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THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

Catching Up with TA

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This is the first issue of 2018 and of Volume 6 of the *TA Connection.* In many ways it is hard to believe that we have already published 10 issues of the newsletter. Time sure has flown by! Each time I begin to put pen to paper (or the modern-day equivalent of keystrokes to word processing document) for the *TA Connection*, I am reminded of this great community that we have formed together—a dynamic and diverse group of practicing psychologists, teachers, researchers, academicians, supervisors, trainers, trainees, colleagues, and friends. It's a delight to be able to highlight through this newsletter the great work being done around the world in TA. I hope that you enjoy the articles in this issue and feel welcomed to this community.

I want to send a special thank you to this issues's contributors, Caroline Lee, Hilde De Saeger, and Raja David; the Associate Editors, Deborah Tharinger, Hale Martin, and Pamela Schaber; and Steve Finn, who provided a close read before this issue was finalized.

This Issue

We depart a bit from the traditional format of the *TA Connection* in this issue by providing two interesting case studies and a highly-informative piece about the ethics involved in working with adolescents in TA.

The first column is a case study authored by Caroline Lee about a client with whom she conducted an end-of-therapy TA. The case focuses on the results and Extended Inquiry of the Adult Attachment Projective Picture System. The client, a high achieving middle-aged woman, was prone to dysregulation and becoming frozen when confronted with negative emotion, particularly sadness. The Extended Inquiry helped the woman understand why she gets stuck and feels alone when she is sad and also provided her with a caring and supportive experience with Caroline as she expressed her sadness—a situation she tried to avoid with everyone else in her life. As the therapy terminated shortly after the TA, Caroline and the client were able to discuss the results in the context of the gains that had been made and how therapy had allowed the woman to mourn and create a new, more accurate and compassionate story about herself.

In this issue:

The second case study, by Hilde De Saeger, presents the TA of a young man who was experiencing intense shame about sexuality and his relationship with his wife due to being raised in a very conservative, Orthodox Christian community. The man's Rorschach contained 6 Sex responses out of 24 total responses. During the Extended Inquiry he admitted to withholding more sex-related responses—all female genitalia. He called himself a sexual psychopath because of his sexual thoughts and past actions. Hilde was able to help the man understand that his past actions were very typical, not in any way a sign of his being a sexual psychopath, and that they were a product of his upbringing in a sexually repressive community. This de-shaming intervention was highly effective and led to the client's being able to share his innermost thoughts with his wife for the first time.

The third column is an elegant discussion of the potentially thorny ethical issues involved in doing TA with adolescents. Raja David uses a case example of working with a 16-year-old young man. He covers the major issues of assent, privacy (and the limitations to privacy for the teen from his or her parents), and how to go about testing parents as part of the adolescent TA. Raja also provides an informative analysis of the proportion of words in TA letters about the adolescent's testing that were related to what the teen shared with him during the TA. This low amount—about 10% (range 6% to 15%)—is a reflection of the privacy afforded the teen and a clear difference from a letter to an adult client that would likely contain closer to 20% to 25% of words being of a personal nature.

The Leonard Handler Fund

This newly-established fund assists economically disadvantaged clients who would benefit from TA but are unable to afford one. Leonard Handler (1936-2016) was a brilliant researcher, teacher, and clinician who developed groundbreaking methods used in TA, especially with children and families. Please consider making a donation to this fund through the TAI website to make TA available to everyone, regardless of income level.

Upcoming TA Trainings

If you haven't attended a live TA yet, it is a very powerful and unique way to learn about the model. The next opportunity for these less frequently offered trainings is November 2–4 in Tokyo, Japan. This is not only a great learning opportunity, but a perfect excuse to visit Japan! The live assessment of an adolescent and family will be conducted by Steve Finn and Noriko Nakamura at the Asian-Pacific Center for Therapeutic Assessment in English and then translated live into Japanese. If you can't make it to Tokyo, be on the lookout for other live TAs in the states and in Europe in the coming years.

Also, if any of you haven't had a chance yet to attend Steve Finn's workshop on shame in psychological assessment and therapy, the next edition will be in Milan, Italy, November 29-December 1, 2018. This new improved version includes a whole day on how to work with clients who are highly defended against shame, and deal with it through aggression or blaming others. Details are on the TA website. And members of the European Center for Therapeutic Assessment are always incredible hosts!

Although the schedule of workshops and presentations has yet to be set, I wanted to issue a "Save the Date!" notice for the 2019 meeting of the Society for Personality Assessment, to be held in New Orleans, LA, March 20–24. There are traditionally a number of TA symposia, paper presentations, and posters presented during the main conference, as well as preconference workshops. The Collaborative/ Therapeutic Assessment Interest Group also meets for an hour, and this is a great opportunity to catch up with TA friends and hear about how TA is being spread all around the world.

For up-to-date information on trainings offered by the TAI, visit our website and click on the Trainings tab at the top.

Become a Member of the TAI

As many of you already know, the Therapeutic Assessment Institute (TAI) recently began offering membership, which gets you two issues a year of this lovely newsletter, access to the members only listserv, and discounts on trainings sponsored by the TAI, and discounts on AAP trainings. The membership fee is very reasonable at $75 per year for professionals and $40 for students. If you sign up now, you can be a member for the rest of 2018 for half price. Please consider joining to receive these benefits and to help support the TAI's mission.

Donate to TA

The TAI is a nonprofit organization and all donations are tax-deductible. 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. And please tell your well-to-do contacts about the worthwhile mission of the TAI. We currently use the majority of donations to support training for students and professionals in need of financial assistance in the form of travel and registration scholarships, and we hope to be able to provide financial support to underserved clients very soon through the Leonard Handler Fund. We count on your generosity to be able to do this.

Future Issues of the TA Connection

If you have feedback or suggestions for the newsletter, email me! Many of the topics covered in the newsletter have come from your sug-gestions, 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.

Please email questions, comments, and suggestions to J.D. Smith at jd.smith@northwestern.edu

Using Collaborative/Therapeutic Assessment and the Adult Attachment Projective Picture System in the Face of Termination

Opening New Doors

By Caroline Lee, PsyD
Private Practice, Dallas, TX

One of my favorite articles in the Therapeutic Assessment (TA) literature is Stephen Finn's "Journey Through the Valley of Death" (2011), which highlights a powerful mid-therapy TA that gave story to a client's personality transformation over the course of long term psychotherapy. The article made me curious as to what it would be like to do an assessment with one of my own therapy clients, as I often wonder what it is like to be "in the shoes" of the referring therapist. What might an assessment illuminate that would otherwise be missed in weekly psychotherapy? How might it help move work forward at a stuck point? With these questions in mind, I encountered a good opportunity to have this experience.

