, and increase hope for the parent, the young child, and their relationship. "Assessment" at a pediatrician's office includes use of universal screening tools, review of available records, behavioral observations, and parent and child report. On average, primary care physicians spend approximately 18 minutes with a family (Olson et al., 2004). Although this time constraint presents a significant challenge for using a TA approach, the advantage exists in the frequency of visits and longitudinal opportunities for "history making" (Hirshberg, 1996). That is, rather than just documentation of historical facts and visit information, the values and practices of TA promote the development of a shared understanding of the infant's and family's needs and challenges within the context of the already-established structure of well-child and sick visits at the pediatrician's office.

The benefit of using the core values of TA can be illustrated through the case example of "Meredith." Meredith is a 2.5-year-old Caucasian female. She lives with her mother, father, and older sister in a house on a military base. When the family first visited at the clinic, they were new to the city and did not have extended family or a support network. Meredith was initially seen when she was 20 months old for a weight check and continued primary care. She presented as fearful and anxious and refused to allow the doctor to examine her. She hid behind her mother and cried when the pediatrician spoke to her, even just to say "hello."

Review of medical records revealed that Meredith was hospitalized 1 month before the initial visit for failure to thrive. She had "inadequate intake" and was referred to as an "inconsistent feeder of solid foods." Meredith refused to take a bottle and was breastfed. Her mother, "Mrs. Smith," was feeding her up to 10 times per day. At their initial visit, Mrs. Smith presented as defensive, guarded, and hesitant to talk about concerns for Meredith. She did not endorse any concerns regarding Meredith's behavior, development, social–emotional functioning, or eating. She completed the Ages and Stages Questionnaire: Third Edition (ASQ-3; Squires & Bricker, 2009), and her responses did not indicate developmental concerns. When asked about additional concerns regarding medical history, Mrs. Smith wrote that she "was hospitalized because her last pediatrician thought she was not being fed due to low weight for her age." As the new pediatrician began to build rapport with the mother at their initial visit, it became clear that she was terrified about what this new experience might be like. Mrs. Smith told her new pediatrician that she changed pediatricians because she felt her previous pediatrician "judged her." We learned that Meredith's previous medical team had to call social services because Meredith was not gaining weight.

In this case our "assessment battery" included ongoing measurement of Meredith's weight, behaveioral observations, and the information provided by Mrs. Smith. During the next 2 months, Meredith was seen weekly to monitor her weight gain. Unfortunately, she still was not gaining weight. The pediatrician began to worry that Meredith's mom was not fully expressing her concerns or the challenges that might be affecting Meredith's weight gain. However, the pediatrician understood that this would be a difficult conversation to have with Mrs. Smith and might cause her to raise her guard more. By using

the TA framework of delivering feedback to families through conceptualizing the "levels" of information to be shared (Tharinger et al., 2008), the doctor was cautious and intentional in the way she shared results, concerns, and recommendations for next steps. During these 2 months, Meredith's mother began to trust the new pediatrician. This relationship allowed the pediatrician to introduce Meredith to the behavioral health clinician (BHC) in a nonthreatening way.

The medical team was concerned that Meredith was not getting enough nutrition from breastfeeding and had been working with her mother to transition to more food and less breastmilk—with the goal of stopping breastfeeding completely. The BHC talked with Mrs. Smith about her challenges weaning Meredith from breastfeeding. Meredith's mother explained that they had made progress during the past month and now she was breastfeeding only one to two times per day. Mrs. Smith stated she has tried to be consistent in saying "no" to the breast and tried to distract her daughter with activities, but Meredith continued to ask. Mrs. Smith explained that the most difficult times have been around nap and bedtime, when Meredith tantrums, yells, cries, and gets on the floor and kicks her feet. Mrs. Smith was also able to discuss her frustration with her previous medical provider and described as traumatic the experience of having social services called. The BHC and Mrs. Smith discussed the pain and confusion this experience had caused her. Mrs. Smith revealed how she struggled to deny Meredith her breast, knowing how much Meredith needs to put on weight.

When explored further, Meredith's mother also explained she has felt very stressed and that she needed a break. She described not getting more than 5 minutes alone throughout the day and expressed frustration that her husband did not help more, particularly because she stated they do not have friends or family in the area to provide support. The BHC empathized with Mrs. Smith about how difficult it must be to set limits around breastfeeding and tolerate Meredith's distress, especially when Mrs. Smith is so exhausted and worried about her daughter's health. The BHC and pediatrician frequently commented about the strength of Meredith and her mother's relationship by highlighting how safe Mrs. Smith made Meredith feel at each visit and pointing out how affectionate the mother and daughter were with each other. The BHC also acknowledged how difficult it must be for Mrs. Smith to not have her own space and reflected with Mrs. Smith about how Meredith might be feeling at each visit.

By approaching Mrs. Smith and Meredith in a collaborative, curious, and empathic way, the conversation eventually shifted from talking about Meredith's weight and feeding (Level 1 feedback) to ways Mrs. Smith might be able to increase her support and ask for help (Level 3 feedback). Talking about Meredith's weight and feeding was Level 1 feedback because she expected this to be the focus of the conversation. However, Mrs. Smith was traumatized by having her efficacy as a parent challenged when social services was called. Therefore, conversations about additional concerns related to her parenting could trigger defensiveness and required handling in the sensitive light of Level 3 feedback. The BHC was able to prepare Meredith's mother for discussing Level 3 information by acknowledging how hard she was working and by empathizing with how difficult it is to worry about her child's health, especially when her ability to care for her child had been questioned. With Meredith in the room for each conversation, the BHC enthusiastically celebrated their progress and emphasized Mrs. Smith's care, strength, and love for her daughter. The pediatrician also prepared Mrs. Smith to be more comfortable with Level 3 information by advocating for Meredith's mother with their caseworker from social services. Eventually, the BHC and Mrs. Smith were able to discuss the potential benefits of therapy and create a plan in which she could go for additional resources. This time, Meredith's mother experienced the recommendation for additional support as a source of strength rather than a punishment.

Meredith and her mother returned for another weight check. When the BHC and pediatrician entered the room together, Meredith smiled instead of immediately hiding behind her mother. Meredith was sitting on her mother's lap and both Meredith and her mother's affect appeared brighter than at their last visit; they were having fun engaging with each other and were playful. Immediately both the BHC and pediatrician enthusiastically commented on how much fun they were having and how happy they both looked. Although Meredith refused to get down from her mother's lap and was still timid, she demonstrated more interest in interacting with the clinicians. She allowed the doctor to look in her mouth and ears without crying and even explored toys that were given to her rather than refusing to take them when offered.

The BHC and pediatrician checked in with Mrs. Smith about how they had been doing since the last consultation. Mrs. Smith proudly stated that after the last appointment, she went home and let her husband

know that she needed more support caring for the kids. Mrs. Smith was surprised that her husband was responsive to her needs. Mr. Smith began helping more so that Mrs. Smith was able to have more time to herself. Mrs. Smith stated she and her husband had begun taking a parenting class on the Air Force base where they live. She described that part of the class was learning more about each other's personalities and needs, which has helped her husband understand why she needs some alone time. Mrs. Smith was proud of herself that she was able to advocate for her needs, and the BHC and pediatrician celebrated her success. The pediatric team took time to process the impact that Mrs. Smith's new emphasis on self-care has had on reducing her level of stress. This decrease in stress translated to Mrs. Smith feeling more confident in setting and following through on limits with Meredith and was also reflected in Meredith's lower level of stress. For the first time, Meredith's mother felt comfortable asking for advice and inquired how she could ask Meredith's father to help share the feeding responsibilities. The BHC, pediatrician, and Mrs. Smith also explored the idea of asking Mr. Smith to help with their daughter's bedtime routine because it was difficult for Mrs. Smith to soothe Meredith at that time because she preferred breastfeeding to anything else her mother offered. The pediatric team discussed the importance of making sure the parents had a clear plan that they were both committed to.

