THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

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Spring Celebration!

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Happy spring to all! This edition of the *TA Connection* continues our early spring celebration that occurred in Austin, Texas. Many of you were participants at both the Pre-Conference Institute on Therapeutic Assessment and the Society for Personality Assessment (SPA) annual conference in March. It was great to gather with colleagues, learn together, and celebrate the 30-year anniversary of the Center for Therapeutic Assessment. After a few years of virtual workshops and conferences, it was refreshing to be in person. On p.29, you'll find some pictures from the pre-conference institute and our barbeque celebration at the County Line in the Hill Country.

While in Austin, the TAI Board of Directors met to do some planning and we want to share some of our work. We discussed our monthly virtual workshops, and ways to translate presentations for our international colleagues. We also discussed preliminary ideas for the 4th International Collaborative/Therapeutic Assessment Conference. We continue to review our efforts to both provide TA trainings and guide those seeking TA certification. The number of psychologists practicing TA across the globe continues to grow, and we appreciated spending time in Austin with colleagues from Latin America, Europe and Asia.

This Issue

If you could not be in Austin, this edition features three articles that were part of the pre-conference institute and SPA conference. We begin with an article by Steve Finn. The 30-year anniversary of the Center for Therapeutic Assessment was an opportunity for Steve to reflect on TA and its evolution. His presentation at the conference, and now this article, strings together core TA ideas in a way that will be educational to all.

Next, Krista Brittain, Alison Wilkinson-Smith, and Rebecca Goffman joined forces to share their wisdom about billing health insurance for TAs. This article is also based on a presentation from the pre-conference institute, and the authors do an excellent job of explaining the "nuts and bolts" of billing CPT codes and how to think about working with managed care providers. This article is incredibly informative and will be a valued resource to many TA assessors in the United States.

In our third article, Diane Santas has put into words her lovely case presentation from the SPA conference. Diane describes the use of the Early Memory Procedure (EMP) in a complicated case. Many in the TA community use the EMP, but this measure has not received such focused attention in a case study, and Diane's beautiful clinical work shines through.

Last, we continue to celebrate assessors newly certified in TA. In this issue, we are delighted to congratulate Dr. Serena Messina on her certification in the adult TA model. Serena practices in Austin, Texas, and conducts TAs and therapy with children, adolescents, families, and adults. As described below, she will lead a TAI webinar this September on attachment and diversity.

TA Trainings

The TAI monthly seminars continue and on June 23rd, Dr. Seth Grossman will host a webinar focused on the Millon instruments and their utility as part of a C/TA. His workshop is entitled: *"What If I tell you I think it's all BS and I want a real diagnosis?" Finding therapeutic dialogue in MCMI-IV and MACI-II to enhance Collaborative/Therapeutic Assessment impact.* This presentation is from 10:00 AM - 12:00 PM CDT and will be available in a recorded format for those who cannot attend live.

In September, Dr. Serena Messina will conduct a webinar entitled: *Attachment and Diversity: Integrating Universal and Contextual Dimensions.* On September 8th, Serena will explore the main tenants of attachment theory and review cross-cultural research on the topic. Participants will learn to consider how the main features of attachment theory manifest within different cultural and socio-economic backgrounds, and how these ideas can apply to both TA and

psychotherapy. While we are still solidifying the date and time, it is expected that this presentation will occur on September 8 or 15, 2023. Information about all of our monthly trainings can be found on the TAI website: **www.therapeuticassessment.com**.

Last, note that there are also opportunities for training on the Wartegg Drawing Completion Test (WDCT) Crisi Wartegg System (CWS), Adult Attachment Projective (AAP), & Rorschach Performance Assessment System (R-PAS) listed in our Upcoming Trainings section. Many TA assessors find these tests to be useful tools in their battery and TAI members receive a discount on those trainings.

Become a Member of the TAI

The Therapeutic Assessment Institute (TAI) began offering memberships in 2017 and currently has close to 200 members. Membership in the TAI gets you two issues a year of *TA Connection*, access to the members-only listserv, discounts on trainings sponsored by the TAI, and discounts on Adult Attachment Project (AAP), Wartegg Drawing Completion Test (WDCT) Crisi Wartegg System (CWS), and Rorschach Performance Assessment System (R-PAS) trainings. The membership fee is very reasonable, at $75 per year for professionals and $40 for students. Please consider joining to receive these benefits and to help support the TAI's mission.

The Leonard Handler Fund

The Leonard Handler fund assists economically disadvantaged clients who would benefit from a TA but cannot 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 donating to this fund through the TAI website to help make TA available to everyone, regardless of income level. The economic effects of the COVID-19 pandemic underscore the need for support. We are continuing to build this fund and hope to have information on the TA website on how TA-trained assessors can apply for these funds to support underserved clients that otherwise could not afford a TA-informed assessment.

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 most donations to support scholarships for students and professionals who need financial assistance to attend trainings, and we hope to provide financial support to underserved clients through the Leonard Handler Fund. We are also developing training materials for those of you who find it difficult to travel to our workshops, and as mentioned earlier, we will continue to sponsor high-quality online trainings. These activities take a great deal of time, and we count on your generosity to do all we do.

Future Issues of the TA Connection

The fall edition of the *TA Connection* will focus on the use of cognitive tests during a TA. If you are interested in writing an article that includes using a cognitive test in a collaborative fashion as part of an Extended Inquiry, Assessment Intervention Session (AIS), or during other steps in a TA, please let me know. More broadly, if you have feedback or suggestions for the *TA Connection*, share those ideas as well.

Please email questions, comments, and suggestions to Raja at raja@mnccta.com

What We Have Learned from 30 years of Being in Our Clients' Shoes

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(Keynote address presented at the Pre-conference Institute on Therapeutic Assessment as part of the annual meeting of the Society for Personality Assessment, Austin, TX, March 28, 2023)

In September 1993 I took a step that at the time seemed to many people like me jumping off a cliff: I resigned my core faculty position in the Psychology Department at the University of Texas, drew a considerable amount of money from my savings, rented and furnished a large office suite in a good part of Austin, and hung up a sign christening it as the "Center for Therapeutic Assessment (or CTA)." Multiple people (including my colleagues at the university) expressed concerns about my judgment and sanity, and in retrospect, I am rather amazed at the excitement and relative lack of anxiety I felt making this move. You see, I had become convinced that collaborative psychological assessment could benefit clients other professionals seemed unable to help, and I wanted to offer this service to as many people as I could, while continuing to do research, write, and train other clinicians. Fortunately, my late husband, Jim, and other friends believed in me, and within 7 months I had negotiated contracts with several large insurance providers, put together a staff of 7 psychologists, and had a 9-month waiting list of clients requesting Therapeutic Assessments for themselves, their children and families, or their couple relationships.

As many of you are aware, a lot has happened with TA in the 30 years since the CTA opened, including there being mounting research evidence that TA is effective with a wide variety of clients, our having a deeper understanding of how and when TA works, its having spread around the world—including to the Centers for Therapeutic Assessment in Milan, Italy and Tokyo, Japan, and the practice/training clinics at WestCoast Children's Center in Oakland California, the Viersprong Clinic in the Netherlands, and the Instituto de Evaluación Collaborativa Isidro Sanz in Buenos Aires, Argentina. At this moment there are 36 psychologists in 6 countries who have completed the rigorous process of becoming fully certified in TA and 29 additional psychologists in 5 countries who have completed the Level 1 certification.

Still, what is most exciting to me is that the procedures and values of Collaborative/ Therapeutic Assessment have started to "seep into the water," with the result that more psychologists recognize that psychological assessment can directly benefit clients (apart from treatment planning and evaluation), more clients are given feedback about their assessment results—even from neuropsychological or forensic assessments—and some practitioners are utilizing strategies like asking clients at the beginning of an assessment what they want to learn from their test results, discussing test responses directly with clients after standardized testing, and/or writing therapeutic fables for children after they have been evaluated. Also, Collaborative/ Therapeutic Assessment is now mentioned in many standard psychological assessment textbooks, and lots of graduate students are exposed to the concepts and procedures of TA during their training. And best of all, some of the psychologists who use collaborative assessment practices have never heard the names Constance Fischer, Stephen Finn, or Leonard Handler, but do these things because they learned about these procedures—which seemed to them like common sense—or they discovered along the way that these ways of interacting with clients can be very useful and therapeutic. Truly, the field of psychological assessment is in a very different place than it was 30 years ago, when it was not uncommon for 1-2 colleagues to walk out of my trainings on Therapeutic Assessment after the first hour, incensed by what I was saying. (I have to confess--I also was more strident and arrogant at that time, and less concerned about creating disintegration experiences in my colleagues.) I believe it is fair to say that TA has contributed to a paradigm shift in assessment, at least in some settings, and I want to thank all of you in the room today for helping to contribute to that systemic change. Let's give each other a round of applause.

Thank you. My goal today is not to try your patience further with more self-congratulatory reminiscing. Instead, I hope to highlight for you all thirteen learnings that stand out for me from 30 years of research, practice, writing, and training on Therapeutic Assessment. Some of these insights may now seem so established that there is no need to review them, especially with those of you here today who are well versed in TA. (Translation: I don't expect anyone to walk out, but we'll see.) Still, I think it is worth noting that these ideas were not so evident 30 years ago, and that there are many places around the world where they still seem strange or even offensive and threatening.

Lesson 1

If the right elements are present, even people with longstanding and complex problems-in-living can experience significant transformations or developmental "course corrections" in a relatively short period of time via Collaborative/Therapeutic Assessment.

It has always struck me how many mental health professionals accept the idea that people can undergo sudden negative transformations (for example, as a result of trauma) but so little attention has been paid to the prospect of rapid positive transformations. TA is a testimony to this possibility. There are now over 40 controlled research papers and 3 meta-analyses published on Collaborative/ Therapeutic Assessment with adults. These meta-analysis have consistently shown that even in a brief period of time (for example in 3-4 sessions), when compared to no treatment, assessment as usual, or other credible brief therapies, C/TA has a significant impact on: 1) adult clients' symptomatology, with effect sizes in the range of .19 to .37, 2) clients' motivation for and satisfaction with subsequent treatment, with effect sizes from .59 to 1.11, and 3) their views about themselves, with clients showing less shame and increases in self-esteem after a TA, with effect sizes from .37 to .42 (Aschieri et al., 2023; Durosini & Aschieri, 2021; Hanson & Poston, 2011; Poston & Hanson, 2010). There is less controlled research on TA with adolescents, children, and couples, but from our clinical experience we know that TA also can be effective with them. Furthermore, while not every client or family shows significant and long-lasting improvement after a TA, there are some people who experience marked transformational change after an Extended Inquiry, an Assessment Intervention Session, or a Summary/Discussion Session. These cases are proof that when the right factors are combined, suffering people can sometimes heal rapidly. I think this is one of the most intriguing findings that TA has brought to our profession, because it challenges us all to identify the elements of change at work, so they can be harnessed more broadly.