After a year and a half of therapy and at a time close to our termination, I assessed my client, Amy. I want to share the experience, as it was one of the best learning experiences I have had so far in my career. It gave me a deeper "felt sense" of the power of C/TA (Collaborative/Therapeutic Assessment) and demonstrated the value of the Adult Attachment Picture Projective System (AAP; George & West, 2012). The AAP is a free response method that assesses adult attachment representation based on the story content and defenses that arise during the story-telling process. Finn (2011) writes about using the AAP mid-therapy, as it is particularly useful for illustrating potential shifts in a client's attachment status and defense processes over the course of therapy (George & West, 2012).

Case Background

A little background about Amy: She is a high-achieving, intelligent middle-aged woman who is as dedicated as they come to her career, family and community. She called me to begin therapy after her daughter, Emma, completed treatment for a rare and serious medical condition. Amy had been the primary

caregiver, medical advocate, and 24-hour nurse during Emma's treatment for nearly a decade. The possibility of losing Emma was always on her mind. Amy somehow managed to care for her daughter while also working, running a household, and avidly volunteering in her community during this ten-year period. After Emma completed her last treatment, she fell into a deep depression. Amy decided to pursue therapy because she was confused about her daughter's depression. Many children died from this condition, so Amy could not bear to feel anything but gratitude for Emma's health. She was alive! At the same time, Amy started having headaches and other physical complaints and noticed herself being less productive at home and work.

After the intake, it was clear that Amy was burnt out. She had been running on adrenaline for a decade. When asked about her early history, Amy had no complaints. She shared, "It was a typical middle class upbringing. I felt close to and loved by my parents and had a good education and close friends." Amy had no emotional problems until her daughter was diagnosed, and even then things were manageable--until Emma was depressed. With this information, I started to form a loose conceptualization: Amy seemed like a resourceful "solo flier" who needed some supportive therapy to recover from the caregiver trauma she endured with her child. I suspected she might have her own underlying depression that was split-off and expressed somatically in reaction to the trauma of the 10-year struggle, as her daughter's condition was fatal for so many families. I did not hear much regarding attachment trauma or insecurity in her history, and her agency certainly seemed sound. I considered that Amy's attachment status might be dismissing, as she minimized the effect of her child's medical condition on her emotional wellbeing, and she described her past attachment experiences as normal, but was otherwise unreflective about them. Amy spent her life focusing on achievement, was self-reliant and used her own remarkable personal strength to get through tough times. I imagined these strategies had served Amy well while caring for her daughter; so well in fact they may have helped keep her daughter alive. However, now these strategies might be preventing Amy from addressing the caregiver trauma she endured over the past decade.

Course of Therapy

In session, Amy was verbose and organized, coming in with discussion points for each session. When we approached sadness, she quickly changed topics, denied she was sad, and questioned the purpose of sadness in this situation stating, "There are so many families whose children died, why would I cry when my daughter survived?" She preferred to spend time learning to cope with her physical symptoms. She learned about mindfulness, deep breathing, nutrition, and yoga. However, over time, Amy developed more debilitating physical symptoms: migraines, nightmares about her daughter's treatments, low energy, and motivation. When I suggested the possibility of depression or reflected her demoralization, she became angry with me. Amy and I felt stuck about six months into therapy, so I suggested an assessment. She was not interested and wanted to dive deeper into alternative treatments for her physical symptoms.

During the next six months, therapy with Amy was inconsistent. She began skipping sessions and focused her efforts on diagnosing her physical symptoms. Amy went to half a dozen doctors in a six-month period, none of whom could find a diagnosis, and many of whom suggested she see a psychiatrist. Amy was angry with her doctors for not listening to her and angry with me that she was actually feeling worse. I was confused and unsure about how to help Amy, so again I suggested an assessment to help us understand how and if her mental health might be connected to her physical symptoms. Amy was again not interested because she was already spending too much money seeking medical advice.

A few months later, I shared with Amy that I was expecting a child and would be closing my therapy practice to do solely psychological testing after I returned from maternity leave. This was difficult to share, as we were both confused about the therapy because she was feeling worse, not better. In a moment of shared confusion and helplessness, I again suggested: "What about an assessment?" This time Amy agreed!

Assessment Questions

Amy's questions were 1) Do I really have a hard time feeling sad? 2) Could I be depressed and not know it? 3) Why can't I focus or get anything done? 4) Why do I lose track of time? We did a brief C/TA together using the MMPI-2 and AAP to answer her (and my!) questions. I chose the MMPI-2 to help answer Amy's questions about depression and distractibility and administered the AAP to answer her questions about sadness and losing track of time. The AAP highlights a person's attachment status, including how clients cope with attachment related emotions, such as fear or helplessness. Additionally, the AAP provides a

measure of underlying attachment trauma (George and West, 2012), and I was concerned Amy may be experiencing some dissociation, causing her to lose track of time.

Understanding Amy's Testing

Amy's MMPI-2 codetype was a 132. When we reviewed the results, Amy was surprised to see that the "depression" scale was elevated. I explained that people with this profile usually learned early on that sadness is not okay and instead learned to be positive, suppress negative emotion, and avoid conflict in relationships. This way of coping was likely necessary at one point (caring for Emma!) but can make it difficult to identify depression, since negative feelings are kept out and seen as a weakness. She agreed and said she felt physically depleted and did not like to feel sad, yet struggled to imagine her mood might be connected to her physical symptoms.

Amy's AAP results (See Table 1) helped us understand even more, including why it had been adaptive for her to avoid her sadness and depression and why she was losing track of time. The AAP presents clients with seven line drawings that depict a range of attachment contexts portraying individuals alone and in dyadic pairs (George & West, 2012). The alone stimuli in the AAP (right side of Table 1) pull for feelings of aloneness, loss, and potential threat. The characters in Amy's stories lacked internal attachment resources, as her characters did not think about their distress or reach out for help when they were alone. At best, her characters were able to take constructive action (very fitting for her!) to manage distress in the Cemetery and Corner stories. However, to my surprise, an unresolved segregated system was present in Amy's window story. Thus, her attachment status was unresolved, letting me know that Amy was really struggling to contain attachment distress in her everyday life. This particular trauma marker fell into the "helplessness/out of control" category on the AAP, helping Amy and me understand why she had become so unproductive and was losing track of time. The breakthrough of segregated systems can be so dysregulating that it undermines people's ability to function (George & West, 2012). Amy's unresolved attachment status let us know she was truly stuck, unable to cope with her distress.

Here are a few examples of her stories:

> **Window:** It's a little girl who wants to go outside to play, but it looks like she is *stuck* inside. I think she is just going to daydream about going outside. I don't think she is sad; I think she is content. That's it. *What might happen after?* I don't know, I don't think I have anything else. *Anything else?* No.

