Volume 6 Number 2 | **Summer/Fall 2018**

THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

Fresh Air

J.D. Smith, Ph.D.
Northwestern University Feinberg School of Medicine

The seasons have again changed here in the Midwest and the holiday season is upon us. This time of year always brings about reflection (at least for me) as a new year is about to begin. I am again reminded of the wonderful community that has formed around Therapeutic Assessment (TA) and I am honored to be able to share the creativity and incredible clinical work that you all are doing. TA continues to grow around the world in incredible ways. I hope this issue of the *TA Connection* provides some fresh air to your day.

I want to send a special thank you to this issue's contributors, Larson Sholander, Emily O'Gorman, Manali Roy, Daniela Escobedo, and Chris Pagano; the Associate Editors, Deborah Tharinger, Hale Martin, and Pamela Schaber; and Steve Finn, who as always found more than a few edits that I had missed before this issue was finalized. I am grateful to each of you for your contributions to the newsletter.

This Issue

This issue of the *TA Connection* features a review of the recently-published book, *Using the Rorschach Performance Assessment System (R-PAS),"* which featured four case applications of R-PAS in the context of a TA. Larson Sholander, Emily O'Gorman, and Manali Roy, graduate students of Drs. Joni Mihura and Greg Meyer at the University of Toledo, provide a brief synopsis of each case and discuss more broadly the applicability of R-PAS to the TA process and also the reasons that TA practitioners might choose to use R-PAS in their assessments. These cases are excellent illustrations of the synergy of these two procedures that increases the potential therapeutic benefit for clients.

The second contribution comes from Daniela Escobedo. She presents the assessment data and clinical details of a TA-informed assessment of an adolescent who struggled with issues of identity, sexuality, complex trauma, and dissociation. Daniela describes this complex psychological profile and testing in a gripping way that mirrors her presentation of the same client at the 2017 Collaborative/Therapeutic Assessment Conference in Austin.

In this issue:

Using the Rorschach Performance Assessment System (R-PAS) in Therapeutic Assessment, *Larson Sholander, Emily O'Gorman, & Manali Roy,* page 3.

Peter: An Adolescent Who Didn't Want to Grow or Grow Up, *Daniela Escobedo,* page 9.

Therapeutic Assessment on a Child Inpatient Unit: Empathy, Collaboration and Transformation, *Christopher Pagano*, page 15.

Photo Album, page 21.

Recent Publications in Therapeutic/Collaborative Assessment, page 22.

Upcoming Trainings in Therapeutic Assessment, page 22.

© Therapeutic Assessment Institute 2018

This case is sure to hold your attention as you read!

The third column by Chris Pagano is an elaboration of an article he and colleagues recently published in the *Journal of Personality Assessment* on using TA with children in inpatient settings. Chris presents the case of Marcos, an 11-year-old Latino boy, whom he encountered in the inpatient unit after the boy expressed suicidal ideation and hallucinations, among other concerns, and a diagnostic-focused assessment was indicated. Chris describes the use of TA in inpatient units and the ways in which it can be synergistic with the current inpatient context; but, he also addresses some of the contemporary challenges to integrating TA with the treatment of children in such settings. This case is not only clinically interesting, but it is highly informative and shows how TA can be adapted to the benefit of all involved to fit both the context of a treatment and the type of client being seen.

The Leonard Handler Fund

Announced in the previous issue of the newsletter, this newly-established fund assists economically disadvantaged clients who would benefit from a 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, such as the Fantasy Animal Drawing and Storytelling Game. Please consider making a donation to this fund through the TAI website to help make TA available to everyone, regardless of income level. Soon we will provide information on how TA-trained assessors can apply for these funds to support underserved clients that otherwise could not afford a TA-informed assessment. Information will be available on the TA website and through the *TA Connection.*

Upcoming TA Trainings

Spring not only brings us showers and flowers but also the annual meeting of the Society for Personality Assessment. This year the conference will be held in New Orleans, LA, March 20–24. 2019. As typical, there are a number of TA symposia, paper presentations, and posters that will be presented during the main conference, as well as two preconference workshops: "Therapeutic Assessment in Clients with Personality Disorder with a Focus on the Restoration of Epistemic Trust" presented by Jan Kamphuis, Hilde de Saeger, and Pamela Schaber and "Using a Collaborative/Therapeutic Assessment Model in Diagnosing Adults with an Autism Spectrum Disorder" presented by Dale Rudin. Both workshops will be held Wednesday, March 20, 2019 from 8AM to 5PM. Additionally, the Collaborative/Therapeutic Assessment Interest Group will meet for an hour—this is a great opportunity to catch up with TA friends and hear about how TA is being spread all around the world. I hope you will all be able to attend.

Another upcoming TA-related event is Steve Finn's workshop on Working with Shame in Psychological Assessment and Psychotherapy. It's probably too late for most of us to book a trip to Milan, Italy, for the workshop on November 29–December 1, 2018, but you're in luck! Steve has another edition scheduled in beautiful Anchorage, Alaska on May 10-11, 2019. Both workshops are "new and improved" and include a whole day with new material on how to work with clients who are highly defended against shame and who cope through aggression or blaming others. Details are on the TA website.

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) began offering memberships, which gets you two issues a year of this lovely newsletter, access to the members-only listserv, 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. You can sign up now for 2019! Please consider joining to receive these benefits and to help support the TAI's mission, and please do also tell your friends and colleagues!

Donate to TA

The TAI is a nonprofit organization with a volunteer Board, 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 scholarships for students and professionals in need of financial assistance to attend trainings, and we expect to provide financial support to underserved clients very soon via the Leonard Handler Fund. We also are at work on developing training materials for those of you who

© Therapeutic Assessment Institute 2018

find it difficult to travel to our workshops. 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 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.

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

Using the Rorschach Performance Assessment System (R-PAS) in Therapeutic Assessment

Larson Sholander, MA, Emily O'Gorman, MS, & Manali Roy, MSc, MA
University of Toledo

We are doctoral students at the University of Toledo training with Drs. Gregory J. Meyer and Joni L. Mihura. In both our clinical and research training, we have focused broadly on multimethod assessment and more specifically on Therapeutic Assessment (TA), the Rorschach Performance Assessment System (R-PAS), and integration of the two. We are thankful for this opportunity to summarize four very interesting cases that were recently published and illustrate the value of using R-PAS in the TA context.

The Rorschach is a behavioral task that provides an opportunity to observe personality characteristics and a range of other psychological processes in action. The foundation of R-PAS interpretation is the response process (i.e., the psychological factors that lead to or that are enacted in task behaviors and response attributes that are assigned a particular code). Armed with an understanding of the response process captured by each code, rather than simply the codes' superficial meanings, clinicians can help clients gain a deeper understanding of their problems as well as their personal strengths.

R-PAS allows for the integration of nomothetic and idiographic inferences. Nomothetic or test-focused interpretations enable normative comparisons, demonstrating how far an examinee diverges from the average person. Extreme scores suggest personally salient content and behavior, which can then be further understood through collaborative discussion with the client. An individual's R-PAS profile pages can be used as a helpful feedback tool; when discussed collaboratively with the client, the standard variable-based inferences can be transformed into a more person-focused interpretation.

The Rorschach task also provides an abundance of idiographic person-focused information through the personalized images and themes that the individual brings to the table. Consistent with the client-centered approach of TA, the person-focused approach of R-PAS is structured to address the client's personal assessment goals as well as explicit referral questions and related implicit content, allowing for individualized and meaningful interpretations encompassing strengths as well as limitations.

Finally, the Rorschach is a crucial component of multimethod assessment, as it provides content that is not necessarily available through self-report tests and that can be integrated with other methods of assessment to provide a richer understanding of the individual. Four cases from the recently published case book by Mihura and Meyer (2018), *Using the Rorschach Performance Assessment System (R-PAS)*, nicely illustrate how R-PAS can be used within the TA framework to enhance client-focused interpretations to help us as clinicians get in our client's shoes.

© Therapeutic Assessment Institute 2018

Jill

The first case is from a chapter called *The Broken Zombie: Using R-PAS in the Assessment of a Bullied Adolescent with Borderline Personality Features* by Jan H. Kamphuis, Hilde De Saeger, and Joni L. Mihura.

Jill was a 15-year-old female referred for a second opinion on diagnosis, treatment, and medication when, after a year of ongoing treatment, her mood and anxiety problems persisted and she was hospitalized for 10 weeks following a severe emotional crisis. Jill had no notable developmental delays, obtained good grades in school, and was described by her parents as "rather quiet, perhaps a little anxious." Her psychological problems had started in primary school when she experienced severe bullying by a female peer. Around the same time, she had also been sexually assaulted by a trusted, same-age uncle. In the aftermath of those experiences, Jill became fearful and withdrew from social relationships. She experienced nightmares, intense mood changes, and nighttime bingeing. Jill also heard voices telling her to harm herself, and she began to engage in deliberate self-harm behaviors. At the time of referral, Jill was diagnosed with Major Depressive Disorder, Post Traumatic Stress Disorder, panic disorder, and psychotic disorder and was being treated with pharmacotherapy (Risperdal), Eye Movement Desensitization Reprocessing (EMDR), Cognitive Behavioral Therapy, and parent counseling.

