THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

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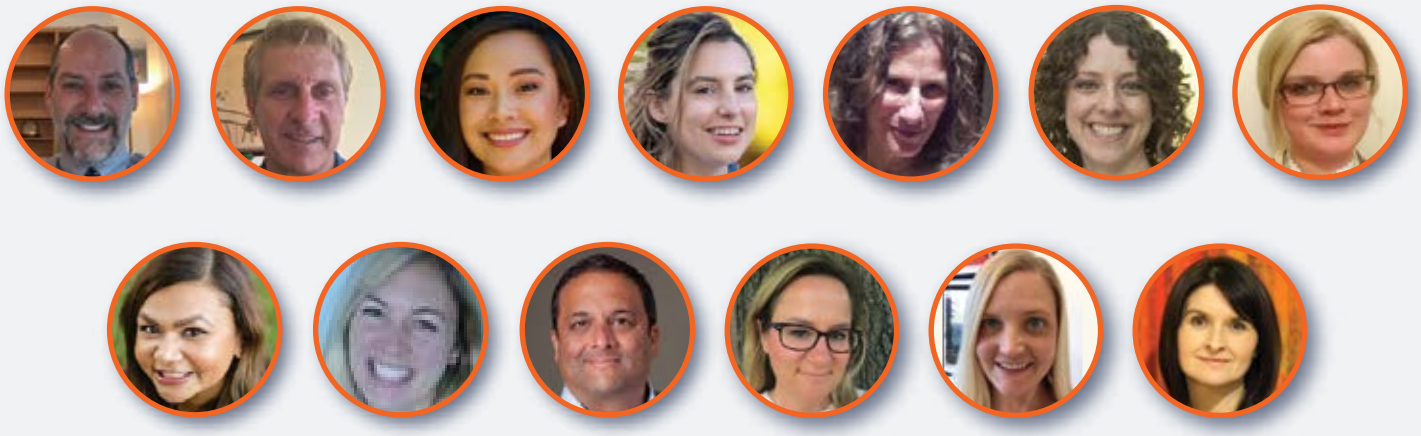

Special Issue: TA in the Community

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This issue of the TA Connection is a Special Issue on Implementing Therapeutic Assessment (TA) in Community Mental Health. It brings me tremendous pleasure to share the stories of four groups who have implemented TA in community mental health clinics around the United States. The successes they have all had have not come without challenges and tribulations. One of the motivating factors for this Special Issue was to provide a balanced perspective of the realities of implementing TA in systems that have competing demands, a need to garner reimbursement for services, and a number of other considerations. As an implementation scientist who researches the ways that evidence-based practices are adopted, delivered with fidelity, and sustained in real-world clinical and community settings, I appreciate the effort and investment that was required for these community mental health agencies and clinicians to successfully implement TA. It is a testament to the perseverance of the assessors, the support of agency leaders, the guidance of leading TA experts, and the attributes of TA itself, which are all critical factors in the success of implementing psychological interventions of any kind. I hope you all enjoy learning about the ways that these four groups overcame challenges and leveraged available facilitators of implementation to get TA into their community mental health centers. Their efforts deserve considerable praise!

This Issue

As mentioned, this Special Issue contains outstanding columns from four community mental health center-based teams in California (Child Haven Inc. and WestCoast Children's Clinic), Minnesota (Washburn Center for Children), and Missouri (Center for Behavioral Health).

Authors Larry Miller, Douglas Novotny, Arwin Cotas-Girard, and Cierra Gromoff discuss the development of a training program in TA within their nonprofit community mental health agency in Solano Count, CA. Their experience at Child Haven highlights the need for a TA champion within the center, leadership support for implementing TA, a need to establish revenue streams for TA, and ongoing training and consultation from a TA expert (in this case, Dr. Pamela Schaber). Their first experience in delivering TA revealed some of the clinical advantages of this intervention by identifying previously unseen concerns in a 17-year-old male that prompted a necessary revision to the young man's treatment plan. This positive outcome "emboldened [Child Haven] to expand the TA program." Scaling up the TA training program came with some challenges but was well supported, which led to successes. Read their column to find out more!

In comparison to the more nascent program at Child Haven, just West in the Bay Area is the well-established TA services embedded in WestCoast Children's Clinic.

For years, authors Barbara Mercer, Jessica Lipkind, and their colleagues have received consultation in TA by Steve Finn and others, trained a cadre of trainee and practicing psychologists, and delivered TA to diverse families in the Fruitvale neighborhood in Oakland. The TA program at WestCoast Children's Clinic has had to navigate a number of implementation and sustainment-related challenges over nearly two decades since the initiative to adopt TA began. The column describes how they have managed the economic, staffing, referral, and training challenges that have led to a mature and stable TA program. Authors Jessica Lipkind and Barbara Mercer go on to describe the reasons that TA is valuable to the clinic and the community, which are among the reasons that they continue to invest the resources needed to maintain the rigorous TA training and first-rate service delivery program in the clinic. A large proportion of the column is devoted to discussing the training program, which allows WestCoast to maintain its high level of quality while also getting trainees up-to-speed on TA as quickly as possible¬—a high priority for training clinics that often only have practicum students and predoctoral interns for a year.

Up north in the Twin Cities metro area of Minnesota is the Washburn Center for Children, which recently began to incorporate TA into its training and services for children, adolescents, and families. Authors Jessica Miller, Christine Brooks-White, Tina Shah, and Raja David share their unique

experiences and perspectives in connection with Washburn's adopting of TA. They are a post-doctoral trainee and champion of TA (Miller), an internal supervising psychologist (Brooks-White), the training director (Shah), and an external TA supervisor (David), respectively. Similar to the other community mental health clinics contributing to this special issue, adopting TA at Washburn requires navigating billing and reimbursement structures, aligning TA with current assessment practices and requirements by payors, and addressing client-related factors, such as attendance and no-shows to appointments. Washburn additionally needed to establish a structure for co-supervision of a trainee in TA that involved an internal and external psychologist. This model is similar to evidence-based implementation facilitation strategies that have been shown to be effective in the adoption of new mental health services in large systems like the VA (Ritchie et al., 2017) in which an internal and external facilitator with knowledge of the intervention (e.g., TA) and the service setting (e.g., Washburn) work together. Reading the perspectives of these four individuals is a truly interesting and informative story of how TA was initially implemented in a community mental health clinic.

Finally, Deana Smith, Ashley Darling, and Marita Frackowiak discuss their journey to bringing TA in a university-based clinic that serves communities in the greater St; Louis area. The Center for Behavioral Health (CBH), based at the University of Missouri – St. Louis, began preparing to use TA in 2015 when Dr. Frackowiak conducted a 2-day introductory training in TA. This was followed by a host of training and educational strategies to increase the internal capacity to supervise, train, and deliver TA in the clinic. These included a TA study group, sending staff to the weeklong TA Immersion Course in Austin, hosting a more advanced TA training, and retaining Dr. Frackowiak for ongoing supervision in the model and consultation on addressing implementation challenges. The authors present the case of Marcus, an 11-year-old boy with disorganized thinking, whose TA was instrumental in helping his family understand his current struggles. The column concludes with reflections on the factors that have contributed to the Center being able to adopt and deliver TA.