Lesson 2

The specific healing properties of Therapeutic Assessment appear to depend on the use of psychological tests within a certain interpersonal context.

Over the years, some individuals have claimed that psychological tests are not a crucial driving factor in Therapeutic Assessment and that its efficacy rests on a combination of so-called "common factors," such as empathic attunement and therapeutic alliance. As you all know, I believe the client-assessor relationship is hugely important in Therapeutic Assessment, and I'll say more about that in a moment. But I firmly believe--based on what our clients have told us over the years--that psychological tests are crucial to TA's success. Here is my current understanding of how tests help us with our clients: They are: 1) empathy magnifiers that reveal where and why our clients are blocked, 2) windows into clients' life worlds that help us understand their characteristic ways of responding to challenging situations, 3) intriguing and authoritative sources of information in the eyes of many people, which elicit curiosity, foster epistemic trust, and help people consider new ways of thinking about themselves , 4) opportunities to discuss significant topics and events that clients might not otherwise bring up in treatment, 5) emotionally arousing stimuli that may elicit past traumas, shame, and dissociated affect states in our clients (Finn, 2011; Finn, 2023; Villemor-Amaral & Finn, 2020), 6) sources of new language and powerful metaphors that provide clients with novel ways of thinking and talking about their problems, and 7) opportunities for intimacy with another person which, when they go well, can help restore clients' hope for positive human connection.

This does not mean that the therapeutic stance of TA cannot be incorporated into other interventions

that do not use psychological tests. It can. But to do TA effectively, clinicians must become experts with psychological tests.

Lesson 3

Changes in clients' narratives are key to the power of C/TA, at least for some people.

The multiple time series analyses that have been done of TA suggest that people show therapeutic shifts at different points in a TA, and we still need more work to understand how and why these improvements happen. Still, at this point, it seems clear that a major aspect of how TA helps people is that it often leads to changes in their narrative identity—to use Jonathan Adler's (2012) term—that is, *"the internalized, evolving story of the self that each person crafts to provide his or her life with a sense of purpose and unity."* Some years ago, after talking to many clients in their TA follow-up sessions, I concluded that TA helps people develop more "coherent, accurate, useful, and compassionate" stories about themselves—or in the case of child, adolescents, and couples TA—more coherent, accurate, and useful stories about their children, teens, or romantic partners. I still believe this to be so. Also, I believe that narrative change is a driving force in many forms of successful psychotherapy, whether that is acknowledged, and that changing narratives is not so easy. As many of you know, the novel techniques of TA, like getting initial Assessment Questions, doing Extended Inquiries or Assessment Intervention Sessions, attending to shame, or considering what is Level 1, 2, or 3 information in a Summary/Discussion Session are all part of overcoming the human tendency towards self-verification and fostering epistemic trust so that people can update their narrative identities.

Lesson 4

The process of changing narratives is an emotionally challenging experience, and if people cannot tolerate the emotions that come up, they will push away new potential narratives.

I am grateful to the clients over the years who have helped me understand that giving up usual ways of thinking about ourselves and the world, and accepting new narratives is not just a cognitive process. Many of us in this room have sat with people as we looked at psychological tests together while they sobbed with sorrow, cried with relief, or raged to realize that, for example, they weren't stupid but had a learning disability, weren't lazy and unmotivated but rather depressed, or that the parents they had always idealized had done their best but in fact didn't provide all that they needed emotionally while growing up. Sitting with clients in their grief as they came to these realizations has been an incredibly moving and life changing experience for me, as it also has been poignant to watch people reject new ways of thinking because they couldn't tolerate what they would feel if they did not. Over the years, I also came to understand that I had to learn to tolerate and accept a myriad of emotions in myself—without trying to rush to quick solutions—or I would not be able to help my clients.

Lesson 5

The nature of the client-assessor relationship is crucial and perhaps more important than specific collaborative assessment techniques.

I have to confess, when I first understood that using psychological tests with clients could produce therapeutic change, I was not fully aware of how important the relational aspects of TA are. I remember an older woman—a Quaker psychologist visiting Austin in the late 1980s—who sat in for a semester on my graduate assessment class at the University of Texas. I was teaching the students the MMPI and Rorschach, an early version of Extended Inquiries, and test feedback sessions. At the end of the semester this wise woman wrote me a note thanking me for permitting her to audit the class and telling me how much she had learned. She also wrote, *"Please remember, all these things you are doing with clients are helpful because you do them with love. Without love, they would be worth nothing—or worse, they might even be harmful. Be sure to teach your students that also."* I didn't fully understand what this woman had written me at the time, but 10 years later I challenged myself to make a list of the core values underlying Therapeutic Assessment. I think all of you have seen them by now: Collaboration, Respect, Humility, Compassion, Openness, and Curiosity. These are not just theoretical concepts—the practices of TA are meant to embody these values, and when we are faced with difficult decisions during a TA, we attempt to make them by considering these core values. We now have some evidence of how important these are.

Earlier, I mentioned the meta-analyses of C/TA's effectiveness. The two most recent of these were led by Filippo Aschieri in conjunction with other colleagues, and in one, the researchers were able for the first time to examine specific aspects of TA that might be related to therapeutic outcome, such as how many elements of TA were used by assessors, or whether the assessors received intensive supervision in TA (Durosini & Aschieri, 2021). All the studies examined used psychological tests in a collaborative manner, including giving feedback to clients, and one or more additional aspects of Therapeutic Assessment. So that part was a given. But when looking beyond those factors, here is the conclusion the authors reached: *"…the most important aspects of Therapeutic Assessment may be its underlying philosophy and values, and—within certain parameters—not so much the exact way in which it is implemented…It appears that when collaboration, respect, compassion, openness, and humility are brought to bear in assessing clients, psychological assessment can be a life-enhancing experience in multiple ways" (p. 971).*

So, it seems my Quaker colleague was right, at its core TA is a way we show love in a professional context to our clients, and this is what matters the most.

Having said that, there are two other interpersonal aspects of TA that have emerged over the years as central to its effectiveness, and I want to highlight these. The first is related to the relatively recent concept of *mentalization*, developed by Peter Fonagy (1998) and his colleagues, and leads to another lesson.

Lesson 6

It is incredibly powerful, satisfying, and beneficial to experience being seen, understood, and held in mind by another person.

Fonagy and colleagues have described mentalization as the process of "holding the other's mind in mind" or as "seeing yourself from the outside and others from the inside" (Allen, Fonagy, & Bateman, 2008). I think I always understood that the experience of being seen, understood, and held in mind was potentially therapeutic if others used that knowledge for our benefit. But after Fonagy and Bateman developed and researched Mentalization Based Treatment, it became clear how essential and life-enriching this kind of interpersonal environment is, and how much it fulfills our basic "wiring" as human beings. This understanding fits with and underlines comments we have had from TA clients over the years, about how they have never in their lives felt more understood than they did during the TA, and how much this impacted them.

Along these lines, many of you are familiar with the qualitative research study done by Hilde De Saeger, Jan Kamphuis, and colleagues (DeSaeger et al, 2016), with 10 patients who had had a TA as part of a Randomized Control Trial several months earlier. The RCT showed that TA significantly increased patients' motivation for and satisfaction with treatment, and that it greatly strengthened their therapeutic alliance, compared to the patients in the control condition (DeSaeger et al, 2014). Look at a few of the comments the patients made about TA in their interviews:

> "They [the TA therapist] first pay attention to who you are, what your character is, what kind of person you are, and what kinds of things you have experienced…At the previous mental health center, it was much more superficial."
>
> "I was asked more about myself, about my personal experiences, and…yes, how I myself actually perceived things…in contrast to what I have experienced [in treatment] before sometimes…that when you give a sketch of your biography you become immediately labeled in one way or another."
>
> "The therapist gave me a narrative that fit me completely…Afterwards she even wrote it in a letter. I had no more questions about myself. I just had to look at the letter."
>
> "The collaborative discussion of the test findings, and whether or not these fit according to me. And that when I did not recognize myself in a test finding, I did not get the feeling I was totally off or wrong. The most important thing was what I thought was right."

To me, all these comments demonstrate how TA helps clients feel mentalized, and how important this is for them. And I will say again, our powerful psychological tests contribute to this experience by allowing us to grasp things about our clients that they can't explain, but which they can deepen and elaborate with appropriate scaffolding from us.

Lesson 7

Many of our clients' problems-in-living are related to overwhelming life events for which they didn't experience enough understanding and support from important others, and TA helps with recovery and repair.

Fonagy's research on mentalization has gone beyond identifying an important healing mechanism in psychotherapy. It also helps us understand why many of our clients struggle the way they do, and this is really important in knowing how to help them via TA. To quote him: *"The essence of trauma is separation from a mentalizing community, which normally helps in the integration of adverse experience and from a teaching community that could change self-perception"* (Fonagy, 2019). In other words, difficult experiences do not inevitably lead to trauma; difficult experiences without the support of a mentalizing community are what lead to trauma. This is why is it so transforming for clients who are blocked by past traumas to have these events and the emotions they produced arise for discussion and joint emotional "holding" during a TA—perhaps as the result of an Extended Inquiry of a Rorschach response or a response to the Early Memory Procedure (EMP). We know now from extensive brain research that tests like the Rorschach, EMP, Wartegg Drawing Completion Test, Adult Attachment Projective Picture System (AAP), or Thurston Cradock Test of Shame are very good at activating memories and emotions from past traumas that have never been discussed, in part because of shame and/or dissociation. And in skilled hands, clients can mentalize these events together with the assessor, which can lead to sudden and long-lasting change.

Lesson 8

To be effective, TA assessors must strive for authenticity and balancing compassion with firmness, and kindness with containment.

