THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

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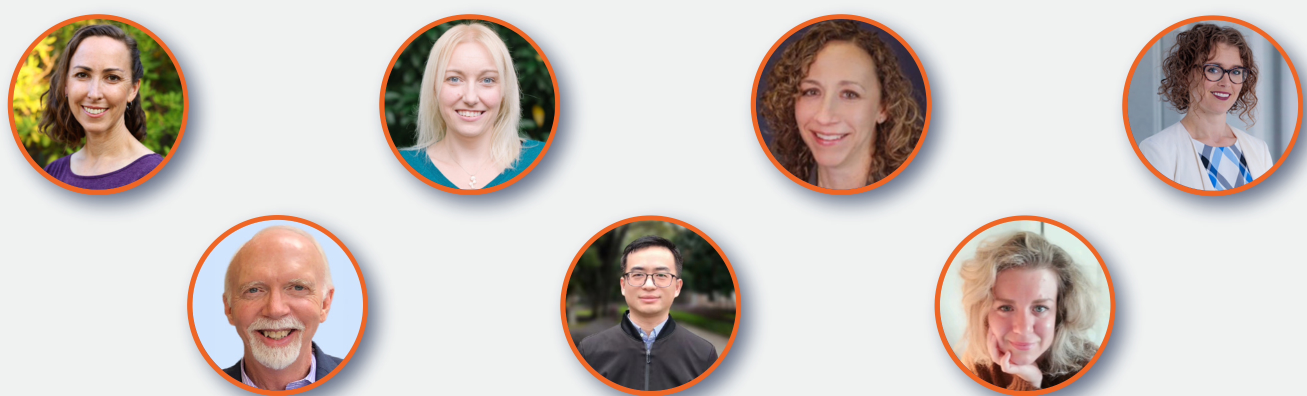

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Special Issue: Integrating TA Concepts, Skills, and Values in Neuropsychological and Educational Assessments with Children and their Parents

Raja M. David, PsyD, ABPP
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This Issue

My first exposure to the therapeutic power of psychological tests was through an unexpected source. I was a doctoral student enrolled in an interventions class, and our textbook was *Current Psychotherapies* (1995), which comprises separate chapters on psychoanalysis, person-centered therapy, cognitive therapy, and other theoretical orientations. In the introduction by co-editor Raymond (Ray) Corsini, he described "an unusual example of psychotherapy" that he believed to be "the most successful and elegant psychotherapy" he ever provided. In a brief vignette, he described a conversation with an inmate who asked to meet Ray, then a prison psychologist. The man was about to be released, and he wanted to thank Ray for changing his life. This proclamation was confusing to Ray, as he had not provided psychotherapy to this man, and after reviewing his notes, realized he only met with him to complete IQ testing. Following testing, he shared the results that indicated the man had a high IQ. Upon hearing this, the man changed his behaviors and associated with other inmates who were not "criminal types," enrolled in a drafting course, and made plans to attend college upon his release. The man's self-narrative (my language) shifted, and he no longer thought of himself as "stupid" or "crazy," as his family members had called him, but his interest in long novels, crossword puzzles, and classical music suddenly made sense to him.

This testing occurred during an era where the information gathering model of assessment was the norm. And yet, I wonder how Ray may have employed those values and skills fundamental to the TA model to help this man shift his narrative. While he worked in the prison system for some time, he was also an Adlerian psychologist who studied with Carl Rogers, and so perhaps had an interpersonal stance that was respectful, humble, and compassionate, allowing epistemic trust to grow. The inmate's description of the shift that occurred sounds like what can happen for TA clients when implicit schemas are given language and made explicit, thus creating a more realistic self-narrative, which contributes to a sense of security and growth.

Regardless of the factors that contributed to that change, it was a vignette that stuck with me. It is a simple illustration of how cognitive test results can be highly impactful. Testing psychologists frequently work with children and their parents, and these assessments are a unique opportunity to shift not only the child or teen's sense of self but also the parent's narrative, as the authors in this edition will describe. I am sincerely grateful to our authors who generously contributed their time to this edition, and they were sought given their high level of expertise conducting cognitive and neuropsychological testing with children and adolescents.

First up, Liz Angoff shares her creative ideas about working collaboratively with children when conducting cognitive testing. She includes practical advice for bringing children along in the process and demonstrates how they are a *key resource* for enhancing psychological assessment.

Next, Stephanie Nelson has written a lovely article describing her experiences as a neuropsychologist who has incorporated TA concepts, skills, and values into her work. How does a traditionally trained assessor shift from standard feedback to parents to something more meaningful? Read Stephanie's article and you'll find many ideas that you can begin applying to your work.

Third, Melinda Kulish and Jennifer Boike-Armerding share their experiences of working collaboratively with children with right hemisphere deficits. In a humorous and insightful way, they help us think about such clients, and how TA techniques and values help inform both the case conceptualization and interventions that can shift a parent's narrative.

The last article in this edition is the speech presented by Steve Finn in honor of Connie Fischer, who was awarded the *Distinguished Contribution to Assessment Award* by the Assessment Section of the Division of

Clinical Psychology, during APA's 2023 annual convention. It is an appropriate addition for this edition, as Connie was a master at using cognitive tests such as the Bender Visual-Motor Gestalt Test and the Wechsler instruments to illuminate client's difficulties and build insights.

Next, we celebrate two newly certified TA assessors. Qi-Wu Sun received certification in the adult model and is the first Chinese psychologist to complete the TA certification process. Annemiek Laros also achieved certification in the adult model and practices in the Netherlands. Besides conducting TAs, Annemiek is a teacher and shares with her students TA ideas. We also include photos from a recent training conducted by Steve in Wuhan, China. Over the past few years, interest in TA has grown rapidly in China, and several TAI faculty have been educating psychologists in both academia and clinical settings. The growth of TA in China has been very exciting. The demand for psychological services in China is high, and our Chinese colleagues are seeing how the TA model can lead to significant client changes in only a few sessions.

Reference

Corsini, R. J. (1995). Introduction. In R. J. Corsini & D. Wedding (Eds.) *Current psychotherapies*, 5th Edition (pp. 1-14). F. E. Peacock Publishers, Inc.

TA Trainings

Spring 2024 has numerous trainings for those wishing to build their TA skills. The TAI continues to offer monthly trainings, and on January 19th, Seth Grossman will present on using the MACI and M-PACI in a collaborative fashion. Next, on February 23rd, yours truly and Abby Hughes-Scalise will present on dissociation and somatic presentation in adolescents, and how to help families think systemically about these symptoms. In addition, there are many TA related offering this spring at the Society for Personality Assessment (SPA) Annual Conference being held in San Diego, CA. See p. 33-36 for more details on these trainings and others.

Become a Member of the TAI

The Therapeutic Assessment Institute (TAI) began offering memberships in 2017 and currently has over 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. To join, go to the TA website at **www.therapeuticassessment.com**

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

This edition is the second to focus on a specific test as part of a TA [See the Fall 2022 edition which focused on the Wartegg Drawing Completion Test (WDCT) Crisi Wartegg System (CWS)]. If you have ideas about areas of focus for special editions or have ideas for articles that you'd like to see included, please share your ideas.

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

Empowering Assessments: Engaging Children as Authentic Collaborators in Neuropsych Assessment

Liz Angoff, PhD, LEP, ABSNP
Private Practice

Traditionally, neuropsych assessment is something we do to children.

First, we meet with parents, teachers, and other adults to understand their questions. Next, the child comes in to "play lots of brain games" and perhaps walk away with a prize. Later, the adults meet to talk about what we learned and decide what to do about it.

However, this traditional approach to assessment misses a *key resource* for understanding the problem, interpreting results, and designing intervention: the child themselves.

In other words, what if we thought of neuropsychological assessment as something we do with children?

Collaborative/Therapeutic Neuropsych Assessment

Collaborative/therapeutic assessment (C/TA) is often associated with psychological assessment, yet there is a strong history of practitioners using these methods in neuropsychological assessment with adults as well.

For example, even in the early days of neuropsychological testing, Luria used a method of "neuropsychological investigation" to enhance a patient's awareness of their strengths and weaknesses, as well as to elicit the patient's input to help formulate the diagnosis and plan treatment (Gorske & Smith, 2008).

In her pioneering work, Fischer (2010) also detailed the power of using cognitive assessments as therapeutic and collaborative tools. She describes "interrupt[ing] standardized procedures at natural breaks, such as at the end of a subtest" (p. 5) to share observations and get the client's feedback on whether these were accurate.

Finally, Gorske and Smith (2009) showed that integrating C/TA techniques into neuropsychological assessments with adults results in deeper insight, better understanding, and perhaps most importantly increased engagement in treatment.

Given the power of C/TA and Therapeutic Assessment in psychological assessments for children and teens (Tharinger, et al., 2008), it would make sense that we could build on this history of collaborative *neuropsychological* assessment to create a model of engaging children and adolescents in cognitive testing in the same way.

In my own practice, I have been considering the following four components to help create a more collaborative process:

- **Intake:** Creating meaningful assessment questions with kids
- **Testing Sessions:** Building a shared language
- **Child Feedback Session:** Co-authoring a new narrative
- **Treatment Planning:** Fostering self-advocacy and empowerment

Intake

Creating meaningful assessment questions with kids

One way to think about the intake process is "socializing the patient to the assessment" (Gorske & Smith, 2009, p. 53.) When approached in this way, we are being transparent with the client about why they are there and what we are looking for, thereby reducing anxiety and increasing engagement in the process.

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Part of this process is creating meaningful assessment questions. As Tharinger, et al. (2010) wrote:

> *Creating assessment questions fosters enhanced motivation to contribute to the assessment by allowing the child, parents, and teachers to take some ownership of the assessment process, and to know that they will receive feedback that is important and meaningful to them. (p. 244)*

In my own work I have found that "creating assessment questions" is a process. While many adults come in with specific questions, children often do not. However, the process of creating these questions can be in and of itself an impactful part of the assessment.

Parent Questions

Sawyer is a 15-year-old child with a history of difficulties with school, attention, motivation, and friendships. At the intake session, his parents came ready with very specific questions. They wanted to know:

- How do we increase his motivation to do well in school?
- How do we help him pay attention and participate in class?
- How do we address his difficulties with peers?

While they were both very invested in the assessment, Sawyer was not.

> *He's upset with us that he has to come in for this. He doesn't want to miss any school.*

At one time I would have assured them that most kids find the testing "fun" and we would come up with a reward he could earn.

But in the past few years, I have taken a different tack. Instead, I asked,

> *How does Sawyer describe the problem?*

Like most parents, this gave them pause. They had never thought about it before.

Together, we thought about recent events when Sawyer was unmotivated, had difficulty getting started on an assignment, or procrastinated.

*He says **he's tired** and that **we nag him** too much.*

The way that adults describe problems and the way children describe these same challenges can differ greatly. **However, if we want to engage children authentically in the assessment process, we need to help them solve a problem that is meaningful to them.**

Therefore, while Sawyer's parents had come in hoping to solve the "motivation" problem and the "participation" problem, Sawyer was much more likely to be interested in the "tired" problem and the "nagging" problem.

I suggested introducing testing as a way to solve these problems for Sawyer:

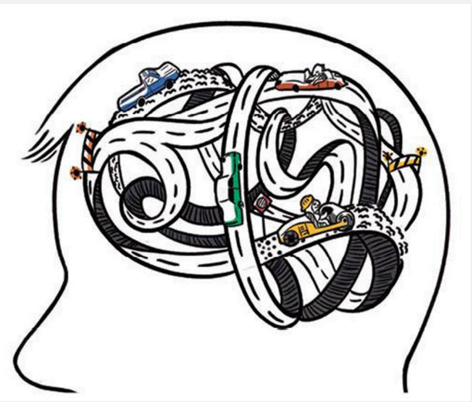
> *You know how you've been saying you're always so tired after school and you don't have enough energy to do your homework? I've hated the way this is getting us into a nagging battle, and I want to learn more about how you can feel less tired and we can do something different than nag. We met with someone who we think can help.*

Once Sawyer's parents presented testing as a way to solve a problem that was relevant to Sawyer, he was intrigued, and agreed to meet with me.

Child Questions

At the child's first session, my goal is to help them ask their own assessment questions. However, as mentioned above, this is easier said than done.

Consistent with Gorske and Smith's (2009) concept of "socializing the patient to the assessment," I have found that being transparent about what we are doing is key to helping kids get curious. So, we start with the brain, using a construction metaphor.



ExplainingBrains.com/brain-visuals

Your brain is made of many different parts, all working together to help you learn and do what you want to do. Your brain works by sending messages from one part to another using special cells called neurons. These neurons connect with each other, making new pathways, like billions of tiny roads in your brain.

Some things come easily. You can think of these as your brain's highways. Some things are trickier or may take longer to learn. You can think of these as your brain's construction projects, or the skills you are building.

In our work today, we'll do a number of different activities to help us understand your highways and construction projects. Some of these tasks will feel easy, others will challenge you on purpose. Your job is to let me know what your experience is so I can understand how your brain works with different kinds of problems.

This metaphor has been a helpful invitation for the child to be a collaborative partner in the assessment, shifting their experience from "I'm being judged" to "we are detectives." We document our discoveries using tools like *The Brain Building Books*, or the handout:

Assessment Summary

Helping you understand your amazing brain!

