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Common Practice

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Often when Connie Fischer was teaching her individualized, collaborative approach to assessments, students would remark, "This seems like common sense." With a slight chortle, Connie would reply, "Common sense, but not common practice." Many TA assessors can recognize the truth in her statement, but there have been several events in 2025 that demonstrate that collaborative and therapeutic approaches to assessment are becoming *common practice*.

To start, in June, the 4th International Collaborative/ Therapeutic Assessment conference was held in Salt Lake City. In the hills of the University of Utah, 152 participants from 14 countries participated in-person and virtually. Over three days, participants were treated to one high-quality presentation after another, as well as opportunities to connect with our community. Much thanks to co-chairs Pamela Schaber and J.D. Smith for their leadership, and the Society for Personality Assessment (SPA), the Colorado Assessment Society (CAS), and the Collaborative Assessment Association of the Bay Area (CAABA) for their partnerships, and sponsorship of scholarships and the Spanish translation. The TAI Board Members were very pleased with the conference and began planning for the next conference to be held in 2028.

Second, in March, the annual SPA conference occurred in Denver, CO and hundreds of participants attended the largest number of C/TA themed presentations yet to be seen at SPA. The SPA C/TA Interest Group also held a meet and greet event, during which attendees participated in a meet-and-greet activity. A challenge for some of our more introverted members, but a special opportunity to build community.

Third, the 6th edition of *Diagnostic Interviewing* (Segal, 2025) was just published. This book is a seminal text on diagnostic interviewing, the likes of which would be a required book in a graduate level course on diagnosing, assessment, or conducting an intake. The book begins with an introduction to conducting an initial assessment, and in chapter two, interpersonal skills and ways of establishing rapport are described. TA is specifically mentioned as an approach that helps professionals build empathy for their clients. The authors note that the collaborative and curious interpersonal stance TA assessors adopt can "mitigate unhelpful negative emotions in interviews like fear, shame, apprehension" (Kenigsberg et al., 2025, p. 39). I suspect most TA assessors have recognized the benefits of a collaborative interpersonal stance with clients, but mention of TA in this text, one that is geared towards mental health professional who may not do psychological testing, seems to be a sign of how the TA concepts, skills, and values are spreading.

Finally, the adult TA manual (*Therapeutic Assessment with Adults: Using Psychological Testing to Help Clients Change*) was published in 2022, and last month the first international edition was published in Italian. The co-authors are thrilled that this text will be accessible to our Italian colleagues.

What constitutes *common practice* appears to be shifting.

Kenigsberg, Z., Bistricky, S. L., & Marek, R. J. (2025). Interviewing strategies, empathy, and rapport. In D. L. Segal (Ed.), *Diagnostic interviewing* (pp. 33-58). Springer.

This Issue

This edition is impressive for a variety of reasons, but paramount is the fact that all the articles are written by leaders in the assessment field. I'm grateful to each of these authors for taking the time to contribute their knowledge.

To start, Jacob Palm and Jessica Lipkind have pulled together their excellent presentation on integrating R-PAS and Wartegg data. Some readers may have been fortunate to see this presentation at the inaugural R-PAS conference in 2024 or at SPA in 2025. If you could not attend either, fear not, as their article captures convincing arguments for the utility of both performance-based measures in TA, and includes a

table that compares different R-PAS and CWS variables related to different psychological domains.

Next Julie Craddock-O'Leary teamed up with Seth Grossman, Donna Kelley, and Jason Turret to describe ways to identify, and work with, shame during a TA. Those familiar with the Thurston Craddock Test of Shame (TCTS) know about the primary shame defenses of Deflation, Aggression and Inflation/Contempt. In this article, Julie describes a new defense: Avoidance. Through complex client cases, each author demonstrates how test data illuminate shame and the Avoidance defense.

Last, Filippo Aschieri has partnered with Annapaola Blasi to describe recent research on Collaborative/Therapeutic Assessment. Clinical experience tells us that C/TAs can be efficacious, but their article highlights why, and common patterns of change.

Become a Member of the TAI

The Therapeutic Assessment Institute (TAI) began offering memberships in 2017 and currently has close to 300 members. Membership in the TAI gets you two issues a year of *The 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), Rorschach Performance Assessment System (R-PAS), and workshops offered through the Minnesota Center for Collaborative/Therapeutic Assessment (MNCCTA). The membership fee is very reasonable, at $75 per year for professionals and $40 for students. Please consider joining to receive these benefits and to help support the TAI's mission.

The Leonard Handler Fund

The Leonard Handler fund assists economically disadvantaged clients who would benefit from a TA but cannot afford one. Leonard Handler (1936-2016) was a brilliant researcher, teacher, and clinician who developed groundbreaking methods used in TA, especially with children and families, such as the Fantasy Animal Drawing and Storytelling Game. Please consider donating to this fund through the TAI website to help make TA available to everyone, regardless of income level. The economic effects of the COVID-19 pandemic underscore the need for support. We are continuing to build this fund and hope to have information on the TA website on how TA-trained assessors can apply for these funds to support underserved clients that otherwise could not afford a TA-informed assessment.

Donate to TA

The TAI is a nonprofit organization with a volunteer Board, and all donations are tax deductible. Please consider contributing, so we will be able to continue to spread TA and provide the best available mental health services to the clients we serve. And please tell your well-to-do contacts about the worthwhile mission of the TAI. We currently use most donations to support scholarships for students and professionals who need financial assistance to attend trainings, and we hope to provide financial support to underserved clients through the Leonard Handler Fund. We are also developing training materials for those of you who find it difficult to travel to our workshops, and as mentioned earlier, we will continue to sponsor high-quality online trainings. These activities take a great deal of time, and we count on your generosity to do all we do.

Future Issues of the TA Connection

I continue to enjoy my role as editor of *The TA Connection* and believe this edition has much to offer. If what you read results in you thinking, "I have an idea for an article," then reach out! I aim to provide a supportive process for contributing authors and whether you've written many manuscripts or none, know that your ideas are welcome and if you want to contribute, guidance will be provided.

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

Complementary and Incremental Contributions of the Rorschach Performance Assessment System (R-PAS) and Crisi Wartegg System (CWS): The Benefits of Using Multiple Performance-based Measures in Collaborative/Therapeutic Assessment

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In today's assessment environment, clinicians find themselves faced with the challenges of both less time and reduced reimbursement. Given these constraints, careful consideration of test selection, productivity measurement, and cost-benefit analyses of the inclusion of additional measures in the assessment battery are paramount to the sustainability of professional practice. Collaborative/Therapeutic Assessment (CTA) has always placed value on the incorporation of multiple test measures—both self-report and performance-based— to aid in conceptualization and understanding of the client… but, in this day and age, can the current assessment marketplace support multiple performance-based measures? That is, is there complementary and incremental validity to utilizing two of the most widely used performance-based measures—the Rorschach Inkblot Method according to the Rorschach-Performance Assessment System (R-PAS) and Wartegg Drawing Completion Test according to the Crisi Wartegg System (CWS)—within the same assessment battery?

The current article supports the use of both measures highlighting the complementary and incremental information afforded by each measure, as applied to the case study of a pre-adolescent client. Brief consideration of current systemic constrictions on psychological assessment, as well as the benefits of multi-method (including multiple performance-based assessments measures) assessment in CTA will first be reviewed. Introduction to the client, including a brief review of her approach to both the R-PAS and CWS will next be offered. A table highlighting the complementary and incremental contributions of both measures will follow. Lastly, a summary of the impact of assessment results will be provided, supporting the use of multi-measure assessment within the context of CTA.

Author Note: This case has previously been presented to the Collaborative Assessment Association of the Bay Area (CAABA), the Colorado Assessment Society (CAS), and at the inaugural Rorschach-Performance Assessment System Conference (2024).

Systemic Constrictions of Psychological Assessment

Assessment psychologists are facing ongoing systemic constriction of assessment services, forcing greater efficiency, emphasis on measured productivity, and reduced reimbursement opportunities (as has been written about previously in *The TA Connection*; see David, 2013). According to the Centers for Medicare and Medicaid Services (2024), reimbursement rates for psychological assessment and related services have decreased by approximately 15% over the last three years, with greater limitations placed on reimbursable hours. These reimbursement reductions and policy adjustments (Therathink, 2025), along with revisions to CPT codes, guidelines provided by the American Psychological Association (APA, 2025), and private insurance carriers cost-containing measures, directly impact work of assessment psychologists (Norcross, Pfund, & Cook, 2021) — including time spent with clients, assessment measures selected, and comprehensiveness of evaluations. Moreover, university, medical-hospital, and other complex systems are implementing outcome-based productivity standards, enhanced by the use of artificial intelligence, to track time spent, measurable impact, and "success" (variably defined) of mental health services, including assessment (APA, 2023). These types of monitoring and productivity-based workplace expectations have been noted to increase the stress-levels and discomfort of workers (Lerner, 2024; Ravid, White, Tomczak, Miles, & Behrend, 2023), as well as negatively impacting comprehensiveness of delivered services, therapeutic alliance, and administrative workload (Bruns et al., 2018; Solstad et al., 2019; Sundet, 2012). Linking time and reimbursement rates to productivity evaluations was noted to "under-value psychological assessment" specifically, given "non-billable services that are also of high value" to client outcomes (Dawson & Speelman, 2023). Given the ever-increasing constriction on service delivery, and efforts to measure productivity and efficiency, why would assessment clinicians choose to utilize two performance-based measures?

Importance of Multi-Measure Assessment in CTA

In many ways, multimethod assessment is the foundation upon which CTA rests, facilitating a nuanced and thorough understanding of the client's experience from multiple perspectives; that is, multimethod assessment leverages the strengths of various tools and measures to capture the complexity of psychological functioning (Finn, 2007). By minimizing the risk of single-method biases (Hayes et al., 2015), use of multiple tests further allows the richness of the client's self-story and personal narrative to emerge (Finn & Martin, 2013), while ensuring reliability and validity of test data as supported by concurrent and incremental findings related to complex psychological constructs (Bornstein, 2017; Meyer et al., 2001). Given the central tenet of collaboration inherent to the CTA model, using multiple measures allows for tailoring the test battery to the client's specific needs and questions (Finn & Tonsager, 1997; Tharinger et al., 2008), while discrepancies between measures and unique findings of specific tests can reveal defenses or unconscious processes to be capitalized on in therapeutic interventions (Handler & Meyer 1998). Lastly, multimethod assessment allows for culturally sensitive measure selection and interpretation, emphasizing the importance of cultural, contextual, and individual differences (Dana, 2005; Groth-Marnat & Wright, 2016), aligning with the idiographic goals of CTA.

While much of the multimethod research has focused on integration of performance-based measures with self-report measures, authors have noted that combining multiple performance-based measures (or projective measures) oftentimes provides a more nuanced and psychologically richer clinical picture specifically beneficial to personality assessment (Weiner, 2003). Bornstein (2011) noted that multiple performance-based measures improve *construct representation* and capture dynamic intrapsychic processes oftentimes missed by questionnaires or interviews used in isolation. Lastly, as in the case presented below, it has been suggested that different performance-based measures access different aspects of personality (Handler & Hilsenroth, 2013), providing a deeper understanding of the client while simultaneously strengthening confidence in interpretations.

Crisi and Shorey (2009) have previously offered comparisons of Wartegg and Rorschach Comprehensive System (Exner, 2003) findings, via case study, noting both complimentary and incremental contributions. Specifically, the authors found "a high level of concordance in relation to affective experience, negative intrusive ideation, coping strategies, and ability to recognize conventional reality. This convergent validity is impressive given the different modes of respond-

ing to the two tests (spoken language vs. drawing)." The measures diverged in domains related to thought process and ideation, as well as suicidal risk, with the Rorschach identifying thinking and reality testing distortions not evident in the Wartegg, and the Wartegg demonstrating higher sensitivity in detecting suicidal risk. The authors recommended further research related to the intersection of the Rorschach and Wartegg tests.