Table 1. AAP Scoring

Dyadic Stimuli	*Synchrony*	Defense	Trauma	Alone Stimuli	*Agency of Self*	*Connected*	Defense	Trauma
Deprt (3)	functional woman/no id -no interaction	Disconnection: Entangling		Window (2)	no agency girl	alone self	Disconnection: Uncertainty	Unresolved: helpless/ out of control
Bed (5)	no response to attach signal Mother/child	Deactivation: Achievement Disconnection: Uncertainty		Bench (4)	no agency teenager	alone self	Disconnection: Uncertainty	
Ambul (6)	functional – no interaction GM/child/GP or parent	Deactivation: Social Role Disconnection: Uncertainty		Cemtry (7)	capacity to act man go get coffee or dinner	*not coded Father or Mother in grave*	Disconnection: Uncertainty	Resolved: Spectral
				Corner (8)	capacity to act child go to bed	*not coded self-reprimand*	Deactivation: Rejection Disconnection: Entangling & Withdrawal	

Bench: This looks like a girl maybe a teenager who is either sad or lonely. Or both. Just kind of introverted and alone. (Tries to hand back.) *Before?* Maybe someone didn't show up that was supposed to meet her there. *Afterwards?* I can't think of anything. I don't think she can either. *Anything else?* No.

Notice in both of these stories the character remains alone and stuck and cannot think of what to do. In the face of attachment distress, Amy became quite constricted and even seemed frozen as she was telling the stories. This was a stark contrast to the verbose and organized woman I saw at the beginning of therapy. When she finished both of these stories, it was apparent she felt flooded, holding back tears, and she was quick to hand the cards back to me. Another story:

Corner: A child in a corner who seems to be ashamed and doesn't want anyone to bother him. He wants to be alone. Maybe he just got caught doing something he doesn't want to do but he doesn't want to be reprimanded again [so] he is kind of self-reprimanding himself. Maybe just kind of craving some alone time. He doesn't want to be consoled either. *What might happen after?* Maybe he'll just go to bed. (Laughs.) Yeah, I think he is seeking total detachment.

Amy's corner story allowed us to see her use of deactivation, and the ability to exclude attachment related information, including distress, from her consciousness. In her corner story, the character remains alone, seeking total detachment. After seeing her AAP, I again wondered what her attachment status might have been at the start of therapy. It seemed that at the beginning, Amy was able to use deactivation (the primary defense in the dismissing attachment adaptation) to exclude feelings of sadness, grief and helplessness from her awareness. However, over the course of therapy, Amy became more dysregulated and described feeling frozen on several occasions. The AAP helped illuminate that her deactivation was beginning to crumble, and her underlying attachment trauma was emerging. As her therapist, this helped me understand just how dysregulated Amy was and why avoiding sadness was necessary: she was stuck, not able to think and had no one to help her. No wonder Amy felt like she was falling apart, because for her, deactivation had helped lead her to success: high achieving in her job, active as a volunteer, and available to care for her daughter and other families who were also suffering.

The lack of connection and interaction in Amy's dyadic stories (left side of Table 1) was also notable and a stark contrast to the way she described her relationships in the initial intake. During therapy, she had few complaints about her relationships with her family members. After seeing her AAP res-ponses, it seemed that initially, deactivation had allowed Amy to divert her attachment needs to her exploratory system: organizing fund-raisers, managing insurance panels and doctors, working a complex job, and managing a busy family life. In fact, excluding her underlying aloneness was a necessity during this 10-year period with her daughter, as her ability to be self-reliant likely helped keep her daughter alive. Therefore, the assessment helped me understand why Amy was angry with me. She wanted therapy to bolster her deactivation in order to return to her old self and keep herself together on her own without having to deal with all this emotion. Amy did not recognize this dysregulated self she was faced with and believed she was a failure as her sense of security fell apart before her very eyes. Now, she was presented with a self that instead felt helpless, alone, and STUCK because the underlying attachment trauma was overwhelming her, and she no longer had a strategy to cope with the dysregulation.

The Extended Inquiry

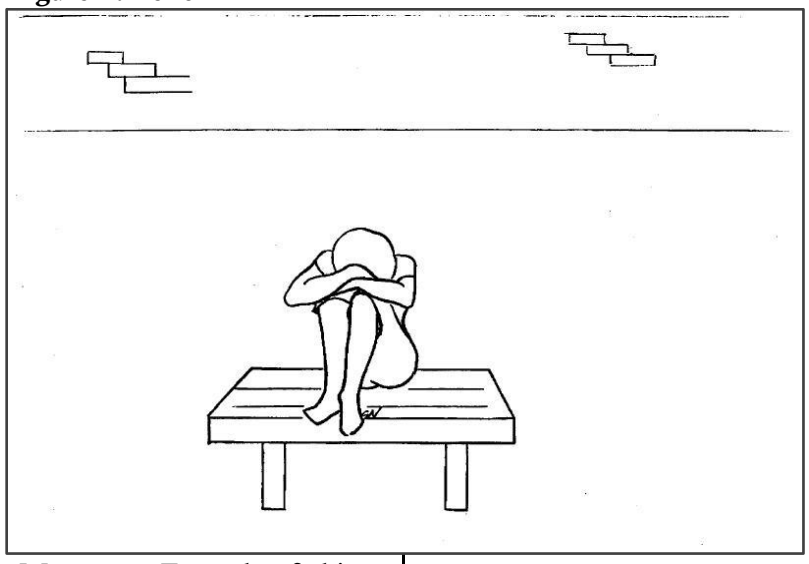
The extended inquiry in C/TA is used to help clients observe their stories and make possible connections to their questions. I was curious about what would come up during the extended inquiry since Amy had strong reactions to the stimuli during the administration. I also wondered about the previous attachment trauma. Was the segregated system related to the caregiver trauma or was there some earlier trauma we had not yet touched upon in therapy?

I asked Amy to take the cards and see if any of her stories might help us understand how she had been feeling lately. She chose the bench card (Figure 1). I asked what about this story reminded her of where she is now?

Amy (A): Because I am stuck too. I did this same thing this morning. I took a shower and had to sit down in the shower because, I don't know, I just couldn't get up. But it's so stupid she should just get up. But she can't. I can't even look at her. She is disgusting, look at her sitting there all weak and pathetic. I don't even want to look at this picture. It's disgusting.

Amy went on for some time about the disgust she felt towards the girl on the bench. It seemed as if she were in some sort of trance, berating the girl over and over, and I wondered where this was coming from? Was this how a parent had spoken to her? I was slightly stunned, not sure how to proceed. So I relied on the guiding principles of TA: collaboration, curiosity, compassion, humility, openness and respect (Finn, 2009).

Figure 1. Bench



Caroline (C): It's disgusting to feel sad?

A: Yes, she has absolutely no reason to be sad.

C: So she is stuck here. Is there anything else you can think of that might help her feel better or get up?

A: No, she can't move. No one can see her this way. It's too embarrassing. Everything is good in her life, and she needs to get over it. Move on. Enough of this weakness. She will just go on her with life and forget about it.

At this point, Amy couldn't make eye contact with me. She was filled with shame, disgust and helplessness. She let me know that reaching out to someone else felt too shameful to bear. She felt weak and disgusting when others saw her in a vulnerable state. I was still confused about who must have spoken to her this way? I had never heard Amy berate herself this way in our sessions. So I decided to ask!