These four community mental health centers have some common shared challenges to implementing TA and their successes underscore a few of the facilitators that can be leveraged in this service context when implementing TA. First, TA appears to offer a clinical approach to the complex cases that commonly present for assessments and therapy at community mental health centers. Second, leadership support is critical as changing to a new way of practicing is not without its hurdles and logistical challenges. Third, each center in this special issue had significant training and ongoing consultation/supervision with an expert in TA. This is not only important for ensuring fidelity to the model but also for sharing experiences of the greater TA community in how to overcome common challenges. The Therapeutic Assessment Institute has collectively amassed more than a century of experience implementing TA in various service contexts, which translates to invaluable guidance to clinics and practitioners as they move through the stages of implementation from exploring if change is needed, deciding to make a change and preparing for it, to implementing the new program and putting the necessary structures in place to sustain it. Guidance in this process from a seasoned TA expert increases the likelihood of success. For those of you who have attempted to implement a new model of care or evidence-based intervention, it is likely not surprising that nearly half of all agencies that begin the process of implementing a new program fail to ever provide the service to a client (Saldana et al., 2014). That is, in preparing to implement, they are unable to overcome barriers and abandon the effort. I hope that the lessons learned and successes of the four community health centers represented in this special issue serve as both a roadmap and an inspiration to take on the transformational endeavor of implementing TA.

First Ever TA Webinar

The first TA Webinar was held earlier this month. If you missed it, don't despair. We will have more in the future! Stephen Finn recorded a compelling webinar titled, "Integrating the Work of Luria and Vygotsky in Modern Cognitive and Personality Testing: Scaffolding and Collaboration in Therapeutic Assessment." TAI members could register for $30 and non-members for $50. The webinar was available for registrants to view between December 1st and 6th, which was then followed by a live Q&A

session with Dr. Finn on December 6th from 12:00 PM to 12:20 PM Central time. The link to the flyer can be found on the Upcoming Events page and on the TAI Website.

TA at the Society for Personality Assessment Annual Convention

I hope that all of you are planning to attend the 2020 SPA annual meeting in San Diego, CA from March 25–29 at the Westin San Diego Gaslamp Quarter. We expect there to be a number of TA-related symposia, paper presentations, and posters in addition to two exciting full-day workshops: Drs. Stephen Finn, Hilde de Saeger, and Jan Kamphuis will be conducting a workshop on Wednesday, March 25 titled, "Restoring Epistemic Trust through Therapeutic Assessment: Building a Relationship 'Superhighway'" and Drs. Pamela Schaber & Filippo Aschieri will hold a workshop on March 29, titled "Introduction to Therapeutic Assessment: Using Psychological Testing as Brief Psychotherapy." The Collaborative/Therapeutic Assessment Interest Group will also convene during a lunch hour of the conference. Check the Society for Personality Assessment convention website for the time when the schedule of events is posted (https://www.personality.org/annual-convention/general-information/). In addition to these formal TA-related events, there are numerous coffee breaks, the poster sessions and accompanying receptions, as well as meals that offer the opportunity to network and catch up with colleagues from around the world.

3rd International Collaborative/Therapeutic Assessment Conference

Another exciting opportunity for the TA community is the 3rd International Collaborative/Therapeutic Assessment Conference that is scheduled for June 19–20, 2020, with preconference workshops on June 18th. Unlike past conferences that were held in Austin, TX, this year we will be on the beautiful campus of the University of Denver. A Call for Workshops is page 18 of this issue of the newsletter and a Call for Papers is on page 28. Registration details will become available very soon on the TAI website. Like the last two conferences, we fully expect this event to be stimulating, social, and an all-around good time for attendees. A special thank you to our conference co-sponsors, the University of Denver, the Colorado Assessment Society, and SPA. And it's not a bad idea to plan to arrive a day or two early to acclimatize to the mile-high elevation! I plan to use that as an excuse to do some hiking in the Flatirons near Boulder. Hope to see you all there!

As always, visit the TAI website (www.therapeuticassessment.com) for information on upcoming trainings and events and check out the Upcoming Events page toward the end of this issue for some international offerings in Finland, by Dr. Filippo Aschieri, and in Tokyo, Japan, by Drs. Stephen Finn and Noriko Nakamura.

The Leonard Handler Fund

This recently-established fund assists economically disadvantaged clients who would benefit from a TA but are unable to afford one. Leonard Handler (1936–2016) was a brilliant researcher, teacher, and clinician who developed ground-breaking 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 in-come level. Soon we will provide information on how TA-trained assessors can apply for these funds to support underserved clients that otherwise could not afford a TA-informed assessment. Information will be available on the TA website and through the *TA Connection.*

Become a Member of the TAI

Membership in the Therapeutic Assessment Institute (TAI) gets you two issues a year of this lovely newsletter, access to the members-only listserv, discounts on trainings sponsored by the TAI, and discounts on trainings on the Adult Attachment Projective Picture System. 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, and please do also tell your friends and colleagues!

Donate to TA

The TAI is a nonprofit organization with a volunteer Board, and all donations are tax-deductible. Please consider contributing so we will be able to continue to spread TA and provide the best available mental health services to the clients we serve. And please tell your well-to-do contacts about the worthwhile mission of the TAI. We currently use the majority of donations to support scholarships for students and professionals in need of financial assistance to attend trainings, and the Leonard Handler Fund provides financial support to underserved clients. We also are at work on developing training materials for those of you who find it difficult to travel to our workshops. None of this is possible without your generosity. Also consider making the TAI part of your estate plan.

Future Issues of the TA Connection

If you have feedback or suggestions for the newsletter, email me! Many of the topics covered in the newsletter have come from your suggestions, and I hope to continue to provide information that is useful to our readers. If you have conducted an exemplary or interesting TA case, want to write about some aspect of TA, or have a suggestion for a topic you would like to see appear in an upcoming issue, please let me know.

References

Ritchie, M. J., Parker, L. E., Edlund, C. N., & Kirchner, J. E. (2017). Using implementation facilitation to foster clinical practice quality and adherence to evidence in challenged settings: a qualitative study. *BMC Health Services Research, 17(1), 294–309.*

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

Therapeutic Assessment at Child Haven, Inc.

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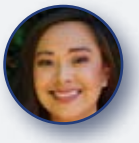

Arwin Cotas-Girard, PsyD
Child Haven Therapeutic Assessment Coordinator

Cierra Gromoff, MA
Child Haven Predoctoral Intern

We recently instituted a Therapeutic Assessment (TA) training program at Child Haven, Inc., a nonprofit community mental health agency serving the families and children in Solano County, California, since 1983. Clinicians at Child Haven specialize in providing services to individuals and families who have experienced abuse and associated trauma, neglect and exposure to violence. Child Haven is also a training agency for postdoctoral fellows, predoctoral interns and practicum students from psychology graduate programs throughout the Bay Area in California.

Most of the services provided by Child Haven are focused on clinical interventions and early childhood developmental issues. The need for psychological assessment has always been obvious to clinicians at our clinic. Unfortunately, there has been a dearth of opportunity for psychological assessment due to the lack of these resources in Solano County. Child Haven had a staff neuropsychologist more than 15 years ago, but that person's departure ended the opportunity to provide in-house psychological assessment.

Groundwork in Development of a Therapeutic Assessment Program

The need for psychological assessments has been highlighted by certain clients whose mental state, diagnosis, case formulation and/or family dynamics left therapists needing more information when progress stalled. In 2017, Child Haven's good fortune was to have a practicum student interested and invested in Therapeutic Assessment (TA).

This student, Cierra Gromoff, M.A., networked with expert supervisors and teachers in the greater Bay Area to begin a pilot project within the context of our training program.

To financially support the pilot services through Medi-Cal (known as Medicaid in some other states), we relied heavily on former executive director Jane Johnson's 10 years of experience and good will with the County. She paved the way for the necessary communication between Child Haven and the County to secure funding for TA services for an initial few clients.

The results of the first assessment conducted by Ms. Gromoff illuminated unseen clinical difficulties and led to new interventions for the client—a 17-year-old high school football player who had been diagnosed with bipolar disorder and possible nascent personality disturbances. The TA included a strong collaboration among the therapist, family, client, and assessor, with the end result being a new understanding of the difficulties that lay at the heart of this client's problems.