The subsequent appointments continued to impress the BHC and pediatrician. At the next visit, Meredith had not only gained weight but also presented as playful and sassy. She arrived to the clinic dressed in a bright pink princess dress and donned large Mickey Mouse sunglasses as if she was a movie star. Mrs. Smith matched Meredith's geniality with a huge smile and excitedly shared that she had begun working part time. The pediatrician, BHC, and Mrs. Smith celebrated the family's successes and reflected on how far they had come in a short period of time. Meredith's father brought her to the next visit and reported that his wife was no longer breastfeeding Meredith.

The assessment and intervention tools used in this case example and in pediatric primary care settings are very different than the more comprehensive assessment batteries and related interventions often used in TA. In this case, the assessment tools included review of records, information from the developmental screening tool (ASQ), medical data (e.g., weight, feeding logs), behavioral observations, and interviewing the mother. By using the TA core values of collaboration, respect, humility, compassion, openness, and curiosity, the pediatrician and BHC were able to assess and intervene with additional factors that were affecting the parent–child relationship and contributing to the presenting problem of low weight. Meredith and her mother's story shifted from focusing on their deficits to focusing on the strengths of their relationship and opportunities to empower Mrs. Smith. As discussed earlier in this article, building rapport and empathically assessing for additional psychosocial stressors does not always feel possible in a 15- or 20-minute primary care appointment. However, the story of primary care is also shifting, with emphasis on preventative care and health promotion. As there continues to be more strategies and initiatives aimed at increasing integration of behavioral health in primary care, TA values and practices can provide a valuable template to assess for risk factors, capitalize on protective factors, and highlight the importance of collaboration, curiosity, and compassion.

References

Buchholz, M., & Talmi, A. (2012). What we talked about at the pediatrician's office: Exploring differences between healthy steps and traditional pediatric primary care visits. *Infant Mental Health Journal*, *33*(4), 430–436.

Finn, S. E. (2009). The many faces of empathy in experiential, person-centered, collaborative assessment. *Journal of Personality Assessment, 91*, 20–23.

Gart, N., Zamora, I., & Williams, M. E. (2016). Parallel models of assessment: Infant mental health and therapeutic assessment models intersect through early childhood case studies. *Infant Mental Health Journal*, *37*(4), 452–465.

Hirshberg, L. M. (1996). History-making, not history-taking: Clinical interviews with infants and their families. In S. J. Meisels & E. Fenichel (Eds.), *New visions for the developmental assessment of infants and young children.* Washington, DC: Zero to Three.

Olson, L. M., Inkelas, M., Halfon, N., Schuster, M. A., O'Connor, K. G., & Mistry, R. (2004). Overview of the content of health supervision for young children: Reports from parents and pediatricians. *Pediatrics*, *113*(S5), 1907–1916.

Oppenheim, J., Stewart, W., Zoubak, E., Donato, I., Huang, L., & Hudock, W. (2016). Launching forward: The integration of behavioral health in primary care as a key strategy for promoting young child wellness. *American Journal of Orthopsychiatry*, *86*(2), 124.

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,* 369–386.

Squires, J., & Bricker, D. (2009). Ages & Stages Questionnaires, Third Edition (ASQ-3). Baltimore, MD: Brookes Publishing. www.agesandstages.com

Tharinger, D. J., Finn, S. E., Gentry, L., Hamilton, A., Fowler, J., Matson, M., Krumholz, L., & Walkowiak, J. (2009). Therapeutic Assessment with children: A pilot study of treatment acceptability and outcome. *Journal of Personality Assessment, 91*(3), 238–244.

Tharinger, D. J., Finn, S. E., Hersh, B., Wilkinson, A., Chistopher, G., & Tran, A. (2008). Assessment feedback with parents and children: A collaborative approach. *Professional Psychology: Research and Practice, 39,* 600–609.

Winnicott, D. W. (1960). The theory of the parent–infant relationship. *International Journal of Psychoanalysis, 41*, 585–595.

Zuckerman, B., Kaplan-Stanoff, M., Parker, S., & Young, K. T. (1997). The healthy steps for young children program. *Zero to Three*, *17*, 20–25.

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Challenges and Rewards of International Training in Therapeutic Assessment: Teaching and Learning

By Hale Martin, Anna Elisa Villemor-Amaral, Erika Tiemi Kato Okino, & Sonia Regina Pasian

International training in Therapeutic Assessment (TA) has been a major emphasis since very early in its development. As the TA community knows well, Steve Finn has been not only the principal agent in creating TA, as an extension of the collaborative assessment approach pioneered by Constance Fischer, but also the main ambassador for TA in the United States and other parts of the world. It is fair to say that his training workshops are legendary. The international component of his work has led to the establishment of the European Center for Therapeutic Assessment in Milan, Italy, and the Asian-Pacific Center for Therapeutic Assessment in Tokyo, Japan, both of which are thriving enterprises advancing TA beyond the United States. Not surprisingly, the philosophy, principles, and techniques of TA have quickly taken root in many countries. It is as if TA speaks to the humanity that unites psychological practice around the world.

As the TA movement matures, training efforts are expanding beyond the work of one person. Other psychologists are taking responsibility for spreading TA to interested assessors and for guiding the TA movement in general. These are signs of a healthy and enduring community. With Steve's encouragement and tutelage, Marita Frackowiak, Pamela Schaber, Filippo Ascheiri, Francesca Fantini, Lionel Chudzik, Lena Lillieroth, Noriko Nakamura, Jan Kamphuis, and Hilde de Saeger have taught TA outside the United States. Some of the trainers have done so while facing significant language barriers and cultural considerations. Although I have been teaching an annual course on TA since 2008 in the Graduate School of Professional Psychology at the University of Denver in Denver, Colorado, I only recently dipped my toe in the waters of international TA training by presenting workshops in Florianópolis, Brazil, in September, 2016. It was a challenging but very rewarding endeavor. My colleagues in Brazil and I would like to present our experiences of this training in an effort to capture the challenges and rewards from both teaching and learning perspectives. Our hope is to not only tell an interesting story, but more important, to provide some helpful insight into the important task and potential benefits of international training in what is becoming a worldwide paradigm in assessment.

Connie Fischer lectured in Brazil several times in the 1990's, but Steve Finn was the first to present the full TA model in Brazil in 2010. Surely it is no surprise that his efforts created fertile ground for TA to take root. Jan Kamphuis followed up Steve's visit, offering a well-received training in Sao Paolo, Brazil, in 2014 at the Brazilian Society for Rorschach and Projective Techniques. I was fortunate to meet Anna Elisa Villemor-Amaral, a Brazilian psychologist, at the Therapeutic Assessment Immersion Course in Austin, Texas, in 2015. She had attended the previous trainings in Brazil given by Finn, helped arrange for Kamphuis to come there, and had been inspired by them to pursue further training in TA. She attended the Inaugural International Collaborative/ Therapeutic Assessment Conference in Austin in 2014, and again undertook the long trip to the United States for the TA Immersion Course. Anna Elisa even started a Brazilian study group for psychologists interested in pursuing further training in TA. After attending the Immersion Course, she invited me to speak at the next Congress (2016) of the Brazilian Society of Rorschach and Projective Methods and to present a 2-day workshop (Congress is the international term often used for a major conference). With encouragement from Steve and Jan Kamphuis, I

took a deep breath and accepted the invitation. I could not have known at that time what a wonderful experience lay ahead.