C: Who talks to her like this? Where did she learn to talk to herself this way*?*

A: *Amy paused for a long while.* I mean I don't see anything wrong with it. It's just how it is.

C: Yes, there is nothing wrong with it. Yet, she probably learned it somehow—to feel disgusting when she is sad.

A: Well, my mom would often tell me that sad people are weak people. And we were not a weak family. And that I wasn't grateful for her if I was sad, and she wasn't going to have spoiled kids. We knew that we had to go to our room when we were upset or else we would get spanked or scolded. But it made me tough.

C: Yes, it made you very tough. And strong. And that has helped you accomplish a lot in your life. Do you think there were any drawbacks for al-ways having to be so tough?

A: *Amy began to cry.* I get so tired of doing it all.

C: Yes, you must be exhausted! I wonder if your response to this card might help us understand your question about sadness.

A: I remember being really sad as a kid and spending a lot of time alone in my room. And being afraid that my mom would find me and scold me. But at some point I just went numb. I don't know when.

C: Yes, you learned you had to have good reason to be sad, otherwise you would be scolded and sent away to your room! And this, Amy, is frightening for children. So they learn really quickly to hide their sad feelings so they don't get the scolding. They learn how to shut it down and take care of it on their own. So on the outside they look strong and tough but on the inside they end up feeling kind of scared and alone. Kids need their parents to comfort them when they are sad instead of sending them away.

A: *Amy cries for several minutes.* I always feel so alone. Even with my husband. I just don't know. I can't stand it for anyone to see me like this.

C: Oh yes, Amy. We have been feeling so stuck here. Do you risk being sad and feeling horribly disgusted with yourself or stay numb but alone? What an impossible situation!

Understanding this was relieving to Amy and helped her understand why she was feeling so stuck. She was taken aback by the disgust she felt towards the girl in her bench story. This helped her make the connection that berating herself might be connected to her losing track of time and why it felt dangerous to feel sad or depressed. Even so, she left the session upset, with

dawning awareness that she might have to continue therapy with a new therapist and start working through these feelings that so disgusted her.

That evening, I got a text message from Amy saying she would not be able to come in for the next four weeks. After our session, she went home and passed out on her kitchen floor while making dinner. She fell on her face, shattered her nose and two front teeth, and had to have emergency reconstructive surgery. Needless to say, I was concerned for Amy and worried I had pushed her too hard, causing her pain instead of relief as a result of the assessment. I saw her a few long weeks later, not knowing what to expect. In the session, Amy shared that while it had been a horrible experience to faint and have surgery, doing the AAP and seeing the way she told her stories made her realize just how much pain she was holding inside. She had spent the last few weeks in bed crying, grieving and talking to her husband about how isolated and helpless she had been since her daughter's recovery. She said the assessment helped her to see it was not HER that was disgusting, but rather her mom's reaction to sadness, much like her own reaction to her daughter's grief and depression. She did not want to treat Emma the same way and decided she needed to continue therapy to work on accepting her feelings and stop berating herself.

Epilogue

TA allowed Amy to witness her underlying sadness and depression that was not just related to Emma's diagnosis but also to her previous attachment trauma, something she had been unable to consider or even see before. As the end of our therapy approached a few weeks later, Amy and I validated and reflected upon the gains she had made. I explained to her that I thought her AAP would have looked different before we started therapy. However, as we developed a strong relationship in the presence of her reaction to Emma's depression, her attachment trauma (i.e., being repeatedly berated for her expression of attachment needs/emotions and subsequently feeling helpless/out of control) started surfacing and was captured in her AAP stories. She felt she was falling apart, but this was the progression of mourning: falling apart a little while learning to relate to herself and others in a new way. This transition allowed her to decide she was not weak but instead grieving the disappointments she had endured over her life. She ultimately saw she had been blaming and punishing herself to avoid grieving traumas in her life. She also saw that the breakdown of this avoidance was likely connected to her physical symptoms (Bowlby, 1980).

Understanding Amy's attachment status deepened my understanding of what was impeding the integration of her most recent trauma with her daughter. She had an underlying attachment vulnerability that arose after enduring the caregiver trauma, Emma's depression, and starting therapy. Without the AAP, I was unaware of the segregated systems and her unresolved attachment status and assumed the grief and trauma reactions were due to the most recent caregiver trauma with Emma. The AAP allowed us to look within her attachment system, illuminating the underlying attachment trauma I had missed in weekly psychotherapy.

After Amy broke her nose, I was expecting her to come in angry with me for pushing her too hard and moving her into her grief too quickly. I was concerned she might then be even more focused on her physical symptoms. Yet, once again, Amy's resilience amazed me. Thanks to the power of C/TA and the AAP, Amy finally understood her dilemma, felt relief from her shame, and endured her grief. All this resulted in closer relationships and a new story about true strength.

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Author

Caroline Lee, PsyD, received her doctorate in 2015 from Rosemead School of Psychology in La Mirada, CA. She was licensed as a psychologist in 2016 and maintains a private practice in Dallas, TX focusing on collaborative/therapeutic assessment with adolescents and adults. Caroline is trained in the Adult Attachment Projective Picture System (AAP) and achieved AAP coding reliability in 2018. She began attending TA trainings in 2015 and is currently working towards certification with adults.

Please email questions or comments about this column to *carolineleepsyd@gmail.com*

It's a Sin!

De-Shaming through Therapeutic Assessment

By Hide De Saeger
The Viersprong Clinic, Holland

I work as a clinician at a center in The Netherlands for adults and adolescents with severe personality disorders and personality pathology. The center provides outpatient, inpatient, and day treatment services using several evidence-based and innovative methods, including Mentalization Based Treatment, Schema Focused Treatment, Dynamic Interpersonal Treatment, Transactional Analysis, and Therapeutic Assessment (TA).

Patients with severe personality pathology are characterized by several traits that make successful treatment difficult. They often have high comorbidity with other psychiatric conditions and have notoriously high dropout rates. They show great ambivalence toward change. The problems they deal with are diffuse, and their cognitions about themselves and the world are often quite rigid. Most of the time they have motivation and commitment issues, and their capacity for introspection is limited (Emmelkamp & Kamphuis, 2007).

TA's emphasis on emotional containment, empathic connection, close collaboration, and recognition of dilemmas of change has been essential in helping these difficult clients. Over the years we have noticed that our patients are extremely sensitive to the sustained empathy that is provided by TA. My clients have a history of severe misattunement from attachment figures. Most of them are punished and /or rejected, resulting in insecure attachments. They have high levels of anxiety and often no one to turn to due to a history of interpersonal difficulties and strained relationships. On the other hand, they often feel they have fallen short in the eyes of their caregivers and have not reached the goals they were supposed to, leading to feelings of low self-esteem. They feel unworthy and bad. Their narratives focus around not being good enough. They are self-punitive and constantly feel that life is not worth living.

All these issue can be thought of as rooted in shame. As Stephen Finn describes, shame can be a state—a way of feeling in the moment—or as a trait—a way of being (Finn, 2012). Fossum and Mason also offer a great description of the experience of shame.