It is with this recommendation in mind, as well as the previously enumerated benefits of multimethod assessment—deeper understanding of complex personality, improved construct representation, access to varied aspects of personality and functioning, and strengthened confidence in clinical interpretations—we present the case of "Darcy," specifically focusing on the convergent and incremental contributions of two performance-based measures within the context of a child CTA—the Wartegg Drawing Completion test, administered according to the Crisi Wartegg System (CWS; Crisi, 1997; Crisi, 2007; Crisi & Palm, 2018), and the Rorschach Inkblot Method, administered according to the Rorschach-Performance Assessment System (R-PAS; Meyer et al., 2011).

Case Application

Methodology: Within the context of a child CTA, the second author (Lipkind) administered both measures to the client presented in the case study. The second author interpreted the Rorschach (according to the R-PAS). The primary author (Palm) interpreted the Wartegg (according to the CWS) without having met the client or discussed the case. Both authors collaborated, via ongoing consultation, on the creation of the comparative table, presented below, which informed CTA interventions, comprehensive case conceptualization, and the current article. It should be noted that this case has been presented at several professional conferences, with feedback from participants used to refine the materials presented here.

Introduction to "Darcy": At the time of referral, "Darcy" was a 10-year-old Biracial female of White and African American descent. She lived with her mother, father, and older sister. Darcy was referred due to concerns about inattention and hyperactivity, as well as significant periods of emotional dysregulation that felt abrupt and unpredictable both at home and at school. Her parents described her as a "very happy" and upbeat child who was creative, loving, and warm, but who also quickly became distressed when she experienced frustration with a task or experienced a misunderstanding with someone else. In these moments, she became tearful, yelled at those around her, and refused any soothing or adult support.

When Darcy's parents were asked why they believed these episodes of emotional dysregulation were occurring, they offered a few ideas. First, they suggested that Darcy tended to hide her less comfortable feelings and prioritized a happy exterior with others, leaving her parents curious about the feelings she was experiencing under the surface. Second, while her family often talked about their racial identities and worked hard to instill pride in Darcy about being Biracial, this was complicated for her. Darcy was phenotypically White-presenting, as she had very pale skin and blond hair, and she often expressed sadness that she did not look like her mother and sister (who are phenotypically Black-presenting). Her parents wondered how this may be affecting her self-concept.

Overall, Darcy's parents indicated that they wanted to understand why these episodes of emotional dysregulation occurred, how to best support her, and how to prevent these behaviors from further negatively impacting peer interactions (as peers had begun to experience her as unpredictable).

Darcy's parents identified the referral questions in Box 1. When provided the opportunity to develop her own questions, Darcy denied difficulties and verbalized no assessment questions.

Darcy presented to the testing sessions as an energetic, positive, and engaging child. She was chatty and eager to share about her favorite movies, as well as describe

Box 1. Darcy's Parents' Assessment Questions (AQs)

1. Does she have ADHD?
2. What is happening with her ability to hold information in memory?
3. How can we help her retain information she's less motivated about?
4. Is her avoidance of stuff getting bottled up?
5. Is she experiencing anxiety?
6. How do we help her learn some healthy coping skills?
7. How do we sustain her confidence?
8. How do we help her tolerate discomfort?

her recent artwork. She put great effort into tasks but easily became tired and distracted and needed frequent breaks during the administration of testing measures. Darcy was highly avoidant of any emotional topics throughout the process. For instance, she displayed significant denial on administered self-report measures (Revised Children's Manifest Anxiety Scale-Second Edition, Piers Harris Self-Concept Scale-Third Edition), elevating the defensiveness scales. On a projective story-telling task, she consistently avoided identifying the emotions of the characters and became frustrated when prompted to add it to her story. Similarly, on a projective sentence completion task, she minimized emotional experiences, idealized relationships, and offered practical memories and aspirations.

The emotional lability reported by her parents was evident on two occasions during the testing process when Darcy abruptly displayed distress—the first during the WISC-V, and the second during the R-PAS (described below in *General R-PAS Observations and Impressions*). First, during the Block Design subtest of the WISC-V, when she recognized that she made an error (i.e., incorrectly completing two designs in a row, leading to discontinuation of the subtest), Darcy's eyes filled with tears very quickly. When asked what happened, Darcy responded, "I always do spelling and math perfect, and I always do them all, and I couldn't do this!" Following empathic reflection from the examiner, and encouragement to think about and discuss her experience, Darcy quickly recovered, minimized her distress, and verbalized a preference to return to structured testing.

General R-PAS Observations and Impressions: While Darcy denied any emotional distress on self-report measures, the R-PAS provided a window into her underlying emotional experience. Although she initially appeared to understand the instructions for the R-PAS, she needed two Prompts, which indicated a need for structure to help her settle into the activity. She also did not turn the card at all, which was unusual for youth her age, suggesting that she may have participated from a more compliant and rule-governed stance.

In general, Darcy's 26 responses to the R-PAS appeared affectively driven, involving creative, fanciful, and pop culture references and content, as well as symbols and reflections. A selection of some of Darcy's R-PAS responses is provided in Table 1.

As mentioned above, Darcy became dysregulated during R-PAS administration, exhibiting distress at the beginning of the Clarification phase. While she appeared to enjoy the Response phase, Darcy immediately appeared concerned that she was not answering posed clarification inquiries correctly. Despite ongoing reassurance that she could not answer incorrectly, Darcy became distressed and cried heavily. She insisted that she "failed" at the task and said she needed "chill time." Upon discussion, Darcy explained that "chill time" involved sitting alone for a few minutes. Darcy was permitted to sit in the room for two minutes alone and then called out to the assessor to say that she felt better and could proceed. Her affect was markedly brighter, and she was able to engage with the remainder of the R-PAS clarification task with no difficulty.

General CWS Observations and Impressions: Darcy approached Wartegg completion without significant confusion, questioning, or need for reassurance/support. She appeared to organize herself by following a Numerical Order of Sequence, spending slightly more time than most children her age in the United States (~8 minutes). Darcy's drawings appear quite disorganized and somewhat bizarre (reflected in six "Level 1" Special scores), somewhat dyscontrolled (Big Drawing noted special phenomenon), and relatively naïve.

Table 1: Selected R-PAS Responses

Card	Response Number	Response Verbalization	Clarification Verbalization
I	2	A symbol.	Well, symbols are usually a shape of something *(What makes this look like a symbol?)* I don't… really… know…. Well, just the whole thing and the shape.
II	4	It also looks like a weird smoke monster. [laughs]	You can't see the tiny bit of pink here and it looks like it's coming out and… excess smoke, the tiny bit of pink. *(What makes it look like a smoke monster?)* Wobbly, goes everywhere too, and it goes everywhere. It has pink legs. The whole thing is the smoke monster.
III	6	An invisible girl.	Because these look like arms, this looks like an outfit. *(An outfit?)* Puffed sleeves and other parts of clothes. *(What makes it look puffed?)* They're circles! Puffed sleeves are normally circles, I know all about puffed sleeves because I've watched Anne of Green Gables. *(What makes her look invisible?)* You can't see the head.
IV	9	The Nowhere King from Centaurworld. It's very specific… but it's a show I watch. It's like a sludge monster.	It looks like the Nowhere King because the Nowhere King has a bone mask and that looks like a bone mask. *(What makes that look like a bone mask?)* Well, it's a similar shape because the bone mask is like a skull of a bird with a long beak. *(Sludge monster?)* The wobbly connecting everywhere. *(What makes it look like sludge?)* The outside is wobbly lines, and it looks like it's dripping everywhere.
V	10	A pegathorn furry.	Well, one, she has a horn, and two, it looks like she has wings. Three, she has legs, and that's her face that you currently can't see any expression on.
VI	13	The sun being consumed by darkness.	Well, because that looks like half the sun because it's a circle, flames, flames, flames. *(What makes them look like flames?)* It's the way people draw them. It's so hard to draw flames, every time I draw them, they come out funny. *(Consumed by darkness?)* Because there's a bunch of dark here and it's moving up toward the sun and it's already consumed the other half, which is why it's only half the sun.
VII	15	It kind of seems like an Egyptian painting.	I believe Egyptians put their hands out like this a lot [models putting hands out behind her]. *(Help me see it.)* That's their nose, mouth, and their arms are out. *(What makes it look like a painting?)* Well, because Egyptians usually have that in paintings.
VIII	19	An old painting.	Well, because this sort of thing is what people, this sort of thing could come up anywhere and archeologists could find it. *(What makes it look like an old painting?)* There are symbols and there's a weird paint color. *(Weird paint color?)* A weird, old pain color. There was some green stuff, but it looks old.
IX	21	Also, the top of a magical staff.	It's another symbol and you can also have the bottom of the staff here and then do exactly what the bad guy does and flip it around. *(What makes that look like here?)* Um… it's colorful.
X	24	A party.	Well, it's colorful and has torches. *(What makes it look like torches?)* It looks like there's wood here and this looks like fire, so torches. It's colorful and torches and two happy monsters here that are smiling.

Note: 26 responses in total; Examiner questions/comments indicated parenthetically.

Her verbalizations, presented in Table 2, appear initially hyper-verbal and over-incorporative, with some degree of strained logic, abstraction, and uncertainty apparent. Performance-based variables, standard scoring markers, and the presence of unusual/specific contents and verbalizations indicate that Darcy's protocol is valid for interpretation, estimated at "Level 3" (externalization) in terms of process.

Complementary and Incremental Contributions of CWS and R-PAS

The results of Darcy's R-PAS and CWS are summarized in Table 3 in the Appendix. For the purposes of comparison, six "complementary domains of assessment" were identified across measures, including: 1) Administration Behaviors & Observations/ Performance-Based Indices; 2) Perception and Thinking/ Reality Testing/ Functional Cognitive Ability; 3) Emotional Experience; 4) Affect Regulation and Coping Approach/ Available Energy & Resources; 5) Self-Concept/ Independence and Autonomy; and 6) Interpersonal Functioning/ Social Skills and Attachment Style. Each domain is presented side-by-side, with relevant test indices and scores noted. Highlighted portions of the table indicate unique and incremental information provided by each test measure.

As Table 3 demonstrates, use of both the CWS and R-PAS in the case of Darcy resulted in significant convergent data, yielding higher confidence in clinical interpretations. Moreover, each measure further provided incremental and unique information related to Darcy's personality organization, thinking, emotional experiences, attachment system, and social functioning.

More specifically, while the Rorschach indicated that Darcy's thinking was flexible, with good ability to synthesize information and make connections, the Wartegg suggested that her thought processes appear idiosyncratic as compared to others and are easily disrupted by her emotional experiences. The Wartegg noted significant tendencies toward sadness and pessimism, with the Rorschach adding specific feelings of helplessness—especially in the face of stressors she may feel unable to control. The Rorschach indicated that Darcy feels her emotions quite intensely, with the Wartegg identifying significant emotional constriction efforts to manage these intense emotions, with this dismissing defense likely reducing Darcy's energy for productivity, adaptation, perseverance, motivation, and problem-solving. The Rorschach identified Darcy's need for structure and support when faced with new tasks (with anxious indications), with the Wartegg suggesting that Darcy may engage with others in a people-pleasing and dependent manner (to avoid negative feedback and rejection). Variability in self-reliance was noted, with the Rorschach suggesting interpersonal caution and reliance on the self for coping, versus the Wartegg's indication that Darcy experiences deep insecurity, an uncertain sense of self, and reduced independence. Lastly, the Wartegg indicated that Darcy experiences challenges in adaptatively expressing her anger (which impacts her problem-solving, adaptive coping, and autonomy), with likely unresolved attachment traits (and associated dismissing defenses).