The Presenter's Experience

By way of the Internet, I was welcomed by Erika Tiemi Kato Okino, who was the president of the Society and in charge of overseeing the Congress. We arranged my trip and the nature of my presentations: a keynote address to the full Congress discussing the value of the Rorschach and projective methods to TA (Martin, 2016), a half-day workshop introducing TA, and a more advanced 2-day workshop after the Congress for the 11-member study group that Anna Elisa had formed. With Steve's help, I prepared for the challenge. Preparation required much time, beginning about a year prior to the presentations with videotaping assessments with my clients.

It was a long flight from Denver to Florianópolis, the site of the Congress, but I was warmly welcomed by Erika and her colleague and vice president of the Society, Paulo Castro, as we all checked into the hotel of the Congress a day early. Florianópolis is a beautiful city, half on the mainland south of Rio di Janeiro and half on a close-by island connected by a very old bridge, which is not in use anymore, and a modern bridge, perhaps foreshadowing changes coming in assessment. The modern hotel had every amenity and was largely filled with the 280 attendees of the Congress (coming from 23 of the 26 Brazilian states). I was immediately struck by the openness, kindness and energy of everyone I met. It quickly became apparent that this society was a vibrant organization of assessors. It was well structured with wise, generous elders, accomplished, passionate mid-career psychologists, and bright, energetic students. What a pleasure to be a part of their meeting!

The half-day workshop was held on the first morning of the Congress and included 25 attendees, self-selected for at least some understanding of English. I had intended to show short clips of one of my students doing an initial session, an assessment intervention session, and a summary discussion session. Fortunately, I had prepared a transcript for the participants to ease the language barrier. When the typical (for me) problems with the video occurred, at least participants had a written transcript of the video clips to follow. I verbally walked through another adult case example in detail to illustrate the prescribed steps of TA. Then I discussed adaptations of TA to children and families and read a story written for a child (and her parents) as assessment feedback. I also briefly discussed couples assessments and the use of the consensus Rorschach technique in this context, and I finished by showing video clips of extended inquiries with children, which were either viewed by parents behind a one-way mirror with a second assessor assigned to them, or recorded to be shown to parents at a later time. Even when the video worked, the transcription of the video again proved very useful for the participants. Given the excellent participation of the attending psychologists and students, the presentation was enriched and the time passed quickly. I avoided cartoons I typically show in presentations in the United States, having heard that humor often does not translate to different cultures. After the presentation, I looked back, frustrated by the mechanical difficulties with the video, but generally felt the workshop had gone fairly well.

The keynote address that evening followed the opening ceremonies and was attended by many who did not speak English; however, it was simultaneously translated by an able translator to headphones worn by members of the audience. I learned that there are two types of translation: simultaneous (with a translator in a booth in the room, translating to headphones as the speaker speaks), and sequential (with the speaker saying a few sentences, then pausing while the translator in front of the room with the speaker, tells the audience what was said). Obviously, simultaneous translation moves much faster than sequential translation, and I was glad to have it go so smoothly. I had provided my PowerPoint slides to the translator two days before the talk and met with him a few minutes before the talk to answer any last minute questions he had. It was a large audience but the first-rate technology seemed to make the presentation seamless. I asked the translator before the talk to do what he could to make me look good—maybe not a bad idea—at least I didn't feel as vulnerable. During the talk I tried to speak slowly to allow the translator to keep up. I have to admit that I became distracted whenever I noticed using a word not on my PowerPoint slide and one that he likely might not understand. The more I tried not to use difficult words to translate, the more I thought of them and spoke them! Poor fellow! Afterwards he was very gracious and convinced me that he had not had significant difficulties. I learned it is wise to cooperate well with the translator. After the address, I very much enjoyed my 15 minutes of fame, which turned into a full two hours of photographs with attendees during the ensuing cocktail social.

I was not able to understand Portuguese, but I did try to stay available throughout the Congress, especially during breaks (hoping for more photographs I

suppose), but because of the language barrier, I did not attend the many presentations offered at the Congress, even though the titles were very intriguing. (Erika had translated the very full and impressive program into English for me and fellow American, Ali Khadivi, who also was an invited guest speaker.) It was clear from the program just how vibrant and motivated this society is—an inspiring group of accomplished assessors! I wish I could have understood their presentations. I noticed many topics with which I was not familiar, and I had private conversations with some of the presenters through which I expanded my view of assessment. It left me with a strong sense of how much we have to learn from one another. This was an important take-home message for me; I probably learned more than they did.

I greatly enjoyed time to get to know and appreciate the extraordinary competence and kindness of Ali Khadivi! At Ali's suggestion, we planned a dinner for some of the group who had been so welcoming and helpful. It felt good to offer this small token of appreciation back to those who had been incredibly supportive and giving. As most of you have probably experienced, this kind of new experience together nurtures strong connections. I look forward to seeing Ali whenever we can—as well as my Brazilian colleagues.

After the formal Congress, I had the great pleasure of working closely for 2 days with a group of 11 extremely bright, highly motivated, and fun people. I had previously sent an introductory chapter to the group to prime them for the workshop (Finn & Martin, 2013), and I emailed a few other articles to the group as they became relevant during our training. We occupied a large penthouse room in the hotel with a beautiful view of the bridges, clouds and ocean, and we worked hard. I was struck by the good energy, excellent questions, drive to learn, and community spirit among them. For the presentation, I walked in detail through the major steps of TA: initial sessions, assessment intervention sessions, and summary discussion sessions. I diverged frequently into discussions of assessment measures with which they were not familiar, such as the MMPI-2 (1989), Crisi Wartegg System (2014), Adult Attachment Projective Picture System (2012), Early Memories Procedure (1995), and other topics that American and Brazilian psychologists approach differently.

I used lectures, case presentations, videos, role-plays, and discussions to deepen the communication. I

presented a case to illustrate the techniques, again using transcriptions of the dialogue when I showed video, which again proved useful to the participants whose English skills varied. I tried to talk slowly. I noticed that it was helpful for me to stop at times and let them have discussions in Portuguese among themselves. This seemed to be an important time for them to teach each other what they were understanding and assimilate it into their ways of thinking. In the future I will be attentive to the value of this technique. We also took time to role-play an initial session and assessment intervention session. From comments I heard from the attendees, the role-plays were extremely beneficial, as were seeing clips of actual assessments. While we were working on assessment interventions sessions, Erika asked if I would role-play an assessment intervention session in front of them. I attempted this and stopped at certain decision points to engage the group's wisdom as to the next step. This also seemed to be an effective teaching technique.

This group worked together, laughed together and ate our meals together (and the food, wine, and company were excellent!). Erika and Sonia Regina Pasian, who was a major contributor and delightful force among the attendees, had a free day after the workshop to do some sightseeing and relaxing in this beautiful part of the world. At the end I felt I had made good friends, with whom I shared a common cause of not only collaborating to be good therapeutic assessors, but also of carrying the torch to improve our shared profession. I will always treasure this experience.