> "Shame is an inner sense of being completely diminished or insufficient as a person. It is self-judging the self. A moment of shame may be humiliation so painful or an indignity so profound, one feels one has been robbed of her or his dignity, or exposed as basically inadequate, bad, or worthy of rejection. A pervasive sense of shame is the ongoing premise that one is fundamentally bad, inadequate, unworthy, or not fully valid as a human being" (Fossum & Mason, 1986, p. 5).

My patients fight against the feeling of shame more than anything else because of the extremely painful nature of shame. They have all kinds of defenses to help them avoid feeling the pain associated with experiencing shame. Some show anger and grandiosity, others avoid almost everything or punish themselves by being extremely perfect. But most of my patients have sadistic internal voices that are constantly self-critical. Bringing these negative self-statements out into the open and into our interaction is necessary but not without risk. TA has proven to be of great help in bringing these split-off negative affect states into consciousness so they can be addressed in psychotherapy.

Jean

The first time I heard about Jean was during our patient staffing meeting, where a colleague of mine mentioned she had a really strange client. When Jean was referred to us, he was 26 years old—but he looked like he was 17. He was the father of 3 children and a nurse at an intensive care unit. Recently he was forced to go to a crisis unit because he wanted to cut off his penis. Initially he reportedly appeared suicidal, but he assured everyone in the crisis unit that he did not want to end his life. He had planned it in detail and was sure he could survive without his penis. The psychiatrist diagnosed him with severe personality pathology without psychosis and referred him to our center. My colleague wanted to check if Jean was on the autism spectrum because he could not seem to establish a connection with him and he was unable to explain the severity of the symptoms. Given these two pieces of information, we decided to do a TA with Jean in hopes of both building a trusting and collaborative relationship with him, as well as gaining a better understanding of his symptoms and their severity.

Jean grew up in a small village near the seaside and was raised an Orthodox Christian. In these small communities that are situated around the church, there is often little respect for human emotions or desires. Everything is devoted to God, seen as being the conductor of all human life.

The prevailing belief about life in these communities is, "You are born in sin, and if you do your very best, maybe, just maybe, you can obtain salvation!" The church and the community were the most important things in Jean's life and in the lives of his family members. The church of his childhood was more punitive than the one he currently attended with his wife. When he got married, he was 21 years old, and his wife was 19. They have 3 children ages 4, 3, and 1.5 years. When I met him at the center, his wife and the children were living with his father. Their community was gossiping about this arrangement.

Jean's parents divorced when he was about 12. Both he and his father described his mother as a woman with personality pathology on the borderline spectrum. She was emotional, inconsistent, sexually promiscuous, and unable to raise her children. The behavior of his mother was not tolerated in the highly religious community. For this reason, Jean's father sought and received permission from the pastor to divorce her. After the divorce, contact with his mother was forbidden. Jean was bullied at school because people in the community did not approve of divorce, saying things such as, "What God has united, man cannot tear apart!"

Jean's older brother could not deal with this situation, and he started acting aggressively towards Jean. Jean ended up being isolated in the family as well as in the community. Eventually the family had to leave this community and go to another one. So at age 12, Jean lost his community, his mother, and the close relationship with his brother. In the new community he finished school and received specialized training as a nurse. He functioned well at work and never had any problems. Socially he became restricted after changing to the new community, and he no longer had close friends. At home, his brother kept bullying him, and at school his nephew constantly devalued him because of his parents' problems. He met his wife at age 20 and got married at age 21 in conformity with the norms of the community.

At the time of the TA, Jean suffered from severe insecurity and extreme low self-esteem. He was so ashamed of himself that he avoided others more than ever. He felt unworthy as a son, a husband, and a father. In the relationship with his wife, he switched between being at times dependent and at other times disparaging. His wife was devoted to him and wanted the best for her family, but she couldn't deal with his emotions. The only place he felt worthy was at work with his patients. He kept his colleagues at a safe distance.

His assessment questions:

- What makes it so important for me to experience control over others?
- Why do I have such a hard time showing my emotions?
- How can I improve my self-esteem?
- Can you offer me therapy?

Questions of the referring therapist:

- How can we understand the severity of his acting-out?
- Is this only personality disorder (cluster A) or is he more on the autism spectrum?

At first we conducted an assessment for autism and decided Jean was not on the spectrum. I then administered the MMPI-2. Jean's results showed a "cry for help" profile on the validity scales. He had a 28/82 profile on the clinical scales, a high 0, and, of course, was high on the Low Self-esteem subscale. In short, this meant that he saw himself as anxious, agitated, tense, and jumpy. He experienced a lot of cognitive problems including difficulty with concentration, confusion, and forgetfulness. He also reported somatic complaints. Throughout the MMPI-2, severe shame markers were evident.

In TA, multi-method assessments are commonplace. I administered a Rorschach using the Rorschach Performance Assessment System (R-PAS) method and scoring. The Rorschach showed only mild thought problems. Jean had his own "special/unique" way of looking at the world, as most of my patients have. His profile also indicated heightened distress and extreme defensive distancing. He had a high Critical Content score as well as limited Human percepts. His scores were not surprising to me, given the traumas he had suffered in his life.

Out of Jean's 24 responses, six of them were sex responses; all female genitals. As he gave each sex response, his face flushed and became increasingly redder. By the end of the administration, he looked almost purple. He kept repeating that there must not be any "strange" answers, half talking to me and half talking to himself. In the clarification phase, he somewhat surprisingly described all six of the female genital responses with anatomical precision.

Consistent with the TA method, I did an Extended Inquiry of the Rorschach responses after the standard administration. I invited Jean up on the observation deck to see if he could do some self-exploration and open up a little more. What we know about Extended Inquiry is that it often helps us bring unconscious material to a more conscious level. Because Jean was so restricted, I moved very slowly and took half-steps, not expecting a lot to happen even though he did give me six sex responses!

In the extended inquiry, Jean told me that he had found the Rorschach extremely difficult. There were no cards he liked more or less, although he had a mild preference for the colored cards.

When I asked him if he remembered when I had to prompt for more answers, he told me it was on cards IV, V, VI and VII. I asked if he knew why these cards were more difficult for him. He could not come up with an answer, which confused him and made him feel bad. So, I moved on and asked him if he had seen or thought things that he did not mention. He went into even deeper shame, admitting he had more sexual answers in his head but did not want to share them with me. Almost every middle area on the cards looked like female genitals to him. In the dark and light areas he could see kind of a cave where he saw a vagina and clitoris.

He then started blaming himself saying he was a monster, dangerous, not worthy to be alive. "A failure of humankind," he called it. The shame took over and filled the room. I just sat with him, tolerating his intense emotions and invited him to tell me more about it. He told me he had extreme sexual desires ever since he was 12 or 13 years old (the age at which he lost his mom, his community, and his brother, but of which he was not aware of at that moment). He masturbated during that time only TWICE a week, he told me very seriously. He not only lost a lot at that time, he failed himself because he could not maintain the expectations of his religion. Masturbation was forbidden and bad. Thus, he also lost his God as well as faith in himself.