Following the TA framework, at the beginning, Jill developed her individualized assessment questions in collaboration with the assessor. Jill asked: (1) Why do I have such problems sleeping? (2) Why do I find it so hard to deal with intense emotions? (3) Why do I find it so hard to go to school? (4) What is my diagnosis? and (5) What kind of therapy might help me? Consistent with TA, R-PAS—like the other measures used in her assessment—was introduced to Jill as a test that would potentially help answer her assessment questions about emotional issues.

Jill's R-PAS results reassured her of her adequate psychological resources and accurate thinking and reality testing, which clarified that her difficulties were not a result of underlying psychotic vulnerabilities. Although R-PAS is not primarily used to assign diagnoses, the results helped rule out psychotic phenomena, though suggested several features consistent with borderline personality characteristics, which also were part of her behavioral presentation.

Jill's experience of her internal world as unpredictable and unmanageable was validated with results indicating that she was strongly influenced by situational stressors, resulting in emotional distress, fear, disruptions in concentration, and impulsive behavior. Her inability to process and continued rumination over aversive emotional experiences contributed signifycantly to her problems sleeping. Jill had a profound sense of being damaged to the extent of not feeling human. She particularly resonated with her response on Card IX, "a broken zombie…it looks like the skin is completely pulled down, the skin is torn" as reflecting her emotional state. Jill had a lot of aggressive imagery on her mind, and her responses with human interactions were characterized by exploitation, abuse of power, and malevolent intent that were representative of her interpersonal hypervigilance. She had difficulty conceptualizing humans as complex and integrated, and tended to mentally represent herself and others in incomplete, unrealistic, and fanciful ways. Jill's sense of being damaged and unattractive, intense mistrust and wariness of others, and difficulty mentalizing made her vulnerable to emotional overload, helped explain her difficulty dealing with intense emotions, and partially explained why she found it hard to go to school.

Jill's R-PAS results suggested that she needed connectedness, acceptance, guidance, and support to help her develop a sense of control and robust self-structure in therapy. Based on Jill's difficulty with mentalization, emotion dysregulation, and behavioral impulsivity that had the potential to turn self-destructive, Mentalization-based Treatment (MBT) and Dialectical Behavior Therapy (DBT) were recommended. The findings and recommendations were shared throughout the assessment process that not only resonated with Jill but also with her parents, who commented that their daughter was finally accurately seen and understood.

Luis

A second case comes from a chapter entitled *Using R-PAS in the Neuropsychological Assessment of an 8-Year-Old Boy* by Jessica Lipkind and Jack Fahy.

Luis was an 8-year-old Mexican-American male referred by his adoptive father for an assessment due to his oppositionality, inattentiveness, and a possible neurodevelopmental disorder. Luis had a genetic disorder that affected his organs, nervous system, and appearance, and frequently contributes to learning and attention problems. His father's assessment questions were "How can I help him be independent?" and "Do you think he's hyper?" In addition to a battery of neuropsychological and self- and informant report

© Therapeutic Assessment Institute 2018

measures, R-PAS was used to help understand Luis's emotional functioning.

Luis was engaged in the Rorschach task and produced a valid and complex protocol, indicating sophisticated processing. Compared to other children his age, he was more likely to integrate his ideas and to identify multiple features. However, Luis typically synthesized information using aggressive objects, such as fire, dragons, bombs, erupting volcanoes, and people harming themselves. Moreover, he had difficulty modulating his reactions when provoked emotionally, so much so that at one point he avoided emotional stimulation by complaining of eye pain and pushing a card away. Luis perceived many implausible relationships and demonstrated reasoning, conceptualization, thought organization, and communication often associated with psychosis. At the same time, he gave a greater number of popular responses than most children his age and had reasonable perceptual accuracy.

Luis's implicit distress was elevated, including a sense that he had little or no control in the face of environmental stressors. Many of his responses involved aggression, fire, explosions, and damaged objects. It seemed likely that irritating internal stimuli were related to his history of childhood maltreatment. Despite his childhood, Luis was able to envision people interacting in meaningful ways and to internalize emotional connections. At the same time, he saw relationships as being marked by aggression and combativeness. There was also some indication that he saw himself as damaged, which could have been related to his medical issues and rejection by his biological parents.

The assessors provided feedback to Luis and his adoptive parents separately. Consistent with Finn's conceptualization of levels of feedback, the assessors started with information that did not significantly challenge Luis's and his parents' self-conceptions and then moved to information that conflicted with self- and other-conceptualizations. The assessors provided his parents with information about Luis's strengths as well as his deficits in attention and impulse control (drawing also on the battery of neuropsychological tests), thereby providing answers to his father's assessment questions. The assessors also discussed Luis's tendency to become emotionally overwhelmed and his difficulty in regulating affect, which is common in children who have been neglected. Relatedly, the assessors discussed his unresolved feelings of loss, anger, and sadness. This discussion appeared to fall within Finn's second or third level of feedback, as Luis's parents experienced more difficulty integrating this information into their conceptualization of him. Psychotherapy was recommended to help Luis process his emotional pain, and additional recommendations were made to address his medical issues and academic challenges.

In a feedback session with Luis, discussing his strong feelings and medical issues together seemed to overwhelm him, so he was encouraged to bring his strong feelings to therapy, which he had just started. The assessors also provided assessment feedback to Luis' treating clinician prior to its start. In a contact 18 months later, the therapist highlighted how many of the issues identified in the assessment played out in treatment, and noted that Luis had improved self-esteem and academic performance, seemed less fearful, and had developed an attachment to one of his female teachers.

Fred and Nora

A third case is from a chapter entitled *How Individual R-PAS Protocols Illuminate Couples' Relationships: The Role of a Performance Based Test in Therapeutic Assessment with Couples* by Filippo Aschieri, Alessandra Chinaglia, and Andrea B. Kiss.

Fred (age 64) and Nora (age 65), a married couple of 30 years, were assessed using TA for Couples (TA-C). Nora and Fred were referred by their son's therapist because the couple's volatile relationship seemed to be negatively affecting their son. During the assessment, Nora and Fred disclosed that Fred's unfaithfulness (i.e., talking to two women online) had precipitated their currently contentious relationship. Their explosive relationship was characterized by cycles of heated arguments, Nora's threats to end the marriage, Fred's profuse apologies, Nora's increased anger, and Fred's emotional withdrawal. In addition to the recent discovery of emotional infidelity, Fred and Nora had difficulty communicating with each other because Fred was emotionally distant and Nora was emotionally reactive. When Nora pressed Fred to discuss his motivations for betraying her, he became aloof and silent. This response increased Nora's sense of betrayal, resulting in intense anger, uncontrollable tears, and verbal assaults on her husband.

Consistent with the TA-C model, the assessors collaborated with the couple to develop assessment questions. Fred had two questions: "Where is the 5% of myself that made me betray Nora coming from? What relation does it have with the remaining 95% of me?" Nora also had two questions: "How did we end up being so distant from each other? How has the betrayal affected our current relationship?" Towards the end of

© Therapeutic Assessment Institute 2018

the first session, Nora began crying and disparaging her husband, leading to her third assessment question, "Why does it feel so good to bask in my pain?"

R-PAS was one of the instruments used to help answer the couple's assessment questions. R-PAS was chosen to help illuminate aspects of Fred and Nora that may have been less accessible to them. Fred's question in particular suggested the possibility of an implicit process that could explain the "5%" of himself that was responsible for betraying Nora. It is important to note that Nora approached the Rorschach task with curiosity, an ideal stance for a TA. Fred, on the other hand, was reserved but willing to engage in the assessment in order to save his marriage.

Fred and Nora both produced valid Rorschach protocols. Fred appeared to have an above-average ability to mentalize human experiences and reflect upon his actions. The relative absence of color-based determinants, in conjunction with his tendency towards reflection, suggested he had difficulty reacting appropriately in the moment and reacting to his own emotions. Consistent with his propensity to "live in his head" and his preference to take a cerebral rather than emotional approach to problem solving, his reality testing and ability to think clearly were diminished by emotionally evocative situations. His responses indicated that he was less sensitive than the average person to subtleties and nuances, suggesting that he may have difficulty relating to people's requests for help on an emotional level. Additionally, his responses indicated that he had a tendency to oscillate between openness and guardedness in his relationships.