The Organizers' and Participants' Experience

Since Steve's first presentation in Brazil, we have been delighted and excited by the potential of TA. However, we are well aware of the challenges that require dedication and commitment to the technical–scientific and practical training required before we become effective with TA in professional practice. To help us learn the theory, methods, and mindset of TA, and to clarify our thinking, we have sought training opportunities. Our first contact with TA occurred with Steve at a conference in Brazil in 2010. Our second training was in 2014 when Jan Kamphuis accepted our invitation to the Congress of the Brazilian Society of Rorschach and Projective Methods. We were thrilled with both experiences and sought more training through our 2016 Congress.

At the VIII Brazilian Association of Rorschach and Projective Methods Conference, in 2016 Florianópolis, Brazil, Hale presented a 4-hour workshop and opened the conference with a keynote address. After these events, we had the privilege of learning TA with him during a 16-hour special training workshop. In preparation for these trainings, our TA study group, whose members live in many places in Brazil at great distance, gathered via videoconference in a recurrent study group over the course of a year. This preparation made the trainings in Florianópolis exciting opportunities to deepen our understanding of TA through in-depth discussions and experiences.

From our side of the experience, learning TA with Hale was both very positive and quite challenging. The lectures he provided exposed the theoretical and technical fundamentals of TA, which we then worked to integrate into our clinical skills, which is our goal in studying TA. Case examples offered through readings and video showed the benefits to clients that can be achieved in a short time through TA. This affluence of possibilities delights us, especially considering the huge demand for psychological care in different contexts in Brazil.

However, it is necessary to point out that there were difficulties in this training program, derived primarily from difficulties with the language. The language barrier required great commitment from everyone. Intermediate English abilities were a prerequisite for all of the participants in the workshop; however, the composition of the group was heterogeneous in language ability. Even with reasonable fluency in English, further explanations in our mother tongue were necessary to better grasp a concept, an idea, or a phrase. We appreciated the periodic pauses Hale provided for us to discuss the material among ourselves. The language difficulty was most evident when the videotape sessions were shown. Being real video sessions in native English without subtitles, we found that some initial global comprehension of the content provided by reading the transcription Hale provided was essential before viewing the video. This then helped us better follow application of specific TA techniques in the video of the cases presented.

Furthermore, the participants in this training noted and were somewhat confused by cultural differences in the way some results in the case examples were applied to the client. Thus, more explanation about the context of the cases was needed to clarify Hale's thoughts, decisions, and technical approaches in each situation. Thus, some explanations about typical cultural characteristics and professional practice differences between countries were necessary to "get in the client's shoes," which is the goal of TA.

Another interesting aspect of the training was the use of some specific psychological instruments that are

unknown, used less, or not adapted for use in Brazil. In fact, before a test can be used in Brazil, it must be studied and approved for use by a national panel of psychologists. Thus, the differences between the United States and Brazil in tests that can be used provided some discussion of what approved measures might be substituted in Brazil and what nonapproved measures might be useful to work on getting approval in our country. This opens wide possibilities for further research on new measures and techniques in psychological assessment in Brazil. Hale was interested that one member of our group, Tatiana Gottlieb Lerman, is working to adapt the MMPI-2 for use in Brazil by translating it into Portuguese and collecting a Brazilian normative sample. This would provide an important method to add to our tools. The issues raised by instruments that were unknown by the group prompted Hale to devote more time to discuss the nature, details, and usefulness of certain measures, such as the Adult Attachment Projective (George & West, 2012) and the Early Memories Procedure (Bruhn, 1995). This took some time but was of interest to the group to consider new possibilities.

Another valuable aspect of the training emerged out of role-playing the major sessions of TA. Similar to openness to the possibilities of new tests, the role-play experience also required our openness to new experience. Perhaps it also gave us some taste of a TA client's experience in being asked to see new options in their lives. These exercises were essential for us to be able to see ourselves acting and practicing these techniques of TA. Although brief, the role-plays gave us the opportunity to experience new ways to interact with clients, even if just in the classroom with colleagues. They allowed us to begin working to integrate TA techniques with our own personal styles. The possibility of applying what we learned through the role-plays in our clinical contexts was exciting and worked as a great motivation to maintain the TA study group.

Another issue that challenged us is that of the written results in psychological assessment. In Brazil, all psychologists work under the provisions and laws enacted by the Federal Council of Psychology (http://site.cfp.org.br/#LEGISLACAO). Among these provisions are specific guidelines for written documents, including traditional, technical clinical reports summarizing a psychological evaluation. To stay within ethical boundaries of practice in Brazil, psychologists must prepare a report using this traditional format. This written report must be forwarded to the client after completion of the assessment. However, we anticipate that psychologists can also write the more personal letter that is prescribed by TA that is consistent with the goals of psychological practice. We suspect that the TA letters written to explicitly answer the client's questions will be helpful to the client, but we must remember that they have to be accompanied by the traditional report. Hale informed us that this was a common practice with TA in the United States as well, where some contexts and referrals for assessment require a technical report to accompany the TA letter.

Of great importance to psychological practice in Brazil is the applicability of TA to socioeconomic diversity, clinical decisions to be made, and mental health care contexts. These aspects are quite important in Brazil, with significant disparities in health care resources related to differences in these factors. Because TA is tailored to a specific person, it seems naturally accommodating to the great diversity of social, cultural and professional contexts existing in Brazil and the diverse paths through which assessors receive clinical referrals.

Given the contributions that TA can make to psychological assessment in Brazil, it seems important to devote time to learn this new method. The innovative features of TA, including the client becoming an active and central contributor to the process, leverages the transformative power of psychological assessment, which decreases the overall required time of service and facilitates spread across service contexts. It will be very interesting to see the future of TA in Brazil. We expect increasing demand for this type of psychological care and hope the health insurance companies in Brazil and the guidelines for public health services will take advantage of its potential to effectively serve a broad range of clients and contexts. It is exciting to think that TA can be a significant contribution to mental health services in Brazil.

References

Bruhn, A. R. (1995). Ideographic aspects of injury memories: Applying contextual theory to the Comprehensive Early Memories Scoring System—Revised. *Journal of Personality Assessment*, *65*(2), 195–236. Lawrence Erlbaum;

Butcher, J. N., Dahlstrom, W. G., Graham, J. R., Tellegen, A., & Kaemmer, B. (1989). *Minnesota Multiphasic Personality Inventory-2*. Minneapolis, MN: University of Minnesota Press.

Crisi, A. (2014). The Wartegg Drawing Completion Test: A new methodology. In L. Handler & A. D.

Thomas (Eds.), *Drawings in assessment and psychotherapy: Research and application* (pp. 148–163). Routledge/Taylor & Francis Group.

Finn, S. E., & Martin, E. H. (2013). Therapeutic Assessment: Using psychological testing as brief therapy. In K. F. Geisinger (Ed.), *APA handbook of testing and assessment in psychology* (Vol. 2, pp. 453–465).

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

Martin, E. H. (2016). *Foundations of Therapeutic Assessment and the important role of projective techniques.* VIII Congresso da Associacao Brasileira de Rorschach e Metodos Projetivos. ISBN 978-85-62020-04-9

Authors

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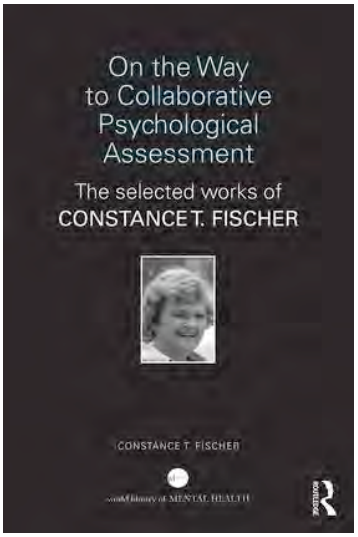
Reviews

On the Way to Collaborative Psychological Assessment: Selected Papers of Constance T. Fischer. Fischer, C. T. (2017). New York: Routledge. Hardback, 190 pp., $148.00.