He told me that in his current life, he was even more obsessed with sex. I asked if he could tell me more about that. He said, when he saw advertisements of women in underwear at bus stops, he became obsessed. So, he started avoiding these places. I took his anxiety about being a sexual psychopath seriously, and I asked some questions to see if he was at risk for being sexually aggressive towards others. However:

- He was never sexually aroused by his patients even when they were young and beautiful and he had to touch them while providing nursing care;
- He had never been sexually preoccupied with his daughter;
- He had never forced his wife to have sex with him or even fantasized about doing this;
- He had never been sexually aroused by another woman, known or unknown.

So, I asked him if he ever had sex education. He could not remember having this before his internship to become a nurse. The first naked woman he ever saw was an older woman he had to bathe.

So there I was, sitting with a deeply shamed young man, who thought about himself as a sexual psychopath whose life was not worth living, and who thought that cutting off his penis would heal him! The Rorschach and the images he described made it possible for him to share this information that he had never shared with anyone before and had never talked about before. This was a devout man and I decided to try and get into his shoes. This is the conversation that ensued:

Me: Jean, do you agree that man is made in the image of God?

Jean: Yes indeed, but only the image.

Me: Of course, I think He (God) did a terrific job, I think we are made ingeniously.

Jean: Indeed.

Me: So God gave us all kinds of systems, systems to keep us warm enough, to keep us nourished. We get signs when there is danger; we feel pain to let us know when there is something wrong on the inside.

Jean: (Agreed on each one of those biological markers I could think about in the moment).

Me: Why do you think he would give us sexual desires if he did not want us to have those?

He then looked up as if a wasp bit him. And said:

Jean: It's very sad, you would think we got these desires for a reason.

Me: I'm sure we did. I don't think God makes mistakes like these.

Jean: But why do I act so exaggerated?

Me: What do you mean?

Jean: Instead of masturbating once, I did it twice a week or so for half a year.

Me: I think you could benefit from some education and explanation on how sexual desires develop during our childhood and adolescence. I think that what you experienced was quite normal, and to the contrary, not exaggerated at all.

He became hyper alert again.

Jean: Are you sure?

Me: Yes, I'm…I think by pushing away these normal feelings, you forced yourself not to think about the elephant in the room.

He expressed that he could see how this worked and how he had been pushing away a normal biological function.

At that point the tension in the room had dissipated and I decided to end the session. By exploring his Rorschach answers, we could talk about a split-off part of himself and bring shameful thoughts into our conversation. By letting him explore the function of sexual feelings, it helped him out of the shame. I decided not to go into the connection of dealing with painful emotions and masturbation, and how it could be that he started to have these feelings at the moment he felt completely alone and abandoned in the world. In my opinion, that still was level 25 information for him.

I took time to meta-process what we had discussed. I explained that I thought he worked really hard and explored a lot of painful feelings with me. I told him these feelings could emerge in the next few days. I had told him he could contact me if he needed me. As expected, he experienced shame when he returned home. He felt badly about himself and even became suicidal during the evening. His wife discovered this and began talking with him about what he was feeling. For the first time, he was able to share his innermost thoughts with someone close. She was also

devout and assured him that sexual feelings are normal, and that it was great that he had been able to talk with me about it.

Summary

Jean was ashamed about the divorce of his parents and his sexual feelings. He had nobody to talk to about these feelings, and started feeling more shame due to not having anyone to normalize his experience. He began to see himself as completely diminished and insufficient as a person. He judged himself constantly. The "blame" in church, the rejection of masturbation and sexuality made him feel fundamentally bad—that he was not a valid human being. The Rorschach helped him talk to me about his most painful and shameful feelings. TA and the Extended Inquiry gave me some tools to help him heal and have a de-shaming experience.

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Ethical Considerations when Conducting Therapeutic Assessments with Adolescents

By Raja M. David, PsyD
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16-year-old Jack had been referred to me for a TA by his individual therapist, as he was struggling to make gains in therapy. Throughout my time with Jack, he was very motivated to figure himself out. His mother was equally motivated to help him, but his father was reluctant, and he wondered why the family was 'wasting money' on therapy. The father did not attend the initial session, but with prompting from me and his wife, he agreed to come in for the parent interview and the parent discussion session.

During the discussion session with just Jack and his therapist, we talked about his anxiety and depression, and life experiences that contributed to those issues, including his father getting sober 10 years ago and his parents' conflicts. For the first time with his therapist, Jack was able to be honest about what those experiences were like for him emotionally, and he recognized how they impacted his mental health.

Jack had already decided not to attend the parent discussion session, which was scheduled for the following week. I broached the idea of sharing with his parents some test data that suggested he had been impacted by these family experiences. After meeting with the parents, my sense was that they knew some of this information and could emotionally handle such feedback. I hoped for further healing in the family if they could connect around these shared experiences. When I asked Jack if it was ok for me to share that test data, he was initially wary, but after further conversation agreed.

Two days later Jack contacted me in a panic and we connected on the phone. He had become quite anxious about how his father would handle the information we discussed and believed his dad would become angry and irrational. I emotionally supported Jack and assured him that the data suggesting he was impacted by family experiences was not so crucial that it had to be shared with his parents. We agreed that the focus of my discussion with his parents would be on his symptom picture and what would help.

Jack was right. During the meeting with the parents, his dad had a hard time seeing his son as having any problems. Even Level 1 information about anxiety and depression was rebuffed, and Level 3 information would have been disorganizing for him. I left the session grateful that Jack had reached out to me, as we were able to determine how best to navigate his privacy.

Ironically, my experience with Jack occurred right after I had presented on ethical considerations related to C/TA at the 2017 International Collaborative/ Therapeutic Assessment Conference. In the months prior I had given a good deal of thought to privacy, consent, assent and how to conduct TAs with adolescents and their parents in a thoughtful and ethical fashion. My experience with Jack was a reminder that the informed consent (assent for adolescents) process is ongoing and the nuances of these ethical matters can be missed or mismanaged.

What follows is a summary of what I presented in 2017 at the 2017 C/TA Conference, with a focus on conducting TAs with teens, which also may include testing parents. Those familiar with providing psychological services to children and adolescents are aware that such work requires a deep understanding of ethics. Koocher (2008) has identified four "Cs" to consider when providing psychological services to minors: competency, competing interests, consent, and confidentiality. In this article I focus on consent and confidentiality and posit that adequately attending to the informed consent process at the onset of the relationship, and as necessary throughout, maximizes an ethical practice. Note that some of what I describe involves forms I've developed for my practice, and if you would like a copy, email me at the address below.