Impact on Assessment Conceptualization and Feedback

The utilization of the CWS and the R-PAS provided a rich clinical picture that would not have been possible given her minimization on self-report measures and would not have been as thorough and robust without the administration of *both* performance-based measures. Integrated findings addressed Darcy's parents' referral questions and informed future treatment recommendations. Moreover, discussion of Darcy's process of completion of both measures, and the dysregulation that occurred specifically during R-PAS administration, provided concrete examples of interpretive hypotheses, grounding the discussion and encouraging Darcy's parents to share their own examples and experiences of the themes, behaviors, and emotional processes identified in the performance-based data.

During the Summary/Discussion Session, conversation centered around Darcy's inner experience of anxiety, as well as sadness and pessimism. There were indications that she puts significant effort into constricting uncomfortable feelings and, while this helps her in the short-term, it is not an effective long-term coping strategy, as she remains bogged down by her intense emotions. The impact of her emotional constriction includes less available energy and motivation to persevere in the face of challenges. In addition, it puts her at risk for episodes of emotional overwhelm

Figure 1: Wartegg protocol of "Darcy," a 10-year-old female assessed within the context of a child CTA.

Table 2: Darcy's Wartegg Picture Gallery Verbalizations

Box	Verbalization
1	This was, like, surfer day. There's a big sun and the dot in the middle was the sun, and there's a wave and this big wave that surfer guy is on, like riding straight toward the sun for some reason, maybe I made the sun too big.
2	The second one is…a bunch of things protecting the….the heart of the world. So, like the squiggly lines, the circle is like a globe protecting it *(Q-mark?)* I used to protect the heart, basically I made copies of it all around the heart.
3	These are, like, stairs leading to an open door and no one knows where the door leads because everyone always falls off the stairs into a pitch blackness.
4	A small quilt with squares…with squares, they're the same size as the printed square and it has hearts on it.
5	The 4 pedestals, the 4 shaped pedestals. Each pedestal has a different shape, a heart, square, star, and triangle.
6	Oh, here, I made a dress with a lot of fluff.
7	I made a jewelry set of earrings and a necklace.
8	A weird person whose face is an eye.
Note: Order of Sequence: Numerical; Test of Sequence performed: + 8 7 3 6 4 5 6 1 -	

and, in these moments, her generally clear and accurate thinking may become slightly disorganized.

Darcy's fragile self-concept further complicated the emotional landscape. As a bright child with a marked attention challenge, she often experienced herself as falling short of her goals and expectations in various settings, and this was a substantial source of frustration for Darcy. These experiences eroded her sense of competence and left her with feelings of helplessness that particularly arose when she felt challenged. The assessor shared with Darcy's parents her strong emotional reaction when clarification began on the R-PAS and they resonated with her tendency to become flooded and reactive when she worried that she was not succeeding at a task. The complexities of her racial identity development and how this connected to her sense of self were further discussed. For instance, her phenotypic presentation left her feeling dissimilar to her mother and sister and also meant that she questioned if she belonged in spaces at school designated for BIPOC youth. This created additional stress for Darcy around forming a strong and positive sense of self, particularly around her biracial identity—important aspects of her daily experience of which her parents were less aware.

Interpersonally, Darcy has many strengths, including her warmth, care for others, and desire for connection. At the same time, findings from the CWS and the R-PAS suggested that she stays somewhat interpersonally guarded to protect herself from feeling vulnerable with others. Since Darcy is unable to tolerate her less comfortable emotions herself, it feels safer to keep them stashed away from both herself and others. However, at the same time, there were indications of dependency needs, although her self-protective mechanisms likely impede her ability to get those dependency needs met. Instead, she tends to engage in a people-pleasing manner—yet her underlying, split-off anger leaks out at times and manifests as oppositionality. Darcy's parents expressed that this was a familiar pattern, as they observed that Darcy vacillated between efforts to please and somewhat off-putting and frustrating behaviors that impacted others' openness to her needs.

During the Summary/Discussion Session, a variety of recommendations were reviewed collaboratively. It was suggested that Darcy initially participate in art therapy, as she would likely be far more open to exploring her experiences through a creative modality than in directly discussing her feelings (recognizing how much she had revealed via her Wartegg drawings!). Darcy's parents agreed that she would likely do best with a biracial or BIPOC therapist, if possible. In addition, parent consultation was suggested to provide her parents with support and tools to assist Darcy with emotional regulation. Lastly, spaces where Darcy could connect with biracial and BIPOC peers and feel a sense of acceptance, were discussed, with her parents indicating that they would prioritize this in considering her participation in activities.

Summary and Conclusions

As Darcy's case illustrates, despite the time and expense required for clinicians to utilize multiple performance-based measures within the same evaluation, doing so offers multiple advantages: greater confidence in clinical interpretation (evidenced through convergence); deeper, and more nuanced case conceptualization (facilitated by incremental and unique data points); additional opportunities to observe clients in performance-based task completion; rich thematic, metaphorical, and conceptual data that can be utilized in CTA Extended Inquiries and Assessment Interventions; idiographic (and culturally sensitive) access to client's "self-stories" through the process of externalization; and elimination of single-test interpretive biases. Thus, the "benefits" of multimethod assessment far outweigh the "costs," contributing significantly to thorough, client-centered, and effective Collaborative/Therapeutic Assessments.

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Appendix

Table 3: Complementary and Incremental Interpretive Statements derived from the Wartegg (Crisi Wartegg System, CWS) and the Rorschach (Rorschach-Performance Assessment System, R-PAS), by functional domain.

Administration Behaviors and Observations/ Performance-Based Indices			
R-PAS		**CWS**	
Interpretive Finding	**Indices**	**Interpretive Finding**	**Indices**
Needed structure to settle into a new task that may have created anxiety	Prompts (2 needed) SS=114	Sufficiently engaged, effortful, motivated	Time of performance (~8 minutes); Level of graphic/ verbal detail (detailed, hyperverbal)
No pulls needed suggesting ability to follow expectations/rules	Pulls SS=96	Need for structure/support; Possible insecurity in the face of ambiguity	Numerical Order of Sequence (with "other focused" TOS)
Rule-governed, compliant	Card Turning SS=86	Rule-bound/Conforming	Numerical OoS; No RB or OD; Normative FQ for age
		Loose thinking (may be developmental); tendencies toward self-criticism	Verbalizations (APx5; CO,→SC)

Perception and Thinking/ Reality Testing/ Functional Cognitive Abilities

R-PAS		CWS	
Interpretive Finding	**Indices**	**Interpretive Finding**	**Indices**
Generally able to get through the day, no indications of thinking disturbance & psychopathology	EII-3 SS=92	Generally adequate perceptual accuracy and thinking (for developmental age/stage); no overt evidence of psychotic process	FQ=75; Box 6=C; EC+%=75; presence of OBJ and ARC
Able to think clearly, displayed generally accurate perceptions	TP-COMP SS=88	Intact functional cognitive abilities, with anxious-depressive interference	Contents=4 (4); low AQ+%=50; elevated IM=0.5; OBJ+ARC% =63;→MR (Box 3); presence of CLD (Box 3); 3rd criteria= +/-
Dysregulation at beginning of clarification, related to internal pressure to excel and fear of failure, not indicative of thought disturbance	SevCog SS=114 (One DV2)	Cognitive slippage and interrupted thought process; (May be related to attempt to "make sense" of drawings, explain self, do a good job)	Graphic APs x 5; Presence of CO (Box 8); O%=19 (with O+%=50); AP in Box 6; ABS in Box 1
Grounded and accurate perceptions, able to view the world similarly to others and grounds perception in external stimuli (as opposed to internal processes)	FQ-% SS=86, WD-% SS=89, FQo% SS=98	Creative and idiosyncratic in thinking, with less perceptual accuracy when thinking independently/idiosyncratically	O%=19; O+=50%; Low P for age (13% with P+=100%)
Flexible thinking abilities	Blends SS=119	No signs of rigidity, although understanding relationships between objects, cause/effect may be challenging	Absence of II; Presence of CO (Box 8); ABS paired with Mma (Box 1); H with variable FQ T
Can integrate ideas & see how one component is related to another	Synthesis SS=102		
Sensitive to obvious cues in environment and picks up on them accurately	Populars SS=100	Overly sensitive to environmental demands, hypervigilant and people-pleasing	EC+%[adp]=100; all H and P in adp area; WIP[adp]=A beta; Boxes 8 and 7 in first two positions
Can be a bit unconventional at times in her thinking, but no indicating of inaccurate perceptions	FQu% SS=113	Repression/Denial/Abstraction cognitive defenses (thinking as protection; less practical)	PAT (Box 8), ABS x 2 (Boxes 1 and 2), OBJ+ARC=63; AQ+%[adp]=38; EC+%[aff]=50

Emotional Experience			
R-PAS		**CWS**	
Interpretive Finding	**Indices**	**Interpretive Finding**	**Indices**
Some stressors & destabilizers impacting her	YTVC' SS=114, CritContents% SS=113	Both depressive and anxious indicators, which can overwhelm	Boxes 3 (AC) and 5 (AD) with negative Box Codes; Box 2=AD; →MR, → SC; →CLD; AQ+%=50; elevated IM=0.5
Significant feelings of helplessness/bombarded by external stress she doesn't have control over	m SS=128, Y SS=110	Pronounced feelings of insecurity/ inferiority in response to environment	IM>AI; CG x 2; Box 1 in last position; →SC
Feels emotions incredibly intensely	CF+C/SumC SS=122, WSumC SS=150, Pure C SS=117	When affect is experienced, it is sad, pessimistic, and helpless	AQ+%[adp]=38; →MR; high OBJ+ARC; "not good enough" combination of Boxes 1, 4, and 5T
Highly sensitive and reactive to emotions and environment	WSumC SS=150, Pure C SS=117, R8910% SS=115	Trying to constrict/avoid her emotional experiences (as her sensitivity is so high and her emotions are negative)	AQ+%[adp]=38; EC=%[adp]=100; A/F[adp] constricted for her age and gender; WIP[aff]=BD beta

Affect Regulation and Coping Approach/ Available Resources			
R-PAS		**CWS**	
Interpretive Finding	**Indices**	**Interpretive Finding**	**Indices**
Has good amount of coping resources she relies upon and they generally help keep stress at bay, until affect becomes too strong/unavoidable	MC SS=127, MC-PPD SS=114 (raw score +2)	Has cognitive resources available, but becomes easily overwhelmed and non-productive under conditions of distress	M=1 (active); A/F=2.5/3 (add=2/3; aff=3/3); IM=0.5 in all areas
Tries very hard to intellectualize to distance herself from the intensity of her emotions	IntCont SS=142	Preferred defenses are intellectualization, denial, repression.	PAT, ABSx2, SIGx2; WIP[aff]=BD beta; AQ+%[adp]=38
Works very hard to constrict emotion	C' SS=117	Attempts to dismiss/constrict, but is not consistently successful, becoming overwhelmed in emotional and interpersonal situations	WIP[aff]=BD beta with EC+%[aff]=50, AQ+%[aff]=63, and A=F; Global Assessment=PTL with +/- in 5th criterion
Tries to utilize her thinking to cope, but is generally driven by emotions	M SS=102, (CF+C/SUMC) SS=122	Constriction reduces energy available for productivity, adaptation, perseverance, motivation, and problem-solving	Box 3=AC; Box 5=AD; low AQ overall; +/- in 2nd criterion; Box 6 with AP