Initially, the client's therapist was concerned about what appeared to be an evolving psychotic process with repeated angry outbursts. Through the TA, Ms. Gromoff was able to determine that the young man was suffering from a traumatic brain injury (TBI) that may have been the result of playing football. The client was then taken off psychotropic medications and referred to a neuropsychologist and a neurologist from whom he received TBI treatment. His behavioral symptoms subsequently decreased. The success of this first case emboldened us to expand the TA program.

A Full-Fledged Therapeutic Assessment Program

The training director, associate training director, executive director at Child Haven, and our founding graduate student, created a blueprint for a full-fledged Therapeutic Assessment program. This program would become a new, separate but linked component of our overall clinical training program for postdocs and practicum students.

Naturally, paying for the program depended on our good relationship with Solano County, who reimburse our clinical services. Our executive director was able to develop a shared vision with the county's mental health personnel. A selling point presented to the county was the research supporting the efficacy of TA, which demonstrated that it was an alternative and likely cost effective intervention that could provide a different model when treatment stalled. This vision was developed even as fewer and fewer county programs provided any assessment opportunities.

The county not only approved our request but helped us by developing a billing code specifically for this type of assessment, an essential tool for successful billing and reimbursement. We were able to use other Medi-Cal billing codes for additional aspects of the assessment. Child Haven proposed an allowance of a certain number of hours per case, which the County, knowing the complexity of these cases because of our close partnership with them, approved. The Child Haven Medi-Cal coordinator would work closely with trainees to bill certain services under the assessment code and other aspects of the assessment under therapy codes. For example, Summary and Discussion sessions were billed as individual and/or family therapy. Assessors writing collaborative feedback stories/fables billed under the case management code.

Once TA was approved by the county we submitted a training budget to Child Haven administration that earmarked funds for three weekly individual supervisor hours, a 1.5 hour seminar/case conference with Dr. Pamela Schaber, an expert in TA, and stipends for postdoctoral fellows. We planned for each client to have a primary assessor (responsible for conducting the assessment with the client and providing written feedback) and a secondary assessor (responsible for video recording, observation, and working collaterally with parents of the client). Both of these roles are important aspects of the TA approach with children and families. We then chose three inaugural students for the program (two advanced practicum students, one being Cierra Gromoff, and a postdoctoral fellow), all employed 20 hours per week and assigned them each a qualified supervisor to oversee the work. A county program aimed at mental health services for 0 to 5-year-old children provided a grant for assessment measures, which allowed Child Haven to acquire necessary testing materials. Prior to receiving the grant, we were using materials from graduate program libraries with which we were affiliated—an awkward and inconvenient arrangement.

Rookie Mistakes

We made a mistake right from the start when we assigned each of the three new TA trainees two cases as primary assessor and two as secondary assessor, so

each student effectively had four cases. This was too much too soon and nearly overwhelmed their nascent abilities. We were fortunate that all three trainees in our initial cohort had some prior experience with TA, had strong work ethics, and got along well with each other, and thus together were able to carry the burden. In our current second year of the program, we have reduced the case load to one primary and one secondary client at a time, and we added two weeks of orientation and didactic preparation before cases are assigned. The orientation included an emphasis that assessors collaborate with the Child Haven therapist who had referred their clients for TA. Throughout our first year this collaboration worked well, but on one occasion, in our excitement to present the results of an intervention to a staff meeting, the therapist who referred her client was inadvertently not invited to be part of the presentation and felt left out of the new therapeutic approach. In general though, therapists were consulted and informed of most aspects of the TA and were part of the process of developing the key questions for the assessment. In addition, they were invited to observe sessions behind a one-way mirror. Perhaps most importantly, when the collaboration worked well, therapists were aware of a different style or quality of intervention than they heretofore provided their client.

What Worked Well

Financially, we exceeded self-sufficiency in the first year. As noted, this was largely due to having laid the groundwork with our County ahead of time. However, we had to overcome a number of hazards that could have sent us into the red and possibly jeopardized our program's sustainability. These hazards included poor documentation (which can result in loss of funds or funds needing to be repaid), lack of referrals, and interpersonal difficulties.

Early referrals came from our own Child Haven therapists. This avenue was especially fruitful in that having both therapist and assessor working in the same clinic, the referral process was clearly defined and streamlined. However, we realized that ultimately we would need to reach out to the community for additional referrals. This required a number of adjustments, including making presentations at other agencies in order to explain what TA is and isn't, why a referral would or would not be appropriate, how TA could be beneficial to the treating therapist, and how to facilitate the communication needed to make the assessment most effective. Additionally, we found it helpful to develop detailed referral forms for external providers to request our TA services.

Honing the Program

At the end of our first training year, we hired our TA postdoctoral fellow as the TA Coordinator. Her expertise in TA and leadership abilities were critical in shepherding our program as it grows and solidifies. At the current size of four trainees and four supervisors, with ongoing challenges in billing, administration and training, and with external recruitment and coordination underway, an in-house leader is very useful for establishing systems, facilitating communications, and resolving the inevitable difficulties.

Technology support was an indispensable aspect of our success. The distant location of some supervisors and the part-time status of the trainees demanded occasional remote supervision, data sharing, and communications. Training seminars had to be accessible to all students and supervisors. These technical achievements (led by Mary Walker and Dave Hall, our in-house technology and HIPAA gurus), allowed the TA program to succeed as well as it did. Child Haven had some existing technology, including one-way mirrors and recording technology, that supported supervision, communication and collaboration. This technology facilitated TA trainees working in teams of two, with one assessor in the room with the child and the secondary assessor working collaterally with parents and caregivers. Protecting patient confidentiality amidst that complexity of information sharing was crucial and complicated. Further, given our facility's distance from major cities, initially finding supervisors for the trainees was difficult. Again the remote technology came to the rescue, allowing supervisors to remotely observe and review recordings of their supervisee's clinical work.

The Waitlist Conundrum

We expended extensive time and energy seeking sufficient appropriate referrals to insure a financially viable program. At the same time, given the critical need for services in our community, we were concerned that opening our doors to external referrals could possibly inundate our resources and create a long waiting list. We believed this would not be beneficial to clients, our program, or the community. To address this concern, we are currently speaking to leaders of other clinics to request only one referral at a time in hopes of regulating the flow of referrals.

We hope that demand will increase based on past success and be answered by an ever-growing training program at Child Haven and hopefully, the initiation of new training programs in other clinics.

Lessons Learned

There are many considerations when developing any new training program. These include developing a supervisory hierarchy, ensuring quality training, creating processes for problem solving, and providing high-quality services. We continue to strive to improve in each of these areas by collaborating with students, supervisors, and leaders of our organization, as well as with the health care community in which we operate.

An Example TA

In this section we would like to present a deidentified case to highlight our process of TA. One of our doctoral practicum students was treating a 7-year-old Mexican-American boy we will call "Jorge " for extreme behavioral outbursts and aggressive tendencies. Jorge was biting teachers, kicking his pregnant mother in the stomach, ripping couches in the therapy room during sessions, and displaying repetitive, apparently auto-stimulating behaviors, while exhibiting delayed speech. His school thought him to be on the autism spectrum based on behavioral rating scales and observations. The doctoral student was less convinced that Jorge was on this spectrum, noting conflicting diagnostic indicators.

Remarkably, Jorge had never received a comprehensive assessment even though he had been receiving mental health services since he was one year old. He was raised by his young single mother in a very chaotic environment. His mother was traumatized from domestic violence perpetrated by Jorge's father. Despite her trauma his mother remained a strong advocate for Jorge and did not agree with the autism diagnosis. However, she was confused as to why Jorge was not making any progress in treatment nor responding to psychotropic medications. She believed that Jorge's condition was worsening.