Adolescent Assent

It is important to think through how the process of child and adolescent consent maps on to core values of conducting TAs, such as "active collaboration," "respect of all clients" and "openness" about the unique individual we are assessing (Finn, 2009). If we embrace these values when working with teens, then they must be active participants in the initial establishments of the relationship contract. The informed consent process begins with the parent(s) during the initial phone call, and continues with them through the written informed consent policy they must sign before proceeding. In addition, initial conversations with the teen and parents during the first session establish guidelines regarding what the process will look like and how privacy will be protected. However, in the spirit of being more respectful to teens, I believe a formalized process where they can agree to what they are participating in can be beneficial. This also has the potential clinical implications of decreasing the power differential between myself and the adolescent, which I find enhances the relationship.

To formalize this process, I developed a document entitled Adolescent Therapeutic Assessment Informed Assent Form. "Assent recognizes the involvement of the child in the decision-making process, while also indicating that the child's level of participation is less than fully competent" (Koocher & Keith-Spiegel, 1990, p. 7). Those who have participated in TA trainings with the Therapeutic Assessment Institute were likely exposed to information sheets that can be given to parents and adolescents participating in a TA. The form I created is influenced by those documents, adding additional language related to privacy. Similar to an informed consent document, I want the adol-

escent to understand what they will actually be participating in, the potential benefits and risks, and how privacy will be maintained. Putting this in writing and obtaining their signature is an additional step that conveys to the teen: this process is about you and should be ben-eficial to you, and I value your input. While some of the teens who have seen this document have brushed it off in a typical adolescent way, others have appreciated the respect it demonstrates relative to their decision-making. As one teen recently said to me at the end of a TA, "From the very beginning I could tell you really valued what I had to say. Thanks for that."

Table 1. Percentage of personal words in an adolescent TA letter

Client Age and Gender	Total Words	Total Words that Were Personal	Personal Words Percentage of Total
15 yo female	3010	460	15%
14 yo female	2002	182	9%
14 yo female	3842	311	8%
17 yo male	2606	159	6%
16 yo male	4360	528	12%
17 yo male	1920	139	7%
Mean	2957	297	9.5%

Establishing Limits on Privacy

The ethics literature is often divided into subsections, such as ethics related to providing therapy and ethics related to conducting assessments. In general, there is more written about the former than the latter. Most clinicians providing therapy to adolescents adopt the policy of maintaining the teens' privacy, except if they discuss matters that could be harmful to them such as engaging in risky behaviors. However, often when psychological evaluations are being conducted, teens are told that everything they say will be captured in the report and sent to the referring party and other relevant adults. Thus, clinicians must determine how to balance these different ways of considering privacy.

When conducting TAs with teens, it is recommended that clinicians follow the ethical guidelines commonly used for therapy. The discussion of the adolescent's rights should be addressed from the very beginning, with information sheets for parents and teens (Finn, 2010). In my practice, the discussion about the teen's privacy continues in the first session with an informed consent document for parents and the informed assent document for the teen. Such procedures are familiar to clinicians who provide therapy to teens. However, where TA deviates from therapy is in the final letter to the teen and parents. As part of the Adolescent TA model, teens can identify questions they want to keep private from their parents, and often different letters are sent to the teen and parent. For Jack's TA, his letter was different than the one sent to his parents as regarded how he was impacted by family experiences. However, parents still receive a letter that contains some of the communication shared by the adolescent during interviews or through the testing, when the parents were not present. Dur-ing the discussion session with parents everything that will be in the letter should be discussed, and parents should not be surprised by what they read in the letter. At the same time, it seems likely that there will be some minor differences in the language used during the discussion session and the language in the parent letter.

Once I started thinking about what is conveyed in the final letter, I decided to conduct some simple research to see how much information the teen shared in private is included in the letter to the parents. On the one hand, I believe capturing the teen's voice is clinically important as related to increasing parents' understanding of their child. Conversely, sharing teens' communication runs the risk of violating their privacy. I wondered how much personally communicated language was in the letters sent to parents.

I reviewed 6 of my TA letters and first identified the total number of words in each (see Table 1). I then reviewed each letter looking for personal language that the teen had shared during interviews. Sentences such as the following: "As Jack told me, he often feels most anxious when he is at school and in classes where he does not have a lot of friends." I specifically looked for language that was orally communicated by the teen during any of our appointments. I reviewed the letters and divided language into categories that included: test interpretation, psychoeducation, supportive statements, and interview data. After identifying sentences that were interview data from the teen, I performed another word count to determine how much of each letter contained such language, counting all the words in each of those sentences.

As outlined in Table 1, only about 10% of the total words were language of a personal nature that the

teen shared during conversations. Some of this language was from the initial session and some from the discussion session when parents were already present, and thus it was not new information. The results of my research were not surprising, but they were comforting as this validated that I was being respectful of the teen's privacy.

During discussion sessions with teens alone, I make sure the most sensitive information is discussed and invite their input regarding what can be shared with their parents during the parent discussion session and in the parent letter. Again, if risky behaviors were part of what was occurring for the teen, we would have already discussed the need to share this information with parents, but if not, this would be part of the conversation. My practice aligns with what occurred with Jack and how, after the phone call, we determined what would be helpful for his parents to hear. At times I have also followed Connie Fischer's advice and sent the letter to the referring therapist and teen to read first and co-edit before it is finalized. Last, I strive to get in the teen's shoes, particularly given how children and adolescents are socialized to acquiesce to adult requests and how that impacts their decision-making. After reviewing the passive characteristics in Jack's test data, I may have been able to foresee that he would say yes to my suggestion we share some of the information with his parents. In hindsight, I wish I had spent more time weighing the pros and cons of that choice with him and let him know that if he changed his mind he could let me know.

Parent Testing as part of an Adolescent TA

Often when conducting TAs with adolescents, parents are encouraged to complete their own testing. This allows the evaluator a more nuanced view of family dynamics when the different personality styles revealed through testing are examined. In addition, parent testing often reveals untreated mental health issues in one or both parents, and the discussion of their difficulties can be a catalyst for entering their own therapy, which for many families is a significant intervention.

While parent testing can be quite beneficial, implementing this practice requires consideration of a few ethical and legal considerations, given parents are consenting to receive a psychological service. To ensure proper informed consent, I created a document entitled: Consent for Family Member Participation in Psychological Testing as part of a Child or Adolescent Therapeutic Assessment. This document was initially focused on "Parent Participation," but after one TA where an older sibling also completed testing, I broadened the title to apply to any other family member.

This document addresses three areas: understanding how the testing will be billed, how the parent's privacy is protected, and the risks and benefits of agreeing to testing and feedback. However, the informed consent process for parent testing really begins during the first phone call when we are discussing what a TA will be like for them and their child. I often mention that parents complete testing as part of the process and begin my discussion of the pros and cons of that choice, while assessing their level of motivation. In addition, I make sure the parent receives a Parent TA Introduction sheet, which explains the TA process and mentions the possibility of parents doing testing.

After meeting with the family and identifying questions, I give consideration to whether parent testing will be beneficial or not. This evaluation is based on my perceptions of how easy or difficult it might be for the parents to examine themselves, and if the testing will really be beneficial. For example, in Jack's TA neither parent completed testing, given his father was reluctant to participate and having only the mother complete testing would have created a strange dynamic.