Self-Concept/ Independence and Autonomy			
R-PAS		**CWS**	
Interpretive Finding	**Indices**	**Interpretive Finding**	**Indices**
Independent/creative/slight oppositionality?	SR SS=113	Poor sense of self; limited confidence and tendencies toward insecurity and inferiority	Box 1 in last position with →SC; EC+%[aff]=50; AQ+%[adp]=38; 1st criteria=-; Box 1 least preferred mark in CODAB
Some tendency to turn inward and rely on herself as her own best resource	r (Reflections) SS=130	Strikes a more dependent and people-pleasing tendency (to avoid negative feedback)	All H and P in adp area; OBJ+ARC=63; CG x 2; WIP[adp]=A beta; Boxes 7 and 8 in first two positions
Tendency toward competitiveness and mastery strivings	AGC SS=118	Given feelings of "not good enough," feels pressures, demands, and expectations from environment acutely; this is distressing and anxiety-provoking	Box 4=D, Box 5=AD; Box 1 in last position; elevated IM
		Anger is not well-integrated, resulting in poor self-advocacy, limited independence, reduced autonomy, and likely socially acquiescent behavior	Box 5=AD with AP; →MR (Box 3); Presence of SC

Interpersonal Functioning/ Social Skills and Attachment Style			
R-PAS		**CWS**	
Interpretive Finding	**Indices**	**Interpretive Finding**	**Indices**
Lower than expected indications of need for nurturance/dependency for her age	ODL% SS=85	Unresolved/Dismissing attachment style (which fails and results in overwhelm); Attempts to shut off dependency needs	WIP=BD beta (with significant adp-aff split); 4th and 5th criteria=+/-
Interpersonally competent: understands interpersonal interactions well and can come across well to others, and	SS=82, M- SS=95 PHR/GPHR=25%	Intact practical social abilities; While able to navigate practical social interactions, sensitivity and insecurity leads to anxiety/ discomfort	Advanced Box 7; Box 8 in first position; Box 2=AD; H paired with ABS and PAT; CG x 2
		When in contact with others, feeling vulnerable, or experiencing the emotions of self or others, client likely floods and becomes overwhelmed (despite attempts to try to dismiss/defend)	WIP[aff]=BD beta; H% and P%=0 in aff area; A=F aff
Generally able to mentalize others, maybe slightly more difficulty than peers her age (complexity adjusted score) and more reliance on fantasy for managing interpersonal interactions	H SS=96 (Complexity Adj. SS=87), NPH/ SumH=88% SS=114	Generally intact, but variable, mentalization ability (including understanding others' intentions and behaviors)	Presence of M/H/P; H with active M (and good FQ); however, H in Box 8 paired with 0.5 FQ
Possibly some preoccupation with aggression in environment	AGC SS=118, AGM SS=112		
Cautious nature, interpersonal wariness	V-COMP SS=121	Strives for people-pleasing and hyperadaptation to navigate the world	WIP[aff]= A beta; Advanced Box 7; Box 8 in first position; OBJ+ARC=63; CGx2
Tendency to rely on herself	r SS=130		
Justifies knowledge based on own experience, however her personalization was more reflective of sharing a memory than defensive on the task	PER SS=114		

Author Bios

Jacob A. Palm, Ph.D., serves as the founder and director of the Southern California Center for Collaborative Assessment, an assessment-focused private clinic in Long Beach, California. He is the United States representative of the *Istituto Italiano Wartegg* in Rome, Italy, where he works closely with Dr. Alessandro Crisi on clinical applications, research, and training of the Wartegg Drawing Completion Test. Dr. Palm facilitates individual and group clinical consultations using the CWS, and regularly presents at national conferences, community-based agencies, and university training programs about the test. Dr. Palm is co-author of *The Crisi Wartegg System (CWS): Manual for Administration, Scoring, and Interpretation (Routledge, 2018).* Dr. Palm is on staff at Miller Children's Hospital at Long Beach Memorial and provides assessment consultation to various programs throughout the southern California area. He provides integrated assessments as a member of the Teen Brain Team at Hoag-Presbyterian Hospital, Neurosciences Institute (Newport Beach). He has previously served as the Director of APA Internship Training and Director of Psychological Assessment for The Guidance Center, a community mental health center (Long Beach, California).

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Avoidance as a Signpost of Shame: How Easily Dismissed Details Guide Assessors toward the Shame No One Wants to Acknowledge

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Since its early conceptualization, the Thurston Cradock Test of Shame (TCTS; Thurston and Cradock O'Leary, 2009) has measured the shame defenses of Deflation, Aggression and Inflation/Contempt as they appear in the stories clients tell to stimulus cards, as well as in client behaviors and extraneous comments during testing. These key defenses are well-supported in the literature and continue to be very useful in terms of conceptualizing interpersonal and intrapsychic shame dynamics. As co-author of the TCTS, I'm quite familiar with the Compass of Shame model (Nathanson, 1992) that Donald Nathanson developed a couple of years before my own work with shame began. Nathanson's model, which served as the foundation for the Compass of Shame Scale (CoSS; Elison et al., 2006), conceptualized four poles that represent the kinds of scripts people use to manage shame affect. These poles, "attack self," "withdrawal," "attack other" and "avoidance," overlap somewhat with TCTS.

I'm endlessly fascinated by shame dynamics and enjoy discovering better ways to understand and conceptualize how clients respond to the TCTS stimulus cards. Parallel to that, I have long wondered if and how avoidance could be captured on the TCTS. For a time, I considered it to be a subcategory of Deflation, since withdrawal in the face of shame can involve avoidance. Over time, TCTS protocols themselves have clarified for me how clients avoid shame during testing, and I have been scoring avoidance for several years. These scores are consistent with the Compass of Shame theory that, "Of all the poles, Avoidance scripts are most likely to operate outside of consciousness" (Elison et al., 2006, p. 223). Feedback from my own clients and assessors for whom I've provided consultation suggests that these scores mirror the avoidant defense that clients engage in their daily lives. It appears that the conceptualization is solid, and I am eager to empirically investigate this theory.

What sets Avoidance apart from the existing TCTS defenses is the way Avoidance manifests in a client's efforts to manage the shame that is elicited during the storytelling process. This differs from the ways that Deflation, Aggression and Inflation/Contempt manifest via scorable Extraneous Comments and Behaviors. Avoidance can best be described as the way clients slow down, distance from, and soften the impact of the word(s) they express during storytelling. While long pauses are always scored, the presence of long pauses alongside scorable Avoidance underscores the strength of an avoidant defense in a particular client. See Table 1 for some examples.

Table 1: Examples of How Clients Engage the Avoidance Defense during the Administration of the TCTS

1. Excessive use of "filler words," such as um, uh, er, and hmm.
2. Tentative language, such as possibly, maybe, perhaps, could be or seems like.
3. Zooming in on card details that are otherwise not important to the story.
4. Zooming out to reflect on big-picture ideas about society or history.
5. Limited projection (e.g., "based on how he is clutching the papers, he seems angry").
6. Phrasing affect in the negative (e.g., "he doesn't feel embarrassed").discomfort?

At the recent SPA conference, some colleagues and I presented a symposium that included three cases that illustrate how defenses serve as a type of GPS to guide us to the underlying shame that has a stranglehold on our clients and creates problems in living (Cradock O'Leary et al., 2025). To my pleasant surprise, each of the cases provided clear examples of content that I believe reflect an avoidant defense. (In both the tables and narrative, example of the Avoidant Defense are boldface.) These cases will be described here to illustrate examples of this defense, as well as to serve as excellent clinical examples of working with shame in Collaborative/Therapeutic Assessment (CTA).

Mike (Jason Turret)

Mike is a 27-year-old, cisgender, unemployed, heterosexual male who was referred by his psychiatrist for a collaborative assessment. He had been working with his psychiatrist and therapist for several years and had been diagnosed with depression, anxiety and Attention Deficit Hyperactivity Disorder (ADHD). Mike's parents were psychiatrists who, unfortunately, prioritized their clients over their own child.

Mike experienced an emotionally neglectful and cruel childhood. He spent his Saturdays in his parents' office while his parents met with clients. In the office, he was confined to a broom closet with his computer for eight to 10 hours a day, missing out on typical childhood activities with friends. Mike reported that when he cried as a child, his father would shout, "Why can't you communicate logically!" When he asked for rides to friends' houses, his parents would yell at him and make him feel like he was an inconvenience. Over time, Mike learned that it was safer to not ask his parents for anything. Even when he had a kidney stone, he felt it was unsafe to directly tell his parents about his symptoms, so he had to be strategic with his language, carefully choosing his words to explain what was happening in a way that would not make his parents angry. Mike told me that he felt "like a piece of furniture, not a member of the family."

When Mike and I began the assessment, he had lived a reclusive lifestyle for about two years. He lived alone and only left his home about once every two weeks for groceries or to see his psychiatrist. He spent his days watching television, playing video games, and daydreaming about fantasy stories he created in his mind.

Assessment Questions

1. Why is it so hard to do anything?
2. Why is it so hard to care about myself?
3. Why am I so dissociative?
4. Why does it hurt so much to be seen?

Mike's Test Data

Mike's test results showed a negative self-image characterized by insecurity, low self-confidence, self-doubt, and low self-esteem. Thus, his chaotic upbringing contributed to an uncertain sense of self and feeling unimportant in his family. Mike's results also suggested underdeveloped emotion regulation skills, shaped by childhood messages that his feelings were unimportant. Sharing emotions often resulted in anger and rejection from his parents, reinforcing emotional suppression. While he could identify and articulate emotions, he tended to intellectualize them. Although Mike is creative and has a rich imagination, he sometimes retreats into escapist fantasy. Escaping into fantasy initially helped him navigate a difficult family environment, but it now contributes to his isolation. Mike's results showed severe alienation, social anxiety, and passivity. He struggles to trust and fears criticism or humiliation, which leads to severe isola-

tion. Although he desires connection, he lives a reclusive lifestyle, where withdrawal cuts off any potential support. Results also showed Mike experienced high levels of depression, anxiety, frustration, and irritability.

Mike's scores on the TCTS suggest he can identify and communicate feelings of shame, as he communicated direct or indirect shame content in nine of the ten cards, but his results suggest that he just talks about shame without fully experiencing the emotion. His stories contained a variety of defenses, but Avoidance was his primary defense for protecting himself from the deeper emotional distress associated with shame. As seen in Table 2, Mike frequently used tentative language or filler words such as "um" when he expressed painful emotion. Avoidance also manifested in Mike's struggle to resolve stories in healthy, adaptive ways. Eight of his stories had maladaptive or unresolved/ambivalent endings, and the two adaptive endings were only superficially adaptive or had "happily ever after" endings.

Table 2: Examples of Mike's Use of Filler Words and Tentative Language to Brace Himself From Emotion

"The second coach is, **um**, feeling secondhand shame of being **kind of** associated with that first coach - or feeling bad for him and feeling bad for the girl." (Card 3)

"And, **um**, he's going to just get a water and walk away and try not to read into being left out of it. And try to **kind of** normalize that it's **kind of** fine, can't be involved in everything. And **um, yeah** that it's, it's a mundane encounter that doesn't go anywhere. **Kind of, kinda** just he has some self-doubts but **um** rational feelings of trying to beat back that self-doubt. [What are they feeling?] feeling **um** anxious and **kind of a little bit** shameful and understanding that that's **kinda** irrational and trying not to feel it. Just **sort of, yeah**, uneasy is a good way to put it."
(Card 7)

Note: Boldface text is indicative of the Avoidance Defense.