Review by Stephen E. Finn, PhD Center for Therapeutic Assessment, Austin, TX



At the Inaugural International Conference on Collaborative and Therapeutic Assessment in September 2014, I had the pleasure of chairing the opening session titled "We Can Only Know Through Our Relation-ship with the World: Constance T. Fischer and Collaborative Psychological Assessment." With Connie Fischer present, two colleagues and I spoke about her life and work, her impact on each of us, and her lasting contributions to the field of psychological assessment. The session was well received by attendees of the conference, and I felt truly honored to have been involved. Afterwards, I was struck by comments I heard frequently from people who attended the presentation, along the lines of, "We knew Connie was important to Therapeutic Assessment, but we had no idea how many of the original ideas were hers!" Thankfully, Routledge's decision to publish a book of Fischer's seminal papers and chapters on collaborative assessment means Fischer's contributions to Therapeutic Assessment are unlikely to be forgotten.

On the Way to Collaborative Psychological Assessment contains 14 previously published articles and chapters by Fischer, arranged in approximate chronological order, and preceded by a previously unpublished autobiography that provides a rich context for all the other selections. The formerly published writings are grouped into three sections. The first, "The Development of Collaborative/Individualized Assessment," contains eight works, beginning with Fischer's very first publication on her approach, "The Testee As Co-evaluator" (Fischer, 1970). The reader will be struck by how completely and articulately Fischer outlined a coherent, rigorous philosophy of science based in phenomenological psychology and then used it to derive a set of collaborative assessment practices that were revolutionary at the time (such as writing assessment reports in a way they could be shared with clients). Other articles and chapters in this section illustrate how Fischer's theoretical base became even more complex and richer over her career, and how this led to more ways of involving clients as "co-laborers." For example, the last selection, Fischer's 1982 chapter, "Intimacy in Assessment," documents how her qualitative studies of intimacy led her to grasp even more deeply the intersubjective nature of the assessment relationship; that is, both client and assessor are impacted by their work together. This insight gradually resulted in Fischer's sharing more of herself and her experiences with clients *during* assessment sessions, a practice that was considered highly questionable at the time. Fischer's "human science" approach to psychological assessment is still greatly needed as we face pressures for narrowly defined "empirically-based" assessment and treatment, and provide us with an eloquent way to argue for an expanded view of "rigorous science."

The second section of this book, "Practicing Collaborative/Individualized Assessment," reproduces four of Fischer's writings containing detailed instructions and accessible illustrations of her pioneering collaborative techniques. Although all four pieces are valuable, I was delighted to see here my favorite chapter from Fischer's (1985) book, that on "Assessing Process." For those of you who have not read the original, this chapter contains more than 25 transcripts of assessor–client interactions involving a variety of clients (children, criminals, heroin addicts, job seekers, confused students, etc.) in which tests are used as interventions. This chapter by Fischer underlay the development of Assessment Intervention Sessions in the Therapeutic Assessment model (Finn, 2007). Essentially, I studied these and other examples from Fischer and derived a set of

semi-structured steps that assessors could use to approximate her creative brilliance.

The third section of this volume contains two pieces that illustrate how Fischer taught her innovative ideas over the years to graduate students at the Duquesne University in Pittsburgh, PA. Fischer developed a number of creative experiential exercises to help students focus on the "life validity" of standardized test scores. For example, when teaching Exner's (2002) Comprehensive System, Fischer asked students to describe real-life events in "Rorschachese." [E.g., One student described a recent dream: "An H in the woods was M^{a}ing towards me, his face illuminated with C' light" (p. 173).] In another exercise, Fischer brought a selection of greeting cards to class, and the students and she collaborated in "scoring" them using Rorschach determinants (C, CF, FC, T, etc.). The other selection is Fischer's 1994 article, beloved by many of us, "Rorschach Scoring Questions as Access to Dynamics." This piece is a wonderful example of how Fischer combined rigor and common sense in her assessments. She explains that when we have difficulty deciding how to score one or more Rorschach responses in a certain protocol, it may reflect something important about the client or the client–assessor relationship rather than some inherent unreliability in the scoring system. These issues can then be discussed with the client, leading to even deeper understandings.

Fischer's opening autobiography is worth the price of this volume in and of itself. Here we read how her early upbringing taught her empathy for people less fortunate, how growing up female in America in the 1940s and 1950s sensitized her to power differences in relationships, and how the intellectual stimulation of Duquesne's program in phenomenological psychology led her to rethink traditional psychological assessment. We also can see Fischer's determination and courage when her initial attempts to publish her ideas were rejected as "dangerous" and "unethical." As Collaborative/Therapeutic Assessment becomes more accepted and continues to spread, it is important that we not forget Fischer's legacy.

Admittedly, this book is not inexpensive (although a paperback version is forthcoming) and some readers may wonder, "Why should I pay to read articles and chapters that are already in print?" First, many of these articles and chapters are not easy to locate, even in good electronic databases, and this volume is an essential reference for those interested in learning, practicing, and teaching Collaborative/Therapeutic Assessment. Second, there is something incredibly powerful about reading Fischer's writings in sequence. One gets a sense not only of her intellectual brilliance and creativity, but also of her "personness." The core values that have come to define Therapeutic Assessment—curiosity, compassion, humility, openness, and respect—stem directly from Constance Fischer and her work. You will be uplifted by how these core principles are visible in every page.

Connie's book can be purchased through this link: https://www.routledge.com/On-the-Way-to-Collaborative-Psychological-Assessment-The-Selected-Works/Fischer/p/book/9781138892088

References

Exner, J. E. (2002). *The Rorschach: Basic foundations and principles of interpretation*. New York, NY: Wiley.

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

Finn, S. E. (2009). *What are the core values of Therapeutic Assessment?* Retrieved from http://www.therapeuticassessment.com

Fischer, C. T. (1970). The testee as co-evaluator. *Journal of Counseling Psychology, 17,* 70–76.

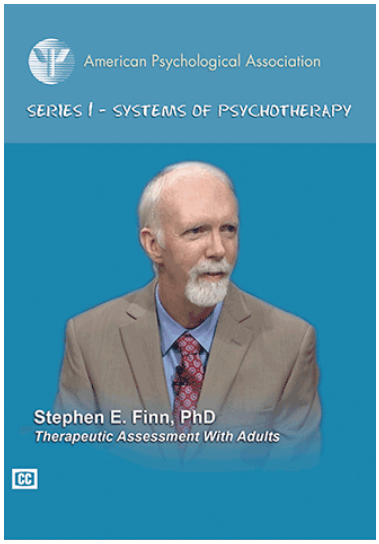
Fischer, C. T. (1982). Intimacy in assessment. In M. Fisher & G. Stricker (Eds.), *Intimacy*. New York, NY: Plenum.

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

Fischer, C. T. (1994). Rorschach scoring questions as access to dynamics. *Journal of Personality Assessment, 62,* 515–525.

American Psychological Association's *Systems of Psychotherapy Series: Therapeutic Assessment with Adults*, by Stephen E. Finn, Ph.D.