However, frequently parents see the value in understanding themselves and their role in the family. In those situations, I return to the discussion of parent testing at the end of the first session with a comment such as, "You all came up with great questions. What would really help answer this question is if you all did your own testing". I then attend to part of the informed consent process by describing some of the pros and cons of that choice and support them if they seem uneasy about the idea. I share the consent form and explain how they can use health insurance for these services, but that would necessitate establishing their own file and most insurance companies would require an initial diagnostic assessment before testing can be completed to verify that the testing is medically necessary. I also offer the option of paying out of pocket, which simplifies the process as a diagnostic assessment is then not a necessity. Lastly, I describe the testing interpretation they will receive, and that we will discuss those results privately without their child or adolescent being present.

The key points in the form are laid out below, and the first three bullets are common informed consent language. The final bullet was added on the off

chance someone wants to come back later and use that test data in a different fashion.

- Dr. David will not bill your health insurance for your psychological testing and you will pay out of pocket at the agreed upon rate.
- Your psychological test results will be kept as part of your child's file, but only you will be able to access those documents.
- Your psychological test results will be discussed with you without your child being present. That discussion will help Dr. David make sense of your test results for your life and what is occurring for your family. You will receive a document separate from the Therapeutic Assessment letter that explains your test results. You may find the test results beneficial to understanding yourself better, but sometimes examining ourselves can be uncomfortable and you may experience unease as well.
- At times individuals need psychological test interpretations for specific reasons (e.g., legal matters, work evaluation, a parent's own therapy). Given the focus of a Child or Adolescent Therapeutic Assessment, outside of the written interpretation you receive, Dr. David will not be able to provide other documents that include your test interpretation.

To date, I have not had any complications arise after a parent completed testing, and believe this form has been beneficial in that regard.

Conclusion

Ethics as related to psychological assessment have come a long way. As a means of comparison, consider that in the 1960s Connie Fischer's articles describing individualized and collaborative assessments were rebuffed by journal editors as her "practices were unprofessional, unethical and harmful to patients" (Fischer, 2010, p. 8). For further comparison, in a chapter on ethical guidelines when assessing children by Koocher and Keith-Spiegel (1990), they discussed issues such as test construction, obsolete test data and consent. In contrast, Bersoff, DeMatteo, and Foster's (2010) chapter on ethics related to assessing children has a section titled "From Informed Consent to Collaborative Assessment" and they suggest that the most ethical way to evaluate someone is to do so in collaborative manner. They wrote, "Collaborative assessment may not be legally required but it enhances the validity of psychologist's findings as depicted in the report of the psychological evaluation. It promotes enhanced ethicality and heightens trust in the evaluator." (p. 60). It has often been said that good ethical practice is good clinical practice. I believe that for those of us who conduct TAs with adolescents it is important to keep all parties informed about the process, that we routinely consider and attend to privacy matters, and that we understand the teen in their familial system.

I hope this article provides some practical advice for those conducting TAs with adolescents. I also hope it inspires others to consider the nuances of ethical issues related to conducting TAs with other populations, and perhaps someone will write another *TA Connection* article on that topic.

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Author

Raja David received his Doctorate in Psychology (PsyD) at the Minnesota School of Professional Psychology (MSPP) in 2002. He was licensed as a psychologist (LP) in 2004, and his clinical work has focused on both psychotherapy and psychological evaluations. He is board certified in Child and Adolescent Clinical Psychology (ABPP), and specializes in working with adolescents and young adults. In addition to his private practice, Raja is the Program Dean at MSPP and teaches courses related to providing psychological services to children and families, and an elective course entitled Therapeutic Assessment. He has participated in a number of TA trainings and in 2015 he earned certification in the adult model of Therapeutic Assessment by the Therapeutic Assessment Institute.

Please email questions or comments about this column to ***drrajadavid@gmail.com***

Photo Album

Left: Filippo Aschieri presenting to the attendees of the Therapeutic Assessment Immersion Course in Massa, Italy, June 2018.

Right: A view of the beach at Monterosso, the northern-most town of the famed Cinque Terre in Italy, during an excursion from the 2018 TA Immersion Course held in nearby Massa.

Above: Filippo Aschieri and Chiara Coda working with their role-play group at the Therapeutic Assessment Immersion Course in Massa, Italy.

Above: Francesca Fantini and Pamela Schaber presenting at the Immersion Course.

Left: Professor Jan Henk Kamphuis holding court during a meal at the TA Immersion Course in Massa, Italy.

Recent Publications in Therapeutic/Collaborative Assessment

Aschieri, F., Fantini, F., & Finn, S. E. (2018.) Incorporation of Therapeutic Assessment into treatment with clients in mental health programming. In J. N. Butcher (Ed.), APA Handbook of Psychopathology (pp. 631-642). Washington, D.C.: American Psychological Association.

Crisi, A., & Palm, J. A. (2018). The Crisi Wartegg System (CWS): Manual for administration, scoring, and interpretation. New York: Routledge.

Kamphuis, J. H., & Finn, S. E. (2018). Therapeutic Assessment in personality disorders: Toward the restoration of epistemic trust. Journal of Personality Assessment, DOI: 10.1080/00223891.2018.1476360

Pagano, C. J., Blattner, M. C. C., & Kaplan-Levy, S. (2018). Therapeutic Assessment with child inpatients. Journal of Personality Assessment, DOI:10.1080/00223891.2018.1447945

Upcoming Trainings in Therapeutic Assessment

November 2–4, 2018: Tokyo, Japan

Title: "Live Therapeutic Assessment of an Adolescent and Family"
Presenters: Stephen E. Finn & Noriko Nakamura
Sponsors: Asian-Pacific Center for Therapeutic Assessment, Therapeutic Assessment Institute, and Society for Personality Assessment
Language: English with Japanese translation
Schedule: Nov 2, 2018 10:00 AM – 5:00 PM
Nov 3, 2018 9:00 AM – 6:00 PM
Nov 4, 2018 9:00 AM – 6:00 PM
Information: asiancta@gmail.com

November 29-December 1, 2018: Milan, Italy

Title: "Working with Shame in Psychological Assessment and Psychotherapy"
Presenters: Stephen E. Finn & members of the European Center for Therapeutic Assessment
Sponsors: European Center for Therapeutic Assessment and Therapeutic Assessment Institute
Language: English with Italian translation
Schedule: Nov 29, 2018 10:00 AM – 6:00 PM
Nov 30, 2018 9:00 AM – 5:00 PM
Nov 4, 2018 9:00 AM – 5:00 PM
Information: segreteria.ceat@unicatt.it

Save the Date!

March 20–24, 2019: New Orleans, LA, USA

Workshops, Symposia, Papers, and/or Posters
Presenters: TBD (members of the Therapeutic Assessment Institute)
Sponsor: Annual meeting of the Society for Personality Assessment
Information: http://www.personality.org/annual-convention/general-information/