The characters in Mike's stories did not receive any help from competent adult helpers and characters were left to manage distress alone. His narrative for Card 2, the classroom scene, mirrors his personal experience. The story features Deflation and Avoidance defenses, an unhelpful adult, and concludes without resolution. For this card, Mike said:

> "**Um,** so **I think** that these three children are asked to the front of the class to do math, definitely. **Um**, the first one is very, **uh**, judgmental, immediately gets it wrong and immediately jumps to making fun of the third kid who can't seem to get an answer or is at least very, **um**, unsure of himself. The middle kid thinks… she's trying **not to be judgmental**. She's, **um**, also thinking of the problem. The teacher is, **um, probably** too harsh. **I think** that she's going to be angry at both the first and third child and second child will feel unsure of how to handle these thoughts, and they will all go home and be **kind of** conflicted [What are they feeling?] Feelings, **um**, mostly **um**, for the three children, the second one is a lot of, **um**, thoughtfulness, a lot of contemplation. Third one is shame, and the first one is **kinda** denial I would say."

Extended Inquiry with Mike

After we completed the TCTS, I did an Extended Inquiry (EI) to explore any patterns or themes Mike noticed in his stories. Together, we observed that his stories contained unresolved emotion, avoidance and withdrawal, and no competent helpers. He shared the following powerful insight:

"For the longest time, I blamed myself and felt broken or not human. For a while, I thought I was the problem. Yeah, I felt like it was a problem with me, like I'd go to school and be unable to breathe or say anything, and I felt like there was something physically broken. Something is so wrong, but I didn't think it was my parents because they're smart and psychiatrists. It must have been me. What's wrong with me? Why am I not trying harder?"

After talking about this further, I asked Mike to create another story for Card 2, this time including a charac-

ter who provides help. Mike began in a similar way, continued to engage Avoidance, and struggled as he attempted to incorporate a competent adult helper.

> "So, **I think** we've got the three students here. The first one gets it wrong but doesn't even realize and immediately makes fun of the third child who is, **ya know**, different. He doesn't have an answer to it. He also has darker skin. The other child **kind of** sees an opportunity to seize on. The middle child is **kinda** quiet and not sure how to deal with it. **Um**, the authority figure, **um** the teacher, she (long pause) is angry at the first child for being, **ya know**, as he is. And **um**, oh jeeze, **um, uh, probably** has him, **um I don't know**, cause, **um, I think** what she does is have everyone sit down. And **um, maybe** has, **um**, the first child go out of the classroom, **maybe** or **maybe** she just has him outside of the classroom afterwards, like there will be a punishment after class **probably**. But, **um**, what she does, she erases the questions except 16 plus 4 and, **um**, talks about how there is nothing wrong with not knowing the answer and tries to walk people through what you do when you don't have the answer, and why it's good to ask questions. **Probably** be something like that and, **um, probably** emphasizing what the actual answer was here, and she does this while being very attentive to how the shamed child is feeling. **Kind of** not, not focusing on him, but being aware of how he's reacting. And, **um, ya know**, if he continues to react very negatively to the onus being put on this, she **probably** just pivots away and goes to the math on it and, **um**, talks with him after class to make sure he's okay. The first child still has to be there because the lesson has to be learned and then he's kicked out afterwards."

We talked about how including a competent helper felt "alien" to Mike because he never had a competent helper and his initial inclination was "shame and punishment." Through this EI, Mike recognized his belief that others cannot help him with his struggles, and he began to understand how his avoidance and isolation acts as a defense against shame. We explored dynamics of shame in his life, a topic requiring delicate care and one that would have been hard to do without the EI. I put myself in Mike's shoes and understood his struggle; if I spent my weekends in a broom closet and lived in fear of shame and ridicule, I would probably confine myself to my home too. I would feel terrible and afraid.

Mike's TA Letter

I referenced our EI in Mike's TA letter while addressing his second question, "Why is it so hard to care about myself?" I explained that the way his parents treated him made him feel flawed and unworthy of love. Although he is no longer living with them, he continues to carry the shame that his parents instilled in him. Part of the reason he avoids is because of the shame he is carrying.

I made several recommendations for Mike, including gradually scheduling activities throughout the week. However, my primary recommendation was for him to enter a residential treatment program, which he has since done. Now, Mike is surrounded by competent helpers and open to the idea that others can help him manage his distress, recognizing that he is worth the support.

Christine (Donna Kelley)

Christine, a 50-year-old widow who had recently left religious life, was self-referred to address issues related to anger, loneliness and prolonged grief. She explained that her life keeps "falling apart" due to a series of bad choices. She recalled a lifelong feeling of not fitting in and wondering what was wrong with her. Her father physically and emotionally abused her mother and emotionally abused Christine, often calling her stupid. Christine had no emotional connection to him and recalled feeling relieved when he died.

Christine's parents disparaged and avoided her debate competition, while they favored her athletic siblings and attended their sporting events. They seemed unimpressed when Christine received a full scholarship to college and were unsupportive of her desire to enter religious life. The intense pressure they placed on her caused her to halt the application process and move out of the family home. When Christine became an accomplished leader in social justice and a frequent keynote speaker at conferences, her parents belittled her achievements. After she received a master's degree, Christine's father remarked that she did not

attend a "real" graduate school, so she did not get a "real degree."

Christine met her husband, Bob, at work. They were married for 15 years when he suddenly passed away. Christine was again alone, as they had no children. Three years after he died, Christine entered religious life. She struggled, believing the sisters disliked her, and coped by isolating in her room. Christine self-diagnosed herself with ADHD and carried a small notebook in which she wrote lists of things she needed to remember. When her formator told her to stop using the notebook, believing Christine was trying to be perfect, she either forgot or was late for community events, causing further distress and reinforcing her feeling of being disliked.

Three years after entering the religious community, Christine was asked to leave. She was told that she had entered too soon after her husband's death, was seeking a safe place to live the rest of her life, and did not have a vocation to community life. Christine was blindsided by this information and became flooded with sadness, loss, fear, and shame. After she left the congregation, she accepted a new job, but the emotional upheaval made it difficult to function and she quit soon after. I suggested that a Therapeutic Assessment might be helpful.

Assessment Questions

1. Why do I feel so lonely without Bob?
2. Over the last seven years, is the pain I feel from mourning Bob due to my childhood experiences?
3. Why do I have a hard time regulating my emotions and how can I fix it?
4. Where do I go from here?

Christine's Test Data

Results from the Millon Clinical Multiaxial Inventory, 4th Edition (MCMI-IV; Millon et al., 2015) and Minnesota Multiphasic Personality Inventory 3rd Edition (MMPI-3; Ben-Porath & Tellegen, 2020) showed no elevated scores, even on scales for family problems and anxiety. These findings appeared to capture the way Christine presents herself to others, as if she is very accomplished and has it all together.

Performance-based measures, however, captured what was happening beneath that fragile façade. The Wartegg Drawing Completion Test, Crisi Wartegg System (WDCT; CWS; Crisi & Palm, 2018) revealed a detached, dependent personality structure and an anxious, preoccupied attachment style. Christine shuts down her emotions and keeps others at a distance to manage insecurity. Her drawing in Box 1, which was the last in her sequence, was "a bullseye with an arrow in the bullseye," suggesting her sense of self is marked with insecurity, inferiority and inadequacy.

Christine's Adult Attachment Projective (AAP; George & West, 2012) revealed an Unresolved/Dismissing attachment style, with indications of trauma, shame and dissociation. Her stories showed a lack of connection to others and a lack of clarity about adult relationships. Some of her story plots consisted of people who provided functional help, such as a woman who made lunch to distract the child in the ambulance story. Other card stories had rejecting and mis-attuned characters. Her attachment story is one of pain, rejection, fear, and shame. This was particularly evident in her story for the final card (Corner). She began her story by saying, "Don't hit me. He is… being punished…" and continued, "The kid is afraid of this adult…please don't hurt me."

Christine liked the TCTS best, since she found the pictures easier to talk about. Her stories were long and detailed. Overall, Christine's stories indicated that she could identify shame, most commonly describing shame-related rejection (e.g., "laughing at," "bully") or self-conscious affect like "insecure." She had two direct shame scores, for describing characters as feeling embarrassed and humiliated. While she engaged in a variety of defenses against shame, her most common defense was Avoidance. Table 3 contains her response to Card 2 to illustrate Christine's avoidant strategies, such as intellectualization, zooming in on extraneous card details or zooming out, to comment on broader issues that were only slightly relevant to

Table 3: Christine's Story for Card 2, which Reflects a Wide Variety of Avoidant Strategies

Intellectualization:

"She has her hand on her mouth because she was coughing. **She has allergies. She's coughing**, umm."

Zooming in to focus on card details:

"**They're all in the same handwriting**, so I'm gonna assume it was the teacher that wrote the problems on the board. Um, **the answers are in the same handwriting**, so that doesn't explain that."

Zooming out to the teacher reflecting on her job, and using many filler words:

"**Um**, she's feeling challenged. **Um, kind of** had to address everybody's needs because and, **um**, she's not overly concerned because this is teaching and, but, kind of challenged. OK, **sort of**, "how do I tend to all of their needs and kind of move this all forward…"

the card. Additionally, Christine ignored some content on stimulus cards, such as never acknowledging the unzipped fly on Card 4.

Her strong use of defenses appeared to impair her ability to resolve stories. Her stories did not include characters who received comfort or assistance and lacked resolution. In fact, three of her stories included characters being left with sad feelings and two stories had no ending. Her stories included some competent adults who provided limited help but not emotional support, mirroring her experience and perception of others as helpful in some ways but complicated enough that she doesn't ask for help.

Assessment Intervention Session (AIS)

For the AIS, Christine and I read a few of her TCTS stories. I then asked her to retell the stories by talking to the character who was distressed. To the little boy with his head down on Card 2, the teacher said it was okay and offered to help him after school. Also, the teacher was careful not to add to the boy's embarrassment. For Card 8, Christine told the boy who struck out that everyone has bad days and reminded him of his successes. She acknowledged that it's hard and embarrassing when we fail and offered to work with him after practice. Card 3 was hard for Christine since the coach reminded her of her father. It was apparent that she felt for the girl and acknowledged her pain. She tried to comfort her with understanding but did not use the word shame. I was surprised at her compassion. Christine noted, "This is how I am with my nieces and nephews." She recognized the difference between her original stories and the new versions. Christine explained that she feels more connected and compassionate to strangers than to people close to her. This provided a nice transition into the Summary/Discussion Session.

Summary/Discussion Session

The Summary/Discussion Session took place over several sessions. I was anxious because I knew it would be difficult, and I didn't want to increase her shame. I started by acknowledging that she has been through a lot and has carried the pain since childhood. She nodded and teared up. We connected the pain to the failed protection of her parents, the loss of her husband, and her more recent dismissal from religious life. I spoke to her strengths and noted she is a survivor.

We reviewed her test findings together. Christine recognized her tendency to present herself as having it all together and to shut down emotions to manage her insecurity and protect herself from pain. She acknowledged that such avoidance has kept her from having close friends and prevented her from staying in touch with acquaintances. Christine also recognized that the abuse she suffered was not her fault, and that she had no one to help her. She understood that her failed mourning was more than the loss of her husband, and was connected to the failed protection of her parents. Shame was a difficult word for her to hear, but she eventually came to identify it. By the end of the Summary/Discussion Sessions, Christine said, "I feel different. Something has lifted and I feel lighter."

Bradley (Seth Grossman)

Bradley, a 19-year-old white, heterosexual, cisgender male who was experiencing diminished involvement and interaction in his college life. This case began when Bradley's father contacted me by email telling me that Bradley "wanted to be assessed for depression, social introversion, ADHD, loneliness…" and a further listing of approximately 15 more potential diagnoses and problem areas, none with an obvious relationship to any of the others. He then remarked, "Really, he just needs to get out of his own way." This was an early indication of how much his father was going to speak for Bradley.