Reviewed by Christopher J. Hopwood, PhD, Michigan State University, East Lansing, MI



Therapeutic Assessment with Adults is a 90-minute video with three parts. In the first part, there is a 12 minute introduction in which Steve Finn discusses Therapeutic Assessment (TA) with a diverse panel of six other professionals and students. Issues such as the populations to which TA applies, its core principles and underlying philosophy, evidence supporting TA, and specific steps in the TA process are covered. This scene closes with Finn setting up the case demonstration.

In the next scene, Steve meets with Bianca, a young woman who presents with body image problems and maladaptive eating behaviors. Steve and Bianca discuss results of the MMPI-2-RF with reference to her question, *"How can I not let triggers take me back to being critical about my body and engaging in disordered eating?"* Bianca clarifies that she tends to make downward comparisons to others, which makes her feel bad about her body, and that she often responds by restricting her eating. This catches up with her when she becomes hungry, and she copes by bingeing. Bingeing makes her feel ashamed, and the process repeats. Bianca reported having used body image and appetite workbooks, and that her eating behavior was under relative control at the time of the assessment.

The 45-minute Discussion session is an excellent display of the core features of TA and of Steve's exquisite clinical skills. The clip does not come across as scripted or canned. Bianca is a real (and brave) client with real difficulties. Steve's genuineness and responsiveness give the impression that the scene was representative of a typical TA Discussion session.

Steve began by explaining how the MMPI-2-RF works. He clarified that the test results are not the absolute truth, which means that the two of them would have to work together to understand the results and what they mean about her question. He then shows her some test data. He first explains that there are no significant elevations, which means that she does not meet criteria for a major mental disorder. However, he notes some general distress and a very high score on Self-Doubt, which he describes as the "most important finding." He interprets Bianca's body image difficulties as part of a more general issue with self-esteem. He wonders with her if there are advantages to containing her general issues with self-esteem in her body image. This is a key aspect of the scene, which shows the importance of excellent assessment skills for TA practitioners. Connecting her eating behavior to the test score allows Steve and Bianca to co-discover how focusing on her body image gives her something specific to blame and makes her self-esteem problems more manageable. Steve also connects this to a broader social and cultural backdrop that makes it easy for women to feel bad about their bodies, and points out that by engaging with images from the popular media, she is actively working through her self-esteem problems.

Bianca and Steve agree that this might explain why she continues to struggle despite having her eating behavior under control, and they generate a new goal of dealing with her broader self-esteem problems more directly. He then provides some psychoeducation about recent findings in self-esteem from the scientific literature. He emphasizes the distinction between two forms. Peripheral self-esteem has to do with feeling good because others notice some positive feature about you. Core self-esteem has to do with feeling like you are a truly worthy person, which Steve frames as coming from early experiences and attachment security. This leads to a discussion of some of the more difficult aspects of Bianca's past. During this part of the session Bianca seems to develop a better understanding of why her eating behavior may have been a way to deal with some of her developmental challenges, and how that is mediated by a desire to manage self-esteem. This normalizes her behavior and leads to some clear and concrete goals for moving forward.

Specifically, Steve recommends psychotherapy, which Bianca can receive for free through her university. He suggests that she should focus on becoming more assertive and appropriately expressing her anger at others rather than blaming herself when things go wrong. They also discuss leveraging her personal strengths and social supports to continue growing and thinking about how some aspects of her development may have contributed to her difficulties. Steve helpfully reframes Bianca's concerns about being self-pitying in psychotherapy to being compassionate toward herself. While TA can sometimes be a short-term therapy, this appeared to be a wise recommendation for Bianca that also demonstrates how TA bridges assessment and therapy.

As the session proceeds there are noticeable changes in Bianca's affect and engagement. She looks at Steve with more confidence, smiles more, and appears to express her affects more spontaneously. By the end, Steve is able to warmly and authentically describe how affected he was by meeting her and how impressed he is with her resilience, which she apparently accepts without shame. It seems clear that she would not have been able to accept this kind of compliment at the beginning of the meeting. Steve inculcated a closeness that helped Bianca tolerate the discussion of her assessment results. She was presumably motivated to take his advice in a manner that would likely be helpful to her moving forward.

In the final, 30-minute section of the video, panel members ask Steve questions with reference to particular clips of the session. This gives Steve a chance to review his thinking during those clips and also to discuss some of the main techniques and values of TA. He clarified that framing the assessment around the client's questions helps the pair define the contract, engages the client in the process, and augurs a therapeutic relationship. He emphasized the importance of getting in the client's shoes, for instance, by being open to tests being wrong and using them as "empathy magnifiers" rather than as truth generators. He described the three levels of test feedback in TA and the importance of beginning with information that the client probably already knows, and progressing to information that may be more difficult to incorporate. He made specific reference to the idea that this is why he does not start with strengths, which would perhaps be ego-dystonic for a person with low self-esteem. Steve emphasized the importance of shame in the case and his hypothesis that Bianca's sense of shame was developmental in origin.

In summary, TA is an increasingly popular evidence-based technique for weaving psychological assessment into psychotherapy to help clients feel and function better. Its core values of collaboration, respect, humility, compassion, and openness were amply demonstrated by Steve Finn in this excellent video. It would be great to have videos like this for every aspect of a TA, but this 90-minute demonstration provides students and professionals with an overall sense of the approach, which could be facilitated by trainings at one of several TA centers around the world. Overall, this video provides a valuable tool for learning how to conduct TA. Moreover, Steve demonstrates the kind of deep empathy and curiosity that provides a useful model for any clinician, regardless of which specific techniques he/she might be using.

This APA video may be purchased through this link: http://www.apa.org/pubs/videos/4310960.aspx

Photo Album

Hale Martin with attendees at his TA workshop in Brazil. Ali Khadivi is second from left.

Attendees and presenter, Hale Martin, at a training in Brazil.

Recent Publications in Therapeutic/Collaborative Assessment

Aschieri, F., Fantini, F., & Smith, J. D. (2016). Collaborative/Therapeutic Assessment: Procedures to enhance client outcomes. In S. F. Maltzman (Ed.), *Oxford handbook of treatment processes and outcomes in counseling psychology* (pp. 541–569). New York, NY: Oxford University Press.

Austin, C. A., Finn, S. F., Keith, T. Z., Tharinger, D. J., & Fernando, A. D. (2016). The Parent Experience of Assessment Scale (PEAS): Development and relation to parent satisfaction. *Assessment*. doi:10.1177/1073191116666950

Brown, J. D., & Morey, L. C. (2016). Therapeutic Assessment in psychological triage using the PAI. *Journal of Personality Assessment, 98*(4), 374–381. doi:10.1080/00223891.2015.1123160

Engelman, D. H., Allyn, J. B., Crisi, A., Finn, S. E., Fischer, C. T., & Nakamura, N. (2016). "Why am I so stuck?": A Collaborative/Therapeutic Assessment case discussion. *Journal of Personality Assessment*, *98*(4), 360–373. doi.org/10.1080/00223891.2015.1119154

Fischer, C. T. (2017). *On the way to collaborative psychological assessment: Selected papers of Constance T. Fischer*. New York, NY: Routledge.