The treatment team decided to include a TA assessor, realizing that in order to effectively plan and provide treatment and answer the question of why he was not improving, all involved would need greater clarity about Jorge's diagnosis. If Jorge could obtain a TA to clarify his diagnosis, a more helpful intervention might be applied.

In advocating for this assessment, we emphasized that TA could ultimately save the county money by ensuring accurate diagnoses resulting in appropriate subsequent treatment. Approval from the county was obtained.

During the TA, Jorge was able, for the first time, to identify that he was upset that his father had left the family. Jorge did not understand why his father had left. Jorge also expressed the wish that he could know more about his father and that he could talk about this with his mother. Due to the years of abuse Jorge's mother endured while in relationship with Jorge's father, she was shut down and unable to engage in the discussions Jorge needed. While watching one of Jorge's testing sessions live, she broke down in tears when she realized how much the domestic violence and the absence of father was affecting Jorge. Importantly, the TA process allowed her to be seen as the expert over her own life, which softened her defenses as she felt understood and supported by the assessors. This then allowed her to be more vulnerable and open to the sadness her son experienced but manifested angrily.

Jorge's mother herself had a long history of loss and great difficulty with attachment. As the assessment team better understood her issues around loss and termination, and how they were affecting her son, they anticipated her needs around termination and appropriately addressed her feelings about the end of the assessment process. By doing this, Jorge's mother was better able to accept the recommendation that Jorge be transferred to a lower acuity mental health agency that could better serve the family's therapeutic needs. The team handled this transition by providing consultation to the new therapist and introducing the new therapist at the Child Haven offices. Overall, Jorge's mother reported that she found TA to be helpful and that "it helped show Jorge how to behave and change a lot." Thus, TA offered substantial therapeutic benefit for Jorge, mother and therapists by revealing underlying issues and obstacles, as well as recommending and facilitating appropriate future treatment.

The Current State of the TA Program

So far, the TA program has served 12 clients between the ages of two to 18. Child Haven therapists report that their clients who have received TA have been more engaged and open in treatment than before the TA. Furthermore, the clients themselves have

expressed feeling better understood by their treatment providers. Some clients were helped so much by the assessment that they were able to discontinue therapy services sooner than estimated due to marked improvement in their functioning.

So far the TA program at Child Haven has been a success due to several factors. One factor has been our collaboration with the county, which has been extremely productive and mutually beneficial. Child Haven has collaborated directly with the county to understand county's needs and their vision for our program. We have worked to be attuned to the county from the onset of the program before providing these services. In addition, the assessment program has been very conscious of billing by staying within a planned range of charges, while still advocating for more resources when necessary. Other factors contributing to the success of the program include selecting excellent initial trainees to spearhead the program, obtaining cutting-edge quality supervisors, having a flexible and talented staff, and offering technology solutions that overcame obstacles of distance and confidentiality.

TA cases within the agency have averaged 6 months in duration. One case lasted nine months due to parental inconsistency and defenses hindering the process. Others took longer due to the complexity of the issues presented. Of note, our trainees learning the TA model are actively dealing with very challenging cases often involving complex trauma. In the first round of cases, neither families, trainees, supervisors nor staff completely understood the time commitment required nor the emotional intensity that TA evokes. We have seen a pattern in which families who were initially motivated began to miss and/or cancel sessions as the assessments progressed into their third or fourth months.

A significant barrier to assessment is a lack of available language translation services. Translation services within the county are scant and non-reimbursable. There was one case in which the client's parents were monolingual in Spanish, yet we did not have any Spanish-speaking trainees available. The assessors on the case had to work with a non-clinical administrative staff member who helped with translation, posing its own predictable set of challenges. Other barriers to service include clients' intense poverty and limited access to transportation.

Parents and clinicians alike have been frustrated by our county's lack of necessary services. Assessors often find themselves making recommendations for particular treatments that are not available in the county. In particular, there have been challenges to find occupational and speech therapy services. Parents often have difficulty finding and affording their own individual therapy. Despite having access to Medi-Cal, this insurance does not offer individual therapy for adults.

In our current training year we have a postdoctoral fellow, a predoctoral intern, an advanced practicum trainee, and the previous postdoc, now a licensed psychologist, who now serves in the new role of TA Coordinator. They continue to work with Dr. Schaber, whose didactic and group supervision time has increased from 1.5 to 2 hours weekly. We have three outstanding supervisors who contribute greatly to our success.

TA Assessors Insights

Our TA coordinator, Dr Cotas-Girard, recently voiced that "learning TA has been the most challenging and rewarding training experience of my career. It has been incredible watching the impact and shifts within my clients' family systems that would likely have taken significantly longer in traditional therapy services. I not only learned how to better hone my assessment skills, I also became a stronger therapist. It has especially expanded my knowledge of family interventions, which was vital across my work within Child Haven."

Cierra Gromoff, M.A. recounted that what drove her to pilot the Therapeutic Assessment program was "the enormous frustration of running into dead end after dead end" in seeking assessment for her underprivileged clients, many of whom "had never been properly diagnosed." A TA program within a community mental health agency is not without its share of challenges. Stefany Alviar, M.A, M.S., a practicum student in the first TA cohort shared, "Barriers faced by my clients and their families involve consistency in attendance and trauma responses. Our agency serves many families experiencing trauma. TA illuminates core issues and trauma within the family. The intensity of TA necessitates emotional effort and time by the families. Families are already juggling different parts of life within their schedules, which can make attending such an intense and exposing therapeutic experience less of a priority."

Future

We hope to begin taking more referrals from external agencies in order to better support Solano County. The TA coordinator would like to spread awareness of the program by giving additional presentations to other agencies and providers on the benefits and process of our services. We hope that Child Haven can also provide consultation to other providers who might be interested in pursuing TA as a service to their clients. We wish to begin efficacy research to better understand the impact on families served. We hope to be able to offer our readers additional lessons learned in the months and years ahead.

Author Bios

Larry Miller, PhD is the Training Director at Child Haven. He began the practicum training program at Child Haven in 2003 after working there as a staff psychologist beginning in 2001. The training program has expanded over the past 16 years to include Postdoctoral, Predoctoral and Practicum programs in addition to the Therapeutic Assessment program. Dr. Miller is a practicing clinical psychologist based in Berkeley, CA where he has a private practice. He also works with capital defense lawyers to assist defendants in their death penalty trials and appeals.

Douglas Novotny, PhD is Associate Training Director at Child Haven. He received a PhD from the University of Chicago in Human Development with an emphasis on Cultural Psychology, and Interned at The Cambridge Hospital. He has long worked clinically with children of all ages and their families, often in Spanish, while supervising and training. Active interests include heterodoxy as an antidote to the Multiculturalist approach to diversity, as well as pro-masculinity, and the life course development of major philanthropists.

Arwin Cotas-Girard, PsyD is a California licensed clinical psychologist. She earned her doctorate from the Wright Institute in Berkeley, CA and completed her predoctoral internship with the Hawaii Psychology Internship Consortium working within the Hawaii Department of Education on Oahu to provide children with counseling and assessment services in public schools. She began her training in Therapeutic Assessment as a postdoctoral fellow at Child Haven with Dr. Pamela Schaber from the Center of Therapeutic Assessment in Austin, TX. Dr. Cotas-Girard is currently the Therapeutic Assessment Coordinator at Child Haven. She maintains a private practice in Lafayette, CA with a focus on collaborative assessment.