In 2017, five colleagues and I presented a symposium at SPA entitled, *"When Empathy Isn't Soft and Gentle: Adversarial Transference in TA."* For those of you who aren't familiar with this term, adversarial transference comes from elaborations of Kohut's (1971) self-psychology and refers to the experience of being opposed and contained by a benevolent other who has our best interests in mind (Wolf, 1988). In the past, I have written about the need for assessors to "balance compassion and firmness" (Finn, 2005) and integrate within themselves the three corners of Karpman's triangle (Finn, 2014). Basically, what clients have taught us over the years is that it doesn't help them for us to be too "nice" or "sympathetic" about their past misdeeds or socially alienating behaviors. If we are too rescuing of them, they can't trust other things we say that are more positive, and they can't really rely on us to keep them safe if they get into deep emotional waters. I'm not only grateful to many clients for teaching me this, but also to my Dutch and Swedish TA colleagues, who have helped me appreciate the value of being blunt and candid with clients at certain times.

Lesson 9

Shame is implicated in many of our clients' problems-in-living, and to help clients with shame we must address our own toxic shame.

Over the years, from listening to clients, we have come to understand that shame is extremely important for various reasons: 1) Research indicates that many clinical conditions are connected to and intertwined with deep shame (Dearing & Tagney, 2011), 2) Shame keeps many individuals from ever seeking mental health treatment, 3) It is now widely accepted that unaddressed shame is a major contributor to many unsuccessful psychotherapies, and, as I have written previously, 4) *"If you have a problem and are ashamed about that problem, it is more likely to persist. If your shame decreases and you experience more self-compassion, you will be more able to make needed changes in your life"* (Finn, 2011). For reasons I mentioned earlier, TA also appears to create many opportunities for working with clients' shame, first, because our tests and procedures bring up material that clients' have been too ashamed to discuss previously, and second, they find the courage to do this during a TA in part because of the non-judgmental, exploratory stance embodied in its core values. Going back to trauma and mentalization, shame is associated with action tendencies to hide or disappear and the belief that we are not fit to belong. Thus, it impedes our ability to process traumatic events with a mentalizing community. By creating an environment where such traumas can be talked about,

TA clinicians can substantially impact their clients' well-being by how they handle such discussions. But this comes with a hitch! As one of my psychotherapist heroes, Philip Bromberg, wrote about again and again, we can only help clients heal points of shame if we have addressed those aspects of shame in ourselves. Otherwise, we are likely to simply avoid those topics with our clients, or worse, to shame clients further when they take the risk of "coming out" to us.

Lesson 10

Often, to facilitate significant and longstanding change via TA it is important to engage other parts of clients' interpersonal systems.

I have heard it said that the field of family therapy sprung up because family members of clients started knocking on the doors of treatment rooms and asking to be let in. I don't know if this is true, but something similar happened in the early years of TA. At first, we were focused mainly on working with individual clients, but at their Summary/Discussion Sessions, people started asking if they could bring in their spouses, friends, parents, and bosses to go over what we had discussed. Gradually, it became clear that not only was it useful sometimes to involve people important to the client at the end of a TA, but also to do so at the beginning—where they could pose Assessment Questions—or during, which led to us beginning to invite parents to observe testing sessions of their children. When we return to the idea that TA helps people change their narratives, all of this makes sense. For as we know, we don't develop our narrative identities in isolation, but rather in interaction with those around us. So, if we help clients change their narratives in a TA, but afterwards they go back into the systems that reinforced their prior narratives, it will be difficult for them to hold onto those new way of thinking about themselves and the world. However, if we can assist the important people around our clients to also see them in a new way, then we will have much more impact. This is even clearer in the assessment of children and adolescents, who developmentally have not yet created firm narratives about themselves. We learned fairly early on in our TAs of children and adolescents that we could not really help them without investing deeply during our assessments in establishing relationships of trust with their major caregivers and teachers. Yet, this way of doing things still stands in contrast to the way most psychological assessments of children are conducted around the world—where generally parents are minimally involved if at all.

Lesson 11

Many benefits of C/TA may only be seen in the months and years after an assessment.

I mentioned earlier that we sometimes witness transformational change in clients after a few TA sessions and that different people seem to change at different points of time. One thing I didn't anticipate when I first started doing TA, and which I have understood from talking to people months and even years after their assessments, is that changes in narrative identity continue to influence them over time, such that their life trajectories may be greatly altered compared to where they would have ended up without a TA. One instance of this that some of you have heard me talk about concerns the couple I wrote about in my book *In Our Clients' Shoes* (Finn, 2007) in a chapter I called "But I Was Only Trying to Help!: Failure of a Therapeutic Assessment." Essentially this chapter was intended as a post-mortem analysis of a couples TA which I believed had traumatized the couple involved. I wanted to understand what had happened so that I could decreases the chances of this ever occurring again, and it led to some important shifts in my thinking and practice of TA, such as asking clients in Initial Sessions, "What is the worst possible thing I could tell you at the end of the assessment." I also stopped espousing something I had initially believed, that, *"If a client asks an Assessment Question, that shows us that they are ready for an answer."* I learned this is definitely not true, as many of our clients have unintegrated aspects of themselves and they can ask a question from one part of themselves that other parts absolutely are not ready to have addressed. In any case, I had the occasion some 10 years after their TA to meet again with the couple I believed had been traumatized by their assessment. To my astonishment, not only did the couple NOT see their TA experience as negative, in fact they explained how it had led to very important changes in each of them and in their relationship. This was surprising and humbling, and while I still hold onto to what I learned from this TA, I have come to understand that we often don't fully understand the impact that our assessments have on clients. For this reason, I always say that Follow-

up sessions with clients are a gift to assessors, and that I would be willing to pay clients to tell me long afterwards what they think about their TA experience.

Lesson 12

C/TA is acceptable and helpful to people from diverse backgrounds and cultures, but first assessors must address their own biases.

This summer the Assessment Section of Division 12 will give Constance Fischer their award at the APA Convention for Distinguished Contributions to Assessment. I will be one of the presenters and I plan to speak about how much in the vanguard Connie was in understanding and appreciating the impact of racism and other forms of prejudice on people in minority groups in the U.S., and in how to use psychological assessment to mitigate these effects. Perhaps some of you have read Connie's autobiography, published in 2017 in the slim volume of her collected papers, *On the Way to Collaborative Assessment* (Fischer, 2017). In it she described many instances of using collaborative assessment with clients of diverse races, cultural backgrounds, and social classes, and how revolutionary her approach was at the time (and still is, I believe). The respect, humility, and openness Connie showed with every client was impressive, and it is a model for how to quietly and powerfully use collaborative assessment to impact the individual lives of people who are often treated as if they are "less then," and thereby act as an agent of change in society.

Besides Connie, I am grateful to my colleagues at WestCoast Children's Clinic in Oakland, CA for their years of exploration of collaborative assessment in highly traumatized, disadvantages communities. They taught me a lot, helped me find some of my own blind spots, and also convinced me that TA is acceptable and affective with these types of clients. And more recently, I am grateful to Hadas Pade, Jordan Wright, and Alea Holman for their work on assessment of diverse and multi-cultural clients and their ideas on ways to make Collaborative/Therapeutic Assessment more sensitive and effective in these contexts.

Last, I would be remiss if I didn't mention that we have now successfully adapted TA to Italy, Japan, the Netherlands, Latin America (particularly Argentina and Mexico), Brazil, Sweden, Denmark, and China. After the break this morning, we will be hearing from colleagues implementing C/TA in some of these places in the world, including the successes and challenges they have had. I am happy to say that TA appears to work well in all these countries, if one is open to some very interesting modifications to each culture.

Lesson 13

TA can be growth producing for assessors as well as clients if we are willing to explore new parts of ourselves that we have not yet been able to integrate.

Years ago, Connie Fischer told me, "If we haven't discovered something new about ourselves or our tests or the world by assessing a client, then we haven't really let ourselves be immersed in the assessment." This leads to another learning I had not anticipated 30 years ago, and which many of you have heard me speak about before: how challenging it is for assessors to learn TA and how much practicing TA presents constant opportunities for self-growth and learning. To truly listen to clients with openness and put ourselves in their shoes, mentalize them, and find our own versions of their dilemmas of change and sit with them in the deep emotions that often arise during a TA requires a kind of commitment to the client and to ourselves that I find at times breathtaking. I have said before, *"TA is not for the faint of heart,"* and while this is true, I also want to acknowledge that there will be times when we or other colleagues are not able to work with certain types of clients, because we are not up to it, or we may even need to pass on doing any collaborative assessments at all for a certain period of time. Also, I have not met a person who did not have to tackle some major personal growth step in order to become fully certified in TA, and I respect those individuals who started the process and turned away from it because they were unable or unwilling to make such shifts. I feel a loss when this happens, but I try not to judge, because who of us can ever fully understand the driving and restraining forces involved in another person's dilemma of change?

What is clear to me is this: TA can only be practiced long term in the context of a supportive community of colleagues who care for us, mentalize us, and treat us with compassion and yes, at times, firmness. As I look back over the last 30 years, the thing that moves me the most is that we have come together—bumpily and

imperfectly to be sure—to create the supportive and dedicated community we now have. And many of us have treasured friends and colleagues that we would not have made without this work called "Therapeutic Assessment." My fondest hope for the future is that we will continue to learn and grow from each other and as we do so, help even more people in this beautiful, crazy world.

Thank you all very much.

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Author Bio

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Billing Insurance for Collaborative/ Therapeutic Assessment: An INCOM or an unexpected COP?

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We're sorry to get your hopes up; this article is not about Rorschach coding. Instead, we are going to discuss insurance billing! Confetti cannon, here. (For those of you who attended the 2023 SPA pre-conference, this article represents the written extension of our presentation in that afternoon's symposium.) You might be wondering to yourself, "Why in the world would I want to work with insurance?" That would be a fair question—insurance companies can certainly be a hassle. With contracted rates, extra paperwork and phone calls, and rumors of payment "claw-backs," working more for less money might not be on the top of your list of "fun things" to sign up for. Billing insurance for the deep, meaningful, emotional work of a C/TA, may seem like an incongruous combination (INCOM), the inappropriate merging of two areas of assessment practice. However, there may be more to this meld than meets the eye.