Question or Concern	
Highways	**Construction Projects**
Helpful Words	**Tools and Construction Crew**

Once we are on the same page, I use the following strategies to help children articulate their questions:

Strategy 1: Brain Observations

As we talk about the brain, children often make observations or share information that lead to an assessment question. At one point Sawyer commented,

It's funny - I pay attention just fine when I play video games but everyone is always telling me I don't pay attention.

This became our first question: *Why is it easy to pay attention to video games but not in class?*

Strategy 2: Agree or Disagree

Based on the conversation with his parents, I asked Sawyer what he thought about his difficulty getting motivated to do homework.

One of your parents' questions was why it's so hard to get motivated to do homework. Do you agree that motivation for homework is hard, or would you say it differently?

Sawyer explained it this way:

I'm spent after school and then my parents are on my case to do homework but I just need a break!

This became our second assessment question: *Why am I so tired at the end of the day?*

Strategy 3: Magic Wand

As we ended our initial interview, I asked Sawyer, *If you had a magic wand, what's one thing you would change about your life right now?*

He shared that he wished the semesters were half as long, because he always seemed to do well at the beginning, but fail by the end, meaning that all his initial work was for naught. This turned into our third, and most important, assessment question:

How do I get through the year sustainably?

Strategy 4: Testing Observations

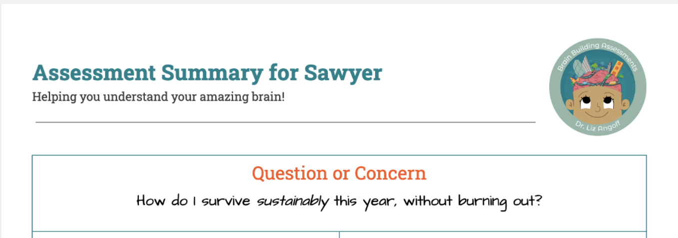
While Sawyer had a lot to say in this initial interview, many children have difficulty articulating their frustrations as well as he did.

When kids are having difficulty, one final strategy is to use the testing itself. I keep my eye out for tasks that seem challenging, tasks that are tiring, or tasks that motivate them more than others. It may sound

like this:

> *I noticed you seemed tired during the reading task but you perked up when you were doing the math problems. I wonder if a good question would be, Why is reading more tiring than math?*

If they agree, we write it down:


Assessment Summary for Sawyer
Helping you understand your amazing brain!
Question or Concern
How do I survive sustainably this year, without burning out?

Find this handout at
www.ExplainingBrains.com/Practitioners

Testing Sessions

Building a shared language

In C/TA, "the patient is seen as the expert on themselves, while the clinician has knowledge and expertise that may help explain aspects of the patient's cognitive and behavioral functioning" (Gorske & Smith, 2009.

This is also true for children, though they may not yet be able to verbalize their self-expertise. Through testing, with strategic inquiry, we can help them put words to their lived experience.

Collaborative Reflection

Now that the child has some "starter" language for talking about what comes easily and what is more challenging through the metaphor of highways and construction projects, we can ask some strategic questions to help them articulate their experience during the testing itself.

These reflections not only help the child advance their own understanding of how their brain works, but can often offer key information to our own analysis.

It is worth noting that asking children to reflect on their experiences *during testing* is a paradigm shift. Standardized administration means giving cognitive and processing tests in a very specific way, without giving the child feedback.

However, as Gorske and Smith (2009) describe, to truly understand what we are seeing in our testing:

> *The clinician must first elicit answers from the patient in regard to how they saw their performance, what skills they see the test measuring, and how the skills related to the patient's daily life (p. 84).*

To this end, building on the approach Fischer (2010) described above, I have found it helpful to ask the following questions during natural breaks, after standardized administration is complete:

- What was that like for you?
- What was hardest and what was easiest?
- I noticed…is that right or would you explain it differently?
- Did you use any strategies to do that task?
- Does this remind you of anything from your life?
- If we could change anything about the task to make it easier, what would that be?

Here is what this sounded like for Sawyer.

Sawyer and I began testing with the WISC-V. Once we finished the 10 standard subtests, I asked,

> *Of everything we just did, which was hardest and which was easiest?*

When asking this question, I am most interested in the child's experience of the tasks, rather than their objective performance. In fact, I rarely share "how they did," but rather use this as a way to understand how they are approaching different kinds of tasks and how much cognitive energy they are expending.

Sawyer shared that the Vocabulary task felt the easiest, but the Matrix Reasoning task was "so infuriating!"

He explained it this way:

> *I wanted you to tell me if I was right or wrong - I need feedback!*

With a little probing, Sawyer was able to explain that he finds it helpful to "get feedback" on whether he is on the right track. He shared that quite often he will complete an assignment only to find out that he had done it incorrectly, and then he would have to redo it - "so infuriating!"

When he gets feedback along the way, he can course correct so he is not expending a ton of mental energy.

This concept of "needing more feedback" became a key insight for understanding why Sawyer was burning out so easily every term.

Next, I gave Sawyer the WRAML-3. Again, we completed the full battery in a standardized way. This time as I transitioned the testing materials, I shared an observation:

> *I noticed that you seemed to remember the stories pretty easily, but when I read you the list of words you suddenly seemed exhausted. Did I get that right?*

Sawyer agreed. He explained that the story felt like "one thing" while the word list was "lots of things."

> *It's like trying to juggle. I can do one ball just fine but if you ask me to start juggling a bunch of balls, they all fall down.*

This metaphor of juggling is a helpful way to understand working memory and organizational challenges, both of which were critical for understanding Sawyer's profile.

While there are many ways to explain working memory and organizational challenges, **Sawyer's own words were the most powerful** in helping to grasp how these difficulties were impacting his life.

Another key example for Sawyer came from the DKEFS Verbal Fluency task. Again, I gave this test using standardized procedures, though Sawyer was clearly frustrated by the task and commented, "Well that was a fail!"

This time, I told Sawyer I agreed it seemed really hard for him.

> *I think we found a construction project*, I reflected. *Let's figure out what's happening.*

While I was concerned that Sawyer would shut down, he reacted with curiosity - perhaps because he knew from our intake interview that we would be encountering challenges like this.

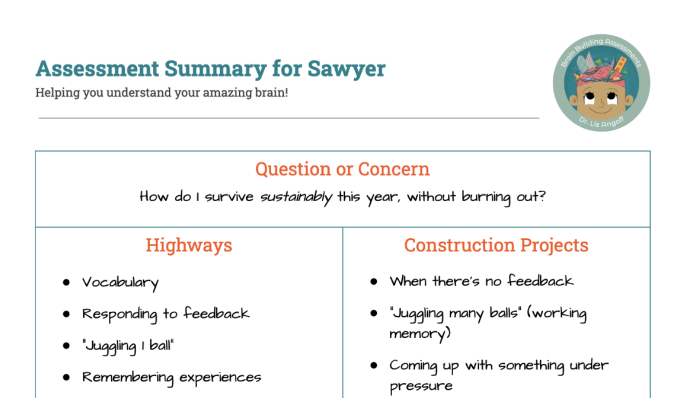
Sawyer first shared that he felt pressured by the 60-second time limit.

> *I don't do well under pressure.*

I asked if this reminds him of anything from his daily life.

> *Yes! It's like in class when they ask you a question and want you to answer right away. I always get nervous - I used to make jokes but that didn't work out for me so well.*

This insight revealed some important information about Sawyer's processing and how it was affecting his daily life. Sawyer takes longer to formulate his thoughts, which was making participating in class discussions challenging and anxiety-provoking.



Assessment Summary for Sawyer

Helping you understand your amazing brain!

Question or Concern	
How do I survive sustainably this year, without burning out?	
Highways	**Construction Projects**
• Vocabulary • Responding to feedback • "Juggling 1 ball" • Remembering experiences	• When there's no feedback • "Juggling many balls" (working memory) • Coming up with something under pressure

Find this handout at www.ExplainingBrains.com/Practitioners

Based on our collaborative reflection, Sawyer and I walked away with some key insights about his story:

- Sawyer often has to redo work because he goes off on the wrong track, and this is infuriating.
- Sawyer struggles much more than others to "juggle" multiple pieces of information.
- While he is very knowledgeable, he has difficulty coming up with information quickly, especially in group or social situations, which causes a lot of anxiety in class and with friends.

No wonder he is so exhausted at the end of the day!

Child Feedback Session

"Co-authoring a new story" (Tharinger, et al., 2010)

Using collaborative reflection around the specific tests, we had started to "co-author a new story" for Sawyer.

Sawyer is not lazy (as his parents worried) or dumb (as he assumed.)

Rather, as he explained himself, Sawyer is a knowledgeable person (Vocabulary) who works best when he can focus on one thing at a time (Story Memory) and has time to process (Verbal Fluency.) Sawyer is exhausted at the end of the day because his brain uses a lot more energy than adults realize ("I need feedback!") to juggle multiple things at once and come up with answers on the spot.

No Surprises

When sharing testing results with families, Therapeutic Assessment describes 3 "Levels" of information (Tharinger, et al, 2008). Lower levels of information are easier to process because they are consistent with their story. Higher levels of information are more challenging for individuals to accept, as they go against how they think of themselves or their story.

During the testing process, one of our goals is to move information from higher levels to lower levels, helping parents increase their empathy for their child and shift their lens in service of helping them take steps forward.

The process detailed above helps us communicate testing results to children in two important ways:

1. We are able to move "Level 3" information to Level 2 or even Level 1 as children begin to reflect on their experiences.
2. We hear from the child what they already understand so that our feedback session simply becomes a recap of what they already know.

In this way, we can help children develop a strong, positive, and helpful narrative about their strengths and challenges without overwhelming them or "surprising" them at the feedback session.

Co-Authoring a New Narrative

Sharing testing results with children is a chance to bring together what we already know (Level 1) and use that language to help them understand their profile or diagnosis (often Level 2.)

Here is what this looked like for Sawyer at his feedback session.

Me: *Sawyer, thank you for coming in today - I'm really excited to talk about what we learned. What do you remember from what we did together?*

Sawyer: *I remember that you wouldn't give me any feedback and I got so mad at you! But I get it, those were the rules. I was also thinking about the memory thing - that I was good at stories but bad at the word list - and I realized that I can remember stories from my own life from like 5 years ago - but I can't remember what my mom told me to do 5 minutes ago. Is that a thing?*

Me: *You're right on. I think you described how your brain works quite well. You do best when you can get a lot of feedback to make sure you're staying on track, and you've got a good memory for things that happen, but it's hard to keep a bunch of little details in mind - like a to-do list.*

Sawyer: *Like juggling lots of balls.*

Me: *Exactly. It turns out, you're not alone. Lots of people have brains with strengths and challenges just like yours. This is what we mean by ADHD.*

Sawyer: *Wait - I thought ADHD just meant I can't pay attention.*

Me: *Well, it's more nuanced than that. ADHD means that your brain does really well when you have one ball to juggle at a time and remembers events and experiences that are important to you; but it can be harder to juggle lots of balls at once or remember things that don't feel as important.*

Sawyer: *Yep! That's me.*

Me: *There was one other thing that felt important to know about your brain. Do you remember when I asked you to say a bunch of words in 60 seconds?*

Sawyer: *Yeah - I hate it when I have to do things fast like that.*

Me: *Exactly. I noticed that you are quite thoughtful and reflective when you have time to process, but it's really hard under pressure. I'm wondering if this is what's getting in the way in class or even with friends.*

Sawyer: *Yes to class - no to friends, unless I'm in a big group, and then I get really anxious.*

> Me: *Interesting. I wonder if you may be feeling anxious in big groups because you're feeling that pressure to respond. Social conversations go really quickly and there's a lot going on.*
>
> Sawyer: *Like juggling lots of balls.*

It is important to note that in this conversation we were not only focusing on the positives. In fact, we talked a lot throughout our session about what was hard.

Yet for Sawyer, this felt incredibly validating, because we had reframed the "lack of motivation" problem, which was not what Sawyer experienced - he really *wanted* to do well - to a "difficulty juggling lots of balls" problem, which more accurately described what Sawyer was experiencing.

It is worth noting that both framings capture what is hard for Sawyer. He has difficulty turning on motivation and getting started.

However, this alternate framing, which came directly from him, is more relevant not only because it describes his experience, but because we can use this frame to help him understand **why the interventions we put in place will help him feel less tired at the end of the day.**

This is what we wrote down on the summary handout:

Helpful Words	Tools and Construction Crew
• ADHD means... *Your brain does really well when you have one ball to juggle at a time, real-world experience, and lots of feedback; but it can be harder to juggle lots of balls at once or show what you know in the moment.* *"ADHD means I can remember things from 5 years ago but not 5 minutes ago." ← great quote from you :)*	• Immediate feedback • Extended deadlines and time • Homework and planned presentations are easier than tests • Brain-rejuvinating activities: video games in moderation, exercise, cat time • Help planning larger projects

Find this handout at
www.ExplainingBrains.com/Practitioners

Treatment Planning

Fostering self-advocacy and empowerment

Once kids have a language for explaining their experience, we can use this information to develop a meaningful treatment plan.

In Gorske and Smith's work (2009), using C/TA strategies in neuropsychological testing increased patient participation in treatment and interventions. It would make sense that the same would be true for children.

Self-Advocacy in the Family

After Sawyer and I spoke, I invited his parents into the room and asked him if he would share what he learned from our conversation.

> *Well, I think we figured out why I'm so tired at the end of the day.*

Sawyer went on to explain how difficult it was juggling multiple things at once, how he felt like he was constantly having to redo work he had already done because no one told him he was on the wrong track, and that it takes him longer to process what people say, which was stressing him out.