Gart, N., Zamora, I., & Williams, M. E. (2016). Parallel models of assessment: Infant mental health and Therapeutic Assessment models intersect through early childhood case studies. *Infant Mental Health Journal, 37*(4), 452–465. doi:10.1002/imhj.21573

Hansson, A., Hansson, L., Danielsson, I., & Domellöf, E. (2016). Short- and long-term effects of child neuropsychological assessment with a collaborative and therapeutic approach: A preliminary study. *Applied Neuropsychology: Child, 5*(2), 97–106. doi:10.1080/21622965.2014.996646

Sapozhnikova, A., & Smith, B. L. (2016). Assessment intervention using the Rey–Osterrieth Complex Figure Test: A clinical illustration. *Journal of Personality Assessment*, 1–7. doi:10.1080/00223891.2016.1212866

Villemor-Amaral, A. E. (2016). Perspectivas para a Avaliação Terapêutica no Brasil [Prospects for Therapeutic Assessment in Brazil]. *Avaliação Psicològica*, *15*(2), 249–255.

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*, *98*(6), 567–575. doi:10.1080/00223891.2016.1146289

Chudzik, L. (2016). Therapeutic Assessment of a violent criminal offender: Managing the cultural narrative of evil. *Journal of Personality Assessment*, 98(*6*), 585–589. doi:10.1080/00223891.2016.1215321

Evans, B. F. (2016). What torture survivors teach assessors about being more fully human. *Journal of Personality Assessment*, *98*(6), 590–593. doi:10.1080/00223891.2016.1180527

Fantini, F. (2016). Family traditions, cultural values and the assessor's countertransference: Therapeutic Assessment of a young Sicilian woman. *Journal of Personality Assessment*, *98*(6), 576–584. doi:10.1080/00223891.2016.1178128

Smith, B. L. (2016). Context matters: Commentary on papers by Aschieri, Chudzik, Evans, and Fantini. *Journal of Personality Assessment, 98*(6), 594–597. doi:10.1080/00223891.2016.1199433

Smith, J. D. (2016). Introduction to the special section on cultural considerations in collaborative and Therapeutic Assessment. *Journal of Personality Assessment, 98*(6), 563–566. doi:10.1080/00223891.2016.1196455

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

Eisman, E. J. & Nordal, K. (in press). The implications for healthcare: Commentary on the special section on teaching, training, and supervision of personality and psychological assessment. *Journal of Personality Assessment*.

Evans, B. F., & Finn, S. E. (2016). Training and consultation in psychological assessment with professional psychologists: Suggestions for enhancing the profession and individual practices. *Journal of Personality Assessment,* 1–11. doi:10.1080/00223891.2016.1187156 Available ahead of print.

Hopwood, C. J., & Blais, M. A. (2016). Model-based approaches to teaching and practicing personality assessment. *Journal of Personality Assessment,* 1–10. doi:10.1080/00223891.2016.1195393 Available ahead of print.

Kaslow, N. J., & Egan, G. J. (in press). A competency-focused commentary on the special section on teaching, training, and supervision in personality and psychological assessment. *Journal of Personality Assessment*.

Mihura, J., Manali, R., & Graceffo, R. (2016). Psychological assessment training in APA-accredited clinical psychology doctoral programs. *Journal of Personality Assessment,* 1–12. doi:10.1080/00223891.2016.1201978 Available ahead of print.

Peterson, C., & Iwanicki, S. (2016). An exploratory study examining current assessment supervisory practices in professional psychology. *Journal of Personality Assessment,* 1–10. doi:10.1080/00223891.2016.1228068 Available ahead of print.

Ramirez, T. V. (2016). On pedagogy of personality assessment: Application of Bloom's Taxonomy of Educational Objectives. *Journal of Personality Assessment,* 1–7. doi:10.1080/00223891.2016.1167059 Available ahead of print.

Roche, M. J., Jacobson, N. C., & Roche, C. A. (2016). Teaching strategies for personality assessment at the undergraduate level. *Journal of Personality Assessment*, 1–9. doi:10.1080/00223891.2016.1147450 Available ahead of print.

Smith, J. D. (in press). Introduction to the special section on teaching, training, and supervision in personality and psychological assessment. *Journal of Personality Assessment*.

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. Available ahead of print.

Upcoming Trainings in Therapeutic Assessment

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

January 21–23, 2017: Austin, TX, USA

Title: Therapeutic Assessment Immersion Course
Chairs: Marita Frackowiak & Pamela Schaber
Sponsor: Therapeutic Assessment Institute and Society for Personality Assessment
Information: marita.frackowiak@gmail.com or drpamelaschaber@gmail.com

February 10–11, 2017: Austin, TX, USA

Title: Working with Shame in Psychotherapy and in Psychological Assessment
Presenter: Stephen E. Finn
Sponsor: Austin in Connection
Information: www.austininconnection.org

Workshops at the Annual Meeting of the Society for Personality Assessment, March 15–19, 2017, San Francisco, CA, USA

Wednesday, March 15, 2017, 8:00 AM–5:00 PM

Title: An Ultra-brief Model of Therapeutic Assessment with Adults
Presenters: Stephen Finn, Hilde De Saeger, and Jan Kamphuis

Wednesday, March 15, 2017, 8:00 AM–5:00 PM

Title: Integrating Multimethod Assessment Results in a Meaningful Way for the Client
Presenters: Pamela Schaber and Filippo Aschieri

Thursday, March 16, 2017, 8:00–11:45 AM

Title: Conquering Assessment Intervention Sessions in Therapeutic Assessment
Presenters: Marita Frackowiak, Lionel Chudzik, and Francesca Fantini

Sunday, March 19, 2017, 8:00–11:00 AM

Title: Using Clinical Judgment in the Therapeutic Assessment of Individuals Who May or May Not Have an Autism Spectrum Disorder
Presenter: Dale Rudin

Information: www.personality.org

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 and Society for Personality Assessment
Information: jd.smith@northwestern.edu

Wednesday-Sunday, January 18-22, 2017
Austin, Texas

Therapeutic Assessment Immersion Course: Essential Concepts and Skills Training

A Workshop Co-sponsored by the Therapeutic Assessment Institute and the Society for Personality Assessment

***Chairs**: Stephen E Finn, Marita Frackowiak, and Pamela Schaber*
With Members of the Therapeutic Assessment Institute:
Lionel Chudzik, Melissa Lehmann, Hale Martin, Dale Rudin, J.D. Smith, and Deborah Tharinger

This training week is designed for individuals who wish to gain in-depth knowledge about Therapeutic Assessment. The training is a recommended first step for individuals who want to achieve certification in Therapeutic Assessment. Dr. Finn and his colleagues will lecture on the essential concepts and skills involved in Therapeutic Assessment of adults, children, adolescents, and couples. Then, participants will view video examples presented by members of the Therapeutic Assessment Institute that illustrate each step in a Therapeutic Assessment: Initial Sessions, Standardized Test Administration, Extended Inquiry, Assessment Intervention Sessions, Summary/Discussion Sessions, and Follow-up Sessions. Following each didactic portion, attendees will participate in structured role-plays during which they will practice the essential skills of Therapeutic Assessment with guidance from the workshop faculty. Role-plays will be tailored to focus on the types of clients who are of most interest to workshop participants.

Objectives

At the end of the workshop, participants will be able to:

- discuss the concepts of self-verification and disintegration anxiety and how they apply to psychological assessment
- assist clients in forming questions during the initial sessions of a psychological assessment
- conduct an extended inquiry following a standardized administration of various psychological tests
- plan and conduct an assessment intervention session
- plan and conduct a summary/discussion session
- describe client-friendly forms of written assessment feedback
- conduct an assessment follow-up session

Schedule

The workshop begins promptly at 9:00 a.m. and finishes at 5:00 p.m. each day from January 18 – January 22. There will be a lunch break each day. Lunch is available for purchase in the Hotel, as well as at other restaurants, within easy walking distance from the hotel. On Saturday evening, there is an optional celebration dinner for everyone.