Fearing failure, Bradley requested and was granted a mental health leave of absence at the beginning of his third semester of college. Upon his return home, his parents quickly moved into action to see what, if anything, could be done to "quickly figure this all out and get Bradley back on his feet to continue on with his life." In a subsequent phone conversation, I provided an overview of the CTA lens, which the family felt would be a good fit for what they perceived as his "downtime."

The first meeting included Bradley and both his mother and father (at Bradley's insistence). However, I negotiated a "split session" to allow Bradley to have the bulk of the time. Immediately after his parents left the room, Bradley noted that he was going along with their wishes for this process, but that he didn't really see much point in it. However, he also remarked that "maybe that's just me being stubborn." His involvement from there on was entirely cooperative. He maintained interest as he articulated questions, and he completed assessments and EIs, although his verbiage during the EIs was typically limited.

While Bradley's assessment was a full-scale CTA, for brevity, I will focus mostly on the contributions of the MCMI-IV and the TCTS to the assessment, both of which highlighted complex shame-avoidant strategies. The assessment also included other performance measures (i.e., the Rorschach and The Early Memories Procedure), the MMPI-2 RF and another, more focal self-report measure, as well as a cognitive performance measure and a self-report measure related to ADHD (as one of his questions involved suspicion of ADHD).

Bradley's Assessment Questions

Bradley had six questions, and his parents contributed two of their own. I will focus on only the two questions below, but I note the other questions included themes of staying focused, incomplete tasks/motivation, and dishonesty (including with himself).

1. Why do I beat myself up when I am not functioning how I'd like to/ how I thought I would?

2. Why do I avoid uncomfortable situations? Can I find better ways to deal with these?

Bradley's Test Data

Bradley's MCMI-IV results reflected personality patterns that were largely characterized by a sense of futility, a tendency to allow the world to essentially "happen to him" rather than act on his own to make changes that might better suit his needs, and regularly finding himself "shutting out" the world and relationships, which he described as a more active defense than simply "giving in." There was some evidence that he may take solace and fulfillment in experiencing difficulty, as well as an indication of a desire to build and maintain autonomy. Overall, these results spoke to a persistent sense of futility that was complicated by independent but unfulfilled strivings, and a desire to self-protect.

A memory from The Early Memories Procedure (EMP; Bruhn, 1989) also lent some context, as Mike described a carnival scene he attended as a young boy, and commented, "I was a happy, naïve child before adult responsibilities came along." The MCMI-IV, as well as the MMPI-2-RF, also indicated severe "double depression," reflecting the likelihood that he was deep in a major depressive episode within the longer framework of a persistent depression. The results were beginning to illuminate a synthesized picture of a deep shame with little to no epistemic trust, and a dearth of others with whom he was willing to be open and supported by. An AIS did not "move the needle" much in terms of insight because his shut-down of affect was too intense.

Bradley's TCTS stories typically featured indirect shame, as opposed to direct expressions of shame. He appeared to engage a variety of defenses, but the predominant one was Avoidance. Examples of this defense can be found in Table 4. As Bradley told stories

Table 4: Bradley's Use of "Filler Words," "Softening Words," Tentative Language, Limited Projection and Phrasing in the Negative Helps Him Avoid Painful Emotion

"**Uhm, I'm not sure, based on her facial expression**. I would say **mild** concern, **uhm, semi-disgus**t, and disgust in a way of… **not being happy about her appearance.** Um, yeah." (Card 1)

"**Uh, it doesn't, uhm,** fully, uh, resolve. **I think** that the girl goes to the bench, and cries, and the other coach **maybe** comforts her **or something**. The coach is **kind of** mad, **I assume** they lose the game, and uhm, maybe somebody stands up to the coach, this would be a happy story but this is a realistic story, nothing really happens." (Card 3)needs and kind of move this all forward…"

to the cards, he seemed to look to details in the drawings for clues (e.g., "Uhm, I'm not sure based on her facial expression–Card 1). Nearly all his stories had ambiguous endings, meaning the story was described as ending in an "either this or that" manner, providing another example of Avoidance—a clear ending.

Card 7 illustrates Bradley's **avoidance** of content as well as his difficulty ending the story.

> "**Uhm**, this **kind of** looks like office gossip. The water machine, **uh, maybe given the other slides. Maybe** it's a teacher's lounge. **Uhm, I don't know** if they're enjoying the conversation, or coffee, **uhm**, one guy's walking in, **I don't know**, they **seem** to be enjoying themselves. They **might have** told a joke about the guy who's walking in, **I don't know**, if we wanted to make it interesting. **Kind of** like, **uhm**, I'm gonna get coffee, then someone made a joke and then, **uhm**, I'm curious about what the joke was all about, or what was so funny. **Something like that. I don't know**, I think it's a natural thing to think that, **you know**, you walk in on a conversation, everyone's laughing, like "what's so funny?" Not like in, **you know**, an aggressive way, but **you know**, a curious way."

Bradley's ending for Card 3 was particularly poignant, since he seemed to consider an adaptive ending, before it was spoiled: "**maybe** somebody stands up to the coach; this would be a happy story, but this is a realistic story, so nothing really happens".

Extended Inquiry

The EI for the TCTS was characterized by Bradley being mostly inarticulate and noncommittal in his reflections. He could not identify any character or picture that produced any kind of affective response, or one with which he might align. While some clients can correctly guess the theme of the test during the EI, Bradley could not. When I revealed the "shame" theme of the test after the EI, Bradley was enlivened. He immediately told a spontaneous personal story about a neighborhood boy with autism and the pity/judgment he perceived coming from other neighbors. Bradley said, "I'm terrified that that's how they think of me being home from college."

Summary/Discussion Session

Just prior to the Summary/Discussion Session, I got a call from Bradley's father, inquiring about the possibility of ADHD explaining everything, which I deferred to the session. Despite Bradley's request that everyone hear everything together, I once again divided this session into a one-on-one session with Bradley, followed by a family triad meeting. In Bradley's individual session, he began to press the question of whether ADHD could cause all his difficulties, and if medication would resolve everything. My response to him was that the limited cognitive testing we had done to answer that question was inconclusive for ADHD, but it did not rule it out, and testing with a colleague more specialized in assessing this area would be helpful. We reviewed all the questions, but Bradley's interest was clearly tied to the "unable to focus" question. As the family joined us, this question was again pressed, and after reviewing the more affect-driven results, Bradley's father stated, "What if I tell you I think all this emotional stuff is B.S., and I want a real diagnosis?" This supported my hunch as to why Bradley was not fulfilling his desire for autonomy.

The family meeting featured a dynamic I had prepared for, as I had given both of Bradley's parents the Millon Index of Personality Styles (MIPS-R; Millon, 2004), an adaptive-range personality instrument. The results, among other highlights, indicated that his father was

one who wanted well-supported and *simple*, black and white solutions (this is also something to which Bradley not only admitted about himself, but seemed to aspire toward), and his mother was much more led by exploring and resolving affect.

As I was able to shift attention away from the ADHD question to recommendations, I mentioned that owing to the apparent double-depression episode, it might be a wise decision to use the time away from school to enter a time-limited intensive outpatient program. I was familiar with one that takes a thorough developmental approach. Bradley's parents both felt this was an ideal solution; it fit both of their desires to help put all the emotional pieces into play, *and* potentially ("if it's *not* ADHD") create a simple and focal solution. They reiterated the potential benefits and pressured Bradley for an answer; his facial expression hardened as he looked toward them, then me, and stated emphatically: "No." His reasoning centered on the stigma of "going to a treatment facility." This was a less-than-ideal response to what was a fitting, but not ideal solution, but I was intensely proud of Bradley for asserting himself.

Discussion

Cundy (2019) wrote, "Defences mark the spot where pain is buried, a flag in the ground indicating the presence of a deeply buried narcissistic wound" (Cundy, 2019; p. 69). The multidimensional TCTS scoring system paints a rich picture of a client's shame dynamics, including how they experience and defend against shame and their ability to resolve shame situations. The addition of Avoidance to the already-existing defenses of Deflation, Aggression and Inflation/Contempt enhances that picture.

The cases of Mike, Christine and Bradley provided clear examples of content that reflect an avoidant defense. The new scoring of TCTS Avoidance allowed Jason, Donna and Seth to understand the unique ways their clients used avoidance to protect themselves from shame. Such knowledge resulted in carefully crafted EI and AIS which helped their clients begin to address the shame that caused such difficulties.

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Author Bios

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Jason Turret is a licensed psychologist who earned his doctorate in clinical psychology (Psy.D.) from the University of Denver's Graduate School of Professional Psychology in 2016. With a deep passion for psychological assessment, Dr. Turret specializes in Attention-Deficit/Hyperactivity Disorder (ADHD), learning disabilities, and collaborative/therapeutic assessment. For the past eight years, he has been serving the Boulder community through his private practice where he also supervises doctoral students. Dr. Turret has Level 1 Certification in Therapeutic Assessment and has been leading the Colorado Assessment Society as president since 2018. In addition to his clinical work, he contributes to the academic field as an adjunct faculty member at the University of Denver where he has taught doctoral students through several courses including the Assessment Seminar, Advanced Personality Assessment and Advanced Rorschach Analysis.

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Outcomes of Collaborative/Therapeutic Assessment: An Updated Overview of Single-Case Studies with Adult Clients

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The objective of this article is to provide an overview of quantitative studies on the short- and long-term outcomes of Collaborative/Therapeutic Assessment (CTA) in single-case quasi-experimental studies with adult participants. Most of the studies reviewed concern individual clients, while others aggregated single-client results and provide a comprehensive view of the course of their assessments.

Smith's Landmark Study (2013)

Research on case studies, which is crucial for practical implications that clinicians can apply to their work, reveals a variety of stories of different individuals following varied paths of change, each showing their own distinct "anatomy of change" (Smith, 2013, p. 6). In his article, Smith extends the conclusion reached by Poston and Hanson (2010) that receipt of collaborative feedback is sufficient to improve client outcomes, through analysis of both individual TAs and family assessments. Specifically, with regard to individual TAs, Smith analyzed three single case experiments that suggest three different trajectories of change: First, Claire, a 21-year-old woman who had experienced trauma and struggled with academic difficulties, low self-esteem, and loneliness. Claire experienced a significant reduction in a composite measure of loneliness, anxiety and self-criticism (*r1 =.55*)1 with improvements as early as the first TA session (Aschieri & Smith, 2012); Second, Sarah, a 52-year-old female stage four melanoma survivor, who had depressive symptoms and emotional volatility. Comparison between the pre-intervention and intervention phases showed a statistically significant decrease in a composite measure of daily self-reported tearfulness, self-efficacy, inactivity, and fear of illness (*r1 = .61*). Claire's improvements were experienced immediately after initiation of TA and were maintained during the subsequent 4 months of biweekly psychotherapy (Smith & George, 2012); Third, Kelly, a 37-year-old woman diagnosed with complex post-traumatic stress disorder (CPTSD), whose symptoms were rooted in a history of family abuse and abusive romantic relationships. Kelly reported a significant reduction in a composite measure of daily loneliness, hopelessness, and anxiety (r1 = .64) and an increase in levels of general well-being, personal well-being, and well-being in intimate and social relationships from baseline to the intervention phase. Kelly demonstrated a trajectory of change similar to that of Sarah, wherein improvements achieved during TA were maintained, though not further enhanced, during subsequent psychotherapy with the same clinician (Tarocchi et al., 2013).