Now, we could talk about what we could do to help so that he wouldn't be so tired and could get through the year - *sustainably*.

Self-Advocacy at School

For Sawyer, this language was especially powerful at his IEP meeting.

Like many high school students, Sawyer was asked to participate in his IEP meetings, though he rarely said anything. But, this meeting was different.

When I presented the testing results to the school, I used his words to help explain the results. Here's an example of what it sounded like:

> *Sawyer has a number of clear strengths. He is very verbal and did well with vocabulary and remembering stories. At the same time, there were things that were harder to remember. Sawyer, can you share what you told me about how you can remember things from 5 years ago but not 5 minutes ago?*

Since these were Sawyer's words, he was able to describe what he meant without difficulty - even though it was a group discussion and he was "on the spot."

Similarly, I asked him at different points during our meeting to describe why feedback is so helpful to him, what it is like to juggle multiple things at once, and why participating in class discussion can be challenging for him.

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One of his teachers remarked,

> *This is the most I've heard you talk in the whole time I've known you, Sawyer. This is really, really helpful. I have some ideas about different ways you can participate in my class without the pressure.*

As the interventions and supports were written into his IEP, I asked Sawyer if he felt they would address the problems he had brought up.

One teacher proposed that Sawyer add his comments to a google doc during class discussion so that he could participate at his own pace.

Another team member shared that teachers could give Sawyer more frequent feedback, but it meant he would have to attend office hours since there might not always be time in class.

Sawyer agreed, much to the shock of his parents.

The school counselor offered to meet with Sawyer to map out some of his longer projects to help him focus on "one ball at a time." Sawyer also agreed to this, despite rejecting this kind of help in the past.

His parents, previously fearing their son was unmotivated and uninterested in school, started to breathe a little deeper.

Conclusion

Neuropsychological assessment can give us incredible insights into how a child's brain works and what they need to thrive.

However, to truly get the most out of this process, we need to involve the child in authentic collaboration.

In this case study, Sawyer's insights and reflections were not only important for developing a more accurate picture about what was going on, but they helped his parents develop more empathy for his experience, and helped the school team develop a plan in which Sawyer would fully participate - because it solved a meaningful problem for Sawyer.

While I don't know for sure, I imagine Sawyer smiled inside when he heard his teacher say how helpful it was to hear his experience. I am hopeful that Sawyer has walked away from this process with a new story that is positive, helpful and empowered.

Additional resources available at www.ExplainingBrains.com, including handouts for parents and children to facilitate collaborative neuropsych testing practices.

References

Gorske, T. T., & Smith, S. (2008). *Collaborative therapeutic neuropsychological assessment.* Springer.

Fischer, C. T. (2010). Collaborative, individualized assessment. *Journal of Personality Assessment, 74*(1), 2-14.

Tharinger, D. J., Finn, S. E., Hersh, B., Wilkinson, A., Christopher, G. B., & Tran, A. (2008). Assessment feedback with parents and preadolescent children: A collaborative approach. *Professional Psychology: Research and Practice, 39*(6), 600–609. https://doi.org/10.1037/0735-7028.39.6.600

Tharinger, D. J., Marchette, L. K., Austin, C. A., & Matson, M. (2011). The development and model of Therapeutic Assessment with children: Application to school-based assessment. In M. A. Bray & T. J. Kehle (eds.), *The Oxford handbook of school psychology (Ser. Oxford library of psychology).* Oxford University Press.

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Discussing Cognitive Test Results During Parent Feedback: Inviting in the Core Therapeutic Assessment Values

Stephanie Nelson, Ph.D., ABPP, ABPdN
The Peer Consult

Let me begin with a confession: standard scores seduce me. They sing to me like sirens, with songs of objectivity and special access. When I worry my assessment insights are too subjective, standard scores soothe me. They surround me with the security of tidy two- and three-digit numbers. When I wonder whether I've unearthed genuinely new information about a child, standard scores reassure me. They promise I've learned something that only a standardized test can tell me. This lure of hard data in which to ground my softer impressions, observations, and intuitions is almost irresistible.

Perhaps you've felt this too. Perhaps you know what I mean when I say that the siren song of standard scores sometimes slips me into a hierarchical feedback style. Perhaps you've noticed that no matter how collaborative you are in the rest of your summary and discussion session, when it comes to discussing standard scores, you easily slide into lecture mode. Perhaps you've seen your trainees unsure how to maintain a collaborative stance when discussing the cognitive test results.

Either way, you know this hierarchical feedback style when you see it. You would recognize when I've been pulled into it. When I'm in my hierarchical mode, the parents and I have clear roles. My job as the clinician is to obtain data about the child through expert procedures (cognitive tests), and then to present this specialized data to the parents. The parents' job is to receive this informational presentation, and to ask questions until they're sure they understand.

There are many currents that sweep me into this mode. One is that this is how I was trained. As Tharinger et al. (2008) note, the hierarchical feedback model, with "the assessor being the knowledge bearer and the parent and child being the knowledge receivers," permeates most literature on how to discuss evaluation results. It "has dominated assessment feedback practice for decades," (p. 601) and certainly dominated how I was taught. Because I came late to the literature on Therapeutic Assessment, I had to unlearn many habits before I could embrace TA's core values of collaboration, openness and curiosity, compassion, respect, and humility. This unlearning process felt shakiest when applied to the cognitive tests results I spent so long learning how to lecture about. It remains the point where I'm most vulnerable to falling back into old habits.

Another is the nature of cognitive tests themselves. Many different helping professionals can interview, observe, review records, form impressions, and diagnose. But cognitive tests are specialist procedures. They require extensive training and expertise to administer, score, interpret, and explain. Their very nature reinforces our status as experts, which can entice us into taking on the role of expert explainer in our summary and discussion sessions. Parents are also sensitive to these signals of expertise, and sometimes experience "oracular transference" (Tharinger et al., 2022). When they view us as oracles of truth, they readily – even eagerly – assume the role of passive recipient of our expert knowledge. Actively collaborating to make meaning together about a child's test scores may require an unlearning process for parents, too.

Finally, there is the problem of wondering what the alternative is. We've learned to lecture about cognitive test results because specialist information is often presented hierarchically. We know from the many lectures we heard during our own schooling that this mode can be effective in transmitting knowledge. At the same time, we all know how much more *alive* we are to new information when we actively engage with it. When

we are partners in exploring new ideas, in analyzing and interrogating, and in making meaning from the answers we find, we integrate the insights at a deeper level. We internalize the knowledge. The questions we ask ourselves – "How does this fit what I expected?", "What frameworks do I already have that this links to?", and "What does this information mean for my life?" – allow us to absorb novelty and complexity into our everyday experiences. New knowledge becomes familiar, practical, and actionable. We want this experience for the families we work with, but how exactly do we get there? In other words, if I don't lecture, then what on earth will I say or do?

What follows are some ideas about how we can invite in the core values of TA to help us answer that question. My aim is to highlight how consciously engaging with these values guides me towards different ways of talking with parents about their child's cognitive test results, and even different ways of thinking about the results myself. My hope is that some of these thoughts will spark your creativity. I hope you'll share your ideas with me, too, and that we'll continue this conversation about how to build more collaborative feedback together.

Inviting in the Core TA Values

To tell the story of how embracing the core TA values opens up new paths for me, and changes how I think and talk about cognitive test scores, I have to reflect on my old habits. This reflection is not easy or comfortable, and not without some grief. I've surprised myself with how emotional I've felt while writing this article, as I see myself from two different sides, and see all the ways I still shift between those sides. This experience has made me more deeply appreciate the vulnerability and bravery the families we work with show, as they bring their worlds into our offices in search of new ways of solving old problems. If they can be brave and vulnerable, so can I. So, let's look together at my old problem: hierarchical mode.

When I'm in my hierarchical mode, I tell parents what the tests are for and why they're important. I explain that we're learning about their child's strengths, her weaknesses, and "how her brain works." The scores themselves feel urgent and essential to me. It hardly matters whether they illuminate the assessment questions or magnify our empathy. Simply having the data is what counts. I also view cognitive test scores as telling us something important *about the child,* though what that important thing is isn't always so clear. Vaguely, I imply that the **scores** can help us predict real world outcomes the parents are interested in – perhaps the test scores tell us what to expect of her academically, or how quickly she should complete tasks at home, or how much her brain injury impacted her development. However, if I'm honest, these brain-behavior and real-world links are a bit fuzzy. The primary role I inhabit is transmitting as much exhaustive, expert detail about her scores as I and the parents can manage. (Again, I'm not alone in this: one of parents' top complaints about assessments is that we talk about the scores more than we talk about the child [Rahill, 2018). Perhaps you are also here with me at times.]

Embracing the TA value of **collaboration** begins to break me out of this mode by giving me a new role. As Tharinger et al. (2008) note, "In collaborative psychological assessment, the assessor seeks to midwife new insights and understandings into being, rather than offering them to clients as new truths to be accepted at the end of an assessment." Viewed through a collaborative lens, the parents and I are no longer in separate lanes as we review the cognitive test results during the summary and discussion session. We now have a shared job: to see what we've learned from these tests, and to make meaning of the findings together. Turning towards the test scores from a shared perspective affords new opportunities to build rapport, trust, and connection:" I saw the same struggles on these tests that you see for Sari at home. I felt some of what you feel when she shuts down." The parents and I can also create shared language for the similarities we see: "I love that distinction you made about Sari being a 'social learner' more than she's a 'school learner' – let's see if the tests can help us understand why."

Collaborating with the family means stepping back from the hierarchical perch where I present the point and purpose of the tests. Partnering with parents means *asking them* what they want to learn and why. We investigate the questions that they think are crucial. The tests become tools in service of their goals. Scores are for getting closer to the answers they seek. What can we learn about why Sari acts out at school, and why this year seems so much harder than the last? How much scaffolding, support, practice, or time does she need to solve a problem her peers can solve independently? When it's time to review the results, the

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data are so much more meaningful in context of the family's real life and their real-world struggles. The test scores themselves are no longer urgent and essential. The answers they illuminate are what count.

Inviting in the core values of **openness and curiosity** guides me to focus on the *process* of obtaining the test scores. Instead of trying to get as many scores as possible, I can devote my assessment attention to finding the 'whys', 'hows', and 'whens'. I can wonder about questions such as "How, when, and in what ways can this child be most successful on these types of tasks?" and "What features of the task or her environment help her feel most comfortable, most empowered, and most excitingly challenged while she's solving these kinds of problems?" Bram and Peebles (2014) describe this process as searching for the "conditions under which" the child struggles or thrives. It's not an overstatement to say that shifting my perspective to viewing cognitive tests as tools for finding the "conditions under which" changes how I practice from the inside out.

In my open and curious mode, the links between test scores and meaning are no longer the least bit fuzzy. The outcomes I'm trying to predict are not vague. The child is having some problem-in-living. She's experiencing something distressing, or she's behaving in ways that are puzzling or concerning. Our crystal-clear purpose is to understand why, and what we can do. The tests are only as useful as their ability to guide us towards real-world answers for this child and her family. This sharp focus means I must wring as much utility from the tests as I can. Becoming curious about the "conditions under which" the child achieved her scores opens up the landscape dramatically. I have so much more information, including ideas, hypotheses, and insights the test scores alone cannot provide. This is not an undisciplined process. As Bram & Peebles (2014) note, we are using "the checks and balances of repetition and convergence of data… that keep our findings objective (i.e., factual and verifiable)" but "without sacrificing the meaning-making and pattern-recognition capabilities unique to an experienced clinician." (p. 5)

The tests are only as useful as their ability to guide us towards real-world answers for this child and her family.

The TA value of **compassion** further shakes me from my hierarchical habits by reminding me of the empathic value of cognitive test scores. We're not only trying to answer questions we've co-created about the child, we're also trying to get into her shoes. Getting in her shoes doesn't mean spending all my time *measuring her feet*. It means finding out if *her feet hurt*. Does one foot hurt more than the other? Does she get blisters when she walks? Does she need *new shoes*? Does the whole family? When I invite in the value of compassion, cognitive test scores assume this radically different purpose for me. I'm no longer interested in telling parents an IQ score reflects something important *about their child*. I want to wonder with them whether a score tells us something important about *what she needs.* The path to empathy doesn't involve the parents listening to a lecture on how a low score highlights Sari's deficit in verbal comprehension. The path runs through getting curious together about whether a low score points us towards a pain point Sari has, or a need that's not being met.

The TA value of **respect** helps me think about high and low scores in a different way. When I'm in hierarchical mode, it's easy for me to forget that cognitive test scores carry special meanings that I've acquired from my training and our culture at large. For example, I tend to grace cognitive test scores that are above average with a halo of 'goodness'. I automatically grant high scores the status of a 'strength'; depending on your training, you might celebrate very high scores as 'superpowers.' The cultural and professional messaging is so strong that a high score *itself* can make a child seem worthy of admiration. I'm tempted to admire a child for her high score even if she is not expressing the strength through any actions that she or her family value. While it feels good to identify strengths, when I'm in hierarchical mode, I don't appreciate the risks of this approach. Such as that I could be creating an impossible standard for the child to live up to, inadvertently reducing her motivation and willingness to take risks and increasing opportunities for shame. Or, that her or her parents' low self-esteem could lead them to reject my attempts at praise (Brummelman, Crocker & Bush-

man 2016), and cause a rift in their trust in me and the test results.