The most compelling rationale for working with insurance for C/TA lies in the values of Therapeutic Assessment: collaboration, respect, humility, compassion, openness, and curiosity. By leaning into these values, we create potential for increased access to the care we are uniquely prepared to provide. At the very least, billing insurance companies for C/TA services puts a new spin on the idea of collaboration in the assessment process. It challenges us to be open to and curious about how we might apply C/TA in more accessible ways. It creates the possibility of providing more access to compassionate, respectful, clinically useful, and potentially life-changing assessment (Finn, Fischer, and Handler, 2012). From these perspectives, it seems that there could clearly be a positive, or even cooperative interaction (COP) between the concepts of Therapeutic Assessment and billing insurance for services.

Reflections on Using TA in a Children's Hospital

When I (Alison) first considered implementing the full Therapeutic Assessment model within my institution, I was equally determined and daunted. It is perhaps a comment on my youthful optimism at the

time that the daunted side of me did not win in the end. Even with a decade of success behind me, I can hardly believe I pulled it off. So, for anyone reading this, if you feel this could never happen in your institution, I sympathize. I also encourage optimism. Allow the core values of TA to influence your attitudes towards bureaucracy, especially openness, curiosity, and collaboration, just as it influences your clinical work. You and your system may be able to reach a mutually autonomous and healthy (MAH) interaction.

The pivot towards using TA within my setting was gradual. As a pediatric neuropsychologist in a Children's hospital within a larger academic medical center, I was juggling a large caseload of children and adolescents with chronic medical conditions and psychiatric comorbidities. Naturally, I found myself reaching into the toolbox of collaborative and therapeutic assessment techniques quite often. Before long, I gained a reputation as the go-to assessor for "difficult" families. Knowing I owed my success to TA, I eventually felt compelled to try integrating the full model into my practice. It took little effort to convince leadership within the Psychology Department that our patients and their families could benefit. I was told billing would likely be an obstacle, but I could try it out. It helped that I knew others had successfully navigated this process before (Finn 2007, Finn & Martin 1997).

Working in a large institution has its perks. Insurance contracts were already in place and, as a salaried clinician, I did not risk my own income should this experiment fail. I will also be forever grateful for the administrative staff who pored through CPT code manuals with me, supported me in obtaining pre-authorizations, and tracked reimbursement success.

Luckily, the first TA was clinically and financially successful. From there, I continued to implement the model with close attention to reimbursement success. We first approached families with insurance policies known to have more generous mental health coverage, but it was not long before we experienced success with almost all the networks with which we contract, including Medicaid.

With more than 100 TAs under our belt, we have learned to bill neuropsychological testing codes for patients with neurological conditions as well as psychological testing codes for mental health. We have developed a training rotation for our post-doctoral fellowship, and thus have billed codes for non-licensed providers working under supervision. Although not every case has proceeded smoothly, the issues have not been notably different from those that occur with our traditional assessments.

* * *

Now that you might be inspired to consider the idea of possibly taking insurance for C/TA someday, let's get down to the nuts and bolts of things, including an overview of insurance billing codes commonly used for assessment, strategies for beginning to integrate insurance into your C/TA practice, and a case example illustrating the billing process.

Billing insurance: A performance-based test?

As you may have guessed, billing insurance companies for C/TA can feel like a performance-based test. We are tasked with making sense of a set of information with very little meaningful guidance or structure. Despite the best efforts of APA and CMS to create clear guidelines, the application by payors is inconsistent and sometimes difficult to decipher (Sharp, 2020). Steve Finn's response to questions of billing insurance from In Our Clients' Shoes (2007, pg. 265) remains perfectly accurate: "There are no fixed answers to these questions." So, much like our clients when handed a Rorschach card, we are left to our own devices and resources to make sense of insurance billing. (Unless you have this article, of course.)

Similar to deciphering an ambiguous inkblot, it can first be helpful to inject some structure into the situation. There are many ways to do this, and the first step is to consider your context—setting, access to support, and level of experience with insurance as well as with C/TA. Here are a few ways you might begin to work with insurance in various contexts:

- If you have never taken insurance before, see if any insurance panels in your area are accepting new providers, then ask your colleagues about the reputations, reimbursement practices, and ease of working with those companies. Choose one and apply to be credentialed. Unless you are paying a person or service to assist you with this process, which can be an excellent idea, it should be free to do this.

- If you already bill insurance for assessment and want to add C/TA, start by shifting your intake session to focus on creating assessment questions rather than completing a full diagnostic assessment. Begin integrating therapy billing codes, where appropriate, for things like the longer intake process, Extended Inquiry time, and the Assessment Intervention Session (AIS). Think about scheduling shorter assessment sessions over several days/weeks instead of trying to get it done in one longer block. See what happens with insurance as you shift how you bill, and make adjustments, as needed.

- If you're working in a highly structured organization, consider talking to your manager about productivity and how beginning to bill for C/TA may initially create some inconsistency. Work to build flexibility around this until you know how to successfully bill insurance for C/TA within your organization. If you have a team that schedules for you, work with them to create a plan to share the scheduling process for C/TA. You may want and need to have more flexibility in scheduling when working with C/TA folks. Be sure to build sufficient writing time into your schedule. Finally, work with your coding and billing team to figure out what to do with documentation when contracts require different billing methods (ex: concurrent v. consolidated).

- If you have a billing department, request one person to be dedicated to C/TA cases and work closely with them so you're on the same page for the process. If you're the billing department, create a system for tracking the flow of the billing process so you'll know when you need to follow up on claims. Many EHR's have a system like this.

- If you're already paneled, try recruiting one or two C/TA clients with insurance so you get a feel for the billing process.

As with deciphering an inkblot, you'll undoubtedly need to engage your resources to bill insurance for C/TA work. External resources may include payor contracts, criteria for medical necessity as you apply for pre-authorization, and CPT code definitions (see chart at end of article). Your internal resources include your personal motivation for billing insurance for C/TA, your personality attributes that support persistence and resilience, the internalized C/TA values, and any experience you may have billing and/or working with insurance or third-party payors. Relational resources may include mentors, billing and coding teams, state psychological associations, and colleagues in the Therapeutic Assessment Institute (including the authors of this article). Using these (and other) resources will begin to make that butterfly come into focus.

Case Example Adolescent Client:

When discussing insurance, one must always give the caveat that there are differences across states, settings, and contracts. This case was seen in Texas, which is not generally a state known for the strength of its mental health services, but success can certainly vary depending on location. A summary of TA steps with corresponding CPT codes and descriptions is included in Table 1 on page 15.

Table 1:
TA Steps with Associated Billing Codes and Descriptions
*Analogous codes for neuropsychology testing with medical diagnoses

Activity	CPT Code	Description
Initial Session	90791 (+90785) 96116 and 96121*	90791: This service includes a comprehensive diagnostic evaluation of psychological and psychosocial conditions and is performed prior to psychological evaluation and test administration and scoring services. 96116 and 96121: Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgement, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report
Parent Session	90846	Family psychotherapy (without the patient present), 26-50 minutes
Testing	96136 and 96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, 16-30 minutes
Adolescent Assessment/ Intervention	90837	Psychotherapy, 53-60 minutes with patient
Video Session	90846	(See above description)
Family Intervention	90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 26-50 minutes
Summary/Discussions	96130 and 96131 96132 and 96133*	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed, 31-60 minutes
Scoring	96136 and 96137	(See above description)
Interpretation and Writing	96130 and 96131 96132 and 96133*	(See above description)

Phase 1: Information gathering

Because this case was seen within a children's hospital, the scheduling team collected information about the insurance plan. They then contacted the insurance company to confirm the clinician's network participation, clarified if pre-authorization was required, determined any limits on the number of hours authorized, and figured out how the assessment would be paid (ex: deductible vs. copay). They documented the date, time, and the name of the representative who provided this information.

If you are doing this on your own, this is the time to consult your payor contract for a refresher on how you will bill (if applicable). Some organizations or payors require concurrent billing (bill as you go for each date of service), while other payors require consolidated billing (billing on fewer dates of service, often with a maximum number of units that can be paid per day). Once the logistical information is gathered, the clinician and client decide whether and how to go forward with the assessment and schedule the initial session.

"Peter" was a 16-year-old biracial boy with a history of generalized epilepsy and non-epileptic events. He had previous diagnoses of Major Depressive Disorder (MDD) and Attention Deficit/Hyperactivity Disorder (ADHD). I (Alison) met with Peter and his parents for an hour and a half in my office, gathering their assessment questions as well as the history of his problems. I spent another half hour reviewing records, including his neurologist's notes and special education records. As a neuropsychologist, I billed this time as one hour of 96116 and one hour of 96121. (See Table 1 for description of CPT codes.) Had Peter not had the diagnosis of epilepsy, I would have billed all of this time as one unit of 90791.

Peter and his parents had questions about impulsive behavior, social skills problems, and mood swings. Following our initial appointment, I completed an insurance pre-authorization for neuropsychological testing and evaluation codes (96136, 96137, 96132, and 96133). The codes were authorized without incident, and his insurance required no pre-authorization for treatment codes.

Next, I met with his parents for an hour-long virtual visit to collect additional background information. As with most every adolescent TA, I spent a significant amount of time during this session helping to foster parents' curiosity about Peter's difficulties and their role in responding to them. Often, I end this session by asking if parents are interested in completing their own testing (typically a Minnesota Multiphasic Personality Inventory, Second Edition, Revised Form [MMPI-2-RF]), but in this case Peter's father was so piqued in his curiosity that he asked for an assessment referral for himself. I billed this visit as one unit of 90846.

Phase 2: C/TA Process

I completed testing with Peter over two sessions which included the Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV), Conners' Continuous Performance Test, Third Edition (CPT-3), Child and Adolescent Memory Profile (ChAMP), MMPI-A-RF, and Wartegg Drawing Completion Test (WDCT) Crisi Wartegg System (CWS). At the time, my hospital required patient and provider masks, so I administered the Brief Observation of Symptoms of Autism (BOSA), Version F2, with Peter and his mother. I billed a total of 11 units of 96136/96137 (4 hours of face-to-face testing, 1.5 hours of scoring) and 3 hours of 96132/96133 (3 hours of interpretation and conceptualization) across these two sessions.

Peter and I then met for the Assessment Intervention Session (AIS). I used the Thematic Apperception Test (TAT) to help him understand that social interactions are stressful and confusing for him, resulting in negative self-talk and emotional overwhelm that sometimes trigger non-epileptic events. I billed this hour-long session as one unit of 90837. I spent another hour in a virtual session with Peter's parents to show them videos of the administration of the WDCT and the TAT. They quickly came to the same conclusion as Peter, that social problems were fueling many of his other symptoms. Peter's father, on a wait list by this time for his own evaluation, saw many of his own life-long struggles reflected in Peter. I proposed the idea of an autism spectrum disorder. This session was billed as one unit of 90846. The family intervention session in my office a week later again used the TAT to help parents learn to validate Peter's frustration with social interactions while gently challenging his self-blaming responses. This session was billed as one hour of 90847.