Applicants to the training are advised that the training is time consuming, emotionally intense, and challenging. It is not advisable to schedule other things (e.g., report writing, phone calls with clients, family outings) while the training is going on. Attendees will have homework each night and will be busy each day, all day. If you are in a difficult period of your life, you may wish to postpone attending the workshop to another time.

Continuing Education Credit

This workshop qualifies for 33 hours of Type I CE credits for psychologists. The Society for Personality Assessment is approved by the American Psychological Association to sponsor continuing education for psychologists. SPA maintains responsibility for the program and its content.

Prerequisite Training

This workshop is open to mental health professionals and advanced graduate students. Participants should have previous basic training in psychological testing and will be provided with readings prior to the workshop to help them prepare. Professionals with previous training and experience in Therapeutic Assessment are also encouraged to attend, as the most current information and techniques will be presented in this training.

The Lead Presenters

Stephen E. Finn, Ph.D., founder of the Center for Therapeutic Assessment, is a licensed clinical psychologist in practice in Austin, TX, and a Clinical Associate Professor of Psychology at the University of Texas at Austin, He is the author of *In Our Clients' Shoes: Theory and Techniques of Therapeutic Assessment* (Erlbaum, 2007), and *A Manual for Using the MMPI-2 as a Therapeutic Intervention* (1996, University of Minnesota Press), as well as other books, chapters, and articles about psychological assessment. Dr. Finn is a Fellow of the American Psychological Association and of the Society of Personality Assessment, and is the recipient of the 2011 Bruno Klopfer Award from the Society of Personality Assessment for distinguished lifetime contributions to the field of personality assessment.

Marita Frackowiak, Ph.D., is a licensed psychologist in private practice at the Center for Therapeutic Assessment in Austin, TX. She is a founding member of the Therapeutic Assessment Institute and a Lecturer at the University of Texas at Austin. Dr. Frackowiak is certified in Therapeutic Assessment with adults, children, adolescents, couples, and families. She lectures internationally on Therapeutic Assessment and offers consultation to clinicians wanting to learn

Therapeutic Assessment. She is the author of a recently published therapeutic fable *Little Bear's Cup and Saucer*.

Pamela Schaber, Ph.D., is a licensed psychologist in private practice at the Center for Therapeutic Assessment in Austin, TX. She is a founding member of the Therapeutic Assessment Institute. Dr. Schaber is certified in Therapeutic Assessment with adults, children, adolescents, couples, and families. She lectures on Therapeutic Assessment and offers consultation to clinicians wanting to learn Therapeutic Assessment. Dr. Schaber is especially interested in Therapeutic Assessment with Adolescents and young adults.

Therapeutic Assessment

Therapeutic Assessment is a semi-structured form of collaborative psychological assessment developed by Stephen Finn and his colleagues at the Center for Therapeutic Assessment. Therapeutic Assessment can be used for many of the same purposes as traditional psychological assessment: diagnostic clarification, treatment planning, and treatment evaluation. However, in addition, research has shown that Therapeutic Assessment can be a powerful therapeutic intervention in and of itself for clients and their families, reducing symptomatology, increasing self-esteem and self-compassion, and promoting positive relationships between family members. Therapeutic Assessment can also enhance subsequent clinical interventions, increasing therapeutic alliance and compliance with treatment recommendations. An independent meta-analysis of this research concluded: "*Clinicians should … seek out continuing-education training related to these models [of therapeutic and collaborative assessment]. Those who engage in assessment and testing as usual may miss out, it seems, on a golden opportunity to effect client change and enhance clinically important treatment processes. Similarly, applied training programs in clinical, counseling, and school psychology should incorporate therapeutic models of assessment into their curricula, foundational didactic classes, and practica*" (Poston & Hanson, 2010, p. 210).

For more information about Therapeutic Assessment, visit the TA website: www.therapeuticassessment.com.

The Therapeutic Assessment Institute (TAI)

The Therapeutic Assessment Institute was formed in 2009 to promote and coordinate training in Therapeutic Assessment. The members of the TAI are psychologists from varied backgrounds, who have studied and practiced Therapeutic Assessment in a variety of settings. The TAI supervises certification in Therapeutic Assessment. Currently there are TAI members in Belgium, France, Italy, Japan, the Netherlands, Sweden, and the United States.

Location

The training will take place at the Westin Austin at the Domain http://www.westinaustinatthedomain.com. Directions to the hotel and pick-up information for the Austin airport are available on the hotel web site. A personalized group web page has been set up with event information: https://www.starwoodmeeting.com/Book/therapeuticassessmentinstituteskillstrainingjan2017.

Housing

A special rate of $199 for single or $199 double occupancy has been negotiated for workshop participants at the Westin Austin at the Domain. Rooms may be reserved at the workshop rate for dates January 18-January 22, 2017. Reservations may be made by calling the hotel directly 866-716-8108 and referring to the Therapeutic Assessment Institute Skills Training 2017. Reservations may also be made online at the personalized group webpage mentioned above. ***All reservations must be received by December 28, 2016.*** Reservations received after the due date will be honored on a space available basis at the prevailing best available rate.

Comments from Previous Attendees

"RUN, DON'T WALK to this training!'"

"This course has reinvigorated my excitement about being a psychologist"

"Excellent faculty—engaging, accessible, brilliant"

"The faculty managed to create a rich, warm group where we could gain expertise and learn from our successes and failures"

"This was the best training I have been to in 25 years of practice"

"You not only learn TA, but enhance your skills as a therapist, and discover a lot about yourself as a psychologist and as a person"

"Therapeutic Assessment is not only on the cutting edge of psychological assessment, but also of psychological intervention."

"This training addresses your left brain AND your right brain. I left feeling more integrated."

"In this week I learned more about how to be a better assessor, colleague, supervisor, and therapist than in years in graduate school."

"I am deeply grateful, inspired, and energized."

Registration Form

Therapeutic Assessment Immersion Course

(Please mail this form to arrive by December 18, 2017 for the early registration rate and by January 8, 2017 for the regular registration rate)

Name _____

Degree_____ Position _____

Institution_____

Address_____

City_____State _____ Zip Code _____

Telephone_____Fax _____

e-mail _____

_____Please enroll me in the January 18-22 workshop. I have enclosed a check for the amount checked below. The registration fee includes extensive handouts and refreshments during breaks.

_____$1500: Early registration, mailed to arrive by December 18, 2016
_____$1700: Registration after December 18, 2016

_____I also wish to attend the dinner on the evening of January 21st and have added an additional $65 to my check.

For the role-play groups, I am most interested in TA with (check one):

_____individual adults _____children under 13 _____adolescents

The final deadline for registration is **January 8, 2017.** We reserve the right to deny participation to any applicant or to cancel the workshop for any reason. If you cancel and notify us before January 8, you will receive a full refund of your fee. Cancellations between January 8 and January 11 qualify for a 50% refund. Due to the limited number of workshop spaces, if you cancel for any reason after January 11, 2017, your registration fee will NOT be refunded.

Please make checks payable to "Therapeutic Assessment Institute."
Return this form with your check to **Therapeutic Assessment Institute, 4310 Medical Parkway, #101, Austin, TX, 78756-3331.**

You will be sent a verification of your registration. If you have questions, or wish to discuss whether the workshop will fit your needs, please email Dr. Schaber at drpamelaschaber@gmail.com or call her at 512-919-0289.