Nora's responses to the Rorschach task indicated that she experienced a significant disturbance in her thinking when presented with unstructured and emotionally arousing features. Her thinking disturbances included problematic logic and disturbing thought content. Her thought disorganization was notable in responses with sexual, anatomic, and traumatic imagery. Additionally, her responses suggested that she often misperceived her environment, and she had preoccupations with anger and aggression in particular that interfered with her reality testing. Her responses also indicated above-average implicit dependency needs, loneliness, and a preoccupation with seeking closeness. She exhibited signs of oppositionality, demonstrated self-justifying defensive reactions, and envisioned aggression as a possible outcome in close relationships, which at times led to faulty judgment towards others. According to her responses, she perceived relationships as unsatisfying and problematic due to her concerns with aggression, sexuality, and female identity.

The assessors discussed the results of the assessment with Nora and Fred. They reviewed Nora's responses involving problematic content (sex and anatomy) with her individually, explaining that such content can relate to previous trauma. Nora acknowledged a history of physical and sexual abuse, along with abandonment by her mother. The examiners mirrored the trauma she had suffered and linked this insight to her assessment questions, suggesting that these traumatic emotions and memories were stirred up by Fred's betrayal. Based on Fred's Rorschach assessment, the assessors suggested that he used emotional numbing to manage his reactivity to overwhelming experiences. Fred agreed and added that he often wanted to help others but felt unsure how to do so. To address Fred's assessment questions, the assessors suggested that he and Nora were not emotionally attuned and that Fred's emotional needs led him to seek emotional connection with women online.

In a joint summary and discussion session a week later, Fred and Nora reported they had discussed their Rorschach results with each other, which helped them make some changes, even leading to an enjoyable weekend away. The joint discussion allowed them to see more clearly how their individual difficulties contributed to their relational problems, and this inspired their desire to work on their marriage and hope that the recommended individual and couples therapy would be successful.

Christina

A final case is from the chapter entitled *Using R-PAS in the Therapeutic Assessment of a University Student with Emotional Disconnection* by Francesca Fantini and J. D. Smith.

Cristina was a 22-year-old university student who sought psychological services to cope with the impact of her parents' divorce, which had occurred one year prior when her father learned that her mother was having an affair. In the aftermath of their separation, her father became increasingly moody and disconnected, while her mother appeared calm and cheerful, behaving as though nothing had happened. Cristina felt angry at her mother for the affair and for her apparent lack of remorse for her actions. Cristina tried to avoid her own anger, which she experienced as intense and disturbing, but she noticed it manifesting indirectly, for example, in strong reactions to minor misunderstandings with her mother. In addition, since her parents' separation, Cristina had found herself feeling increasingly disconnected from her friends and boyfriend, as well as from her own thoughts and emotions.

© Therapeutic Assessment Institute 2018

Cristina hoped to gain insight into her emotional functioning through the TA, posing two related assessment questions: "How can I get rid of the anger I feel toward my mother? Why do I often feel disconnected from my emotions?"

Cristina's self-reported experiences suggested that she perceived herself as being able to manage stressors and to cope with difficult situations without feeling overwhelmed by her emotions. She reported few emotional difficulties, obtaining low scores on MMPI-2-RF scales that would suggest the sort of sadness or distress that would have been appropriate and perhaps expected for someone in her situation. Though largely unremarkable, Cristina's profile did suggest a tendency to internalize anger and bottle it up rather than expressing it. Consistent with her report in the interview, she seemed to be conflicted with regards to expressing and experiencing anger, and she avoided conflict in her interpersonal relationships as a result. Although Cristina's self-reported experiences provided important information about her self-perceptions and conscious emotional experiences, it was hoped that the Rorschach would enable both her and the clinician to see conflicting implicit processes more directly in a situation with more emotional stimulation than the interview or self-report task.

Cristina produced a valid, highly complex, and elaborated Rorschach protocol. She demonstrated a strong ability to notice and articulate subtleties present in her environment and to find relationships among different concepts and ideas. In contrast to her high receptivity to environmental stimuli, Cristina's ability to sense and articulate her inner experiences was much lower than would have been expected given the level of sophistication in her responses overall. Her responses did not reflect significant sadness, helplessness, or distress, in spite of her difficult family situation. Consistent with her self-report results, Cristina seemed to be stable and resilient, even when facing difficult and upsetting situations. However, her strong capacity to cope seemed to be partly a consequence of her low sensitivity to distressing emotions. Cristina also displayed a strong capacity for mentalization and an ability to envision human actions and experiences. These abilities waned, however, in emotionally arousing situations, particularly those involving anger. The presence of aggressive ideation seemed to impede Cristina's ability to think clearly, leaving her vulnerable to unusual or inaccurate views of others and to reacting in potentially ineffective ways. Cristina herself noticed these reactions and was disturbed by them, as was evident from her first assessment question and from discussion of feeling trapped by parental expectation in an Extended Inquiry (EI) of selected Rorschach responses. It seems that, unsure of how to express her anger, she avoided it in an effort to protect herself and her relationships.

In the feedback session, Cristina resonated with the view she faced a "dilemma of change," with her desire to overcome her emotional disconnection requiring her to connect with the negative emotions associated with her parents' divorce. In a subsequent follow-up session, Cristina described disclosing her anger to her mother, which left her feeling more authentic and less disconnected. Unique to this case, the chapter authors provided single-subject experimental results covering daily ratings by Cristina on her individualized problems. The ratings began one week before the TA and continued for two weeks after, with the significant results suggesting that the Rorschach EI activated her personal difficulties, which then were largely resolved with the Summary and Discussion session.

Concluding Remarks

In these cases, the use of R-PAS in the context of a skilled TA helped to reveal a level of personality functioning that was not readily visible in self-report responses but that illuminated salient day-to-day struggles in the lives of the individuals undergoing the assessments. Where interview and self-report provided the clinicians with information about their clients' conscious thoughts and feelings, the Rorschach provided a sample of behavior that enabled the clinicians to see how their clients perceived and made sense of their environments. Of key importance in the context of TA is that R-PAS assisted the clinicians in broaching topics that their clients may otherwise have found threatening, while also enabling clients to become aware of and express aspects of their experiences of which they had not previously been aware.

Ultimately, Jill's TA helped the clinicians to understand what she needed emotionally and interpersonally from treatment that she had not obtained in the past and to recommend a course of treatment that would meet her needs. In the case of Luis, R-PAS allowed the assessors to provide information about the child's unresolved experience of loss and difficulty modulating his emotions in ways that he could not express. For Fred and Nora, R-PAS helped showed them their strengths, their interpersonal abilities and difficulties, and the maladaptive results of their interacting coping styles, which contributed to Fred betraying Nora and led each of them to respond in mutually exacerbating ways when attempting to discuss and process the betrayal. Finally, R-PAS helped the clinician to better

© Therapeutic Assessment Institute 2018

understand Cristina's emotional functioning, and the extended inquiry and feedback session provided a forum for Cristina to more fully and stably connect with emotions and attitudes that previously were incompletely in her awareness and counter to her self-image.

In light of the summary above, it is evident that TA provided an excellent framework for using R-PAS to elicit the client's involvement in the therapeutic assessment process. Through the extended inquiry, clients were encouraged to discuss their responses and how their responses related to their life experiences. This level of involvement engaged the clients' curiosity and led to new insight into their behavior and inner processes. In short, *Using the Rorschach Performance Assessment System (R-PAS)* provided several excellent examples of how TA and R-PAS worked in tandem create a rich therapeutic experience.

References

Aschieri, F., Chinaglia, A., & Kiss, A. B. (2018). How individual R-PAS protocols illuminate couples' relationships. In J. L. Mihura & G. J. Meyer (Eds.), *Using the Rorschach Performance Assessment System (R-PAS)* (pp. 158–186). New York, NY: Guilford Press.

Fantini, F., & Smith, J. D. (2018). Using R-PAS in the therapeutic assessment of a university student with emotional disconnection. In J. L. Mihura & G. J. Meyer (Eds.), *Using the Rorschach Performance Assessment System (R-PAS)* (pp. 138–157). New York, NY: Guilford Press.

Kamphuis, J. H., De Saeger, H., & Mihura, J. L. (2018). The broken zombie: Using R-PAS in the assessment of a bullied adolescent with borderline personality features. In J. L. Mihura & G. J. Meyer (Eds.), *Using the Rorschach Performance Assessment System (R-PAS)* (pp. 65–83). New York, NY: Guilford Press.

Lipkind, J., & Fahy, J. (2018). Using R-PAS in the neuropsychological assessment of an 8-year-old boy. In J. L. Mihura & G. J. Meyer (Eds.), *Using the Rorschach Performance Assessment System (R-PAS)* (pp. 348–365). New York, NY: Guilford Press.

Mihura, J. L., & Meyer, G. J. (2018). *Using the Rorschach Performance Assessment System (R-PAS).* New York, NY: Guilford Press.