Peter and I met for a final one-on-one visit to discuss the new diagnosis of autism spectrum disorder. He had gained new empathy for himself and the prob-

lems he has in relating to others. He understood how he had been blaming himself for not having friends and that this was worsening his depression and stress. Peter's parents and I also met for a final session to develop a plan to build Peter's social skills, support him in school, and help him meet other teenagers on the autism spectrum. Peter's father had gone through with his own evaluation, resulting in his own autism diagnosis. He was looking forward to learning more about autism together with Peter. These sessions were billed as 96132 and 96133. I mailed the family their neuropsychological report and two summary letters (one for Peter and one for his parents) about two weeks later, and I heard back from them that Peter had joined a social skills group and his non-epileptic episodes had become less frequent.

Phase 3: Billing

Per the requirements of the children's hospital where this case was seen, billing was concurrent. This means each session was billed independently, shortly after the session took place. Peter's case is fairly typical of my practice. Although not every family experiences such a positive outcome, the number of sessions, general workflow, and amount of time spent is reasonably standard. I met with Peter's family over the course of three months. Altogether, I billed for 11.5 hours of face-to-face time and 5 hours of record review, scoring, conceptualizing, and writing. Two hours were billed as neurobehavioral status exam, 10.5 hours were billed as neuropsychological testing and evaluation, and 4 were billed as individual or family therapy.

Phase 3 again: Billing another way

The above case provides an excellent example of concurrent billing; however, some payors request or require consolidated billing, which provides an opportunity to bill appropriately for all services provided across dates of service. Tables 2 and 3 represent approximated dates of service in a recent adult TA where the assessment questions centered around attention difficulties, stress, and anxiety.

Table 2:
Adult TA Dates of Service and Billing codes

Date of Service	90791	96136/7	96130/1	90837
3/1	9-10am		12-1pm records review	
3/7		9-11am test admin		
3/9		9am-12:30pm admin. + scoring	3-4pm conceptualization, integration of scores/data, consult w/referring therapist	
3/13			1-2pm conceptualization, integration of scores/data, test selection for AIS	
3/14		9:30-10am AIS-TAT admin.		10-11am AIS
3/15		12:30-1pm scoring		
3/22			11am-1pm integrative report writing, integration of scores/data	
3/24			2-3pm summary/discussion	
4/3			12-3pm integrative report writing	
4/4			1-2pm summary/discussion	
4/7			9-11am integrative report writing	

Table 3: Adult TA Summary of Services Billed				
Date of Service	**90791**	**96136/7**	**96130/1**	**90837**
3/1	1 unit 90791			
3/9		1 unit 96136 10 units 96137		
3/14				1 unit 90837
3/15		1 unit 96136 1 unit 96137		
3/24			1 unit 96130 5 units 96131	
4/7			1 unit 96130 5 units 96131	

When doing consolidated billing, it is important to maintain accurate clinical records of the actual dates, start and stop times, and services rendered for each date of service to maintain ethical practice and in case of an audit. In this specific case, my knowledge of the insurance contract allowed me to bill accordingly and get reimbursed fully for the hours billed. I can't emphasize enough the importance of knowing your provider contract and the plan you're working with to minimize billing surprises. In this example, the contract was clear that billing multiple services on the same date (ex: 96136/7 and 90837) and billing more than the daily allowed number of units for a service code (ex: more than 7 units 96130/1 per day) would result in denied claims.

Reflections from the authors

How many of you read the Phase 3: Billing paragraph of Peter's case (above) with some degree of skepticism? We hear you and know that feeling well. Doing work that you do not get credit for is not unique to C/TA, to psychology, or even to healthcare in general. I (Alison) have come to accept that dedication to my clients' best interests will always eclipse my desire to get credit for every hour of my time. As a result, I want to make sure that all my time, whether billed or not, is maximized. For example, I will happily attend a school meeting by phone. I will answer lengthy emails from parents. I spend time brainstorming for therapeutic fables. I balance this out by not agonizing over long reports, automating as many of my scoring processes as possible, and leaning on our support staff for as many administrative tasks as I can (the perks of working in a large system)

In private practice, I (Krista) also do a lot of unpaid work outside of the clinical realm. Of course, this is part of what I signed up for when I went into private practice, and it means I tend not to underbill. I am fortunate to practice in a state where some insurance companies have reimbursement practices that do not require underbilling as much as those in other states. This is extremely fortunate for the clients I serve because they are able to get extremely thorough C/TA's that are almost completely covered by their health insurance plans. The reality of the insurance situation in Iowa also allows me to take some cases pro bono, which is important to my passionate work toward increasing access to care in my community (and beyond).

In our own ways, our work with insurance companies is aligned with the core values of TA. We collaborate not only with our patients and their families, but also with our institutions, (which have a legitimate desire to collect on services!) and insurance companies (which have a clear motivation to reduce their costs by managing the amount they pay out for services). We respect our own time while allowing compassion to guide us in making the most of it. We are open to the needs of our community, including families with very few financial resources. We are curious about where

C/TA will lead us next and how it can continue to enrich the lives of clients and assessors. Finally, we humbly suggest many of you reading this are quite capable of achieving similar success. We hope you'll see that, although doing C/TA for clients using health insurance might seem like a pink cat with antlers, they might actually go together like two women lifting something heavy, together.

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"Why have I always wanted to be dead? When did that start?" Using The Early Memories Procedure in a Collaborative Therapeutic Assessment of a Chronically Suicidal Young Woman Who "Failed" Dialectical Behavior Therapy

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There is a well-known quote from American novelist William Faulkner (1919), "The past is never dead. It's not even past" (p. 73). This quote came to mind repeatedly in thinking about a young woman I will call Charlotte, where the Early Memories Procedure (EMP) proved central in understanding her dilemmas of change and chronic suicidality. While it was a multi-method assessment, the EMP was the key that unlocked the mystery of Charlotte's early depression and persistent suicidality.

Like many referrals for C/TA, Charlotte had been through years of treatment with very limited success. In addition, I am always curious when skillful dialectical behavior treatment does not work for suicidality, since it's a highly effective, evidence-based treatment of choice. Charlotte and her family had participated in a comprehensive, skills-based DBT program with an explicit goal of "building a life worth living." While she benefitted, her suicidality remained impervious and not well understood by her or anyone else, including her highly skilled DBT team.

This collaborative therapeutic assessment did not accomplish a dramatic shift. There were many constraints, yet it was still helpful. Charlotte went to great lengths to open up to me even when the process was painful and the results uncomfortable. Her parents contributed some critical early memories of their own even as they grappled with their intense guilt, burn-out and sadness. No one in the family was willing to follow any of my recommendations, but in the end, Charlotte, the therapist and her family had some possible answers to her poignant assessment question: "Why have I always wanted to be dead?"

The Early Memories Procedure

The EMP was first developed in 1989 by Dr. Arnold Bruhn who specializes in using early memories to understand current conflicts. He developed the EMP to be used as an assessment tool in an evaluation, as well as in early sessions of therapy (Bruhn, 1989). Formulated as a projective technique in the tradition of the TAT and the Rorschach, the EMP is believed to be the only projective test of autobiographical memory. Clients talk to us about their early and more recent memories often in both therapy and assessment; memories are actively constructed and reconstructed and can themselves be stories clients tell about themselves. Early memories can be said to inform an internal blueprint that organizes our responses, much like the internalized map of attachment relationships. The nature of early memories—and how to use the EMP to understand the client's primary unresolved issue and how they got stuck trying to resolve it—can be of critical importance in our assessments.

As a projective technique designed to explore current life concerns, and lending itself well to Extended Inquiry, the EMP is particularly well suited to C/TA. Early memories often reflect the issues we are working on now, and what we remember is not haphazard but rather personally meaningful. What we remember is

also not always an accurate account of the past, and this point is important. How the client constructs the event remembered is what matters—it is not the event itself that is important as much as "how the story is told," in TAT terms. Very clear or vivid memories, particularly negative ones, are conceptualized as "spotlighting major concerns" or highlighting unresolved major issues. Some writers have termed these concerns "the headlines" and Faulkner might have described these as "never dead, or even past." This was certainly the case for my client.

Charlotte

Charlotte was a 21-year-old young woman who had just finished her third year of college when the assessment began. She had grown up in an affluent suburb in Silicon Valley with educated, professional parents who worked in the tech industry. It was a large family; Charlotte had an older brother whom she admired, a twin sister she hadn't been close with since early childhood, and two younger brothers she was fond of, all two years apart.

There was no significant medical history; the twins were born healthy at full term, and there were no developmental problems. According to her mother, the twins were close as small children but Charlotte avoided conflict from the time she was a toddler, always the one to give in, to "go along to get along," whereas her twin, Claire, was defiant, intense, argumentative and "never backed down." Both were successful students, good athletes and had friends. There was no history of mental illness in the immediate family.

At the time of the assessment, Charlotte was living at home with her parents and younger brothers for the summer, taking classes and working part time. Charlotte had two good friends locally, one from childhood and one she met while hospitalized in high school. On the surface, her functioning looked typical for her age, and she had had a successful year at college with strong grades (mostly As), she liked her math major, and she had a plan for living with college friends the following year.

Not so typical, this young woman had felt strongly since childhood that she was "not meant to live," a feeling that became more acute in adolescence. She kept this feeling well hidden till 10th grade, when her twin sister discovered her journal and outed her to their parents, creating a family crisis and an almost two-year cycle of inpatient hospitalization, residential treatment, partial hospital program, and finally an intensive outpatient DBT program, from which Charlotte emerged feeling more "in control" and stable—but less hopeful and still suicidal. These programs all included family therapy, which Charlotte found excruciating. She insisted she wasn't angry that her sister shared her journal writings, though she did not speak to her twin for over a year, and she was adamant that only she was to blame.

Even with high quality and intensive state-of-the-art treatment, Charlotte's feelings and their origins remained puzzling to her and to her family; there was no apparent history of trauma, she was outwardly successful and it was her twin sister who had been the "problem" child. She seemed to herself and others to have "a life worth living" but fought daily with overwhelming depression, hopelessness and wishes to die, most of which she hid effectively from everyone except for her therapist—and now me.