Cierra Gromoff, MA is currently providing Therapeutic Assessments as part of her predoctoral internship at Child Haven under the training of Dr. Pamela Schaber and is graduating from the Wright Institute in Berkeley, California in the Spring of 2020. Cierra began her training in Therapeutic Assessment three years ago, as she piloted the program at Child Haven. She is level-three trained in the Crisi Wartegg System and actively working on certification. She hopes to expand into researching the impacts of Therapeutic Assessment within public mental health and to continue providing accessible Therapeutic Assessment to children and families.

Integrating Therapeutic Assessment and Community Mental Health

Jessica Lipkind, PsyD

Barbara L. Mercer, PhD

History of Therapeutic Assessment at WestCoast Children's Clinic

WestCoast Children's Clinic (WCC) is a non-profit, community mental health center located in Oakland, California. Prior to the move to Oakland in 2006, the clinic was in a church basement and then in a small building behind a church in El Cerrito, CA. WCC was established in 1979 by a British psychologist who was originally from the Tavistock Clinic in London (Mercer 2019). Training was a foundational principle of the clinic and the first "staff" were unpaid interns who were committed to providing high-quality therapeutic services to children who did not have access to private-pay treatment settings. The treatment model implemented at the outset was a systemic approach grounded in the psychoanalytic underpinnings of Bion and Winnicot, combined with attachment principles from John Bowlby. From the start of WCC, the child was seen as the primary client and the child's caregivers, surrounding community, and the greater systems in which they interacted were also considered to be participants in the child's care.

Assessment was a small component of the services provided at WCC in the early years, but became a more formalized program in the late 1980's when Dr. Barbara Mercer began overseeing the training of assessors at the clinic. She started with an assessment seminar and, with the support of the clinic director, created a formalized assessment program. Dr. Mercer, through her long-standing membership in the Society of Personality Assessment, became exposed to the Therapeutic Assessment (TA) model. She hired Dr. Caroline Purves as a supervisor, who integrated tenets of the Collaborative Assessment approach by Dr. Constance Fischer in her assessment seminars. Over time, Dr. Mercer developed a collegial relationship with the founder of the model, Dr. Stephen Finn. This relationship fostered the formal

integration of the TA model at WCC, as Dr. Finn presented to the assessment team on multiple occasions. His trainings included the use of readings, case discussions, and videos of himself and his colleagues and their successes and challenges in the work. Dr. Finn also held a number of live TAs at WCC for training purposes.

In 2006, WCC moved to the current Oakland location, in the Fruitvale district. The clinic's commitment to ongoing training, including advancement of the TA model, was evident in the build-out of this office. For instance, some treatment rooms were equipped with audio and visual recording equipment, as well as flat-screen televisions that permitted viewing live sessions in the rooms wired for recording and observation as is customary when using the Child TA model (Tharinger et al. 2012). In addition, the "Training Area" seats a large number of people for presentations, which can also be used to project live feeds from the treatment rooms when necessary. This infrastructure permitted the full implementation of the TA model more efficiently and allowed WCC to host Dr. Finn many times over the years to provide all levels of his trainings for in-house staff and trainees, as well as attendees ranging from assessment psychologists in neighboring agencies to those across the world.

Community-Based Therapeutic Assessment at WCC

The agency's move to the Fruitvale district has led to deep and ongoing conversations clinic-wide about what it means for us to provide services in the community and these discussions are incorporated into the assessment trainings and administration, as well. The conversations are centered around race, power, and privilege in all aspects of the clinical work. Our clinicians meet with clients in the clinic and in the field, which includes meeting youth and families in their schools, homes, parks, libraries, or fast-food restaurants, among other locations. Being immersed in the communities our clients live in requires us to consistently and deeply examine how various aspects of our identities intersect with those of our clients, but also with the communities in which we are working. Fruitvale is a highly diverse neighborhood with a predominately Latinx population, but also communities of people of African-American, Middle Eastern, Southeast Asian, and African descent, among many other backgrounds. In addition to our work in Fruitvale, we work in broader Oakland, as well as other towns and cities within our 90-mile catchment area. In the last fiscal year, we provided mental health services to over 1200 children, teens, and families and approximately 500 psychological assessments were completed from 2015 until the present (October 2019). Our clients are primarily youth of color from underserved communities, many of whom are currently or previously involved in the foster care system. The presenting problems and referral questions are often connected to the long-standing histories of complex trauma and community distress our clients and families have experienced. As WCC has evolved, we expanded from the outpatient therapy and assessment services to programs for transitional age youth, mental health screening services for children first placed in foster care, specialized treatment for young adults experiencing severe mental illness, case management across departments, and a program for commercially sexually exploited minors. These programs were developed to provide diverse services to youth in our broader communities as we observed needs that were not being addressed adequately.

Referrals for assessments at WCC are initiated by children's caregivers, school staff, clinicians at local community mental health agencies, Child Welfare Workers in the foster care system, and clinicians in the various programs within WCC. Funding for assessments comes from the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) contract the clinic has with two counties. This funding is a combination of federal, state, and county money dedicated to the provision of mental health services for children. EPSDT reimburses for individual, family, and group therapy, as well as psychological testing, case management, and Intensive Care Coordination (ICC) services. Moreover, EPSDT provides funding for the clinician's travel time related to clinical service delivery. This is key to providing long-term services to our youth, who experience a high degree of instability in their lives, including changing placements in foster care, families abruptly losing their housing and moving often, and families moving farther from the clinic due to the high cost of living in the Bay Area.

While the EPSDT funding has provided a wide stream of referrals and provided our clinicians with great flexibility in providing services to youth near and far, more stringent restrictions were implemented in 2015 which have affected the flow of referrals. Prior to 2015, youth were seen without preauthorization for a psychological assessment. In July 2015, the county Behavioral Health administration instituted stricter guidelines for approval for testing and all testing had

to be preapproved for a limited number of billable hours. For instance, all children referred for an assessment must be in therapy for a minimum of three months prior to the assessment and the goal of testing is to inform the therapist of the child's accurate diagnosis. These guidelines also include restrictions in the domains that can be assessed, as they must be deemed medically necessary by the county behavioral health reviewers. Because our clinic had a pre-existing contract with the county to provide testing using the TA model, we have been able to continue to provide our comprehensive services, by billing codes for individual therapy and other interventions.

We have been very fortunate that, despite these restrictions and the challenges that followed, our administration has demonstrated unwavering support for testing services. The Chief of Clinical Programs, Dr. Kelley Gin, indicated that there are a range of challenges to manage. For instance, he noted the difficulty of ensuring adequate staffing and infrastructure, specifically for a specialized service like testing, which consistently requires expensive materials. In addition, the administration must contend with limitations on the referral rate and restrictions on reimbursement. Moreover, having a program dedicated to using the TA model means a smaller pool of potential staff and supervisors to hire.

Despite these challenges, Dr. Gin explained the numerous benefits of using TA in the assessment service. He noted that, especially when working with disadvantaged and marginalized populations, the TA model offers an "experience-near intervention that privileges their voice and perspective, taking into account their unique situations and circumstances, especially when they are system-involved" (K. Gin, Personal Communication, 2019). Dr. Gin further stated that the TA model allows assessment clinicians to partner with children and families instead of engaging with them in the role of "patient or court-dependent." He explained that clients and families, other providers, and local courts have reported that our reports and feedback letters and fables (Tharinger et al., 2008) are "markedly different and helpful" (K. Gin, Personal Communication, 2019).