Authors

Larson Sholander, MA, received his master's degree in counseling psychology from Moody Theological Seminary in 2015. He is currently pursuing his Ph.D. in clinical psychology at the University of Toledo (UT). His clinical and research interests include multimethod assessment, therapeutic assessment, personality disorders, and anxiety disorders. He is a member of the Psychological Assessment Lab at UT and is receiving training in Therapeutic Assessment and the Rorschach Performance Assessment System from Dr. Gregory Meyer and Dr. Joni Mihura.

Emily O'Gorman, M.S., received her master's in experimental psychology from Villanova University in 2017 and is currently pursuing her Ph.D. in clinical psychology at the University of Toledo. Her clinical and

© Therapeutic Assessment Institute 2018

research interests include multimethod assessment, personality pathology, and transdiagnostic factors in psychopathology. At UT, she is a member of the Psychological Assessment Lab and is receiving training in Therapeutic Assessment and the Rorschach Performance Assessment System from Dr. Gregory Meyer and Dr. Joni Mihura.

Manali Roy, M.Sc., MA is a current fourth year doctoral candidate at the University of Toledo training in the Psychological Assessment Lab under Dr. Mihura and Dr. Meyer. She has earned her M.Sc. in clinical psychology at the University of Calcutta, India and MA in psychology at the Adelphi University. Her clinical interests include personality disorders, serious mental illnesses, the R-PAS, multimethod assessment, and therapeutic assessment.

Please email questions or comments about this column to *Larson.Sholander@rockets.utoledo.edu*

Peter

An Adolescent Who Didn't Want to Grow or Grow Up

By Daniela Escobedo
Autonomous University of Nuevo León, Mexico

This case study illustrates the use of select Therapeutic Assessment (TA) techniques in a psychological assessment with a 14-year-old adolescent boy, Peter. Projective drawings, self-report scales, and performance-based tests with Extended Inquiry were used to clarify the diagnostic picture and address a set of Assessment Questions.

A Sense of Peter

Peter had some challenges as a child, including separation anxiety and being bullied at school. His major problem surfaced two and a half years before this assessment began: an excessive fear of growing up. He did not eat much because, according to his own research, food contains nutrients that promote physical development. In addition, he adopted a stooped posture to hide his height and began to distort his voice, using lower volume and higher pitch than usual. Peter also searched the Internet to learn how not to ejaculate and was greatly concerned with the development of secondary sexual characteristics. Every time he noticed a physical change associated with his growth, he experienced fear and anxiety, and considered undergoing multiple surgeries to hide pubertal growth. If people told him that he looked taller or older, he became extremely upset and cried.

Peter related being bullied when he was eleven years old by a classmate whose position in line was right be-

© Therapeutic Assessment Institute 2018

hind him: "He picked on me very much, so I wondered if I could hide my height, and be reassigned to another place. I have this impression that shorter people are treated better; others are more considerate with them. I started doing it all the time, bending my knees, but it was useless, I kept on growing, so I bent my back too. My parents scorned me, but never asked what was happening to me, and I never told them."

Due to his food intake restrictions and presumed intermittent purging behaviors, Peter lost more than 26 pounds in the year before I met him, and was at the 25th percentile, according to the BMI expected for his age and gender. However, he did not report alterations of his perceived body image, which was mostly accurate. Peter was able to perceive his fears about growing up as excessive, but argued that the expectations that adults face were overwhelming: getting a partner, being independent, having more responsibility and obtaining financial stability. He also worried that once he reached a certain age, he would be more likely to get sick and die.

Peter was also distressed by other aspects of his physical appearance. He had Latin American features, such as brown skin and dark hair, but his ideal of beauty was that of a Caucasian, "like Hollywood stars," according to his own definition. He admired everything related to the United States. Although he had never been there, he collected information related to the US through the media.

Developmental and Family History

Peter's family came from a conservative Catholic background and the lower socioeconomic class. His parents reported that he had a normal early development. His father used to travel a lot for work, while the mother stayed at home taking care of Peter and his older sister. The mother at times felt depressed, due to her husband's absence. At age 5, Peter had difficulties adapting to pre-school, and was diagnosed with Separation Anxiety Disorder, for which he received psychotherapy once a week for a few months. The results were good and he achieved total remission.

Peter's father believed that his son was refusing to grow or grow up to be annoying or to get back at him for having been away such a long time due to work. He tried to solve the problem by putting corrective posture belts on him and squeezing the curvature area tightly with his hands. The conflict between father and son was strong and constant until both decided to maintain a greater distance from one another, further reducing communication. They even went so far as to avoid being in the same room.

Due to his anxiety and fears, two years prior to the assessment, when he was 12, Peter consulted with a psychologist with whom he had good rapport and was able to talk for the first time about having been sexually abused in the past. He shared with his therapist that starting at age 6, he suffered unwanted sexual experiences from a 16-year-old neighbor boy. The neighbor made him touch his genitals, sometimes while he also touched Peter. According to Peter, there had been no penetration. He did not report the incidents to anyone at the time. However, his parents reported having noticed an emotional change in him: a greater tendency to cry and to avoid going over to play with the neighbor's brother, who was his age. He did not remember how long the abuse went on, but did recall that it was repetitive. It was noteworthy that he did not connect any of his actual current symptoms or discomfort to his abuse.

Unfortunately, within a few months, the therapist moved to another city and the family quit treatment. As the symptoms and manifestations got worse in the following 6 months, the family consulted another therapist, who treated Peter with CBT over the course of a year. Peter reported feeling pressured, misunderstood, and even humiliated by this therapist, who described Peter as arrogant, as he recalled. Because of the lack of change, his therapist along with his parents decided to refer him to our institution.

Psychological Assessment

Before I met Peter, I was worried because the doctors he was working with at our institution, Dr. L and Dr. A, the child psychiatrist and the family therapist, had warned me that he had an extremely peculiar appearance. They also told me that I could frighten him if I raised my voice or treated him in a firm way. Dr. L had been seeing him for about 3 months. She treated him with 20 milligrams of Fluoxetine. Although she was confident about the diagnosis of Body Dysmorphic Disorder, she wondered if we were missing underlying psychotic symptoms. The dynamics at home were extremely conflictual, and Peter refused to attend the family sessions with Dr. A or if he did, he refused to talk. The family therapy resident in training was very overwhelmed because he could not get Peter and his father to talk to one another. In addition, some of the supervising team members felt Peter was exaggerating his symptoms.

When I finally met Peter, he arrived punctually with his mother and that day he did not seem so stooped. Both were cooperative. His mother was a bit worried about her husband's lack of work and his son's illness, which she summed up as: "He began to bend." Peter seemed reluctant to talk and mostly remained silent. However, he insisted that his mother avoid telling me everything, asking me, "Hasn't Dr. L already told you about me?"

Figure 1. House Drawing

We agreed on the conditions and schedules of the assessment and began as soon as possible. I had recently started implementing collaborative techniques in my assessments, mostly asking patients for their main questions for the assessment and using Extended Inquiries (Finn, 2007). With this in mind, I encouraged Peter to discuss why he was in treatment with us. He described: "I usually feel anxious and angry; the meds Dr. L gives me have somewhat helped me." He said he was not quite sure about the purpose of the assessment. I told him that the tests could help us understand a little bit more of what he was feeling or thinking. He added, "There are some things that are difficult to think about, I do not think about them." I tried to reassure him that he could take his time and that I would follow him. Then I asked what his main concerns were. He explained, "I want to be shorter and have a different face (while he touched and rubbed his eyes in anguish). I want a different nose. I do not know, different." I then asked, "Have you thought what type of nose?" And he said: "Yes ...", and after a silence, added "I do not know." He explained that he would like to look younger, around 12 years and 4 months old. After saying this, he added, "It is difficult" (showing a grim look).

Figure 3. Drawings of Human Figures

Although in this first session Peter was fairly cooperative, sometimes he left sentences unfinished, was silent, or spoke so softly that it was difficult to hear him. This was even more evident in the relatively superficial exploration of difficult issues, as he stated that he could not tolerate going deeper, making comments such as, "It is difficult ..." (silence). To which I asked, "Is it difficult to think?" and he replied, "It's hard to think about some things. I do not think ..." (silence).

We decided to start with the aim of broadening our understanding of why aspects of his body image were so crucial for him. If there is no contraindication, I usually start with some projective drawings, with children and some adolescents, in this case: House-Tree-Person (Buck, 1948), Most Unpleasant Concept (Horrower, 1950), and a variation of the most pleasant concept. Peter's first drawing of a house (Figure 1) showed a friendly and healthy side of his psychological functioning: his interest in technology and his capacity to fantasize about a day when he would be able to have things that would make him feel good. It was a very active drawing, and he spent a long time on it. While we reflected upon the drawing, he shared that he would like to own a similar house in the future.