Charlotte was in outpatient therapy weekly with a young, sensitive and talented DBT-trained therapist after completing the comprehensive DBT program in high school. Her therapist had been recommending a collaborative therapeutic assessment for several years to better understand Charlotte's persistent difficulty feeling that her life was worth living. A year after Charlotte left for college, she revealed to her therapist that she had been lying about her mental health and was more suicidal than ever. She also worked with a psychiatrist since high school and had been taking Wellbutrin, Lamictal and Seroquel for several years.

Charlotte presented as a very well put together and attractive young woman who wore a mask (we were past mandatory mask mandates), was guarded in her manner (though not in what she said), and she expressed little emotion. She came to the assessment with low expectations, stating she had felt suicidal as far back as she could remember, and did not even realize it was abnormal to feel that way until she was a young teen. She didn't think or expect that to change, she just wanted to know why. Thanks to her previous treatment she felt more in control but not more hopeful, stating she now felt "if anything, more detached and my will to live is less." She had never made an actual suicide attempt, claiming she would kill herself only if everyone stopped caring about her

because she felt too guilty otherwise. She had plans—or rather fantasies that were comforting to her—but no immediate intent. She believed she had become more skilled at masking her depression, explaining she had short-term plans for her life so she could keep going, but no hope. Her only questions for the assessment were, "Why have I always wanted to be dead? When did that start?"

I thought, "Uh, oh." But Charlotte was willing, appealing, surprisingly curious and able to collaborate, taking off her mask by our second meeting and pushing herself to share difficult feelings and memories with me even when she got very overwhelmed and upset by them. She took care to inform me several times over the course of the assessment that I was getting lucky—sometimes she clammed up entirely, which her therapist confirmed. Once we were past the initial session, there was a flood of memories and very painful feelings that she communicated, usually in writing, and without much emotion in the room.

She explained, as I'm sure she had done many times with many providers, that she had a privileged upbringing with no trauma, abuse or neglect or anything that had caused significant hardship. In fact, she had always been a successful student, a good athlete, with friends, financial security, and an intact family. These statements revealed Charlotte's story about herself: Nothing terrible had ever happened to her, she was just broken and a burden. As we talked and while doing the EMP, Charlotte came up with several other questions for the assessment: "Why was I depressed in the first place? Why did I get more serious about wanting to die in 10th grade? What is the cause of my emptiness?" I wanted to know why she wasn't getting better. Charlotte herself answered one of her questions in the first session, showing strong insight: She believed that she became more suicidal in 10th grade for developmental reasons: she was more aware by then, the stakes were higher, there was more talk of college—and a future she didn't want. We agreed that made sense; it was a start.

I shared my thoughts in that first interview about the limits of our assessment instruments (and my skills) to directly answer some of these questions about the past, especially about when things had started for her, but we agreed to go forward anyway. I wasn't sure what I could do if years of therapy had not answered these questions, but I kept in mind that our assessment tools can be powerful. Charlotte was adamant that she would not see me with her parents in the room. She did not want to stress them out or be stressed by them; she could not talk to them. She did not see them as a resource (a clear red flag), and had not for a long time. She agreed I could speak to them on the phone to collect questions and history as part of the assessment process and maybe share test results at the end. Maybe. There was a clear budget of time and money from parents. Charlotte and I agreed to go forward with these constraints in mind, and, as it turned out, extensive Extended Inquiry with the EMP was the critical piece in this assessment.

Test Results

Charlotte was administered the tests listed in Table 1.

Table 1: Psychological Tests Administered to Charlotte
Minnesota Multiphasic Personality Inventory 3rd Edition (MMPI-3)
Rorschach Performance Assessment System (R-PAS)
Thurston Craddock Test of Shame (TCTS)
Trauma Symptom Inventory-2 (TSI-2)
Behavior Rating Inventory of Executive Function-Adult (BRIEF-A)
Beck Depression Inventory 2nd Edition (BDI2)
Early Memories Procedure (EMP)

Results were mostly Level 1-2 information for Charlotte, revealing a high-risk profile with impulsivity, hypomanic activation, suicidality and profound depression. Results confirmed Charlotte's report that she felt damaged, unworthy, passive in relationships, and that she relied only on herself, shutting down her needs for intimacy and depending on others. Outside of the EMP, Charlotte engaged most with the Rorschach, and I was glad to have a performance

measure with scores (R-PAS). The Rorschach showed how Charlotte was either overwhelmed with her feelings or shut them down entirely. Painful feelings temporarily hijacked her ability to think or reflect, thus her clamming up in therapy sessions when upset. This was convergent data: there were many examples in the EMP of how Charlotte's ability to think and reflect as a coping approach was consistently eclipsed by her painful emotions. Her difficulty telling stories during the Thurston Cradock Test of Shame also showed intense avoidance of feelings, as well as fear of conflict, shame and more fluid thinking when emotions were stirred. As Charlotte herself noted, "It's hard for me to just verbalize things, hard for me in general, it makes them more real…" No competent adults were introduced in her stories.

Although Charlotte knew her executive functioning was impaired, she appreciated it when I said I was struck by how hard she must be working to get the grades she did in college, when the BRIEF-A showed a very significant level of difficulty staying organized, profound depression and difficulties concentrating. I believe Charlotte appreciated that I wasn't seeing her as just impaired or just a success story. I was seeing what her success was costing her and how hard she had to work. In DBT terms, she was successful and a "hot mess" at the same time.

Early Memories Procedure: The Key

Charlotte engaged with the EMP more than with any other measure, in spite of the fact that she clearly struggled with it. We did the first few memories in the office, so it was a shared experience and I could see she had the hang of it, and then I sent the booklet home with her. I got a lot back: Charlotte wrote pages and pages, noting herself that she didn't follow all the directions and was unable to finish. She indicated that many of her memories were important, negative or traumatic. She had trouble choosing and rating them and trouble knowing or describing her feelings. Dr. Bruhn's standardized procedure was not followed exactly, but we were able to see patterns and to begin to collaborate on interpretation, both spontaneously and in the Extended Inquiry; it was incredibly helpful, a good example of "good enough."

At the end of the EMP, there are questions in the booklet: "Are there memories that you recalled in the process of completing the EMP which were just too difficult or painful to write down? If so, can you describe them briefly now?" Charlotte wrote: "I don't like thinking. I'm overwhelmed. I didn't finish." She wrote that she had remembered events that were previously forgotten: "I tried to forget about things. I usually block out that whole sophomore year (high school)." She viewed the memories as experiences that (1) had traumatized her, (2) reflected how she was then, and (3) reflected her concerns, attitudes and needs now. She noted that she learned a "fair amount." At the end she wrote, "I don't think I followed all of the directions, sorry!" I chose not to push for more, observing how painful it was for her and how she tried to "not think or remember" because she felt so alone, overwhelmed with pain and intense guilt, unable to ask for (or feel entitled to) support. This was another moment when I tried to communicate my understanding of Charlotte and her difficulties with reflecting on overwhelmingly painful experiences.

All of Charlotte's memories were told in a way that made it clear that she knew she still feels the way she felt then. The memories were about the present as well as the past. This awareness made collaboration and the Extended Inquiry easier. Charlotte knew in her bones that "the past is never dead—or even past." Interestingly, her most significant memories were about siblings, important relationships too often neglected in psychology. One such was as follows:

Third Early Memory, Age 6-7

We were talking about siblings. Me and Claire did gymnastics in elementary school. My mom was into us trying different sports. It wasn't too competitive, but there were rankings, and Claire and I were equal in terms of athletic ability and academics. I'm not competitive naturally, I'm more passive, and if I win, someone else loses. My success was Claire's failure. People compared us constantly, it's hard with twins. I felt Claire started to resent me with all the comparisons, it got to her. I was like "Yeah, whatever" when people would talk about liking me more. A spot opened up for one rank above us and I heard the junior coaches say there was just one spot and it would either be me or Claire. Claire was more into it, so I didn't try, and Claire moved up.

Clearest part of the memory: "Kind of knowing that, not everyone is going to win. Measuring my feelings."

Strongest feeling: "Tired. Not physically. Realizing I would do this, not try, and let her take it. I was more subdued."

If you could change the memory in any way, what would that be? "I don't like thinking of that. I can't change it. I minimized my achievement to others. I do that now with my grades. It's how I approached relationships, minimizing and making it convenient for others. It's such a long habit, to notice how what I do will affect others. And I didn't confide in anyone. *It's not connected to wanting to die.*"

We returned to Charlotte's need to deny this connection in the Extended Inquiry; it was a "methinks the lady doth protest too much" moment. I could see her extreme avoidance here, not just of her feelings, but of making connections and meaning, which she was able to reflect on with me. It was easier for her to see that her feeling "tired" and "subdued" in this memory could be a sign of depression for a young child.

This memory reminded Charlotte of other, similar memories that took place later (age 13-14); for example, when she and Claire both qualified in a county swim meet to move up to the competition ranks. Claire was really happy, but no one knew Charlotte had also qualified because she kept quiet—and "let Claire be excited and get praise." As she said: "I had no joy or satisfaction in winning." She repeatedly made the point that Claire had never asked for her to hold herself back, no one had, it was her doing and hers alone.

Charlotte's memories showed how she held back her own strivings, dampened and erased herself. For her, there was (is) only room for one to "win" (i.e. exist fully- or have a life). If she felt good about herself, someone else would feel bad—her achievements would be at someone else's expense. In erasing her competitive strivings, self-assertion, and self-interest, she lost her vitality and will to live. Another sibling memory gave us insight into her current attachment dilemmas, self-blame and self-hatred after she texted her older brother to ask him about sobriety in college.