Training in the TA Model

For most of our staff and trainees, they are first introduced to TA when they come to WCC. In soliciting feedback from them about their experiences, many indicated that they now view the approach as integral to their work and cannot imagine returning to the information-gathering approach to assessment, which was how they were trained in graduate programs. For instance, one postdoctoral resident explained that she had never worked on a team as an assessor prior to WCC and that the benefits included having collegial thinking support on difficult cases and help integrating the findings throughout the process. Moreover, she indicated that the feedback fables have been one of the most powerful parts of the process, not only for the children who receive them, but particularly impactful for their caregivers. A staff assessor noted that, "the TA model has made my sharing of assessment results and feedback with clients much more humanistic and inclusive and aligns with my values as a clinician." An assessment supervisor shared that our model of collaborating on large treatment teams can make the assessment feel protracted, as there are so many parties with whom to conduct feedback (i.e. the client, caregiver, family, treating therapist, psychiatrist, lawyer, school staff, and county social worker) and so many varied narratives with which to contend. However, she also observed that it is a powerful process to watch a team coalesce around a child and to support a trainee in leading that process as they are guided by the test data.

We spend a significant amount of effort and time ensuring our predoctoral interns and postdoctoral residents are trained thoroughly in TA. Training begins with a bi-monthly seminar that addresses the fundamentals of the model. All postdoctoral residents participate in this seminar before they are offered the opportunity to conduct a week-long therapeutic assessment with a family. Over seven weeks, we review the steps in the semi-structured model, from how to help caregivers formulate their assessment questions, to working behind the mirror, to writing fables to children for feedback. Readings are assigned prior to each seminar, mostly from the Journal of Personality Assessment (JPA) and colleagues in the TA community. Trainees also watch videos of cases conducted during the week-long trainings with cohorts that preceded them. At times, this includes the supervisors who are now part of the seminar faculty, but were conducting the cases as trainees or staff clinicians. We hope that by showing their supervisors engaging in challenging cases and experiencing both successes and difficulties, that we can slightly shift the inevitable power dynamic that occurs when postdocs engage in didactics with their supervisors. We strive to hold in mind what Drs. Leonard Handler and Greg Meyer (1998) stated in the first chapter of the book Teaching and Learning Personality Assessment. Drs. Handler and Meyer commented that assessment is,

"a collaborative enterprise that is not done 'to' people, but rather must be done 'with' people." We feel there is a parallel in training to the TA model, that we are engaging in learning with our trainees, allowing us to embody the spirit of the TA model from the beginning that nobody is the expert on one another and we must hold curiosity about dynamics throughout the process. This sets the stage as we move forward into a week-long, immersive TA with a family.

In order to accommodate our entire cohort, we conduct two different week-long assessments within a few months of each other. Despite the stated excitement by the postdoctoral cohort, there are varying levels of comfort, training, and experience amongst our group members each year. Some see themselves as assessors at heart, others participate in testing because it's part of our training program, but are clear that it is not their love nor part of their career trajectory. These varying levels of comfort with assessment can translate into differing levels of anxiety about participating and allowing oneself to become vulnerable and immersed in the process. For instance, we both videotape the sessions and supervisors watch them live, which is anxiety-provoking for even the most enthusiastic assessor, and can feel overwhelming for those who do not feel as confident in their assessment skills or at implementing the TA model. As supervisors, we must stay attuned to the fact that we hold power throughout the process as their seminar leaders and those who are eventually completing their evaluations.

In addition to videotaping and a live feed, we also have the "lead clinician" wear a Bluetooth bug in the ear so we can communicate directly during the sessions. This often makes clinicians anxious about how they will stay present for the process with the caregivers, while also taking in live feedback. It can be a challenge for the supervisors to choose optimal moments to provide brief nuggets of support and guidance, as often we feel the pull to say too much and insert ourselves in the room as though we were the clinician. While we've made a concerted effort to provide comments only when they may be most impactful, they can still land as intrusive, and sometimes, can feel to the assessor as though we're critiquing their clinical skills. Despite this anxiety about our intrusions, we often receive feedback from the clinicians at the end of the process that guidance in the moment is very helpful, especially when they feel stuck in their thoughts or countertransference.

Many factors are considered in determining who will be assigned to each case. All assessment supervisors participate in this process so that we are attending to any alliances and/or conflicts that exist in the group. At times, when we have a postdoctoral cohort of five, we have a staff clinician participate in one of the weeks to have a team of three assessors. This can raise anxiety for the trainees about their level of skill in comparison to the staff member, as well as stress for the staff member of entering a cohort that is already established. However, we feel it is important to have two clinicians with the caregivers to support one another in guiding the caregiver through the assessment and manage the intense affect that often arises, to step in when the other clinician feels stuck, and to provide the opportunity for all trainees and staff members to participate in the TA.

A significant factor in our decisions about team assignments are the various identities of our postdoctoral residents. We are attentive to the racial and gender composition of the assessor team, as we try to be thoughtful about the pairing of clinicians and clients based on what we know about the family's request and presenting needs. Often, the family we work with for the week-long TA is already in therapy at WCC and sometimes makes requests about various identities of their clinical team. For instance, if the family indicated that they'd be more comfortable with clinicians of color, bilingual clinicians, or providers of a particular gender, we work hard to honor those requests in case assignment. Moreover, we may have information from the treating therapist about how the client's identity development may intersect with those of team members and how this may lead to fruitful discussions in the case about the client's sense of self. The referring therapist often feels strongly about who would be a good match to work with their client, particularly from the lens of supporting the client's positive racial identity development. Thus, if we are working with a client of color, the therapist often has advice for the supervisors about the composition of a team they prefer. At times, we can accommodate these requests, and at others, we cannot and need to be thoughtful about how these pieces of the client's identity can still be held in the process of the assessment.

Complicating matters further is determining which supervisors will be assigned to which weeklong TAs. We also encounter questions such as: Did this supervisor and supervisee work together during the internship year? How did each person feel about their supervisory relationship? Which supervisors currently work with which postdocs and how will it be for some of the

postdocs to have their current supervisor on the team and for others not to? What dynamics may arise if a supervisor has two supervisees on one team? Will there be a pull to present oneself as the "star" of the team? What are the gender and racial dynamics of the supervisor/supervisee teams and what significance may this have for the family with whom we'll be working? And, of course, all these dynamics are compounded by those we encounter when the assessment actually begins, sometimes escalating these dynamics in the form of enactments related to relationships within the family. We are not necessarily intending to avoid these dynamics, as they can be critical in exploring those of the family, but we work to be attentive to the possible ways they manifest or even complicate the team's ability to attend to the family's needs.

Throughout the weeklong process, we give feedback to the team members about the ways they are integrating the Therapeutic Assessment model into their interactions with the family. We work to provide feedback in a parallel process with what is provided to families throughout the week. As we train the clinicians to start recognizing and thinking about ways to incorporate Levels 1, 2, and 3 feedback (Finn, 2007) we also approach our trainees with the same mindset. We start with the areas they acknowledge are challenging or new for them, and then as the week progresses, we work to open up their curiosity about the moments they succeed, the moments where they struggle, and what information they can provide about the case. For instance, when one clinician consistently avoids pushing the family a bit deeper at an opportune moment, we try to engage their curiosity about what feelings may have come up at that moment or further understand their conceptualization of the utility of their approach at that time. Often, with our families, there are profound histories of trauma. We frequently see clinicians fearful of opening up the narratives around trauma, as they worry this will re-traumatize the family. In some cases, this can be due more to the trainee's own fragility in the face of traumatic stories and the narrative about what they believe the family can handle may also be their way of avoiding painful stories. They may also not have confidence in their skills to manage the painful affect that arises in these conversations. Thus, their collusion with families about avoiding traumatic material needs to be held by the supervisor team to build their sense of efficacy, so they can scaffold this ability for the families. As the week progresses, we hope to see the trainees begin to incorporate pieces of growth they may not have made space for earlier in the process. By doing so, they can travel the journey with the family. We hope that as the caregivers make space for empathy and understanding of the child, the trainee will have a greater understanding of their skills and compassion for themselves as they grow as a clinician and assessor.