With respect to the house drawing, he expressed, "It is a nice house, a nice roof, with big windows through which you can look outside and if there is a landscape, you can enjoy it. [There is] a laptop, a plasma screen, kitchen, stove and a refrigerator, a stereo, flowers and roses."

In the Drawing of the Human Figure (Figure 2) he began with a male. This time his affect was different; he seemed very distressed. The figure had no facial expression and the marked and compulsive strokes, especially in the area of the body and at the base, denoted intense anxiety.

"He's a man on a mountain of dirt," he said. "Can you tell me more about it?" I asked. "With earth and things" he replied. "How did you imagine it?" I insisted, "Like everything stirred up." He assigned him an age of 11.

With the female figure he had less difficulty. His stroke was less intense and he just asked, "Shall I draw it facing to the front or backwards?" Then he described: "It's a girl with big pony tails." He drew it with a smile on her face. Spontaneously, he changed the age of the boy from 11 to 13, but when I questioned him about it, he reassigned him 11 years. I asked him for a story about the two drawings, and it went like this:

"In a town there was Oscar, a citizen of a very lonely place, where he could imagine and live in a world of fantastic things, imagine everything he wanted. Near the place was a tree ... of desires and it granted 2 wishes per day. Since he was always alone with his parents, he asked the tree to grant him a friend, and soon afterwards, a girl moved in town. Sonia and Oscar met and were friends, but then Oscar discovered that Sonia had a hearing problem and that everything he told her was in vain, since she did not hear anything. He thought sadly, 'Why didn't I realize it before?' Everything was in vain, but in spite of everything, Sonia was his friend and he decided to learn the language of the deaf and the two finally understood each other."

When I pointed out the sense of loneliness and the need to feel listened to and understood in his drawings, Peter explained that perhaps since he was 8 or 9 years old, he began to have the idea to be thin because his peers bullied him about being fat. In his words, "There wasn't anyone who did not say that about me." However, he also talked about having been able to make some friends at that time, whom he kept still.

At the end of this first session, I validated that he did a great job helping me understand the way he worried about his body and the idea of growing up, through the drawings of the Most Unpleasant and Most Pleasing Concept (Figure 3), in which he emphasized:

Unpleasant: "The growth of body hair and height… he is watching himself in a mirror."

Most Pleasing: "United States and an X-Box." He also wanted to express in his drawing the possibility of turning back time or for time to pass more slowly.

I told him that some teenagers expressed these concerns in the same way, for which he exclaimed: "Teens? Disgusting, I do not want to know anything about teenagers." Even though he did it in a childlike manner, his attitude was firm about not accepting being classified as one of them.

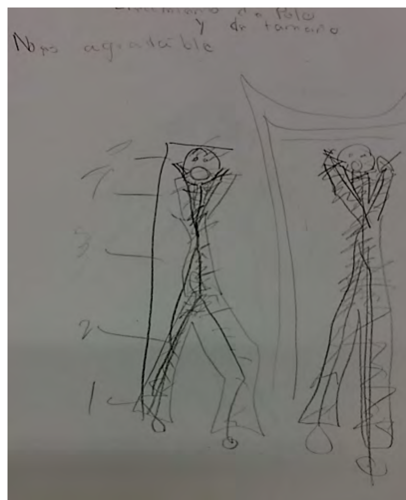
The second session was much more difficult. Peter looked apathetic and uneasy, asking when the session would be over, when we had not yet even started. He kept spitting in the same disposable tissue that he refused to change during the whole session. He would slip it in and out of the pocket of his jacket.

I was trying to convince him to cooperate, when he flipped over the Tell-Me-a-Story Cards (Constantino, Malgady, & Rogler, 1988). Seeing that they were American, he expressed with astonishment and emotion, "Ah! I didn't know they were from the United States! Okay, they look funny to me! I can do those." By then I experienced some tension in our relationship and felt somewhat coerced to have to treat him cautiously and accede to his demands. I thought it was likely that his parents occasionally felt this tension while interacting with him, for example, when they said that it was impossible to convince him to stay with his father in the same room.

Peter identified himself with a story he made up about saving money and how there were times when he wanted to save some for buying nice clothes or gadgets, but it was difficult for him to pursue this goal since he usually bought candies instead. And there was this story, which caught my attention:

"A boy is looking in the mirror because he suffers problems of knowing who he is because he is hermaphrodite. He is dressed as a boy but in the mirror, he is seeing how he looks in both ways. He is confused because, as he is hermaphrodite, he does not know if he is a man or a woman."

Figure 3. Most Unpleasant and Most Pleasing Concept



I asked him what he meant by hermaphrodite. He gave me this huge lecture, based on the documentaries he watched on Discovery Channel. His psychiatrist suspected he had a diverse sexual orientation and possibly gender dysphoria; however, this was a topic he refused to talk about, and I left it as Level 3 Information.

In our third session, we did the Rorschach. He was cooperative; however, I was overwhelmed by the traumatic quality of many of his responses.

In the Extended Inquiry, we reviewed the following responses:

- Card I, R1, W: The lower part of the skeleton, the pelvis of a woman.
- Card II, R5, D3: Bleeding of a person, I can't ...: bleeding from the anal part ... I do not know ... it could be ...
- Card III, R10, D2: Dead pigeons. Dead because they are in red, as if dead, red.
- Card IV, R11, Dd99: A ripped dress. This is a stick and it ripped it apart.
- Card IV, R13, W: A person with a wooden pole going through him and bending him over (showing anguish) without his head.
- Card VI, R18, W: A dog with blood all over… the blood flows throughout the entire place.
- Card VII, R22, Dd22: Two deformed cats on two rocks, crooked.
- Card IX, R27, DS8: A tooth with cavities.

Leavitt and Labott (1998) proposed a coding system for responses that emphasize the experience of physical oppression commonly found in protocols of patients with dissociative manifestations. Peter's responses were good examples. With that in mind and considering his Critical Content Index of 56% (Viglione, Towns & Lindshield, 2012), I explained to Peter that these responses were common responses in people who suffered from images or thoughts that came to their mind without being able to control them and that produced fear, disgust or anguish. He said, "I knew it would come out." Almost as if he had been waiting for that moment. I asked him what did he mean? "That, that." He added. He explained that it was something that had been happening to him for a long time. With difficulty, he clarified that in particular he saw images of homosexual men having sexual intercourse. I asked him if they were aggressive images (due to the content of his answers). He explained to me that they were not, just men having intercourse, which was unpleasant to him. He added that he also heard "bad words", noting the following: "fuck you, bitch;" "bitch;" and "faggot," as if a man was yelling them. He described how in the past this happened to him when he was doing homework and at any given moment, so he had to distract himself by writing very fast (he made a compulsive movement on the desk to demonstrate).

Given what Peter revealed to me, I proposed to answer some questions about these types of experiences through Putnam's Adolescent Scale of Dissociative Experiences (Armstrong, Putnam, Carlson, Libero & Smith, 1997). Being a scale in which each item is scored from 1 to 10, Peter self-rated himself 6 or above on all items, which we explored one by one:

- *I do not recognize myself in the mirror.* To which he added: "Sometimes I feel that I am not ... I do not know ... It could be up to a 9 (the score) ... I say, "it cannot be me.'" I asked: "How do you feel about that?" "Awful", he replied.
- *I have thoughts that do not seem to belong to me.* When asked what they were, he replied, "I do not want to answer."
- *I realize that I can make physical pain disappear.* To which he added, "If you cut me, or something like that, I can manage not to feel."
- *I feel as if I have walls inside my mind.*

Both Peter's suffering of traumatic intrusive images and his ability to dissociate were key points to understand him. On the Rorschach, it was impressive that after giving three responses of traumatic content, he recovered to the point of elaborating others with good perceptual accuracy and positive attributions

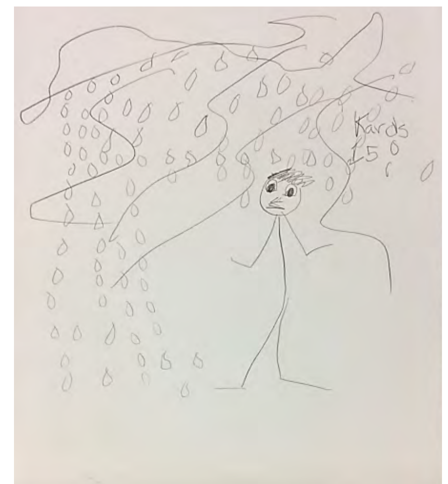


Figure 4. Person Under the Rain

such as, butterfly in a landscape, flowers, and fairies. I thought that just as his picture of The Person Under the Rain shows (Figure 4), it does not matter that we are experiencing extreme fragility, anguish, or fear, if we can focus on an alternate reality, as he described, [It's] "pretty, I drew it nice in the rain and the thunder."