A more pressing concern is that once I've identified high scores as good and worthy, low scores must then suggest the opposite. In my hierarchical mode, I swallow this "medical model" whole. I accept the premise that low scores are "deficits" by definition. I accept that a child could actually possess a "deficit of intelligence" or some other cognitive skill. Since deficits are neither good nor worthy, when in my hierarchical mode, I dread talking to parents about low scores. In my worst moments, my fear becomes contagious, and the parents also begin to feel that low scores are circumstances to be mourned. In my better moments, I use low scores to evoke empathy and sympathy: "What must it be like for Sari to have this brain, this struggle, this burden? How can we help her? How do we take away shame around her challenges with language?" But in my hierarchical mode, I rarely feel genuinely respectful of the child or empowering in how I talk about her lower scores.

The TA value of respect for the child and her family in all their diversity rescues me. When I embrace this value, I can try on new models for viewing low scores, such as the social model, the disability-as-difference model, or the disability-as-universal-experience model (Kirby, 2004). Seen through these models, I can view the child's lower scores as reflecting *differences* in how she currently thinks, learns, and problem-solves. If these differences cause her to experience significant distress or functional impairment, she may meet the criteria for a *disorder,* and her differences may contribute to *disability* if her current environment cannot accommodate the ways she moves through the world. Certainly, these circumstances may inspire grief, or rage, or anxiety, and it will be essential to make space for these emotions during the feedback. But the child is not her circumstances. She is good and worthy no matter her scores or her situation. Now the parents and I are viewing her in all her wholeness and humanity, with radical respect for who she is.

This framing is not just word choice, nor puffed up politeness and political correctness. By being open to these models, I'm no longer centering deficits exclusively within the child. Instead, deficits are situated in her environment, or in the child-environment interaction, and this changes the game. Because when I think through these lenses, the intervention possibilities I can talk about with the family expand exponentially. For example, whether and how much we want to directly address the child's differences become *choices* that can be informed by her and her family's values and goals. I respect what is important to the child and her family. Do Sari or her family *want* her to get better at the skill we're talking about? How much better, and at what cost? What values does the family have that could inspire the hard work of improving?

The TA value of **humility** is perhaps the most essential path out of hierarchical mode. This value involves accepting the limitations of our expertise and our assessment tools in the service of getting in the child's shoes (Tharinger, 2019). Adopting a humble posture opens up space for me to talk with the family about strengths that were not measured by the cognitive tests, but which may have important roles to play in solving this child's problems-in-living. I can shine a light on traits and behaviors the child shows that are worthy of admiration. How do Sari's positive attitude, her infectious energy, and her supportive comments to her peers bring value to the classroom? I can point to behaviors that she could do to express her latent strengths in ways that she and her family value. "Sari is so willing to take risks when she's learning a new activity like riding her bike, and you really value her bravery and willingness to grow. How can we help her express this trait at school?" I can share with the parents what we've learned about the child's values, preferences, and goals. We can bring her voice into the room. When I embrace my humility, I can let the true expert be the communication behind Sari's behaviors, scores, and struggles.

Practical Strategies

Embracing the values of TA gives me the freedom to shrink the test scores back down to their rightful size and importance. The test scores become only one source of a wide body of information I have about the child, her world, and her triumphs and struggles. And the process of obtaining those scores becomes as important – if not more – than the scores themselves. The "conditions under which" the child thrives take precedent. Many of the techniques we regularly use in both Therapeutic Assessment and standard assessment are helpful to me when I'm looking for these "conditions under which." Examples include extended inquiry, testing the limits, and exploring for discon-

tinuities in a child's performance within and across tests. I must take care not to employ these techniques solely to see if I can get the child to achieve a higher score, and must guard against the urge to simply get more scores, more data. Instead, I must center the goal of discovering ideas, possibilities, and alternative ways of addressing puzzling problems or experiences the child has in her real life.

Let's get a little more practical here. Recall that the tests we administer to children vary in many ways that have little to do with what the test purports to measure. For example, some tests are longer, or require more independent work, or ask the child to point instead of providing verbal responses (see box 1 for a non-exhaustive list of examples). We can pay at least as much attention to those variances as we do to the scores we obtain. During a test session, we can also conduct experiments (after our standard administration of a test), to see if we can modify the task conditions to better promote the child's success. Examples here might include providing more time, more modeling, or more scaffolding.

We also intuitively do many things to support children during testing. We can experiment with deliberately ramping these "natural interventions" up or down, to see if we can create conditions that support the child. Each child we work with also brings different values, goals, and non-cognitive skills to the test session, and we can look for behaviors through which she expresses her goals and values She also has her own ideas, opinions, and preferences about what supports her, and we can elicit those directly or look for how she

What Features of the Task Best Supported the Child?	What [Noncognitive] Values, Goals, and Skills Was the Child Able to Draw Upon?	What Features of the Child-Environment Interaction Best Supported the Child?
Examples: • Length • Amount of structure • Predictability • Modality of stimuli (e.g., words; pictures) • Modality of response (e.g., pointing, drawing; one word; sentences) • Degree and slope of difficulty of task (e.g., easy at first) • Amount of independent work required • Pace • Novelty • Complexity • Abstraction • Detail focus vs. big picture focus • Performance demands or stakes of task • Feedback provided • Practice allowed • Sample to match to • Repetition allowed • Thinking time provided • Guessing allowed/ encouraged/ required	**Examples:** • Self-confidence and self-efficacy • Self-worth • Beliefs that testing is important and helpful • Orientation towards success, effort, growth, people-pleasing, curiosity, sensation-seeking, power, etc • Self-talk strategies • Ability to self-advocate • Creative avoidance strategies • Ability to self-reflect • Humor • Flexibility • Enthusiasm, energy, liveliness • Trust and comfort with accepting help, reassurance, and co-regulation from adults • Curiosity • Openness • Persistence • Tolerance of uncertainty • Resilience and recovery after mistakes	**Examples:** • Degree of social connection offered during/between tests • Evaluator's level of emotional expression • Amount and type of rewards used (e.g., praise, encouragement, prizes, play) • Boundaries and limit setting techniques used • Co-regulation strategies offered • Amount of choice and voice offered • Efforts undertaken to reduce stereotype threat • Match of tasks to child's interests and preferences • Discussing and trying out the child's ideas for solving friction points • Examiner ideas for reducing friction offered and tried • Physical characteristics of office (e.g., noise, distraction, space)

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communicates her preferences through her behavior. What I now aim for during cognitive testing is to systematically look at these features of the task, the child, and my interaction with her, to elucidate patterns that span test domains. I cross-reference the conditions I've found with strategies that the child, her family, her teachers, and other helpers have discovered. These patterns and possibilities become what I explore with the parents during the summary and discussion session. That is, these are what I replace my lecture with.

A sample of how I might bring these "conditions under which" into the summary and discussion section goes something like this: "We've been puzzled about why Sari gets in so much trouble at school. I noticed some patterns across the tasks she and I completed together. Can I share them with you to get your thoughts? What I noticed is that whenever the task involved movement, Sari shined. She expressed her curiosity through exploring the task with her hands and eyes. She kept going with those tasks even when they were hard. She looked to me when she got frustrated and let me show her suggestions. I was so impressed with her persistence and willingness to accept help. I also noticed that when tasks involved sitting still or listening to a lot of words, Sari let me know through her actions that the tasks were not a good fit for her. She physically pushed tasks away. She covered her ears. Her eager curiosity disappeared. Sari also turned her body away from me if I offered suggestions out loud, which was a big change from how she responded to my physical demonstrations. I could tell in those moments that I was not meeting her needs! Does that sound like her? Can you share a story when you saw something similar? So, I'm wondering about this big difference between Sari when she's moving and Sari when she's listening and sitting still. Have you seen similar patterns at home? What are your thoughts about what these patterns could mean?"

Here are some other specific ideas to try:

Use the test results to create connection

Think of the testing process as a method for bringing child's problems or struggles "into the room." Expand the parents' trust in the results by sharing what you saw during testing that's similar to what they see at home. Build rapport by sharing how the child's struggles and successes made you feel. Create a shared language together that puts the test scores into words and metaphors the family already uses.

Privilege the process

Release any pressure you feel to be the perfect tester who always gets a child's highest, "true" scores. Focus on where, when, and how she feels comfortable showing her skills. Focus on the conditions under which she is most and least comfortable.

Get curious with the family about the "conditions under which" that you find

Tell the story of what you tried during testing and what the outcome was on the child's performance or emotional experience of the task. This might take the form of "I noticed this [child behavior, expressed feeling, or test performance], so I tried this [intervention], and then this happened [outcome]." Ask the parents how they understand that story ("Does that seem like her?"). Ask if they have similar stories ("Are there times when you've seen something like that?"). See if there are different ways they would tell the story ("I'm wondering if this means [hypothesis], and I'm curious about your thoughts on that?").

Elicit parent hypotheses about "conditions under which" you may not have thought of

Describe what the child needed to do on a task and ask for their ideas about what would have supported her practically or emotionally during that activity. Activate their expertise by asking questions about successes they've had in similar situations, or ideas they've thought of that they want to try.

Model how the parent can use extended inquiry after a task a child struggles with

Relate the conversation you had with the child after she completed a task that was hard for her. Subtly highlight how you asked the child what the experience was like, and how you solicited her suggestions and preferences. Share any curiosity, joy, confusion, or surprise you felt in response to her thoughts. Ask the parents about their emotional response, too. Discuss how you acted on the child's ideas, and what the outcome was. Wonder with them what it would be like to try an extended inquiry at home after a real world problem.

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Explore differences within the child

Make room for contradictions and inconsistences within the test scores. These gaps are where possibility lives. Explore with the parents how the differences within the child (e.g., her mood, her motivations, her moment-to-moment experiences, her growth across time), in the task demands, and in the perspective of the person working with that lead to different scores on different tests all tell us something about the "conditions under which." These differences may help us see that what seems like a strength can also be a weakness (or vice versa) depending on the circumstances. These differences help us understand how to change those circumstances.

Explore differences within the family

Ask about the family's hopes, fears, attitudes, and values around cognitive tests and cognitive skills. Wonder about differences in cognitive style within the family that could create points of connection, confusion, or consternation. Map out intergenerational patterns ("What was it like for you when you were a child?"). Explore how the family's culture intersects with how they understand the test results.

Talk about goals, values, strengths, and needs rather than numbers

Look for and celebrate the child's behaviors and values, rather than high scores. For example, highlight how she wants to feel successful, likes to learn new things, wants to avoid making mistakes, or likes to have choice in how she completes tasks. Share what you learned about the many things our cognitive tests do not measure, but certainly elicit (e.g., creativity, resilience, bravery, wit, charm, wisdom).

Bring the child's voice into the room

Help the parents become curious about their child's experience by making her self-talk more visible to them. ("What do you think she was saying to herself in her head while she worked on this task? Can I share what I overheard her say to herself? Where has she heard those words before? What words would you like her to have instead?"). Reflect on how behavior is communication and wonder with them about the meaning behind her actions and responses to the cognitive tests. Convey your optimism about how her positive response to ways you modified the tests (e.g., adding more structure, support, predictability, time, movement, etc. to the task) mean she can positively respond to things they do differently at home.

Conclusions

Allow me to revisit the confession that began this article: standard scores still seduce me. I believe that standard scores have something important to tell us. Cognitive tests do require specialized training, and I still hold on to the expertise I bring to each evaluation. However, inviting the core values of TA into my work provides richness and context that gives scores a deeper meaning to the families I work with. As I dive deeper into collaboration, curiosity, compassion, respect, and humility, I've learned to apply those values not just to assessments with individual families, but to my work on a broader, meta-analytic scale. I have been humbled by examining the appeal the hierarchical model holds on me. I respect the quality of the training that I received in cognitive testing and the validity of the scores provided, but my analytical side must work in collaboration with my empathetic side. I also endeavor to stay curious about my own process and development. Perhaps most importantly, I remain compassionate with myself as I unlearn old habits and stretch myself professionally. My hope is that so long as I keep these values in my heart and mind, I can move in the direction that is right for me. As you reflect on your own practice, I invite you to engage ever more deeply with these core values. Let's keep working on this together.

References

Bram, A. D., & Peebles, M. J. (2014). *Psychological testing that matters: Creating a road map for effective treatment.* American Psychological Association.

Brummelman, E., Crocker, J. and Bushman, B.J. (2016), The praise paradox: When and why praise backfires in children with low self-esteem. *Child Development Perspectives, 10*(2), 111-115.

Kirby, J. C. (2004). Disability and justice: A pluralistic account. *Social Theory and Practice, 30*(2), 229–246.

Rahill, S. (2018) Parent and teacher satisfaction with school-based psychological reports. *Psychology in the Schools, 55*(6), 693-706.

Tharinger, D. J. (2019) Assessing children in public schools using Therapeutic Assessment values and methods. *The TA Connection, 7*(1), 11-16.

Tharinger, D. J., Rudin, D. I., Frackowiak, M., & Finn, S. E. (2022). *Therapeutic Assessment with children: Enhancing parental empathy through psychological assessment*. Routledge.

Tharinger, D. J., Finn, S. E., Hersh, B., Wilkinson, A., Christopher, G. B., & Tran, A. (2008). Assessment feedback with parents and preadolescent children: A collaborative approach. *Professional Psychology: Research and Practice, 39*(6), 600–609.