Outcome Research

Our assessment team developed an outcome project to further our client collaboration, improve our assessments, and provide data to our county funding source. We wanted to evaluate if our assessment process was working, to gather information pre- and post-assessment to determine if the family's understanding of the child's behavior had shifted, and to gather parent satisfaction feedback. We utilized three measures to do this. The first was the Parent Experience of Assessment Scale (PEAS) (Finn, Schroeder, and Tonsager (2004); Austin, 2011). The second measure was adapted from Deborah Tharinger's pilot measure, Parent Positive and Negative Emotions (PPNE) (2009), titled "My Feelings". This scale is a survey of the caregiver's feelings about the assessment in relation to their child and is administered pre- and post-assessment. The third measure is the Client Satisfaction Questionnaire (CSQ-8) (Atkinson & Zwick, 1982; Larson, et. al 1979) and is sent to social workers, therapists, and caregivers about their experience of the assessment.

The quantitative and qualitative results were compiled by our research department, led by Dr. Danna Basson. On the PEAS, the highest mean score (N=21) for Collaboration during a recent year period on a Likert scale (1-5) was 4.64. The Assessor-Caregiver Relationship mean was 4.56. Caregiver reports on our 2018 My Feelings measure that changed significantly between pre and post assessment were: "Today, as I think about my child's challenges and future, I feel:" "Less at my wits end, "Less Stuck", "Less Tired", "Less Frustrated, "Less overwhelmed" and "Less scared". Caregivers felt significantly: "More encouraged" and "More patient." On the CSQ, 92% of client's social workers and referring therapists rated the quality of the assessment as "excellent;"92% of respondents also said that they received the service they were seeking. All participants indicated that they would recommend the services to a friend or client. In a review of qualitative feedback we received from various caregivers, many indicated how the assessment helped them understand their child and ways to strengthen the relationship. For instance, one parent commented, "It helped me see my daughter when she shuts down so I can come back when things are calmer." Another caregiver identified how the assessment clarified confusion about the presence of psychosis for her child and how the assessor

supported the team in making a plan that was accurate to his treatment needs. One other mentioned the feedback fable that was provided to the client and how the assessor utilized the client's interest in Anime to communicate the findings in a manner that resonated for the client.

Concluding Thoughts

We hope to have illustrated the various benefits and challenges of integrating TA into a Community Mental Health agency with a large training component. We have found the TA model to be easily adaptable to working in the field because of its emphasis on partnering with the client and families. It incorporates flexibility to meet the client where they are; both literally and figuratively. The foundation in attachment matches well with the work we do and the interventions we hope to provide to our clients to strengthen bonds in their family systems and communities. We strongly believe there is no other assessment model that fully permits the clinicians to join the clients in their experience and simultaneously hold and promote hope, particularly when working with complex trauma and attachment disruptions in the assessment of children.

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Author Bios

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Barbara L. Mercer, PhD, served as the Assessment Program Director and clinical supervisor at WestCoast Children's Clinic, a community psychology clinic in Oakland, California from 1986-2018; she is currently supervising assessment at WestCoast Children's Clinic. Dr. Mercer and her colleagues authored and edited *Assessing Children in the Urban Community,* published in 2016 by Routledge/Taylor and Francis. Dr. Mercer has taught psychological assessment and child therapy, chaired doctoral dissertations, and been in private practice. She recently relocated to Washington State where she continues to pursue supervising, training, and writing projects in community psychology, foster care, and therapeutic assessment.

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The inaugural CTAC in 2014 and 2nd CTAC in 2017 were a great success and served as an opportunity for members of the CTA community to learn and to socialize with colleagues from around the country and the world.

We invite proposal submissions for full and half-day workshops on topics pertaining to CTA. Proposals are due December 15th, 2019. Notification of acceptance will be sent by December 20th.

These events are continuing education (CE) bearing and are approved for their appropriateness in satisfying the continuing education needs of doctoral-level psychologists as defined by the American Psychological Association. A 400–500 word description is required for submission along with 3–5 learning objectives. Please also include a complete list of presenters (including affiliations and contact information). Half-day workshops are either 8:30AM–12:00PM or 1:30PM–5:00PM, which includes a 15-minute break, and Full-day workshops are 8:30AM–5:00PM which includes a 15-minute break in the morning and afternoon and a 90-minute lunch from 12:00PM–1:30PM.

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THE COLORADO ASSESSMENT SOCIETY

Implementation of Therapeutic Assessment in a Community Mental Health Training Site: Potential Barriers, Implications, and Benefits for Adolescents and Their Families

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Introduction

It's not uncommon for those being trained in TA for the first time to hold two different feelings at once. There is simultaneously excitement about the impact TA can have on clients and the opportunities to flex our creativity, interpersonal skills, and critical thinking, coupled with some apprehension and uncertainty about how the model will work in the clinical setting where the psychologist is employed. Mental health systems both in the U.S. and abroad have various policies, procedures, and methods for billing, that at least in the U.S. typically follow a medical model approach to behavioral health services. Even within a given state, there may be wide variations in how systems operate when it comes to these factors, often leaving those new to TA to wonder, "How can I implement this in my workplace?"

Given all of this, the four of us endeavored to implement TA for the first time at a community mental health center (CMHC), with each of us considering our various roles and the obstacles and successes we noted throughout the process. What follows are four separate descriptions of what each professional experienced. We first provide a brief description of the practice setting, and then Jessica, who was the post-doctoral fellow who conducted the TA, describes her experience. Next, Christine (Jessica's primary supervisor) and Tina (the Training Director), layout the challenges and successes they experienced. Lastly, Raja provides some thoughts as an outside consultant, as he was trying to assist both Jessica with her clinical work and Christine and Tina in their administrative roles.

Description of the Community Mental Health Center

Washburn Center for Children (WCC) is a non-profit CMHC that provides assessment, consultation, and therapeutic services to children, adolescents, and families in the Twin Cities metro area of Minnesota. WCC serves nearly 3,600 children and their family members, who present with a wide variety of mental health issues. More than 65% of the children served by WCC are from families with low incomes. In 2016, 72% of clients receiving services were enrolled in state-funded health care programs or were uninsured. In addition, the clients served represent the broad range of ethnic diversity and marginalized populations.

WCC is committed to training students studying to be mental health practitioners, and approximately 75 students from undergrad to postdoctoral fellows provide services to our community through our training program every year. WCC has had an APA approved pre-doctoral internship since 2012 and

interns and postdoctoral fellows are an integral part of the training team. Since WCC is committed to the ongoing process of creating an inclusive environment that celebrates, honors, and respects the seen and unseen diversity of all individuals and families we serve, interns and postdoctoral fellows receive training and supervision regarding inclusive and culturally responsive practices in order to provide effective forms treatment to the diverse populations we serve. Given WCC's emphasis on being collaborative with the clients served, this site was an optimal setting for implementing a TA.

Perspectives of a Postdoctoral Fellow for Implementing TA

By Dr. Jessica D. Miller

I was fortunate to be able to take an elective course on TA in graduate school with Raja as the instructor. Through that course I first learned the foundations of the model and deepened my understanding of how to artfully meld therapy and assessment skills together to elicit change. There were several aspects of the theoretical underpinnings and techniques of the TA model that resonated with me and influenced my approach to conducting assessments with children, adolescents, and their families throughout my internship and postdoctoral fellowship experiences in community mental health settings. Specifically, I was initially drawn to relational and collaborative stance used to assist clients with clarifying what they would like to learn from the assessment process and the use of self-verification theory to structure the order of test administration and how feedback is presented to clients and their families. During internship, as I deepened my understanding of TA, my insight about how to link the assessment results to my clients' daily lives and scaffold information to promote curiosity and decrease defensiveness and shame also increased.