Conceptualization

Looking across the findings from the various assessment instruments, and the Extended Inquiry, it became clear to me that Peter's symptoms suggested complex trauma rather than psychosis. The clinical team felt more informed knowing about his sexual abuse and wondered how it had affected him, as well as being bullied by his peers. Katz, Barnetz, and Hershkowitz (2014) discuss the often-significant impact of sexual abuse without penetration, which tends to be minimized by society. With the help of his psychiatrist, we talked about his symptoms as part of a response to several difficult experiences he had gone through and as an action of self-protection. Peter never mentioned the sexual abuse amongst them, and emphasized his feeling of rejection from peers and his family as the main stressors in his life. His psychiatrist adjusted his medication according to clinical guidelines for patients with PTSD symptoms and Peter agreed to cooperate in family sessions. We talked about his resources, particularly his capacity to focus on pursuing goals. He said that although he was less distressed and less sad, he was quite skeptical about the possibility of accepting his physical image as he (wisely) thought, it depended more on him than on the medication. The family went through a Solution-Focused Brief Systemic Therapy (De Shazer & Dolan, 2007), which consisted of 8 sessions over the course of a year, and attended 12 sessions of the Family-to-Family program promoted by the National Alliance for the Mentally Ill (NAMI). Within the first couple of months, Peter gained weight. He continued his therapy with Dr. L, who used a Mentalization Based Psychotherapy approach (Allen, Fonagy, & Bateman, 2008), and after Peter graduated, he continued treatment at the Psychiatry Department, and went to high school where he achieved average grades. Recently, he applied to a psychology graduate program but he did not pass the admission process. He was very sad about this. However, he still has a group of friends and began dating a young man not long ago.

Conclusions

It was remarkable to me how Peter and I collaborated in the exploration of his subjective experiences. Peter exemplifies the possibility of expressing emotions and cognitions, including a sense of the self, in concretized body metaphors, where the "as if" of a mental experience, in this case, fearing to grow, turns into an "is," bending the body (Skarerud, 2007). Collaborative and Therapeutic Assessment techniques probed to be useful tools to uncover aspects of the lost symbolization associated with complex trauma and unreflective mental states, adding up to the autobiographical narrative and promoting the cohesion of the self (Skarerud, 2007). Implementing therapeutic techniques, such as the Extended Inquiry, with projective drawings, self-report scales, and performance-based instruments, can inform an ongoing selection of tests throughout an assessment, making each combination of tools tailor-made for a particular client and the client-assessor dyad.

Acknowledgements

I would like to thank the clinical team: Perales-Blum, Lugoleos-Cano, Juárez-Treviño, Vyeira-Chacón, Rickman-Garza, and Peñuelas-González.

Author's Note

The clinical description of this case was previously published in: Perales-Blum, L., Juárez-Treviño, M. & Escobedo-Belloc, D. (2014). Severe growing-up phobia: A condition explained in a 14-year-old boy. *Case Reports in Psychiatry*, Article 706439, 1–6. doi: 10.1155/2014/706439

References

Allen, J., Fonagy, P. & Bateman, A. (2008). *Mentalizing in clinical practice*. Washington, DC: American Psychiatric Publishing.

Armstrong J., Putnam F. W., Carlson E., Libero D., Smith S. (1997). Development and validation of a measure of adolescent dissociation: The Adolescent Dissociative Experience Scale. *Journal of Nervous & Mental Disease*, *185*, 491–497. doi: 10.1097/00005053-199708000-00003

Buck, J. N. (1948). The H-T-P technique: A qualitative and quantitative scoring manual. *Journal of Clinical Psychology*, *4*, 317–396.

Costantino, G., Malgady, R., & Rogler, L. (1988). *TEMAS (Tell-Me-A-Story) manual*. Los Angeles, CA: Western Psychological Services.

De Shazer, S., & Dolan, Y. (2007). *More than miracles: The state of the art of solution-focused brief therapy*. Birmingham, NY: The Haworth Press, Inc.

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

Harrower, M. R. (1950). "The Most Unpleasant Concept Test." *Journal of Clinical Psychology*, *6*, 213–233.

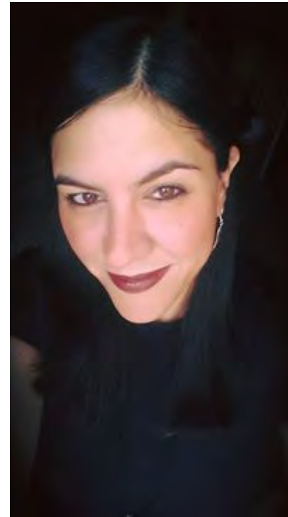
Katz, C., Barnetz, Z., & Hershkowitz, I. (2014). The effect of drawing on children's experiences of investigations following alleged child abuse. *Child Abuse and Neglect*, *38*(5), 858–867. doi: 10.1016/j.chiabu.2014.01.003

Leavitt, F. & Labott, S. M. (1998). Rorschach indicators of dissociative identity disorders: clinical utility and theoretical implications. *Journal of Clinical Psychology*, *54,* 803–10. doi: 10.1002/(SICI)1097-4679(199810)54:6<803::AID-JCLP7>3.0.CO;2-H

Skarerud, F. (2007). Eating one's words, Part II: The embodied mind and reflective function in anorexia nervosa—Theory. *European Eating Disorders Review*, *15*(4), 243–52. doi: 10.1002/erv.778

Viglione, D. J., Towns, B. & Lindshield, D. (2012). Understanding and using the Rorschach Inkblot test to assess post-traumatic conditions. *Psychological Injury and Law*, *5*, 135–144. doi: 10.1007/s12207-012-9128-5

Author



Daniela Escobedo has completed postgraduate training in Psychotherapy at the School of Medicine at Autonomous University of Nuevo León (UANL) and is currently working on a Ph.D. focused on borderline personality disorder, attachment theory, and economic games at the UANL. She is a licensed psychologist in México, and her clinical work has focused both on psychotherapy and psychological assessments. Daniela is the former president of the Mexican Society of Rorschach and Psychodiagnostic Methods, and she has been attending TA trainings since 2013.

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

Therapeutic Assessment on a Child Inpatient Unit

Empathy, Collaboration, and Transformation

By Christopher J. Pagano, Ph.D.
Cambridge Health Alliance/Harvard Medical School, Cambridge, MA

Let me introduce you to Marcos, an 11-year-old Latino male who lives with his mother, stepfather, and 13- and 18-year-old brothers. Marcos attends a therapeutic day school and sees his biological father on weekends; this is his first inpatient admission. As the psychologist on the child inpatient psychiatric inpatient team, I am introduced to Marcos in the same fashion as everyone on the team, namely, the paperwork which proceeds him:

"Marcos, an 11-year-old Latino male with obesity and a history of a diagnosis of childhood onset schizophrenia, was admitted to the inpatient unit due to several days of agitated behavior, both at home and school, which included throwing chairs, swearing and threatening to kill a peer, and voicing suicidal ideation. Marcos also reported auditory hallucinations telling him to hurt others and himself." A common and understandable reaction to hearing this narrative might be: "Wow, this boy sounds frightening, dangerous, and disorganized." However, as a psychologist, and additionally one who is trained in Therapeutic Assessment (TA; Finn, 2007), my reaction, which did include the aforementioned fear response, also included compassion, empathy, and curiosity. Also, because I was fortunate to lead a team of psychology trainees whom I was helping to train in TA—along with a daylong seminar given to our Psychology staff at Cambridge Health Alliance by Stephen Finn—I immediately started to plan how we could engage this child and his family in a brief TA that would include, what in my mind is the single most important and effective component of child inpatient TA, an Assessment Intervention Session (AIS). But first, let's get a window into the prevailing culture and direction of modern inpatient child psychiatric care in the U.S. to better contextualize the contribution of TA to this population.

Contemporary child inpatient psychiatric care in the U.S. is driven by a managed care insurance model that is characterized by very short stays, about 7 days on average, with a model of treatment that is primarily limited to achieving "stabilization" and that utilizes medication and teaching "coping skills" as the primary therapeutic interventions. Clinical encounters with the child, the family, outpatient providers and other caretakers, are focused on gathering data on symptoms, psychosocial and family history, including mental illness, developing a diagnosis, and providing medication and coping skills associated with that diagnosis. Ongoing, brief symptom assessment, with an eye towards reduction in presenting symptoms, is provided primarily by psychiatrists, nurses, and social workers. The clinical interventions, aside from medication, are delivered primarily in a group format, but also include some individual work. The latter often consists of creating a "safety plan" that provides a map for what coping skill to engage under various circumstances in order to avoid the behaviors which brought the child into the hospital (e.g., "when you feel you are getting angry, take some deep breaths, walk away;" "when you are feeling sad and thinking of self-harm, reach out to a friend, your therapist, or your parent"). The other major components of inpatient intervention are: educating parents on the nature and course of the child's illness, and related interventions, such as medication compliance and positive parenting techniques (e.g., incentives for good behavior, collaborative problem-solving techniques), and outpatient individual and family therapy.