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How an Understanding of Right Hemisphere Difficulties Shapes our Understanding of Personality and Guides Feedback: A Collaborative Approach

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[2]Noran Neurology

The story of the right hemisphere is one of redemption. Like the Bad News Bears, the right hemisphere (RH) was once considered inferior – even the location of lunacy! The left hemisphere (LH), meanwhile, was the star, known as the seat of language (McCarthy & Warrington, 1990), and because the RH's role wasn't yet clear, some thought it simply took up space but functionally did very little (Forrest, 2007). This notion seems rather silly in light of our current understanding of the brain, of course – we know that the brain folds back in on itself over the course of development to create more surface area, and evolution would simply never waste that much space. And yet, with the exception of Luys in 1879, little attention was initially paid to the RH; Ogle (1871) even argued that right-handedness was the result of the LH's "superiority" over it. Hughlings Jackson (1876) was a voice in the wilderness, writing of the RH's specialization in "visuoperceptual" skills.

The clinical spotlight shifted to highlight the RH in the middle of the 20th century (McCarthy & Warrington, 1990), when science first began to appreciate and understand our hemispheric underdog for its unique contributions to cognitive functioning. During this period, researchers noted structural differences between the two hemispheres (Geschwind & Levitsky, 1968). In addition, researchers articulated the array of functions mediated by the RH, namely: visuospatial and visuomotor processing, specific aspects of math, and non-verbal communication such as gesture, prosody, and facial expression. Facial recognition is also predominantly a right hemisphere function, as is the processing of the *"gestalt,"* or overall arc, of a set of cognitive data. We've since learned that the RH is likely dominant in the processing of attention and music. Finally, we now know that RH mediates all sensory information in the left hemifield and on the contralateral side of the body (with the exception of olfaction). While this list isn't exhaustive, it gives a flavor of the complexity and variety of functions mediated by the RH. In addition to having discovered how the RH functions relatively independently, we also now better understand the ways in which the RH and LH cooperate in cognition (Forrest, 2007). Their connection by several bands of fibers – primarily the corpus callosum – supports this cooperation (Kolb & Whishaw, 2003; Heilman & Valenstein, 1983). For example, our ability to process conversations fully and efficiently requires the integration of data from both hemispheres: the LH understands the literal words, while the RH tracks the subtler "feel" of what is being said.

There are subtle architectural and processing differences between our two brain hemispheres, and, as we've discussed, functional differences as well. While the LH and RH often work in unison, at other times they operate more independently. We think of these two ways of working as "functional integration" and "functional specialization" (Van Horn & Poldrack, 2008). Rather than containing one hemispheric "star" and one "dud," we now know that – like the Greek gods Apollo and Artemis – our brain contains two strong and equally valuable players who are constantly changing the nature of their relationship: sometimes cooperating, sometimes operating independently, sometimes even competing.

Not surprisingly, however, the early lack of clarity about the role of the RH has led to confusion and misunderstanding about developmental disorders that are associated with it. Still today, many of the RH-based disorders that are recognized in clinical practice are not included in our formal classification systems. Though much empirical validation is still necessary, we believe that these syndromes, like others not yet formalized in the nomenclature (e.g., complex trauma), will become more universally recognized as our understanding deepens. For our purposes, we want to discuss two neurodevelopmental disorders that share a number of features, including difficulties based in RH dysfunction: a clinical syndrome previously thought of as Asperger's Disorder and Nonverbal Learning Disability (NVLD). While neither profile necessarily meets diagnostic criteria for autism spectrum disorder (ASD), there are similar signs and symptoms often observed in individuals whose behavioral, social, and emotional challenges fit that category (Wolf et al., 2007).

Research has shown some overlap between ASD and NVLD (Topal et al., 2018), and Dinklage (2015) also notes similarities between NVLD and what was previously called Asperger's Disorder (AD), which is now subsumed by the broader category of ASD in *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association, 2013). In his description of the typical NVLD neuropsychological profile, Dinklage also relays studies from the Yale Child-Study group, which indicated that upwards of 80% of children with AD also had NVLD.

Given what appear to be regional differences in the acceptance and clinical use of NVLD in particular in the diagnosis and characterization of symptom profiles, we want to more explicitly outline it, below. Summarized diagnostic criteria for ASD as given in DSM-5 (American Psychiatric Association, 2013) are presented in Box 1, and for contrast, Dinklage (2015) outlines NVLD in Box 2.

Importantly, and most relevant for our discussion, is that these two disorders share a RH mediated difficulty with non-verbal social communication, which can have profound implications for psychotherapy, the interpretation of psychological testing data, and feedback. To that end, we offer the following clinical examples, taken from our experience with clients and families with whom we have worked over the last several years and whose neuropsychological profiles reflected the kinds of RH-mediated challenges

Box 1. DSM-5 Autism Spectrum Disorder Criteria

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history:
   1. Deficits in social-emotional reciprocity
   2. Deficits in nonverbal communicative behaviors used for social interaction
   3. Deficits in developing, maintaining, and understanding relationships

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history:
   1. Stereotyped or repetitive motor movements, use of objects, or speech
   2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior
   3. Highly restricted, fixated interests that are abnormal in intensity or focus
   4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay.

Box 2. Characteristics of NVLD (Dinklage, 2015)

1. NVLD can be conceptualized as an imbalance in thinking skills—intact linear, detail oriented, automatic processing with impaired appreciation of the big picture, gestalt or underlying theme.
2. It is not nearly as common as language-based learning disabilities
3. Typically social/psychiatric concerns are raised before academic problems are identified.
4. While the overlap is not complete, NVLD children may meet the criteria for Pervasive Developmental Disorder Not Otherwise Specified (PDD NOS), Aspergers Disorder, or Schizotypal Personality.

Neuropsychological Profile (NVLD):

5. Full range of IQ
6. Visual spatial deficits are most pronounced: poor appreciation of gestalt, poor appreciation of body in space, sometimes left side inattention/neglect
7. Pragmatic use of language is often impaired
8. Rhythm, volume, and prosody of speech can be disturbed.
9. Motor and sensory findings are common, left side worse than right.
10. Attention is usually reported to be impaired

Continued on next page >

Box 2. Characteristics of NVLD (Dinklage, 2015) (continued)

Academics (NVLD):

11. Inferential reading comprehension is weak relative to decoding and spelling skills.
12. Math is often the first academic subject to be viewed as problematic.
13. Handwriting is usually poor.
14. Organization skills are weak, particularly in written work.

Social/emotional issues (NVLD):

15. Peer relations can be impaired
16. They often lack basic social skills
17. They can often be seen as "odd" children who "just don't get it"
18. They may show poorly modulated affect, not matched to verbal content.
19. Lack of empathy and social judgment may shield them from fully experiencing the hurt of peer rejection, while the same factors increase the likelihood of being rejected.
20. History of unusual thinking can often be obtained: rituals, stereotypic behaviors, rigid routines, and magical/bizarre beliefs.

described above – all in different ways and to varied degrees of severity. We share some case material illustrating how we used TA values and techniques to help these clients and their families 1) broaden their concept of their problems-in-living, 2) better understand themselves based on their test findings, and 3) begin the process of effecting beneficial change in their lives. Names and some details have been changed to protect confidentiality.

Royal

Royal was a 13-year-old boy whose parents requested a neuropsychological evaluation due to their ongoing concerns about his anger, poor self-control, and challenges with executive functioning, inattention, and hyperactivity. They wanted to figure out "what was wrong with his brain" and their existing story was generally that that he was intentionally being difficult. However, Royal had been previously diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD), which also ran in the immediate family, so his parents were familiar with what it meant and agreed with the diagnosis. They were, however, totally perplexed and frustrated with what they perceived as Royal's "refusal to learn from consequences." He struggled greatly with behavioral and emotional self-control and would often explode into dysregulated outbursts which seemed, to his parents, to be immature. These outbursts would then lead to heated family fights, and despite parents' best attempts to give Royal some very logical strategies to help himself, they stated that he was, much to their chagrin, "uninterested." They couldn't understand why he "wouldn't *want* to feel better!" They were constantly annoyed that he would talk at length about topics that seemed to interest no one else, and they were exhausted from his "defiance." They were quite explicit in their sense that that he was the problem, and Royal saw himself that way, too: we saw how down and discouraged he could get when talking about what his parents wanted from him that he "just couldn't do." The family was considering sending him away to a residential school because they were unable to change his behavior and clearly fed up.

There was no significant developmental, medical, or neurological history of note, but Royal's parents did describe him as an introverted child. He was a bright kid who had done well in school, though the personality "fit" between him and his teacher always seemed to be a more significant factor in his academic suc-

cess than for other children. When we met with him, his attentional difficulties were clear and quite severe. However, we also noticed some social differences that seemed outside the bounds of what is usually attributable to ADHD alone. He was certainly hyperactive, but his behavior was also socially atypical and at times, he seemed quite angry. He enjoyed talking about certain topics, but wasn't particularly interested in either of us. With permission to do some additional testing, we administered more direct measures of social cognition and communication, and it quickly became apparent that Royal's profile would also meet criteria for ASD. His severe ADHD, we believed, had masked it for some time. But it was our hypothesis that his parents were especially unaware of this fact and that they had a vested interest in seeing him as the problem.

We knew that simply presenting this family with an additional diagnosis would only confirm their existing story that their son as the problem and was unlikely to lead to change. We needed to help them cultivate some empathy for their son and show them how his problematic behavior was not simply due to purposeful refusal to learn from consequences. Rather, it was due to *inherent* difficulties understanding others and understanding the impact of his behavior on others. Our hope in helping them to better understand the "why" behind Royal's behavior was to enable them to shift their internalized narrative of him as the "bad" child, thereby enabling them to respond to his challenging behavior with compassion, emotional sturdiness, and strategic support rather than becoming emotionally overwhelmed and dysregulated themselves.

We decided on an assessment intervention session with the parents and showed them cards from a social cognition test depicting different social scenes (Social Language Development Test; SLDT-A: NU, Bowers, Huisingh, & LoGiudice, 2017). In standard administration, test-takers are asked to use perspective-taking skills to infer what the characters are thinking, and identify the social information they used (e.g., facial expression, body language) in their inferences. Children with ASD often struggle on this task, as Royal had. First, we administered the test to each of Royal's parents. Both performed in the average range. Without Royal in the room, we then asked his parents to tell us what they thought *Royal's* answers to the task had been. They imagined that he had answered just like them, that he had generally understood what characters felt, could identify what social "clues" led to that determination, and was able to take others' perspectives. They were very surprised to learn how difficult this task had been for him, and were shocked at some of his responses, which clearly demonstrated his social inference and communication challenges. It was clear that learning that Royal was truly struggling – not just intentionally being irritating – was complicated for them, and not a comfortable emotional experience. His father, more than his mother, had a way of hiding his hostility with intellectual and biting humor. At other times, there were distractions unconsciously designed to obfuscate our view of the family dynamic (twice, he brought their new and rambunctious puppy to the office without asking, which created quite a bit of chaos). Royal's mother was a bit more remote and passive, and harder to read. We felt we had to straddle the line between reframing Royal's difficulties while still affirming that he could be difficult to manage. We used this as a springboard to help them shift their narrative about Royal and begin to integrate the Level 2 information that he was actually sometimes *unable*, rather than simply *unwilling*. Interestingly, Royal himself was not at all surprised or particularly distressed to hear that we felt his profile fit criteria for ASD. We also made some additional recommendations for changes to his overall care plan, and parents later reported to us that he found a social skills group very helpful and enjoyable. While we never learned whether he was sent away to residential school, we could see that we had helped start a powerful process of process of change for this family.

Abby

Our evaluation with Abby was an unusual and complex one that demanded our flexibility, patience, and commitment to allowing the family to lead the way. Abby was a 9-year-old girl whose parents were mostly concerned about her anxiety, poor emotion regulation, and insistence on acting older than her age. She was constantly questioning why she was not allowed to participate in "adult activities" (e.g. drinking wine, going on dates with her parents, watching mature movies), and despite her parents' attempts to explain and hold boundaries around these activities, she struggled to understand and would often perseverate on specific details in arguments about them. She seemed to have a hard time cognitively "connecting the dots," or seeing the forest for the trees, so to speak. This kind of cognitive inflexibility is often observed behavior-

ally in those whose profiles fit NVLD, but this didn't become clear in Abby's case until later on in our work with her. Her parents, in turn, were easily pulled off track during arguments, and would eventually relent when her dysregulation became severe and unsettling to them. Abby had friends, but relationships never seemed to "stick" very long for her. She was miserable and had begun making passive suicidal statements, and her parents were very worried. Their existing narrative of her was similar to that of Royal – that there was "something wrong with her," and we all needed to find out what it was.

We began with psychological testing, both for Abby and her parents. As we learned a bit more about each of them individually, we decided to bring them in for an assessment intervention session to play a problem-solving card game together. This way, we could observe how arguments tended to play out in their family. We watched as Abby often acted very dismissively toward her mother, but also commented that her mother was "always so soft on me!" Her mother seemed anxious in general, but especially so around Abby. Meanwhile, Abby's father seemed to be working hard to get along with everyone. When arguments arose, Abby indeed seemed to get "stuck" on particular details in ways that were puzzling to us. She had a very hard time seeing the "bigger picture."

In subsequent sessions, we talked with Abby's parents about how her comments about her mother "being soft on her" were actually her way of saying that she felt deeply insecure and was asking for more consistent boundaries from them. We hypothesized that Abby had been the "orphan child" in her family – isolated and allowed to be too independent – and that her hyperfocus on acting older than her age was her way of *showing* her parents that she needed *more* and firmer boundaries, not fewer. While from their perspective, Abby seemed to be demanding more freedom, we shared our idea that she actually wanted *less.* She didn't actually *want* to be allowed to participate in activities that were inappropriate for her – despite demanding this exact thing. They accepted this idea, and committed to some additional treatment steps we recommended.