The analysis of these individual TAs, and of other published cases of family assessment, led the author to state that "the anatomy of change differed somewhat in each case," (Smith, 2013, p. 6) and if some clients improve soon after the assessment begins, collaborative feedback cannot be the only mechanism of change; rather, it is the progression of steps in the model that, together with the use of different techniques, makes the whole model a robust intervention approach that gently guides clients toward change. Our work aims to provide an update to these findings

[1]Note: *r* represents the measure of the effect size of the therapy. Given the variation among the articles in their analytic plans, we report three different typologies of effect sizes; r_1 refers to the difference between the baseline and the TA (intervention) phases; r_2 refers to the difference between only the TA (Intervention) and the follow-up phases; r_3 refers to the difference between the Baseline and the TA (Intervention) combined with the follow–up phase. To increase readability, when r is positive, it corresponds to an improvement, when it is negative to a worsening.

by reviewing the published literature on quasi-experimental repeated-measures research on individual cases.

New Publications on Single Case Studies

In 2017, Durosini and colleagues published an article about Anthony, a 51-year-old Italian man with complicated grief disorder, comorbid with major depressive disorder and PTSD, emerging after the death of his father (Durosini et al., 2017). Unlike previous cases (Aschieri & Smith, 2012; Smith & George, 2012; Tarocchi et al., 2013), Anthony's assessment did not lead to a linear reduction of symptoms, but rather to a transient worsening of symptoms ($r_4 = .52$)[2], followed by a significant decrease in a composite measure of loneliness, suffering, emotional numbness, sense of failure, and longing for his deceased parents ($r_2 = .49$).

A similar pattern was observed in the 2018 case study by Fantini and Smith, involving Cristina, a 22-year-old university student who reported uncontrolled outbursts of anger, lack of motivation, feelings of disconnection from others, and detachment from her emotions. She had witnessed a family secret that ultimately led to her parents' separation. Cristina experienced a significant increase in a self-reported composite measure of anxiety and fear of losing someone significant ($r_4 = .80$) after the Extended Inquiry phase of the Rorschach Inkblot Method (RIM, Rorschach, 1921), followed by a significant decrease in the same measure after the final session of TA ($r_2 = .73$).

These two cases reveal a shared pattern: the initial emergence or intensification of symptoms during TA, followed by symptom alleviation. During TA, Anthony was gradually exposed to stimulation elicited by the testing situation, which in his case led to a transient intensification of the sense of loss for his deceased parents, and a rise in negative emotions related to confronting his characteristic defense strategy. This strategy, referred to by Anthony as "the ball," is a state that allowed him to dissociate, detach, and avoid overwhelming emotions related to grief and the loss of his parents. The authors suggested that the important protective role played by "the ball" in shielding him from emotional overload may also have prevented him from processing his grief. "On this basis, the subjective worsening of self-reported symptoms may be interpreted as a weakening of the defenses against contact with painful memories and representations." (Durosini et al., 2017, p.13). The assessment with Cristina, on the other hand, shed light on the emotional detachment she described. It made it possible to recognize the protection behind this mechanism, which shielded her from possible re-traumatization and the emotional overwhelm associated with her parents' separation. Her internal statement "You can't think about this now," allowed her to function in everyday life, while also revealing its disadvantages. To avoid feeling pain, Cristina developed the ability to numb her emotions. Her TA enabled observation of the multiple sides of this capacity—its advantages and disadvantages—a defense, but also a problem. Through the RIM, Cristina was exposed to stimulation that penetrated beneath the surface of her defenses, just as it had for Anthony. Anthony's "ball," like Cristina's inner command "you can't think about this now," are both examples of the *change dilemma* that clients often face in therapy: a defensive mechanism that prevents the client from "mourning," from letting go of their symptom, because doing so would come at a great cost of having to tell a new story about themselves. One that, although marked by the positive qualities of compassion, still involves a grieving process.

Another client is Cam, whose story is presented in a single-case empirical study conducted by David et al. (2022), aimed at evaluating test validity, therapeutic alliance, and the mutual experience of the client and the therapist during a virtual TA. Cam was a 20-year-old adult, biologically assigned female at birth, who identified as trans-masculine non-binary and uses "they/them/their" pronouns. Cam had a history marked by their parents' divorce and their struggle to accept Cam's sexual orientation. About 15 months prior to the beginning of this TA, Cam came out as non-binary and began gender-affirming Hormone Replacement Therapy. At the time of the assessment, Cam had already engaged in three years of therapy, focused on depressive symptoms and the development of healthy relationships. Cam reported consistently high levels of satisfaction, a strong positive relationship with the assessor ($M = 4.92$), high perception of being present throughout the virtual sessions (>70%),a new under-

[2] Note: *r4* refers to the correlation that "determines the strength of the relationship between the dependent variable data stream and an a priori model" (Aschieri & Smith, 2012, p. 7), designed by the researchers to test specific trajectories of change.

standing of self (*M = 4.46*), and slightly lower levels on the Positive Accurate Mirroring Subscale (*M = 3.92*) suggesting the client's feeling of not being as understood or appreciated as other clients . Overall, they reported a total satisfaction mean score of *4.25*.

In 2024, Sun and colleagues published a time-series case-based project in which they explored the effects of an "ultra-brief" TA protocol involving an initial session, test administration and Extended Inquiry and a Summary/Discussion Session with three Chinese clients: Su-Min, a 28-year-old woman who felt stuck in an open relationship; Gao-Qiang, a 19-year-old man who struggled with unstable emotions and conflict over intimacy; and Mei-Fang, a 21-year-old woman who reported that her pain "is quickly relieved only by a man." All three clients experienced improvement of their symptoms after the Summary/Discussion Session (r_3 = *.38; .52; .69* respectively).

The Two Trajectories of Change

The presentation of these single case studies highlights a pattern observed in the literature: the presence of two different trajectories of change during a TA. The first trajectory shows a linear improvement in the clients' problems from the first to the last TA session; the second demonstrates a pattern of initial intensification of symptoms followed by reduction

As far as the first trajectory is concerned, Smith et al. (2015), in their pragmatic replicated single-case study, proposed that Collaborative Assessment appears to reduce clients' symptoms and enhance important process variables (*rcorr ranging from .19 to .68*). This trajectory suggests an incremental effect of TA in reducing client symptoms and distress, with a deceleration of the effect during the follow-up phase. However, going into the details of the study by Smith et al. (2015), the level change analysis showed that six of the nine participants experienced statistically significant reductions in the mean level of symptomatic distress, but one client experienced a nonsignificant increase in symptomatic distress. This trajectory of change allows for the introduction of the second trajectory showed by a second group of case studies (e.g., Durosini et al., 2017; Fantini & Smith, 2018) presenting an inverted U-shaped trajectory of change, in which an initial worsening of the client's symptoms, following implementing TA, was followed by improvement (correlation with a priori inverted U-shaped slope: r_4 = *.52 and* r_4 = *.73*, respectively).

Hypotheses About Different Trajectories of Change

Aschieri et al. (2023) hypothesized that these findings suggest, for some clients—particularly those overwhelmed by their problems and experiencing acute distress—that TA may produce an immediate effect, thus justifying a linear trajectory of symptom improvement. For others, particularly those with more rigid defense mechanisms, an initial and transient worsening may be followed by improvement in their condition.

This hypothesis is partially confirmed and further elaborated by the replicated single-case study by Aschieri et al. (2024) which involved eight university students and revealed heterogeneous responses to TA. Two distinct patterns of change were identified: The first showed a significant improvement in symptomatology during follow-up compared to baseline and intervention phases, with effect sizes ranging from small to medium in one case (r3= .36), and from medium to large in the other three (r3= .59; r3 = .77; r3 = .58). The second involved clients who did not report a statistically significant improvement in symptoms but instead showed variability in the symptom trajectory. While linear improvement might be attributed to the development of a strong therapeutic alliance, a post-hoc analysis of presenting problems, Assessment Questions (AQs), and case conceptualization allowed for a more nuanced understanding of the differing trajectories.

Indeed, clients who experienced significant symptom improvement reported less stable psychological defenses and greater overwhelm from their problems. Conversely, for those who did not experience significant improvement, TA primarily impacted the stability of their defenses (e.g., getting in contact with unmentalized but enacted sadness and anger; or addressing emotional disconnection that prevented contact with pain). In these cases, TA helped clients come into contact with unacknowledged painful emotions, which were partly responsible for both their symptoms and the stability of their defensive mechanisms.

This hypothesis supports the interpretation put forth by Aschieri et al. (2023). The authors further proposed an alternative explanation for the difference in change trajectories, related to the type of presenting problems. On the one hand, clients who benefited from TA mostly presented with self-related concerns; on the other, those who did not benefit primarily presented with relational issues.

This could mean that this population improves more rapidly when focused on the self rather than on the relationship with others—or perhaps that TA is less effective for relational problems in student populations.

What Improves in Clients: The "Game-Changer"

Finally, when considering what specifically improves in clients, regardless of their trajectory of change typology, TA has shown a positive impact on a variety of symptoms, including: general suffering (both for oneself and for others), longing for deceased loved ones, loneliness, emotional numbness and sense of failure, anxiety, health anxiety, fear of losing loved ones, tearfulness, inactivity, and self-efficacy. The effect sizes reported were small ($r < .30$) for one variable, moderate ($.31 < r < .50$) for 12 variables, and large ($r > .50$) for seven variables. In studies that reported only composite variables (derived from the average of daily ratings of individual symptoms), the effect sizes ranged between $r = .22$ and $r = .73$. Thus, although single-case studies should be interpreted with caution, their qualitative analysis appears to support the positive effect of CTA on distal outcomes, as demonstrated by meta-analytic findings.

It is crucial to emphasize the need for research investigating the immediate outcomes of specific Collaborative/Therapeutic Assessments. The convergence of these methodologies highlights that the transformative effect of CTA in clients' life trajectories is not solely because of structural components or the specific tests administered; rather, the "game changer" seems to lie in the collaborative approach to test administration and interpretation—an approach grounded in the principles of collaboration, respect, compassion, openness, and humility. Through the application of these principles, the clinician can gently assist each client with the development of a new self-story.

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Author Bios

Filippo Aschieri, Ph.D., is a licensed psychologist and Associate Professor of Psychology at Catholic University of Milan, Italy. He is the Coordinator of the European Center for Therapeutic Assessment at the same university. A Fellow of the Society for Personality Assessment, Dr. Aschieri is certified in Therapeutic Assessment with adult clients, families with children and adolescents, and couples. He is currently serving as Editor-in-Chef for *Rorschachiana*, the journal of the International Society of the Rorschach.

Annapaola Blasi is a graduate student in Clinical and Health Psychology at the Catholic University of the Sacred Heart in Milan, Italy. She is currently completing her postgraduate internship and is interested in research in TA precisely because of her strong passion in the field.

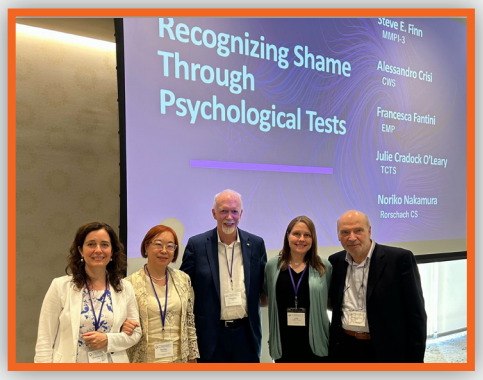
4th International Collaborative/Therapeutic Assessment Conference

June 12 – 14, 2025
Salt Lake City, UT

Over 100 people gathered at the University of Utah campus during some warm summer days to enjoy learning, presenting, and community.

Sarvenaz Sepehri talks about integrating technology into a TA.

Plenary speakers Steve Finn & Alison Wilkinson-Smith.



Francesa Fantini, Noriko Nakamura, Steve Finn, Julie Cradock-O'Leary, & Alessandro Crisi.

Mitsugu Murakami, Jacob Palm, Sarah Bharier, & Stephen Seger.

JD Smith, Fil Aschieri & Krista Brittain connect during a break.