Sibling Memory, Age 16

He said that the first year in college was the roughest for him, sobriety and mental wise. He never went to a therapist, he said he was dealing with a lot of anxiety and stress. He said that some days when crossing the train tracks to work/school he considered just getting run over… He told me that I was his motivation to get better… that he wanted to get better because of me… and I was the reason for him to start to sort things out. I started crying when he told me that. Silently crying so he wouldn't hear me, but crying nonetheless. I didn't really know what to feel. I mean I'm crying right now thinking about it, LOL, He was and still is my biggest role model. I admire him the most, even though I'm not completely sure why, I guess I felt a lot of responsibility when he told me that. Not like he meant to, but I felt like I had made a significant difference, like *I had actually affected something. And I hated it. I felt so guilty. I hated myself. I hate myself. My desire to not have an impact was further shattered.* I mean I'm glad I was at least some use to him, but the idea of being an impact scared me, it made me feel. *It made me feel. I don't know what to feel. I did feel guilty, that was something that I felt. He means a lot to me…*

Charlotte's clearest feeling in this memory was guilt, and it illustrated several of Charlotte's dilemmas of change in her attachment relationships: If she felt love or someone cared for her, or she connected with them and made a difference, it meant she mattered and could hurt them—and that was too painful. Instead of connecting with her brother around the positive difference she had made and their shared depression, Charlotte turned inward and "cried silently," not allowing herself to reach out for nurturance and intimacy. Feeling connected was—and is—just too painful. She couldn't—can't—ask for more support. She couldn't—can't—kill herself because she would hurt others.

It was difficult for Charlotte to choose a "most traumatic memory" but one stood out and illustrates her dilemmas of change in relationships: When she

returned from residential treatment in high school, Charlotte began sharing with her friends more about her distress and what she had discovered. She felt her friends' tiring of her changing moods, and she pulled away. Her closest friend believed a vicious (untrue) rumor about her and turned on her. Here we see how the EMP, particularly negative and vivid trauma memories, reflects the most current attachment problems—her strong feelings of being damaged goods and a burden, or worse, a destructive force:

Traumatic Memory

Emily was one of the ones in the group that I was closest to. I loved her, so it really did hurt… She said that she wished that she had never met me. She said that I had ruined her year. She said that it would've been better if we hadn't been friends. Honestly, I wished she would've told me to kill myself. It hurt. It still hurts so bad. I hate myself. I was a terrible friend… Even now, my first instinct is to forget. To not think about it… A dark part of me was validated at that moment. I was destructive. I am destructive. I need to be suppressed. I cannot feel too much. I cannot care too much. I cannot get too involved. I can't. For the sake of other people. And myself.… I guess this is also a memory that I feel shame from. I can't think about what I would've done or what I would change if I could somehow go back in time. If I could, if I could do anything, I wish I would've killed myself before anything started.

Charlotte could not even imagine a better ending or assign anyone accountability but herself. Again, we saw the fluidity of past and present in the EMP and her intense self-blame: If she's hurt or upset, or if she upsets others, it's her fault—and she's destructive. We agreed this was not a "life worth living" as long as she felt so tortured. Other therapists had tried to convince her she was traumatized based on this memory, and had the right to be angry, but she didn't accept that. She could accept when I softened it to say that her friends were young and immature, and I don't blame teenagers for handling their anger poorly or for being overwhelmed, and they were also cruel. She could accept my saying she was terribly hurt at a vulnerable time, and it wasn't her fault either. We could see her dilemma of change here: She wishes to be "seen," cared for and vulnerable with others, yet her experiences of doing so have left her anticipating (and experiencing) disappointment, abandonment, criticism and rejection.

Charlotte then described intense internalized emotions on a daily basis, including anger, and how she suppressed her feelings, sometimes viciously. Through discussing her memories during the Extended Inquiry, she could begin to see how she made herself smaller and smaller, cutting herself off from her feelings, from her own vitality, unable to express any form of anger or advocate for herself. She was invisible, stuck in a life that was being performed for others. In her letter, I commented that she expressed love and affection in her family as a way of placating them, and that really resonated. Who would want that life?

Mother's Early Memories of Charlotte

I decided at this point to talk to Charlotte's mother to find out more about her early development and history, with Charlotte's permission. What was this young woman like as a very small child? What I got was a tearful account of mother's most significant early memories of Charlotte and Claire, things that Charlotte did not herself remember (age 18 months to about age 3). This phone call was very emotional and was an important contribution to the assessment.

What I learned was that from very early on, Charlotte's twin Claire was a "handful," with big feelings, frequent and prolonged tantrums, and defiance—it often took both parents to cope. Charlotte was the quiet twin, who got quite upset when Claire was having a tantrum or when parents intervened. Her mother described how young Charlotte begged her twin to calm down, stop fighting and comply and was repeatedly very upset when Claire escalated and was held down. She herself ran to her room, made no demands. The parents were very caught up with Claire. Her mother was sure that Claire would be the one with problems later in life.

This view of the twin dynamic tracked with what I heard from Charlotte: From very early on she shrunk herself and her needs to make room for her more assertive and expressive twin. Conflict and anger scared her and felt destructive and out of control.

Mother also reported that Charlotte was quite cuddly as a toddler and young child, which brought a fountain of tears and guilt. She remembered Charlotte wanting to sit in her lap and not having time for that, and wondered, "Did I deny them the affection they needed?" Her mother clearly felt rejected, describing Charlotte as affectionate with the family till age 10, when she withdrew and had been unapproachable since.

I took this information back to Charlotte as evidence for us both that at one time, she had the normal needs of any small child and wanted closeness, protection and comfort from her parents, which she did not remember at all and couldn't even imagine. She could see how her parents got overwhelmed with Claire's needs and left her alone to cope. She could accept my comments that small children in this situation are terribly vulnerable—that they unravel emotionally, feeling frightened, isolated, helpless and overwhelmed with a storm of emotions they can't manage on their own. After a while this dissociated state can lead to numbing, withdrawal, shutting down one's needs or feelings.

While she agreed that this history and her mother's memories were important, Charlotte still struggled to see connections between what happened and the loss of her will to live. I proposed a hypothesis: She had big feelings too, and when she couldn't get her needs for closeness, protection and comfort met (when she saw Claire take up all the space, when everyone was so overwhelmed, when her parents couldn't help her cope with her feelings), she lost her sense of being worthy of love, of having a right to take up space, and this feeling invisible ultimately led to erasing herself and losing her will to live. She was important only as a drain on others.

Self-hatred and emptiness started early, connected to emotional deprivation, anger turned inwards and self-blame. Charlotte tentatively began to make these connections herself, reluctantly, pulling in threads about her history that I didn't know—the classic "new material" in therapy. It didn't change how she felt, but maybe it made more sense. It was clearly a case of failed mourning, which she could begin to see. Knowing why was helpful, though it didn't change how she felt.

Dilemmas of Change and Outcome

In the Summary/Discussion Session, Charlotte and I discussed one of her dilemmas of change: She feels strongly that she cannot let go of suicidal thinking and fantasies as long as her life feels this painful, caught between a death by suicide that she won't inflict on others—and feeling resigned to an empty, tortured, "twisted" life she doesn't want. What she wrote in high school was still true: "I'm scared of wanting to live, because wanting to live means that even if I fail, I have to keep going. It means I can't give up. It leaves no backup plan."

Charlotte was open to the connections we had made between her own memories, her mother's account, and her suicidal feelings, pronouncing it "food for thought" in therapy, "not shocking" but "hard to think about." She liked her letter, thought it rang true, and gave me permission to meet with parents and share the results and the letter, repeating that she would not meet with them herself or discuss the results with them. I sent parents her letter, qualifying that the resulting formulation was not the same as a factual account of Charlotte's history, but was meaningful in helping Charlotte understand her feelings and not condemn herself, which contributed to her hopelessness. As I wrote, "She is adamant that she does not blame anyone in her life and isn't angry with anyone, but she does and has blamed herself—and I tried to soften that. She did resonate with the idea that what has happened to her is no one's fault, including her own. I hope she really believes that now…"

Parent Meeting

Parents were sad, guilty and tearful in our session, clinging to one another on the couch. They were completely receptive to my formulation about early attachment trauma and failed mourning, and appreciated "the thoroughness" of Charlotte's letter, which surprised me. They understood the high-risk nature of the picture, and were willing to continue paying for therapy. However, neither parents nor Charlotte were willing to intensify the treatment to twice a week, which was my main recommendation: long-term, intensive, attachment-based psychodynamic therapy.

Therapy and Future Directions

Charlotte's therapist felt the test results "cracked open" the door to understanding, and described how Charlotte was struggling to talk about it in therapy and open the door further. The EMP in particular, combined with my collaborative approach, inviting Charlotte into the conversation and mentalizing her accurately, had all been helpful to her and to her therapy. To the therapist's credit, she had already shifted away from DBT to a more attachment-based approach and Charlotte was able to ask for more support in the form of an extra session. Though Charlotte was not yet ready to pivot away from suicidality as a central part of her identity and destiny, with support and a different story about herself, I hope that she condemns herself less and that with time, she can take her life in new and more satisfying directions.

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Author Bio

Dr. Santas has been in full-time independent practice in the California Bay Area for over 35 years, doing collaborative assessments and therapy with children, teenagers and adults. She began her career as a psychoanalytic psychotherapist, often seeing patients multiple times a week, and that experience has been invaluable in her collaborative therapeutic assessment work. For over ten years, Dr. Santas has been an Assistant Clinical Professor at UC Berkeley, supervising graduate students in their assessments, and now does supervision and trainings at The Wright Institute in Berkeley as an Adjunct Clinical Faculty member. She completed the Therapeutic Assessment Immersion course in 2017 in Austin, and has presented cases multiple times at the Society for Personality Assessment and at the Collaborative/Therapeutic Assessment Conference.

Spotlight on Recent TA Certifications

Newly Certified in TA

Serena Messina, PhD

Serena obtained her certification in TA with adult clients working in consultation with Dale Rudin in 2023. Serena now works as a licensed psychologist in Austin, Texas, practicing TA and therapy with children, adolescents, families, and adults. Serena offers therapy and assessment services in English, Spanish, and Italian. As an Italian immigrant and an experienced clinician working with a diverse population, she is passionate about considering cultural and ethnic identities as a key factor for the clients' emotional development.

She has published peer-reviewed articles and chapters about attachment, psychopathology, assessment, and trauma. She gave national and international presentations on attachment and related assessment measures, as well as risk and protective factors for emotional wellbeing from an attachment perspective.

Serena completed two doctoral programs, one at "Sapienza" University of Rome and the other one at The University of Texas at Austin. During her first doctoral program, she developed extensive research expertise on attachment theory and was trained by Dr. Deborah Jacobvitz in the Adult Attachment Interview. Serena is trained to administer and reliably code the Adult Attachment Interview, the Reflective Function System, and the Manchester Child Attachment Story Task.