Months later, Abby's parents returned to us with new concerns. Despite arguments going somewhat better at home, Abby had continued to struggle emotionally, in school and with peers. Her parents reiterated that her tendency to get "easily stuck on minor details" was ongoing. Her school had administered some testing for special education eligibility, and to their assessment, Abby didn't qualify, but she continued to perform poorly. So, we switched tacks, and after conducting additional neuropsychological testing, identified that Abby's profile did indeed fit an NVLD (nonverbal learning disability).

Finally, Abby's unique constellation of challenges made sense! Her tendency to get easily "stuck" on minor points at the expense of other information was a consequence of some mild executive dysfunction and difficulty with the right hemisphere-mediated, "big picture," holistic thinking often a struggle for those with NVLD. She struggled to see how her parents' explanations were relevant to her because she couldn't understand them in context. Her social struggles and difficulty maintaining friendships fit with the weaknesses in picking up on social cues that are often seen in NVLD, and much of her anxiety stemmed from feeling that she couldn't quite connect with others her age the way she wanted to. The areas of greatest struggle for her in school were those that depended on nonverbal, multipart content.

Again, we chose a simple intervention: showing Abby's parents her reproduction of the Rey-Osterrieth Complex Figure Test (ROCFT; Rey, 1941, & Osterrieth, 1944). We explained to them how this was both an example and a metaphor of her challenges with "big picture" thinking. She got stuck on "irrelevant" details in arguments because she had a much harder time seeing how smaller parts also comprised something broader. They could also see clearly how, despite being of above-average intelligence, Abby's unique right-hemisphere makeup would make it more difficult for her to fully *demonstrate* that ability.

We chose these two particular clinical examples because of how important RH-associated difficulties were in understanding the data and in deciding how to help these families. Had Royal simply been diagnosed as an angry and depressed child with ADHD, we can imagine a very different intervention and set of recommendations. To be sure, he was often hyperactive and dismissive – even mean at times. But once we became more aware and diagnosed his ASD, we understood his behavior much differently. In fact, we were able to empathize with him *and* his parents, as we no longer saw his behavior as (solely) a reaction to

his parents and their own struggles; instead, we understood it to be driven by neurodevelopmental factors and shaped by the dynamics in his family. Similarly, we would have missed some important factors in our work with Abby's had we not realized her profile fit NVLD. Though she was a bright, vivacious and adorable girl, something didn't quite add up. The diagnosis was the missing piece of the puzzle for us: in our experience, the combination of NVLD and other emotional symptoms can look larger than the sum of their parts. That is, emotional symptoms expressed in the context of NVLD can look confusing and quite disturbed. Once we understood the unique combination of emotional and neuropsychological factors relevant in Abby's story, we could better account for her symptoms and clinical presentation. Most importantly, we understood how best to communicate the findings to Abby herself.

In our practice, we have the luxury of doing what we refer to as "combined" batteries: full neuropsychological evaluations and a full set of personality/projective tests. We often comment about how many times we would have missed an aspect of a case had we done just one "half" of the battery, or the other. We use the word "half" because we have come to believe that more often than not, these combination batteries were critical in understanding our clients, their data, and how best to deliver feedback. The idea of levels of feedback – scaling our discussion of test findings according to what can be tolerated and used effectively in beginning the process of change – as outlined by Finn (2007), takes on new and greater meaning when one also needs to consider neuropsychological findings such as a previously unknown learning disability or attentional disorder. We have been particularly struck by the interplay between emotional and cognitive symptoms, as well as the unique challenges and joys of helping them to understand those symptoms, in those clients with the kinds of RH-based disorders discussed here.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Bowers, L., Huisingh, R., & LoGiudice, C. (2017). *Social Language Development Test--adolescent: Normative update.* Pro-ed.

Dinklage, D. (2015). *Aspergers disorder and non-verbal learning disabilities: How are these two disorders related to each other?* AANE. http://www.aane.org/asperger_resources/articles/miscellaneous/asperger_nonverbal_learning.html

Finn, S. E. (2007). *In our client's shoes.* Routledge..

Forrest, B. (2007) Diagnosing and treating right hemisphere disorders. In Hunter, S.J., & Donders, J. (Eds.) *Pediatric Neuropsychological Intervention* (pp.175-192). The Cambridge University Press.

Geschwind, N. & Levitsky, W., (1968). Left-right asymmetries in temporal speech region. *Science 16,* 186-187.

Grossmark, C., & Grossmark, R. (2023) A contemporary psychoanalytic consideration of nonverbal learning disabilities. In Margolis, A. & Broitman, J. (Eds.), *Learning disorders across the lifespan: A mental health framework* (pp. 195-204). Springer.

Harrison, D. W. (2015). *Brain asymmetry and neural systems.* Springer.

Heilman, K. M., Bowers, D., Valenstein, E., & Watson, R. T. (1986). The right hemisphere: neuropsychological functions. *Journal of Neurosurgery, 64*(5), 693-704.

Heilman, K. M., & Valenstein, E. (1993). *Clinical neuropsychology, 3rd Ed.* Oxford University Press.

Hugdahl, K., & Davidson, R. J. (2004). *The asymmetrical brain.* The MIT Press.

Kolb, B., & Whishaw, I. Q., (2003) *Fundamentals of human neuropsychology, 5th Ed.* Worth Publishers.

Osterrieth, P. A. (1944). Le test de copie d'une figure complexe; contribution a l'etude de la perception et de la memoire. *Archives de psychologie, 28*, 1021-1034.

Rey, A. (1941). L'examen psychologique dans les cas d'encephalopathie traumatique. *Archives de psychologie, 28*, 286-340.

Rourke, B. P. (1995). *Syndrome of nonverbal learning disabilities.* The Guilford Press.

Van Horn, J. D., & Poldrack, R. A. (2008). Functional MRI at the crossroads. *International Journal of Psychophysiology, 73*(1), 3-9.

Wolf, J. M., Fein, D. A., & Akshoomoff, N. (2007) Autism spectrum disorders and social disabilities. In Hunter, S.J., & Donders, J. (Eds.). *Pediatric neuropsychological intervention* (pp.151-174). The Cambridge University Press.

Author Bio's

Melinda Kulish, Ph.D.

Melinda Kulish is a neuropsychologist and trained psychoanalyst. She first became interested in psychological testing as an undergraduate at the University of Michigan, where she did research on The Early Memory Questionnaire and the TAT with her first mentor, Dr. Martin Mayman. She went on to complete her doctorate in clinical psychology at Northwestern University (division of psychology, department of psychiatry and behavioral sciences). She completed her APA accredited internship at The Cambridge Hospital/ Harvard Medical School. She went on to complete 4 years of post-doctoral training. The first two were in adult neuropsychology through The Cambridge Hospital/Harvard Medical School. She then completed two years of post-doctoral training in adolescent neuropsychology through Tufts Medical School/The Massachusetts Department of Youth Services. Dr. Kulish completed her adult psychoanalytic training at the Boston Psychoanalytic Society and Institute. She has also trained with Dr. Stephen Finn in Therapeutic Assessment. She is the founder and director of Integrated Assessment Services in the Boston area, a testing clinic that synthesizes neuropsychology and personality assessment across the lifespan. Dr. Kulish is on the faculty at Cambridge Health Alliance/Harvard Medical School.

Jennifer Boike Armerding, Psy.D., LP

Jennifer is a clinician and neuropsychologist who is particularly interested in an integrated, therapeutic style of testing which appreciates brain-behavior relationships alongside the deeper and dynamic emotional life. She completed her APA clinical internship at the University of Minnesota Medical School in pediatric neuropsychology before completing a two-year postdoctoral associateship conducting integrated neuropsychological and psychological testing with children and adults at Integrated Assessment Services with Dr. Melinda Kulish (Concord, MA). Currently, she is a staff neuropsychologist at a neurology clinic in Minneapolis/St. Paul, MN, where she conducts neuropsychological evaluations with older adults. In addition to her assessment experience, Jennifer has conducted individual psychotherapy with clients across the lifespan; has worked in case management for adults with severe and persistent mental illness; and has experience as a home-based therapist for children with emotional and behavioral disorders.

Jennifer's doctoral research explored the role of family environment in the relationship between life stress and psychopathology in internationally adopted children. Additional interests include attachment, affective neuroscience, and developmental psychopathology. She also has training in Therapeutic Assessment and is working toward certification.

Jennifer earned her doctorate in clinical psychology (The Chicago School of Professional Psychology) following her B.A. (New York University) and M.A. (Columbia University). Prior to her career shift into psychology, she was a professional dancer in New York City.

Appreciating Constance Fischer's Openness to Diverse Lives

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Online presentation on the occasion of the presentation of the Distinguished Contribution to Assessment Award, *by the Assessment Section of the Division of Clinical Psychology. Annual Convention of the American Psychological Association, August 4, 2023*

First, I would like to say how honored I am to speak to you today and how much I celebrate the Assessment Section for recognizing Connie Fischer's immense contributions to psychological assessment. Although Connie has received important accolades, including SPA's Bruno Klopfer Award and Division 32's Carl Rogers Award, I personally think her influence on our field is underappreciated. Therefore, I welcome this chance to recognize Connie and highlight an aspect of her work that I believe has not yet been spoken or written about.

As many of you know, Connie contributed to an on-going paradigm shift in which psychological assess-ment is now increasingly seen as an enterprise that can directly benefit the people being tested, as well help the professionals who work with those individu-als. Connie is also recognized as a pioneer in *collabora-tive* psychological assessment, as she undertook such practices as inviting clients to discuss the implications of their standardized test responses (Rorschach per-cepts, TAT stories, ways of approaching the Bender Gestalt Test and the WAIS) and link them to their usual ways of approaching real life situations. And Connie was a huge proponent of writing psychologi-cal assessment reports in plain language that could be shared with clients, and she typically asked assessees to write comments on their reports, which were then shared with other readers.

All these facets of Connie's work with assessment have been recognized before. What I would like to draw our attention to today is Connie's incredible ability to be in relationship with people from widely diverse back-grounds and to gain their trust through her respectful yet unwavering efforts to understand their life worlds. I believe this quality of Connie's approach is relevant to dilemmas facing psychological assessors today, and that understanding Connie's "radical openness" (to use a phrase from Carl Rogers, 1961) can help us all as we aspire to work responsibly with clients from diverse backgrounds.

Characteristics of Fischer's Assessments of Diverse Clients

Fortunately, over the years Connie left us detailed accounts and transcripts of her interactions with many different types of clients. During her practicum and internship training in Lexington, KY and Pittsburgh, Connie worked with hospitalized psychiatric patients and prisoners, and we have some accounts of these experiences. Mainly, however, Connie wrote about her assessments of outpatient adults and children struggling with a variety of problems-in-living, including relationship and work difficulties, academic problems, depression, anxiety, suicidality, alcohol and drug dependence, psychosis, and obsessive-compulsive disorder. In addition, throughout her career, Connie did forensic assessments, mostly pre-sentencing and parent-fitness evaluations. She also did screening assessments of individuals applying to be nuclear plant operators, police, and air traffic controllers. The individuals she described so vividly in her written cases came from a variety of races, cultural backgrounds, and economic classes. I wish I had time to read some of those case accounts to you here today, as they are fascinating and compelling. Instead let me highlight what stands out to me from careful reading of the transcripts of Fischer's assessment sessions and her assessment reports:

1. In each assessment, Connie was curious and open to learning from the clients and asked them to teach her about their perspectives and their lives.

2. Connie kept the goals of the clients and referring professionals foremost in her mind and tried to connect all discussions of test responses and results to those goals.

3. Connie adopted the language of the clients and asked questions that made use of the information they brought to the discussions about their life contexts.

4. Connie was empathic, in terms of extending herself to understand the clients' experiences, but she was not overly sympathetic or rescuing of the clients. She spoke to clients clearly, simply, kindly, and sometimes bluntly.

5. Connie made use of standardized tests, but not in a rote or overly formulaic manner. She saw tests as opportunities to learn more about her clients' lived experiences and struggles and as she often said, she "prioritized the life world" over test scores.

6. Connie was acutely aware of her clients' contexts and how they were connected to their struggles. Reading her psychological reports, there is a sense that she saw not only where clients were and how they got there, but also where they could go in the future.

I would like to suggest to you that these aspects of Connie's work are a good model for all of us when we are asked to assess clients from different races, cultures, national origins, immigration statuses, gender identities, sexual orientations, or physical abilities. If we can do this, I believe all our clients would feel understood, respected, and enhanced by our psychological assessments and that we could help them find their individualized next steps in their growth process.

To help us all be more "Connie-like" (or at least those of us who strive to be so) I want to share my thoughts about how Connie developed her "radical openness" to other people. There are 4 factors that come to mind. Because of time, I'll speak briefly about the first three and say more about the fourth.

Early Secure Attachment

First from talking to Connie about her growing up years, my sense is that she had stable, responsive, trustworthy parents and hence developed a secure attachment early on. I believe the internal security she developed as a result of this made her more flexible and less anxious about "losing herself" if she truly opened up to other people. It also gave her the internal secure base necessary for exploring new ways of working and withstanding criticism, for example when she deviated from societal expectations placed on her due to her gender, class, or race.