Having worked for 17 years as the Director of Psychology on the child and adolescent inpatient unit at Cambridge Health Alliance, a Harvard Medical School teaching affiliate, I saw firsthand several dangers associated with this model of child inpatient care, which include: 1) over-medication, primarily aimed at subduing anger and related violent behaviors, often leading to the creation of dangerous metabolic diseases. [Procyshyn, et al. (2014) documented the enormous increase in use of "second generation antipsychotics" in the 2000s in the U.S., including an alarming trend towards initiating the use of such agents during youth inpatient stays.]; 2) reducing the child to a diagnosis; 3) a lack of empathy that contributes to an intrapsychic and systemic avoidance of core affect (i.e., grief, anger, love, joy, among others); and 4) a *failure* to facilitate parents' ability to engage with their child in a healing relationship. The frequent outcome of these dangers and failures in clinical care include, but are not limited to, a) a child who feels invalidated, unseen, and who experiences increased shame around her pain, leading to increased self-hatred and subsequent self-harm and suicidal behavior; b) increased denial, distancing, and numbing within the entire system regarding the child's core pain and suffering; and c) rapid readmission; national readmission rates for child inpatient units are around 30% within the first 90 days post-discharge, and 40% within 1 year (Blader, 2004). What can we, as psychologists, do about this alarming problem? One effective, and refreshingly compassionate and collaborative response to this problem is TA. I have had the good fortune to provide TA for dozens of children and adolescents on the inpatient units at Cambridge Health Alliance, and have witnessed families respond with gratitude for the care and support provided by the psychology staff, and with appreciation for the experience of healing within the family engendered by TA. Let's return to Marcos.

Feeling skeptical about Marcos' diagnosis, and alarmed at the heavy, adult-dose of antipsychotic medication that he had been taking prior to arriving at the unit (he was also on an alpha-agonist, designed to lower his blood pressure, and relatedly, his aggressive tendencies), I suggested to the team that I wanted to assign one of my psychology trainees to work with him and do some psychological testing. The offer was imm-

ediately embraced by the team, and we went to work. An initial meeting with Marcos' mother revealed a complex background that helped us start to develop a different narrative. His father had been incarcerated when Marcos was 4, and released when he was 8, although details of why were not shared. Marcos' difficulties with aggressive behaviors started when he was 4 and steadily increased until age 9, when he reported hearing voices and seeing visions, and was diagnosed with childhood onset schizophrenia. Early history included delayed language acquisition (single words at 18 months; using sentences at age 3 to 4 years; diagnosed with dysarthria; an early cognitive assessment indicated a Full Scale IQ in the "borderline" range of functioning; bullied in school and later became identified as a bully). Recent stressors included maternal grandmother's serious illness, and mother's preoccupation with her care as well as mother's 19-year-old niece who had recently been hospitalized for mental health problems. The development of TA questions in the interview with his mother rendered the following: "Why is Marcos behaving so aggressively? What is his diagnosis: schizophrenia, autism, and/or post-traumatic stress disorder?"

Because of the short length of stay on inpatient units, I often faced the need to pare down the standard personality assessment, and in this case, I asked my trainee, Sara Kaplan-Levy, to limit the assessment to a clinical interview, projective drawings, and about a half-dozen cards from the Roberts Apperception Test (Roberts & Gruber, 2005). Highlights of the responses follow:

Fantasy Animal Drawing

Marcos described the fantasy animal as a dog bear human, who can fly, run super-fast and is very strong; he wishes he to be very smart and never die; he has no friends but he's not lonely. He resisted telling a story about the animal, but ultimately told the following: "Once upon a time the dog/human/bear saved a cat from falling out of a tree. The end."

Draw A Person of the Opposite Sex

Marcos said, "She likes to play outside; she has five friends, they like to text boys; her mom takes care of her; she is 15 years old; people treat her nice." His story: "Once upon a time she was singing and she tripped on a wire and the guy (referring to the 'lonely' male he drew first) caught her, and they fell in love." The assessor asks, *Where did she fall?* "She fell at the pizza place. You know how they have stages at those places sometimes?" [apparently referring to a small music stage at a local pizza place] Assessor: *How is she feeling?* "She's feeling in love."

Roberts Apperception Test

Card 9 (Depicts a boy, on the left, with fists cocked and in an aggressive posture, standing over another boy who is sitting on the floor, and it looks like he was just knocked down and is feeling scared):

Marcos: Once upon a time these kids were arguing and that guy, the guy on the left, punched him and knocked him out. The end.

Sara (the assessor): Why were they arguing?

M: I don't know. They were arguing about food. About candy. Because they wanted the same piece and there was only one left.

S: How does the guy on the left feel?

M: Mad.

S: What is he thinking?

M: I want to hit this little kid so bad.

S: And how is the other guy feeling?

M: Sad.

S: What is he thinking?

M: I want to punch this little kid so bad.

At this point in the testing, Marcos becomes acutely agitated, stating, "I don't want to do this anymore!," and he gets up and starts to leave the room. Sara, tries to help him articulate why he's upset, but he's unable to. Nonetheless, he agrees to stay and does one more Robert's card:

Card 13B (Depicts a boy with a chair raised above his head, looking like he's about to slam the chair on the ground):

M: Once upon a time this kid got mad at his dad because he didn't give him no money so he slammed the chair and he broke it.

S: Why did he want money?

M: He wanted money to go buy chips.

S: How is he feeling?

M: Mad.

S: What is he thinking?

M: I want to hurt my dad so bad.

While clearly, we had minimal data to go on, Sara had begun to create a strong empathic connection with

both Marcos and his mother, and some clear themes and diagnostic impressions were emerging. These included: Marcos' production of coherent and logical narratives that were *not* consistent with a psychotic disorder; a brevity of language and grammatical structures that suggested expressive and possibly receptive language deficits; emotional themes suggesting a focus on a wish for nurturance (symbolically represented as food, which he experiences as lacking and/or withheld by parents) and love (literally "falling" in love); loneliness and denial of the same; poor impulse control that is paired with an awareness of right and wrong and a capacity to hold back (e.g. "I want to hurt my dad so bad!"). With these themes in mind, Sara and I designed a brief individual AIS with the goal of 1) priming the pump to increase awareness of experiences of maternal nurturance in order to scaffold Marcos's capacity to communicate his needs without engaging in violent behavior and 2) eliciting feelings of jealousy, which presumably he felt in relation to his mother's recently directed attention to her ill mother and niece, and then scaffolding safe and effective communication of needs. The final step would involve returning to the original cards in which he offered stories depicting poor impulse control and actively encouraging him to apply his increased awareness of the possibility of feeling empowered to express his needs and collaboratively arrive at a more adaptive resolution to his original stories.

Assessment Intervention

Card 2B (Depicts what appears to be a mother and her son kneeling on the floor, hugging, the mother consoling her child).

M: Once upon a time there was this kid. He punched, no, no, no, yeah, he punched a kid and after he felt guilty and then he started to cry to his mom.

S: How did the kid feel?

M: So mad so he punched the kid.

S: How come mom gave him a hug?

M: She knew he felt so sad.

S: How did she know?

M: She knew because of his face.

S: And how does he feel after hugging mom?

M: Still sad. Kinda feels better.

S: He's still sad?

M: He's kind of upset because that was the wrong thing to do, to punch a kid.

Card 10B (Depicts a latency-aged boy looking on longingly as his mother feeds her baby):

M: Once upon a time mom had her baby and the son came home and was asking about what's that crying? And then mom was like, "Oh, that's my new baby. I forgot to tell you about him."

S: How is the son feeling?

M: Mad.

S: How come he's mad?

M: He thinks the mom won't care about him anymore.

S: Do you think there's something that he can do to let her know that he's worried that she won't care about him anymore?

M: Tell her!

S: That's a great idea. What could he say?

M: Mom, I feel like you don't love me no more because the new baby's in the house.

S: That's a really great way to express your feelings! And how do you think she would respond?

M: She'd say, "I still love you."

Return to Card 13B

After praising his ability to come up with an effective way of having the characters express their feelings in the last two cards, Sara then explained to Marcos that they would go back to the two cards she had shown him the day before, but this time she would like him to apply what they had just talked about and create new stories for those cards. She then reminded him of the story he had told on Card 13B, and showed him the card again.

S: Based on what we just talked about with these two cards, I'm wondering if you think there's a different way that this story could have ended?"

M: Talking.

S: What kind of talking? What could the boy have said?

M: Could you please let me go to the store? I'll buy you [referring to the dad] something.

S: So, he could have asked again…offered to do something nice for the dad. Great. I'm wondering how the child felt at the end of the first story? After he threw the chair.

M: He felt guilty.