Once she moved to Austin in 2009, Serena obtained a position as a lecturer and visiting scholar at the University of Texas at Austin, where she continued doing research on attachment with Dr. Jacobivtz and where she taught Child Development and Developmental Psychopathology classes.

In 2010, Serena started her doctoral program in School Psychology in the department of Educational Psychology at the University of Texas at Austin. The focus of this second doctoral program was primarily clinical, and through the program Serena gained significant experience in counseling, consultation, and assessment in public schools, inpatient psychiatric hospitals, and mental health community agencies. Serena completed an APA-approved pre-doctoral internship at Fort Worth Independent School District, serving children across K-12 educational settings. During her internship, Serena developed extensive expertise in bilingual assessment (English/Spanish) of both academic and socio-emotional difficulties in children and adolescents.

Serena was first exposed to the TA model during her doctoral program at the University of Texas at Austin, where she had the opportunity to work with Dr. Steve Finn and Dr. Deborah Tharinger. Serena was immediately fascinated by the power of the TA model, which corresponded with her passion for attachment with the assessment tools and model.

Serena completed her post-doctoral year at Austin Child Guidance Center, where she offered therapy and assessment to children and families, as well as supervision to practicum psychology students. She then was hired as the bilingual psychologist on staff and worked there until 2020. Her work at Austin Child Guidance Center allowed Serena to develop a deep awareness of how trauma impacts children's emotional functioning and diagnostic presentations within the assessment process. At the same time, Serena was able to incorporate more and more collaborative and therapeutic practices within her assessment work.

In 2018, Serena started her private practice and sought both group and individual consultations with Dr. Stephen Finn and Dr. Dale Rudin, to be able to fully incorporate the TA model within her clinical work. She is truly enjoying being part of the TA community, both on a professional and personal level.

In her personal life, Serena loves spending time with her husband and two kids. She enjoys traveling, going back to Rome, and visiting her husband's family in Taiwan and China. She is a tango dancer and loves taking classes and getting together with the Austin

Society for Personality Assessment (SPA) Pre-Conference Institute on Therapeutic Assessment

March 28, 2023
Austin, TX

Stephen Finn presents: *What We Have Learned from 30 years of Being in Our Clients' Shoes.*

Some of the conference participants settle in for the afternoon presentations.

TAI board members JD Smith and Pamela Schaber enjoy a pre-dinner drink with Mike Troy (Retired, Children's Hospital Minneapolis, MN).

Alessandro Crisi (Italian Institute of Wartegg, Rome) and Filipo Aschieri (Università Cattolica del Sacro Cuore, Milan) make a toast.

Over 80 friends and colleagues gathered for a barbeque dinner to celebrate the 30-year anniversary of the Center for Therapeutic Assessment.

Recent Publications

- Asai, K., & Asai, K. (2023). Therapeutic assessment with brief therapy: A single case study of an elementary student's school refusal. *International Journal of Brief Therapy and Family Science, 13*(1) 43-49.

- Aschieri, F., van Emmerik, A. A. P., Wibbelink, C. J. M., & Kamphuis, J. H. (2023). A systematic research review of collaborative assessment methods. *Psychotherapy.* Advance online publication. https://doi.org/10.1037/pst0000477

- Da Fonseca Glasson, F., Cardoso Ribeiro, L., & Morales Cardoso, L. (2023). O florir da violeta: Um estudo de caso em Avaliação Terapêutica [Violet blossom: A case study in Therapeutic Assessment]. *Psicologica: Ciência e Profissão*, *43*, 1-15.

- Dorceus, S., Le Corff, Y., & Yergeau, É. (2023). Representations of guidance counselors, psychologists, and psychoeducators regarding psychological assessment. *European Review of Applied Psychology, 73*(2). Advance online publication. https://doi.org/10.1016/j.erap.2022.100821

- George, C., Wargo Aikins, J., & Lehmann, M. (Eds.). (2023). *Working with attachment trauma: Clinical application of the Adult Attachment Projective Picture System.* Routledge.
  - *From unresolved to earned secure attachment: The AAP as a powerful clinical tool in psychotherapy.* Stephen E. Finn.
  - *Opening the attachment trauma floodgates: Preoccupation with personal suffering.* Caroline Lee & Carol George.
  - *Failed Mourning: The sounds of silence.* Melissa Lehman.

- Mercer, B. L., Macdonald, H., & Purves, C. (Eds.). (2023). *Psychological interventions from six continents: Culture, collaboration, and community.* Routledge.
  - *Introduction: Culture, collaboration, and community.* Barbara L. Mercer, Health MacDonald, & Caroline Purves.
  - *Beginnings: Psychological service delivery.* Barbara L. Mercer.
  - *Assessment, training, and social justice in community psychology.* Health Macdonald, Barbara L. Mercer, & Caroline Purves.
  - *Assessment of Japanese children: Hikikomori.* Noriko Nakaumura.
  - *Growing empathy with complex clients in developing countries: Collaborative/Therapeutic Assessment in Latinoamerica.* Ernesto Pais & Daniela Escobedo-Belloc.
  - *Collaborative assessment from a transcultural perspective: Cooperativa Crinali's experiences in Milan, Italy.* Marta Breda, Nicole Fratellani, Francesca Grosso, Ilaria Oltolini, Benedetta Rubino, & Stefania Sharley.
  - *"Different cultures wear different shoes!" Therapeutic Assessment with a 17-year-old immigrant boy in the Netherlands.* Hilde de Saeger & Inge van Laer.

- Waldron-Perrine, B., Rai, J.K., & Chao. D. (2021). Therapeutic assessment and the art of feedback: A model for integrating evidence-based assessment and therapy techniques in neurological rehabilitation. *NeuroRehabilitation, 49*(2), 293-306. doi: 10.3233/NRE-218027. PMID: 34420989.

Upcoming Trainings

June 9 – 10; Milan, Italy

Grandiosità, svalutazione, esibizionismo e aggressività: come i test ci aiutano a comprendere pazienti "impossibili". L'Assessment Terapeutico di Madeline G.

Presenters: Stephen E. Finn, Filippo Aschieri, Camillo Caputo, Erica Dell'Acqua, & Francesca Fantini.

Sponsors: European Center for Therapeutic Assessment

Language: Italian

Schedule: June 9, 9:30 AM – 6:00 PM; June 10, 9:30 AM – 5:30 PM

Information: https://inbreve.unicatt.it/sws-assessment-terapeutico

June 23; Virtual

"What If I tell you I think it's all BS and I want a real diagnosis?" Finding therapeutic dialogue in MCMI-IV and MACI-II to enhance Collaborative/ Therapeutic Assessment impact (2 CE Credits)

Presenter: Seth Grossman

Sponsor: Therapeutic Assessment Institute

Language: English

Schedule: June 23, 10:00 AM – 12:00 PM CDT

Information: www.therapeuticassessment.com

July 28 & 29; Virtual

Therapeutic Assessment with Children & Adolescents (8 CE Credits)

Presenters: Raja M. David & Alison Wilkinson-Smith

Sponsor: Minnesota Center for Collaborative/ Therapeutic Assessment

Language: English

Schedule: July 28 & 29, 10:30 AM – 2:45 PM CDT

Information: www.mnccta.com/training-consultation

September 8; Virtual

Attachment and Diversity: Integrating Universal and Contextual Dimensions. (2 CE Credits)

Presenter: Serena Messina

Sponsor: Therapeutic Assessment Institute

Language: English

Schedule: September 8 10:00 AM – 12:00 PM CDT

Information: www.therapeuticassessment.com

October 8 - 9; Tokyo, Japan

Case Consultation on a Client with Severe Shame

Presenters: Stephen E. Finn, Noriko Nakamura, Alessandro Crisi, Francesca Fantini, & Julie Cradock O'Leary

Sponsor: Asian-Pacific Center for Therapeutic Assessment

Language: Japanese

Schedule: October 8 and 9, 10:00 AM – 6:00 PM

Information: https://www.asiancta.com

Upcoming Psychological Test Trainings

June & July; Virtual

Level 1 Training on the Crisi Wartegg System (CWS): Introduction, Administration, and Scoring (13 CE Credits)

Presenter: Jacob A. Palm

Sponsors: Southern California Center for Collaborative Assessment & Istituto Italiano Wartegg

Language: English

Schedule: June 9 & 30, July 14 & 18 (9:00 AM – 12:30 PM CDT)

Information: www.sc-cca.com/CWS-Trainings.html

Upcoming Trainings: Continued

June, July & August; Virtual

Level 3 Training on the Crisi Wartegg System: Intermediate Interpretation and Case Conceptualization (16 CE Credits)

Presenter: Jacob A. Palm

Sponsors: Southern California Center for Collaborative Assessment & Istituto Italiano Wartegg

Language: English

Schedule: June 16, July 7 & 21, August 4 & 18 (9:00 AM – 12:30 PM CDT)

Information: www.sc-cca.com/CWS-Trainings.html

June 15 - 17; Virtual

Introduction to the Rorschach Performance Assessment System (R-PAS) for Users of Exner's Comprehensive System (CS) (14 CE Credits)

Presenters: Donald Viglione & James H. Kleige

Sponsors: R-PAS

Language: English

Schedule: June 15, 16, & 17 (11:00 am to 4:30 pm EDT)

Information: r-pas.org/#Trainings

September 21 – 23; 26 & 27; Virtual

Introduction to R-PAS: Rationale, Administration, Coding, and Interpretation (25.5 CE Credits)

Presenters: Donald J. Viglione, Philip Keddy, & James H. Kleiger

Sponsor: R-PAS

Language: English

Schedule: Sept 21, 22, 23, 26 and 27 (11:00 am to 5pm EDT)

Information: r-pas.org/#Trainings

October; Virtual

Adult Attachment Projective Picture System Fall 2023 Classification and Coding Training Webinar

Presenter: Melissa Lehman

Sponsor: Adult Attachment Projective

Language: English

Schedule: October 6, 13 – 16, 20, & 22 (11:00 AM – 3:00 PM CDT)

Information: www.attachmentprojective.com/training-consultation

October 20 & 21; Virtual

Introduction to the Rorschach Performance Assessment System (R-PAS) for Users of Exner's Comprehensive System (CS; 14 CEs)

Presenter: Gregory J. Meyer

Sponsors R-PAS

Language: English

Schedule: October 20th and 21st (9:00 am to 5:30 pm EDT)

Information: r-pas.org/#Trainings