Early Encounters with Different Cultures

Connie's father was a career military officer, and as is typical, he was transferred to different locations every 2-3 years. These moves thrust Connie into contact with many different types of people and cultures, and it had a lasting effect. To quote from Connie's 1985 book, *Individualizing Psychological Assessment:*

> *By the time I had finished college, I had attended 17 schools in three countries and 10 states, and hence had developed a respect for parochialism—for richness found with differences, for the transcendent universality of which all the differences were constituents, and for the difficulty of communicating across differences of background and purpose.* (Fischer, 1985, p. 11)

As an example of these experiences, Connie told me how disorienting it was after being in integrated military schools in Europe to return to the USA (Georgia in particular) and see whites' treatment of "the colored." She quickly recognized this as a version of the Nazi's treatment of the Jews and other minorities.

Being a Member of Several Depreciated Groups

Next, I believe that Connie's openness to and appreciation of people of different races, social classes, and cultures was based in her own experience of being a member of several different depreciated groups. When her family was stationed in Europe, they met with open hostility from some of the French and Germans, and again, her parents supported her and her brother in understanding these incidents. (Thankfully, the family also experienced moments of great kindness.) But more important, in my mind, was Connie's experience of being an intelligent, vibrant, and creative woman at a time when women were depreciated even more than they are today (at least in the USA). For those of you who are interested, I recommend Connie's autobiographical chapter at the beginning of her collected papers (Fischer, 2017), in which she recounts many incidents of egregious, demeaning and threatening behavior by male faculty and colleagues. Still, she persisted in her education and became the

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incredible person she was, but I believe these experiences left her with empathy for people who are put down by our culture at large.

A Phenomenological World View

From many conversations over the years with Connie, I believe the biggest factor underlying her "radical openness" is that she deeply internalized a phenomenological world view, both as a result of her study of European phenomenologists early in her career, and of being part of the psychology department at Duquesne University, initially put together by Amedeo Giorgi. Duquesne is still internationally renowned for its existential-phenomenological perspective, and as many of you may know, the Duquesne faculty developed a "human science" approach to psychology that contrasts with the "natural science" or "positivistic" approach that permeates graduate education in many other places.

For those of you who are not familiar with the terminology I am using, "positivism" (sometimes called "logical positivism") is a philosophy of science that posits that true knowledge can only be derived from mathematical and logical analysis of direct sensory information. Introspective and intuitive knowledge is largely rejected, and quantitative research is seen as essential for identifying presumed quasi-absolute laws of nature (i.e., "Truth" with a capital "T"). In contrast, "phenomenology" rejects the notion of "absolute truth" and instead focuses mainly on *experience.* Experience is seen as resulting from an interface between the properties of the natural world and how those properties are perceived and interpreted by us humans. As an example, phenomenologists recognize that whether you experience the weather this weekend in Austin as "hot" doesn't depend just on the actual physical temperature and humidity, but also on whether you arrived here from Sweden or Tokyo, have ever lived in Texas before, and grew up in a warm or cold climate. As I once heard Connie say, "We can only know through our relationship with the world."

Giorgi's phenomenological psychology brought a new kind of rigor to the study of subjective experience and demonstrated, for example, that qualitative research methods could be equally scientific and valuable in understanding the world, and that such approaches were sometimes more useful than quantitative methods. Connie and her colleagues were pioneers in the development of these rigorous, empirical, qualitative research methods. They posited that because human beings are inherently meaning-making organisms, we needed a new "human science" psychology that would require different methods and assumptions than those used in the natural sciences, such as qualitative research.

When Connie was asked to teach the "testing course" (as it was then called) at Duquesne University, she brought this "human science" approach to psychological assessment and subsequently turned traditional the practice of assessment on its ears. For example, a very common method in qualitative research is to check at the end of a research project whether your research subjects resonate with and agree with the conclusions you have derived about their lives and experiences. Similarly, Connie and her students began showing psychological reports to clients after an assessment and asking clients to comment on whether they were accurate and helpful. This was during a time when the majority of psychological reports were clearly stamped on the front page: "Do not under any circumstances share with the patient."

As Connie demonstrated, if you believe that "truth is perspectival" and there is no "Truth with an absolute T," then you will *inevitably* start inventing or incorporating collaborative procedures into your psychological assessments, such as asking clients to comment on your test interpretations or inviting them to share what they noticed or experienced about their test responses. Such practices are seen as essential to truly understanding others' lives. And if you believe that there is no such thing as a truly "objective observer," you will strive to become aware of your own stimulus value and influence on the information you are provided and on the conclusions that you draw. In my mind, this phenomenological perspective leads to humility, curiosity, and openness towards our clients that in turn profoundly influences their relationships with us. And I believe this way of viewing the world is the primary "magic ingredient" underlying Connie Fischer's radical openness to clients of many diverse backgrounds.

In closing I want to caution that if you aspire to be radically open like Connie in your psychological assessments, it is not easy, and you may find yourself more in touch with anxiety and insecurities. When

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we take off our "white coats" and adopt an intersubjective perspective, we cannot hide behind fixed test interpretations or standard labels to make us feel expert or knowledgeable. And when we truly understand that we inevitably influence the understandings we derive of our clients, then we must face things about ourselves we might otherwise have preferred not to know. Robert Stolorow (Stolorow & Atwood, 1992) has written about the "unbearable embeddedness of being" that comes with a phenomenological perspective, and I believe it takes courage and commitment to view the world and do psychological assessments with this kind of awareness. Thankfully, Connie provided a good model, and it was clear to all of that she had a great time doing her work. I will always be incredibly grateful for her example and for her personal support of me.

References

Rogers, C. (1961). *On becoming a person: A therapist's view of psychotherapy.* Constable.

Fischer, C. T. (1985). *Individualizing psychological assessment.* Brooks Cole.

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

Stolorow, R. D., & Atwood, G. E. (1992). *Contexts of being: The intersubjective foundations of psychological life.* Analytic Press.

Author Bio

Stephen E. Finn is the founder and President of the Therapeutic Assessment Institute. He practices at the Center for Therapeutic Assessment in Austin, Texas.

Spotlight on Recent TA Certifications

Dr. Qi-Wu Sun

Qi-Wu Sun completed his certification in TA with Adults in October 2023 under the mentorship of Stephen Finn. Qi-Wu completed his Ph.D. in 2011 at Central China Normal University in Wuhan, China, where he is now an Associate Professor and Director of the student counseling center. He spent a year in the USA in 2018-19 as a visiting scholar at the University of North Texas. Qi-Wu was well trained in humanistic and psychoanalytic psychology and himself began to contemplate how psychological assessment could be therapeutic for clients. He did some research online and to his surprise and delight he discovered TA. He emailed Steve Finn in 2020, they began to work together, and Qi-Wu began both to learn TA and to introduce it to Chinese colleagues. Under his leadership, there have now been a series of workshops and courses in China: on TA, the MMPI-2, the Crisi Wartegg System, and the Early Memories Procedure. (See p. 32 for a report of recent activity in Wuhan.)

Qi-Wu is a busy and productive person. Besides his other duties, he is a committee member of the Division of Clinical and Counseling Psychology of the Chinese Psychological Society and a member of the Ethics Committee of the New Oriental Institute. He also helps run TAISI, a private practice clinic in Wuhan that specializes in psychological assessment. Qi-Wu's next adventure in TA will be pursuing certification in TA with Adolescents. He is married to Elaine Gao and has an 8-year-old son, Boen. His hobbies include traveling and listening to classical music.

We are delighted to have Qi-Wu in the TA community and grateful to him for introducing TA in mainland China.

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Dr. Annemiek Laros

My name is Annemiek Laros, and I work and live in the Netherlands. Since 2008, I have worked in a team with Hilde de Saeger. I trained with Steve Finn at the Viersprong, and later in Milan at the European Center for Therapeutic Assessment. I started my career there and moved to different jobs over the years. I have worked in a medical setting (voluntary and inpatient treatment) and in an ambulatory setting with general psychiatric problems. I have participated in multiple trainings in different therapy models. However, ever since the TA trainings, I kept coming back to Collaborative/Therapeutic Assessment and received consultation from Hilde. Besides working in the mental health care, I also teach assessment in a specialized training program for mental health specialists in the Netherland. As part of that work, I give my students a flavor of Collaborative/Therapeutic Assessment. Last summer, after multiple prompts from Hilde, I started the TA certification process. It was a pleasant and educational process, which strengthened my confidence that working with TA really fit me.

In my personal life, I am together with Wicher, and I am a mother of two beautiful daughters. Being a mother has taught me a lot about myself and about kids, and it helped me build more respect for my clients. Being a mother also made it easier to understand why my clients became the adults they are. I have a special interest in personal development and deepening my relationships with my loved ones, and I guess it is the choice to be vulnerable that keeps me learning and helps me engage authentically with my clients in TA. During non-work time, I enjoy painting and writing. I also love to be in nature and go on adventures with my family. I am very pleased to be a part of the TA community and I would love to meet some of you in person someday.

As her mentor and supervisor, I (Hilde De Saeger) was always impressed by Annemiek's authenticity. With her calm demeanour, she naturally builds trust with her clients. It has been a pleasure to be her mentor over the years and I look forward to what we can do together for clients and with TA.

TA Training in China

Steve Finn recently conducted 4 days of TA training (on Initial Sessions and Extended Inquiries) in Wuhan, China. The training was organized by Dr. Qi-Wu Sun (newly certified in TA—see p. 31) and Dr. Ming Wang. Twenty-four people attended all 4 days of the training, and participants came from Wuhan, Beijing, Shanghai, Guangzhou, and Chongqin. A celebration dinner was held on the third day, and in keeping with Chinese tradition, people took turns reciting poems, signing songs, and giving toasts. Another training is planned for next fall, and there is growing interest in TA in China.

Attendees sang songs at the celebration dinner.

Attendees applauding a role play.

An attendee asked questions

Attendees focused on the role play

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Recent Publications

- Fantini, F., Aschieri, F., & Finn, S. E. (2022). Therapeutic Assessment: Linking assessment and treatment. In Asmundson, G. (Ed.), *Comprehensive clinical psychology, 2nd Edition* (pp. 321-335). Elsevier.
- Klibert, J., Simpson, M., Weiss, B., Yancey, C.T., Pritulsky, C., Luna, A., Houseman, H., & Samawi, H. (2023) Increasing character strength knowledge, interest, and skill: Preliminary evidence for a collaborative and multimethod assessment procedure. *Frontiers in Psychology,* 14:1179052. doi: 10.3389/fpsyg.2023.1179052.
- Satapathy, S., Kaur, M., Yadav, P., Bagri, S., Dhandapani, N. K., Hans, G., & Sharan, P. (2022). Therapeutic assessment as a brief and intensive intervention for avoidant restrictive food intake disorder, belching, and histrionic personality disorder: A case report. *Indian Journal of Case Reports*, 397-399. 10.32677/ijcr.v8i12.3728.
- Thomas, K. M., & Finn, S. E. (2022). Therapeutic Assessment: Psychological assessment as an intervention. *Reference Module in Neuroscience and Biobehavioral Psychology*. doi: 10.1016/8978-0-323-91497-0.00088-6.
- Yan, W., Shen, Z., Yue, B., Sun, Q., & Wang, M. (2023). Effect and mechanisms of Therapeutic Assessment and its development in Chinese culture. *Advances in Psychological Science, 31*(10), 1952-1965.

Upcoming Trainings

January 10 & February 14, 2024; Virtual

Brief Therapeutic Assessment with Adult Clients

Presenter: Stephen E. Finn

Sponsor: Collaborative Assessment Association of the Bay Area (CAABA)

Language: English

Schedule: January 19 & February 24, 6:30 PM – 8:00 PM PT

Information: www.caaba.info

January 19, 2024; Virtual

"I didn't know I could talk about that." Using the MACI-II and M-PACI to build alliance and therapeutic dialogue in a Collaborative/Therapeutic Assessment framework. (2 CE Credits)

Presenter: Seth Grossman

Sponsor: Therapeutic Assessment Institute

Language: English

Schedule: February 19, 10:00 AM – 12:00 PM CT

Information: www.therapeuticassessment.com

Upcoming Trainings: Continued

February 23, 2024; Virtual

When the Body Tells the Story: Understanding Dissociative and Somatic Presentations in Adolescent Assessment (2 CE Credits)

Presenters: Raja M. David & Abby Hughes-Scalise

Sponsor: Therapeutic Assessment Institute

Language: English & live Spanish translation

Schedule: February 23, 10:00 AM – 12:00 PM CT

Information: **www.therapeuticassessment.com**

March 13, 2024-San Diego, CA, In-Person (Society for Personality Assessment Annual Meeting)

Using the Adult Attachment Projective Picture System (AAP) as a Therapeutic Tool (3.5 CE Credits)

Presenters: Stephen Finn, Carol George, Caroline Lee, and Melissa Lehmann

Sponsor: Society for Personality Assessment

Language: English

Schedule: March 13, 8:00 AM – 12:00 PM PT

Information: **www.personality.org/2024-spa-convention**

March 14, 2024-San Diego, CA, In-Person (Society for Personality Assessment Annual Meeting)

Embrace the Complexity: Integrating Assessment Results into Client-Centered Feedback Sessions

Presenters: Hilde De Saeger & Pamela Schaber

Sponsor: Society for Personality Assessment

Language: English

Schedule: March 14, 8:00 AM – 12:00 PM PT

Information: **www.personality.org/2024-spa-convention**

March 14, 2024-San Diego, CA, In-Person, virtual (Society for Personality Assessment Annual Meeting)

Fostering Therapeutic Change Through the Early Memory Procedure: An Attachment Perspective-Symposium