S: And how do you think the boy would have felt if he tried talking to his dad instead

M: Not guilty

S: Okay, great. Last time you said that the boy was mad at his dad, which is why he threw the chair. Do you think there's any way his dad might have known he was mad even if he hadn't thrown the chair?

M: Yes. He would have known he was mad because he would see his fists!

S: Oh, wow, his fists. Great. Anything else?

M: His face.

S: What did his face look like?

M: He was looking away; his eyebrows were down because he was mad.

S: So, his face looked really mad. And what do you think he'd want his dad to say if his dad knew he was mad?

M: His dad would say 'yes' and let him go.

S: Sure, it would be great if his dad would let him go. What about if his dad said something like, "I'm sorry you're upset that you can't go to the store."

M: Yeah.

Return to Card 13B

Based upon the assessment we were then able to give face-to-face (and later, written) feedback to Marco's mother, which included dropping the diagnosis of schizophrenia and embracing a diagnosis of attachment trauma on top of an expressive language disorder. Relatedly, our assessment findings helped encourage the inpatient psychiatrist to cut Marcos' antipsychotic medication by 1/3. We shared some of his stories, which provided a moving experience in which his mother could absorb the knowledge that Marcos knows that his aggressive behaviors are wrong and he feels guilty about them, but that he feels shame about his underlying needs and vulnerabilities and has trouble finding the words to express his feelings and needs. He wants to do better, and he has the capacity to engage in collaborative problem solving, but he needs a lot of help in understanding, containing and processing his emotions in the moment. With a lot of empathy and support, he can develop the skills necessary to express his negative emotions more safely.

Concluding Remarks

The challenges to creating empathic, collaborative, containing, and healing relationships with children and families on an inpatient unit are great, yet instrumental if we are to engage the child on a level where she can feel safe being vulnerable. Without such connections, intrapsychic shame and avoidance, systemic mis-attunement, anger from providers and caretakers, and a medication-dominated response will cloud our vision, and our children and families are destined to repeat patterns of hurt, shame, fear, rage, self-harm, emotional-numbing, and rehospitalization. A summary of meta-analytic studies which look at components of the therapy relationship that demonstrably contribute to positive outcomes, found that empathy and collaboration have two of the highest effect sizes (Norcross & Lambert, 2018). TA is a semi-structured and compassionate approach that provides empathic attunement and collaboration to children and families, allowing both the child and her caretakers to feel comfortable enough to trust and have a transformational experience in a short period of time. I am excited to be able to share more case studies, and a summary of best practice recommendations for applying TA to children in inpatient settings, through an article that I co-authored with two former psychology trainees, Meghan Blattner and Sara Kaplan-Levy (Pagano, Blattner, & Kaplan-Levy, 2018).

References

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

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy, 55*(4), 303–315. doi: 10.1037/pst0000193.

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

Procyshyn et al. (2014). Prevalence and patterns of antipsychotic use in youth at the time of admission and discharge from an inpatient psychiatric facility. *Journal of Clinical Psychopharmacology, 34(1),* 17–22. doi: 10.1097/JCP.0b013e3182a607dd.

Roberts, G. E., & Gruber, C. (2005). *Roberts-2 manual*. Los Angeles: Western Psychological Services.

Author

Christopher Pagano is a psychologist in private practice in Wellesley and Brookline, MA, the former Director of Psychology Training at Cambridge Health Alliance's Child and Adolescent Inpatient Units, and an Assistant Professor of Psychology at Harvard Medical School. He is a "Level I" Advanced Experiential Dynamic Psychotherapy (AEDP) practitioner.

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

Photo Album

Above: Marita Frackowiak at dinner with members of the Board of the Australian Psychological Society (APS)—the sponsor and organizer of a TA training in Melbourne, Australia in Summer 2018.

Above: Stephen Finn, Noriko Nakamura, Marita Frackowiak, and attendees enjoying dinner during a workshop on TA with Adolescents and Families in Tokyo, Japan in November, 2018.

Above: Stephen Finn and Noriko Nakamura present on TA with Adolescents and Families in Tokyo, Japan in November, 2018.

Recent Publications in Therapeutic/Collaborative Assessment

Kalow, N. J., Finklea, J. T., & Chan, G. (2018). Personality Assessment: A competency-capability perspective. *Journal of Personality Assessment,* 100(*2*), 176–185.

Rudin, D., Nakamura, N., & Finn, S. E. (2018). Difficulties in the diagnosis and treatment of Autism Spectrum Disorder: A neurodevelopmental disorder. *Japanese Journal of Psychotherapy, 44*(2), 159-167.

Upcoming Trainings in Therapeutic Assessment

November 15, 2018: Free Webinar
Title: "Using the MMPI-2-RF in Therapeutic Assessment"
Presenter: Stephen E. Finn
Sponsor: Pearson Assessments
Language: English
Schedule: 12:00-1:30 EST
Information: https://cc.readytalk.com/registration/#/?meeting=1iu1djaxh96n&campaign=nl9bmjlgdsp7

November 27, 2018: Open Lecture, Milan, Italy
Title: "Vergogna, colpa o capriccio?: Come crescere figli responsabili e sicuri di sè senza essere genitori perfetti"
Presenter: Stephen E. Finn
Sponsor: European Center for Therapeutic Assessment, Catholic University of the Sacred Heart, Milan
Language: Italian
Schedule: 8:30-10:30 PM
Information: segreteria.ceat@unicatt.it

November 29-December 1, 2018: Milan, Italy
Title: "Working with Shame in Psychological Assessment and Psychotherapy"
Presenters: Stephen E. Finn & Camillo Caupto,
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

February 6, 2019: Free Webinar
Title: "Using the MMPI-2-RF in Therapeutic Assessment"
Presenter: Stephen E. Finn
Sponsor: Pearson Assessments
Language: English
Schedule: 12:00-1:30 EST
Information:https://www.pearsonclinical.com/events/webinars/currentlisting.html

---

March 20–24, 2019: New Orleans, LA, USA
Symposia, Papers, and Posters
Presenters: TBA (members of the Therapeutic Assessment Institute)
Sponsor: Annual meeting of the Society for Personality Assessment
Information: http://www.personality.org/annual-convention/general-information/

Workshops at SPA in New Orleans

March 20
Title: "Using a Collaborative/Therapeutic Assessment Model in Diagnosing Adults with an Autism Spectrum Disorder"
Presenter: Dale Rudin
Sponsor: Annual meeting of the Society for Personality Assessment
Schedule: 8:00 AM – 5:00 PM
Information: http://www.personality.org/annual-convention/general-information/

March 20

Title: "Therapeutic Assessment in Clients with Personality Disorder with a Focus on the Restoration of Epistemic Trust"
Presenters: Jan H. Kamphuis, Hilde de Saeger, and Pamela Schaber
Sponsor: Annual meeting of the Society for Personality Assessment
Schedule: 8:00 AM – 5:00 PM
Information: http://www.personality.org/annual-convention/general-information/

April 2, 2019: Webinar

Title: "Understanding and Assessing Shame"
Presenters: Stephen E. Finn and Diane Poole-Heller
Sponsors: Trauma Solutions
Languages: English
Schedule: 6:00 – 8:00 PM CST
Information: dianepheller@gmail.com

April 27, 2019: Tokyo, Japan

Title: "Day of Open Consultation with Stephen Finn and Noriko Nakamura"
Presenters: Stephen E. Finn and Noriko Nakamura
Sponsors: Asian-Pacific Center for Therapeutic Assessment
Languages: English and Japanese
Schedule: 10 AM – 5 PM
Information: asiancta@gmail.com

April 28-29, 2019: Tokyo, Japan

Title: "Building Parents' Empathy Through Therapeutic Assessment: Four Types of Children and Families"
Presenters: Stephen E. Finn and Noriko Nakamura
Sponsors: Asian-Pacific Center for Therapeutic Assessment
Languages: English and Japanese
Schedule: April 28: 10 AM – 5 PM
April 29: 9 AM – 4 PM
Information: asiancta@gmail.com

May 7, 2019: Webinar

Title: "Helping Clients Heal from Shame"
Presenters: Stephen E. Finn and Diane Poole-Heller
Sponsors: Trauma Solutions
Languages: English
Schedule: 6:00 – 8:00 PM CST
Information: dianepheller@gmail.com

May 10-11, 2019: Anchorage, Alaska

Title: "Working with Shame in Psychological Assessment and Psychotherapy"
Presenters: Stephen E. Finn
Sponsors: Therapeutic Assessment Institute and Society for Personality Assessment
Language: English
Schedule: May 10, 2019 9:00 AM – 5:30 PM
May 11, 2019 9:00 AM – 5:30 PM
Information: Call 1-512-329-5090, ext 2
Flyer: https://therapeuticassessment.com/docs/Alaska_shame_flyer_2019_final_(2).pdf
To register: https://memberleap.com/members/calendar6c_responsive.php?org_id=TAI