Spotlight on Recent TA Certifications

Erich Bieber

My name is Erich Bieber. I work and live in the northern parts of Sweden with our family—my wife and our two, almost adult daughters. The whole family loves outdoor activities such as skiing in the winter and hiking in the summer. My hobbies are sports of all kinds and reading.

Professionally, I work at a public mental health center focusing on child and youth psychiatric problems. Over the last couple of years, I had various positions in this regional centre – for the last 5 years I am head psychologist at the clinic. My focus has always been neuropsychological assessment, where I have a specialization in since 2011. I have worked with families and children/adolescents my whole professional career.

TA came to me in 2010 when Steve was presenting at the Swedish congress for neuropsychology in Sundsvall. Even though assessment procedures differ from how it appears to be typical in the US, the thought of putting together the concepts of assessment and therapy fitted my thinking of doing assessments and raised my curiosity for TA. The basic concepts of TA such as collaboration, respect, humility, compassion, openness, and curiosity are concepts we already tried to implement in our procedures, but with the framework of TA we got a better chance to do it.

Over the years, I have both attended and arranged several TA workshops with Steve, Marita, Lionel, Pamela, Francesca and all the others sharing your wisdom and insight, which has been a big part of my professional and personal development.

After getting certified in the CWS in 2020/2021, I felt ready to start my certification process by getting to know Pamela, who was my patient mentor for the last couple of years of gradually developing my skills in TA for children and families.

I am very thankful to her for being part of that journey, but also thankful to the TA community for sharing your insights with me. When stuck both professionally and also privately, I have come to the understanding that humility, compassion and respect are good values to fall back onto.

Thank you for doing a good job of reminding everyone of that…

As Erich's mentor and supervisor, I (Pamela Schaber) was deeply impressed by the complexity of the cases he managed. The children and adolescents he works with often face multifaceted challenges, including neurodiversity, intricate family dynamics, and limited resources. Erich approaches each client with remarkable compassion, humility, and warmth, demonstrating a genuine commitment to understanding their unique needs and providing thoughtful, effective support throughout the assessment process. I greatly appreciate our collaboration and look forward to continuing to learn from one another.

Mette Kyung

Mette Kyng recently completed her certification in Therapeutic Assessment with children with Stephen Finn as her mentor, after also studying TA with Deborah Tharinger from 2020 to 2022.

Mette is a licensed clinical psychologist and works in private practice in Copenhagen, Denmark. She is also a board-certified specialist and supervisor in child neuropsychology. She studied psychology at the University of Copenhagen and worked as a research assistant at the Center for Autism, where she first developed her strong interest in psychological assessment. Mette studied psychology at the University of Copenhagen and worked as a research assistant at the Center for Autism when she was a student, where she became interested in psychological assessment. Since graduating in 2003 she developed a specialty in neurodivergent assessment, mostly focused on ASD diagnostic assessment and psychiatric co-morbid conditions,

neuropsychological assessment of children to support their learning and development, attachment and relational assessment, personality/projective assessment, and assessment of parental competence. Mette is certified as an international trainer of the ADOS-2 and ADI-R by Catherine Lord group, Marisela Huerta, Ph.D. and Somer Bishop, Ph.D., professor, and often conducts courses across Denmark on these instruments as well as occasionally assisting on courses in the US. She translated and published the Early Memory Procedure (EMP) in Denmark and is helping Danish psychologists use it with their clients.

Mette writes: *"With TA, it's like all my areas of interest and values can be integrated and developed in my work life. It feels like a great gift, and I think it can help my clients more deeply. I am very happy and feel inspired by connecting with the international TA community."*

Apart from work, Mette enjoys spending time with her husband and two daughters (who are in their 20s). She listens to music, attends concerts, goes to art museums, hikes in nature, and does Buddhist meditation and retreats.

On October 25, 2025, Mette will present an online half-day workshop for the SPA Expert *Insights Conference* on *"Why is My Child So Angry?": Therapeutic Assessment for Early Childhood Autism.* We urge you to attend!

Nina Madsen Sjö

Nina Madsen Sjö of Copenhagen, Denmark, recently completed her certification in Therapeutic Assessment with children, with Stephen Finn as her mentor. She also studied TA-C with Deborah Tharinger from 2020 to 2022.

Nina completed her B.A. and M.A. at the University of Copenhagen with a specialty in neuropsychological assessment. As part of her Ph.D. (Aarhus University, Denmark), Nina developed Danish national norms for the assessment of socio-emotional and cognitive skills for children 0-7 years old.

In her private practice, Nina does neuropsychological assessment and broad child/ adolescent assessments with a special interest in writing fables and creating meaningful visual feedback to adolescents and parents.

As a researcher, Nina has been part of over 10 intervention studies. Currently, she is part of two research projects. One study focuses on the assessment of well-being and academic skills for children placed in out-of-home care, and another focuses on how to use video feedback methods to contribute to the professional development of early-childhood-care teachers.

Nina first became interested in TA after reading some of Deborah Tharinger's articles on using fables to provide assessment feedback to children and parents. Nina reached out to Deborah and then helped arrange a small monthly consultation group for Danish psychologists interested in TA. After Deborah retired, Nina began working with Stephen Finn, showing videotapes and quickly achieving certification.

When she is not working, Nina enjoys spending time with her two young adult children. In addition, Nina also enjoys bicycle racing, walking, yoga, knitting sweaters for family members, and working on renovating her apartment in a historical building in Copenhagen.

Recent Publications

- Kenigsberg, Z., Bistricky, S. L., & Marek, R. J. (2025). Interviewing strategies, empathy, and rapport. In D. L. Segal (Ed.), *Diagnostic interviewing* (pp. 33-58). Springer.
- Perry, L., Mossman, B., Garcia, S., Kircher, S., Dunn, A., Alonzi, S., Easwar, S., & Hoerger, M. (2024). Personality feedback with tailored self-care recommendations improves sel-efficacy for cancer management: A randomized controlled trial. *Psycho-Oncology, 33.* https://doi.org/10.1002/pon.70023
- Schneider, W. J., & Tobin, R. M. (2024). Sophisticated simplicity: Writing reader-friendly assessment reports. In R. Flanagan (Ed.), *Clinical guide to effective psychological assessment and report writing* (pp. 1 - 11). Springer. https://doi.org/10.1007/978-3-031-67184-5_1
- Woods, S. E. O., Brook, A., & Angoff, L. (2025). Principles of neurodiversity-affirming collaborative assessment. *Neurodiversity, 3.* https://doi.org/10.1177/27546330251342069

Upcoming TA Trainings

September 12-Virtual

Title: **The Early Memories Procedure (EMP) from an Attachment Perspective: How to Use the EMP to Work with Attachment Defenses, Promote Self-Compassion, and Spark Therapeutic Change**

Presenter: Serena Messina, Fillipo Aschieri, & Diane Santas

Sponsor: Therapeutic Assessment Institute

Language: English

Schedule: September 12, time TBD

Information: www.therapeuticassessment.com

September 5 & 12-Virtual

Title: **An Introduction to Therapeutic Assessment (9 CE Credits)**

Presenter: Raja M. David

Sponsor: Minnesota Center for Collaborative/Therapeutic Assessment

Language: English

Schedule: September 5 & 12 10:00 AM–3:00 PM US Central Time

Information: www.mnccta.com/training-consultation

October 11-13, 2025-Tokyo, Japan

Title: **Memory Reconsolidation in Psychotherapy and Psychological Assessment**

Presenters: Stephen E. Finn and Carol Middelberg

Sponsor: Asian-Pacific Center for Therapeutic Assessment with the Therapeutic Assessment Institute

Language: English and Japanese

Schedule: October 11 (10:00-17:00), October 12 & 13 (9:30-17:00) (Japanese time)

Information: www.asiancta.com

October 23, 2025-Virtual

Title: **"Why is My Child So Angry?": Therapeutic Assessment for Early Childhood Autism**

Presenters: Mette Kyung

Sponsor: Society for Personality Assessment

Language: English

Schedule: October 23 11:00 AM-2:30 PM (US Eastern Time)

Information: https://www.personality.org/events/expert-insights-virtual-convention-2025#agenda

October 31-Virtual

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

Presenter: Raja M. David & Abby Hughes-Scalise

Sponsor: Minnesota Center for Collaborative/Therapeutic Assessment

Language: English

Schedule: October 31, 10:00 AM–12:00 PM Central Time

Information: www.mnccta.com/training-consultation

November 14-Virtual

Title: **Applying Attachment Theory and Parts Work in Therapeutic Assessment: Toward a More Integrated Self**

Presenter: Caroline Lee

Sponsor: Therapeutic Assessment Institute

Language: English

Schedule: November 14, time TBD

Information: www.therapeuticassessment.com

Upcoming TA Trainings

December 5-Virtual

Title: **Collaborative/Therapeutic Assessment for Learning Differences: Embracing the Whole Person**

Presenter: Jason Turret & Hale Martin

Sponsor: Therapeutic Assessment Institute

Language: English

Schedule: December 5, time TBD

Information: www.therapeuticassessment.com

Upcoming Psychological Test Trainings

Autumn 2025-Virtual

Title: **Level 1 Training on the Crisi Wartegg System (CWS): Introduction, Administration, and Scoring** (16 CE Credits)

Presenter: Jacob A. Palm

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

Language: English

Schedule: September 29, October 13, 20, & 27, November 10 (9:00 AM–12:30 PM Central Time Zone)

Information: https://sc-cca-com.3dcartstores.com/

Autumn 2025-Virtual

Title: **Level 2 Training on the Crisi Wartegg System (CWS): Diagnostic Meaning and Basic Interpretation** (16 CEs Credits)

Presenter: Jacob A. Palm

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

Language: English

Schedule: October 3, 17, & 31, November 7 & 21 (9:00 AM–12:30 PM Central Time Zone)

Information: https://sc-cca-com.3dcartstores.com/

Autumn 2025-Virtual

Title: **Level 3 Training on the Crisi Wartegg System (CWS): Advanced Training** (16 CEs Credits)

Presenter: Jacob A. Palm

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

Language: English

Schedule: September 5, 12, & 26, October 10 & 24 (9:00 AM–12:30 PM Central Time Zone)

Information: https://sc-cca-com.3dcartstores.com/

August 2025-Virtual

Title: **Attachment Doll Play Procedure Assessment** (36 CEs)

Presenter: Carol George

Sponsor: Adult Attachment Projective

Language: English

Schedule: August 1-5, 8-11

Information: https://www.attachmentprojective.com/training-consultation

Upcoming Psychological Test Trainings

September 2025-Virtual

Title: **AAP Classification and Coding Training** (30 CEs)

Presenter: Anna Buchheim

Sponsor: Adult Attachment Projective

Language: German

Schedule: Various dates in September

Information: Contact Dr. Buchheim Anna.Buchheim@uibk.ac.at

September 2025-Virtual

Title: **Using the Thurston Cradock Test of Shame (TCTS) in Therapeutic Assessment: From Administration through Assessment Intervention Session** (8 hours CE)

Presenter: Julie Cradock O'Leary

Sponsor: Thurston Cradock Test of Shame

Language: English

Schedule: September 26, time TBD

Information: www.testofshame.com

October 2025-Virtual

Title: **AAP Classification and Coding Training** (30 CEs)

Presenter: Melissa Lehmann and Caroline Lee

Sponsor: Adult Attachment Projective

Language: English

Schedule: Various dates in October

Information: https://www.attachmentprojective.com/training-consultation

January 2026-Virtual

Title: **AAP Classification and Coding Training** (30 CEs)

Presenter: Julie Wargo Aikins

Sponsor: Adult Attachment Projective

Language: English

Schedule: Various dates in January

Information: https://www.attachmentprojective.com/training-consultation