Presenters: Serena Messina-Chair, Diane Santas, Pamela Schaber, & Melissa Tester

Sponsor: Society for Personality Assessment

Language: English

Schedule: March 14, 3:00 PM – 4:30 PM PT

Information: **www.personality.org/2024-spa-convention**

March 15, 2024-San Diego, CA, In-Person, virtual (Society for Personality Assessment Annual Meeting)

Truth Be Told: How Feedback Using the AAP Resonate with Client's Lived Experiences

Presenters: Carol George & Melissa Lehman

Sponsor: Society for Personality Assessment

Language: English

Schedule: March 15, 8:00 AM – 9:30 AM PT

Information: **www.personality.org/2024-spa-convention**

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Upcoming Trainings: Continued

▶ *March 15, 2024-San Diego, CA, In-Person, virtual (Society for Personality Assessment Annual Meeting)*

Therapeutic Assessment in the Wild: (Trying To) Put Theory into Practice

Presenters: Sara Boilen, Ori Elis, Caroline Lee, Anna Sapozhnikova, Sarvenaz Sepehri, Katherine Thomas, & Elizabeth Winston

Sponsor: Society for Personality Assessment

Language: English

Schedule: March 15, 2:00 PM – 3:30 PM PT

Information: **www.personality.org/2024-spa-convention**

▶ *March 16, 2024-San Diego, CA, In-Person (Society for Personality Assessment Annual Meeting)*

"How do I Exist in this World? Do I Have to Die?" Drawing from Client Belief Systems in the Assessment Intervention

Presenter: Anna Sapozhnikova

Sponsor: Society for Personality Assessment

Language: English

Schedule: March 15, 9:00 AM – 10:30 AM PT

Information: **www.personality.org/2024-spa-convention**

▶ *March 16, 2024-San Diego, CA, In-Person, virtual (Society for Personality Assessment Annual Meeting)*

Epistemic Trust in Therapeutic Assessment: Walking a Tightrope with our Clients

Presenter: Jan Kamphuis

Sponsor: Society for Personality Assessment

Language: English

Schedule: March 15, 9:00 AM – 10:30 AM PT

Information: **www.personality.org/2024-spa-convention**

▶ *March 16, 2024-San Diego, CA, In-Person, virtual (Society for Personality Assessment Annual Meeting)*

Using the Consensus Rorschach in Ultra-brief Therapeutic Assessment with Couples

Presenters: Stephen E. Finn, Noriko Nakamura, & Filippo Aschieri

Sponsor: Society for Personality Assessment

Language: English

Schedule: March 15, 4:00 PM – 5:00 PM PT

Information: **www.personality.org/2024-spa-convention**

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Upcoming Trainings: Continued

May 3 – 5, 2024, Tokyo, Japan

Using Psychological Assessment to Help Clients Recover from Unhealthy Shame

Presenters: Stephen E. Finn & Noriko Nakamura

Sponsor: Asian-Pacific Center for Therapeutic Assessment

Language: Japanese & English

Schedule: May 3 – 5, 10:00AM – 6:00PM JST (Japan Standard Time)

Information: www.asiancta.com

May 16, 2024-Virginia Beach, VA, In-Person (Inaugural Rorschach Performance Assessment System [R-PAS] Conference)

Using R-PAS to Facilitate Client Change in Therapeutic Assessment

Presenters: Raja M. David

Sponsor: Rorschach Performance Assessment System (R-PAS)

Language: English

Schedule: May 16, 9:00 AM – 12:15 PM ET

Information: https://sites.google.com/r-pas.org/conference-2024/

THE WRIGHT INSTITUTE
EDUCATING CLINICIANS TO SOCIETY

BRIEF THERAPEUTIC ASSESSMENT WITH ADULTS

Instructor: Stephen E. Finn, PhD

2 Day Workshop - Live via Zoom

Session I: January 10, 2024 from 6:30pm - 8:00pm

Session II: February 14, 2024 from 6:30pm – 8:00pm

General Admission: $20 for each session

Free for paid CAABA Members

To become a member:

https://www.caaba.info/caaba-members

Free for current Wright Institute Faculty, Students & Staff

Must register with wi.edu email to qualify for free spot.

SESSION I REGISTER BY:
JAN 9, 2024

Scan or Click QR Code

SESSION II REGISTER BY:
FEB 13, 2024

Scan or Click QR Code

CE Credits: 3 CE hours (1.5 each day)

The Wright Institute is approved by the American Psychological Association (APA) to offer continuing education for psychologists. The Wright Institute maintains responsibility for this program and its content.

Course Level: Introductory

This workshop is useful for psychologists new to the field. This workshop is primarily for psychologists; psychology students/trainees may also attend.

Description:

Therapeutic Assessment (TA) and Collaborative Assessment (CA) are short-term interventions utilizing psychological assessment to help clients and significant people in their lives understand and address persistent life challenges. The effectiveness of C/TA has been substantiated in over 40 controlled research studies and more than 100 published cases. In this two-part workshop series, Dr. Finn will outline and showcase an empirically supported concise TA model for adult clients, encompassing two to four 60-minute sessions. The objective is to enable clinicians to utilize a condensed TA approach in situations where 1) there's a high demand for services, 2) clients have limited financial resources, and/or 3) a complete TA isn't feasible due to other constraints. These presentations will also highlight how TA is adaptable and suitable for diverse client backgrounds. As TA prioritizes respect, humility, and collaboration with clients throughout the assessment process, it holds the potential to empower disadvantaged clients and foster positive perceptions of mental health professionals.

Session I:
Dr. Finn will delve into the research surrounding brief TA for adults, exploring its structure, core objectives, and guiding principles. He will subsequently concentrate on the primary step of this concise TA approach: the Initial Session. Here, he'll review its goals and specific techniques, offering insights through video demonstrations featuring his interaction with an actual client.

Session II:
Dr. Finn will discuss and demonstrate the second and third phases of brief TA: the Extended Inquiry involving a standardized test and the Summary/Discussion Session. He will outline the objectives and specific techniques for each phase, providing visual demonstrations through videos showcasing his interactions with an actual client.
(Written consent from the client has been obtained, permitting the use of these videos for training.)

Learning Objectives from Session I	Learning Objectives from Session II
• Summarize the research findings concerning Collaborative/Therapeutic Assessment; • List the procedural steps involved in brief Therapeutic Assessment; • Explain how Therapeutic Assessment is suitable for diverse clients.	• Describe the goals of Extended Inquiries; • Explain the significance of scaffolding in Therapeutic Assessment (TA); • Explain the objectives of Summary/Discussion Sessions;

Presenter:

Stephen E. Finn, Ph.D., founder of the Center for Therapeutic Assessment, is a licensed clinical psychologist in practice in Austin, Texas, USA, a Clinical Associate Professor of Psychology at the University of Texas at Austin; Honorary Professor at the Universidad Abierta Interamericana in Buenos Aires, Argentina; Senior Researcher and Director of Training at the European Center for Therapeutic Assessment at Catholic University of Milan, Italy; and Director of Training at the Asian-Pacific Center for Therapeutic Assessment in Tokyo, Japan. He has published 90+ articles and chapters on psychological assessment, psychotherapy, and other topics in clinical psychology, and is the author of In Our Clients' Shoes: Theory and Techniques of Therapeutic Assessment (Erlbaum, 2007), which has been translated into Italian, Japanese, Korean, French, Portuguese, and Spanish. The latest books Dr. Finn has co-authored are Therapeutic Assessment with Children: Enhancing Parental Empathy Through Psychological Assessment (2022, Routledge) and Therapeutic Assessment with Adults: Using Psychological Assessment to Help Clients Change (2022, Routledge). Dr. Finn has won numerous awards for his work on Therapeutic Assessment, including the Bruno Klopfer Award in 2011 from the Society of Personality Assessment for distinguished lifetime contributions to the field of personality assessment and the Carl Rogers Award in 2018 for an outstanding contribution to theory and practice of humanistic psychology from the Society for Humanistic Psychology (Division 32 of the American Psychological Association).

Please contact us in advance if you require special accommodations on the day of the event.

The Wright Institute Continuing Education Program does not receive any commercial support for any of our programs.

When the Body Tells the Story: Understanding Dissociative and Somatic Presentations in Adolescent Assessment

SPONSORED BY THE THERAPEUTIC ASSESSMENT INSTITUTE AND THE UNIVERSITY OF DENVER

Friday, February 23, 2024 | 10 am - 12 pm CST

Presented by: Raja M. David, PsyD & Abby Hughes-Scalise, PhD

Dissociative and somatic symptoms are common in adolescents even when traumatic experiences are not evident, and yet are often overlooked during psychological assessments. This two-hour workshop is designed for clinicians who are looking to improve their understanding of how to assess for dissociation and somatic distress, understand the role these symptoms play in adolescent and family functioning, and how to discuss these issues with adolescent clients and their caregivers. After an explanation of key concepts and common assessment measures of dissociation and somatization, an adolescent clinical case will be shared. This case will explore how dissociative and somatic symptoms can be addressed in the context of a Therapeutic Assessment, and how to conceptualize these symptoms from a family systems perspective. Interventions for both treating these symptoms and shifting the family system will be explained. This workshop will help increase understanding of how to work with clients who present with dissociation and somatization, both for those following a traditional model of assessment and those following a collaborative/therapeutic approach.

OBJECTIVES

By the end of this training, participants will be able to:

- Explain dissociative and somatic disorder presentations, with particular emphasis on how these symptoms can be integrated into a case conceptualization.
- Identify 2-3 measures that are useful for assessing dissociation and somatic distress in adolescents.
- Describe how Therapeutic Assessment values and skills benefit the process of talking to adolescents and caregivers about dissociation.
- List 3-4 treatment recommendations that can be useful for a case with dissociation and related family system dynamics.

TENTATIVE SCHEDULE

10 min: Introductions and workshop overview
15 min: Overview of dissociation, somatic symptoms, and related diagnoses, with an emphasis on typical adolescent presentations.
15 min: Centering dissociation and somatic symptoms in case conceptualization for adolescent psychosocial functioning.
20 min: Helpful measures for dissociation and somatic symptoms, as well as a review of how to identify these symptoms in commonly used psychological tests.
15 min: Case background, Assessment Questions (AQs), and test data.
15 min: A growing case conceptualization and identifying Levels of Information to inform the Family Assessment Intervention Session.
10 min: Talking to adolescents and caregivers about dissociation and somatic expression of psychological distress.
10 min: Integrating these ideas for a successful Summary/Discussion Session and treatment recommendations that caregivers will follow.
10 min: Questions and discussion

REGISTER

YOU CAN REGISTER ANY TIME PRIOR TO FEBRUARY 22, 2024.

PRICING

$50 – Professional Members of the Therapeutic Assessment Institute (TAI)
$75 – Professional Non-Members of the TAI
$25 – Student Members of the TAI
$40 – Student Non-Members of the TAI

Raja M. David, PsyD, ABPP, LP is the founder and owner of the Minnesota Center for Collaborative/Therapeutic Assessment. He has written various chapters and articles on Therapeutic Assessment (TA), and is co-author of the "TA manual," *Therapeutic Assessment with Adults: Using Psychological Testing to Help Clients Change* (Routledge, 2022). Raja routinely consults with clinicians and organizations looking to implement the TA model and teaches TA through workshops and graduate courses. In 2022, he joined the Therapeutic Assessment Institute (TAI) board of directors and took over editorship of *The TA Connection*.

Abby Hughes-Scalise is the Program Director for Augsburg University's Clinical PsyD Program in Minneapolis, MN. She began her career investigating relationships between child psychopathology and family systems. As her interests in health psychology grew, she shifted to working with family systems in the context of complex illnesses requiring multidisciplinary care, such as chronic pain, conversion disorder, and epilepsy. Her publication history includes co-authoring a chapter in the *Handbook of Cognitive-Behavioral Therapy for Pediatric Medical Conditions* (2019; R. Friedberg & J. Paternostro, editors) on intervention approaches for psychogenic non-epileptic seizures and multiple journal articles on parent-child relationships in the context of mood disorders. She is on the Editorial Board for the *Journal of Child and Family Behavior Therapy*.

Continuing Education

This program includes 2 CE. The University of Denver Graduate School of Professional Psychology (GSPP) is approved by the American Psychological Association to sponsor continuing education for psychologists. GSPP maintains responsibility for this program and its content. CE credits are included in the price of the webinar.

Non-Discrimination Statement

The TAI does not discriminate on the bases of race, color, national origin, religion, sex, disability, military status, sexual orientation, gender identity or age. The TAI is committed to accessibility and non-discrimination in all aspects of its continuing education activities. Participants who have special needs are encouraged to contact program organizers so that all reasonable efforts to accommodate these needs can be made.

Conflict of Interest

In compliance with continuing education requirements, the presenter must disclose any financial or other associations with companies to which they have a direct and/or financial relationship related to the topic/content of this presentation. There is no commercial support for the program, instructor, content of instruction, or endorsement of products.

Special Accommodations

GSPP is compliant with the American with Disabilities Act. For any special accommodation needs, please contact drpamelaschaber@gmail.com.

Cancellation Policy

Cancellations before **February 22nd** will lead to a full refund. Cancellations after the date will receive a 50% refund. If the event is cancelled for any reason, we will refund your fee in full. We reserve the right to deny participation to any applicant or to cancel the workshop for any reason.

Grievance Procedures

Your satisfaction is our goal. Concerns should be addressed to: drpamelaschaber@gmail.com.