With these successes in mind, I was eager to further develop my TA skills during my postdoctoral fellowship at WCC. Early into my fellowship, Raja and I discussed the possibility of him consulting on a TA case. I approached my supervisor, Christine, and the site's training director, Tina, about my interest in implementing a TA under their guidance and with consultation from Raja. Since he had previously lead didactics on the TA model with the training team, they were particularly interested in how this model could be used with the populations that we serve. In addition, many of the interns and other postdoctoral fellows were interested in learning more about TA with a didactic on the approach.

Once the team established that we would implement this plan, I received several client referrals from the other postdoctoral fellows and interns. Unfortunately, given the time constraints caused by initiating the implementation of the TA during the last two months of my postdoctoral fellowship and the barriers faced by the populations we serve at WCC, I ended up completing just one TA with an adolescent client who was being seen for therapy by one of my colleagues. This particular client was an adolescent female who presented with symptoms of anxiety and depression that had persisted despite her participation in therapy for two years. This TA spanned roughly five weeks, for a total of nine sessions, and was completed right before my fellowship ended.

Challenges to Implementation

While we initially encountered several challenges for getting the TA started, my supervisors and colleagues were helpful in assisting me with navigating uncertainties at both an institutional and client level. Given that WCC already has a system in place for the process of conducting psychological assessments, one of the first hurdles was coordinating with our billing department to determine how to structure and bill for the TA sessions. We were still adjusting to the changes in billing codes that occurred for psychological testing in January of 2019, and there was initially some apprehension about how the TA model could fit within the framework of our new billing codes. Given that a TA had never been previously implemented in our setting, this took a number of conversations with our billing department and compliance director in order to ensure we followed our policies, procedures, and MN Department of Human Services standards for billing. We were able to figure it out correctly but given the various constituents that needed to be involved, this process took longer than expected. In addition, the client also had private insurance and did not need a prior authorization for psychological testing which may have made the reimbursement process easier for this case than some of the other testing clients who required multiple appeals to receive authorization for testing hours.

During the same period, we determined the types of releases needed for Raja to act as an outside consultant. Since WCC has a history of collaborating with other professionals in the community, this process ended up being easier than expected, but it again required a number of conversations and time spent educating various individuals about the model.

Finding a way to communicate with clients and the clinicians working with them about the model in a clear and concise way proved to be another challenge. Fortunately, Raja provided me with information sheets that were based on materials from his trainings with members of the Center for Therapeutic Assessment. These documents explained the TA approach to clients and their families, and helped the client's therapist proactively orient the family to the TA process before it commenced. Overall, I think that having two supervisors who were passionate about the TA approach, colleagues who were enthusiastic about learning more about the model, and a consultant who was experienced in implementing TA was beneficial for overcoming these various challenges.

In addition to navigating several institutional barriers for implementing TA in this setting, some challenges occurred at the client level. Since WCC often serves clients who experience difficulties accessing care, one of the first problems I experienced occurred with an initial referral for a child client whose family struggled to begin the process. Despite agreeing to the TA, they were unable to attend their first three scheduled sessions. As a result, the TA was suspended so that the family could focus their energy and resources elsewhere. While such issues impact many of our clients regardless of what type of service they are receiving, the time requirements for TA may be more difficult for some clients to navigate before they have additional supports in place. Conversely, altering the number or length of sessions could be a way to ensure clients are able to complete the entire TA. The adolescent I completed the TA with had access to reliable transportation and was able to drive herself to sessions, but many of the families we serve at our site have limited access to reliable forms of transportation. As a result, it may be beneficial to schedule several hours of testing when completing TAs with clients and their families who are unable to access transportation in order to attend one- to two- hour sessions twice a week when

We experienced some additional challenges, but these are not necessarily unique to implementing a TA at WCC. For example, we do not currently have onsite scoring for the personality assessment that I used with this client, as we mail in the protocol and wait several weeks to receive the results. Since this particular test was an essential element for figuring out why the client was feeling "stuck" in therapy, Raja assisted us by scoring the test so the results could be used in a timely manner during extended inquiry and assessment intervention sessions. Further, since many of the clients we see at our setting present with attachment-related difficulties and tension within their family systems, I had difficulty navigating between the client's resistance to engaging her family members in the process and the potential benefits of doing so. In the end, the adolescent decided to limit the involvement of her family in the TA process. This resulted in me not being able to do all aspects of the model as intended (e.g., family assessment intervention session). However, gains were still made with the adolescent.

Benefits of TA

During the TA, the extended inquiry and assessment intervention sessions provided unique opportunities for the client and me to collaboratively process the test results and gain additional insights into her areas of strength and difficulty. One aspect of the TA that I found especially beneficial was that we were able to use the results to normalize her experiences by placing them within the context of her experiences. Many of the individuals served by WCC have felt shame regarding their mental health symptoms and/or trauma experiences. TA could be especially useful for helping our clients gain insights into how their previous experiences have contributed to the development of their current areas of strength and difficulty, which may be beneficial for reducing shame and the stigma around receiving a mental health diagnosis. By attending to the real-life behavioral manifestations of the assessment results and using the dynamics within the therapeutic relationship throughout the TA, the client was able to identify how the results of the assessment played out in her here-and-now relationships with others. Since the vast majority of the clients seen at WCC often present with interpersonal difficulties that have contributed to and maintain their presenting problems, I believe that the TA model's focus on assisting individuals to connect the assessment results to their daily experiences was particularly beneficial. Throughout the assessment process, the client made multiple comments that she finally felt understood when reviewing the assessment results and ultimately ended up disclosing pertinent information regarding her history and current areas of difficulty that she had not previously disclosed to her previous therapists. By engaging the client in a collaborative discussion about how the assessment results fit with her life experiences while also normalizing her responses, the client was able to identify her defense mechanisms and feelings of shame in order to effectively process her emotional experiences during the TA.

In addition, the client was able to identify how the results gave her insights into why she was feeling "stuck" in therapy. By engaging the client in collaborative discussions relating the results of her assessment to her and her parents' questions, the client independently identified how she would like to focus on gaining new attachment experiences in her future therapy sessions in order to reduce her current symptoms and improve her relationships with others. Those working in organizations similar to WCC know that the clients served often have extensive histories of experiencing multiple chronic long-term life stressors, and many receive different services for multiple years. As a result, the TA model may be especially beneficial for providing clinicians and their clients with a more cohesive and coherent case conceptualization that may be beneficial for informing the treatment course for individuals who require more long-term forms of intervention to address their complex histories and chronic stressors. Overall, the TA approach may be beneficial for a number of our clients because the collaborative stance promotes a sense of empowerment, self-mastery, and hope for the future in children, adolescents, and their families who may have not had these experiences previously.

Perspectives of a Clinical Supervisor for Implementing TA

By Dr. Christine Brooks-White

Similar to Jessica, I was intrigued by the potential benefits of implementing the TA model with the populations that we serve at WCC, as psychological assessment is one of the core clinical services that doctoral psychology trainees provide. While there are a handful of staff psychologists that provide psychological assessment, at our agency it is largely provided by trainees. Consequently, when Jessica approached me about an opportunity to conduct a TA with a client under Raja's guidance, I was interested. I was aware that Jessica had studied TA in graduate school and was eager to put her experience into practice. I had some reservations about how the process would unfold given the many hoops and challenges, primarily around billing and the barriers our clients face for accessing services on a consistent basis. However, I was surprised by how easily it was integrated into our "typical" psychological assessment process once we committed to the process.

One of the challenges that we face with providing clinical services to youth and families is attendance, as Jessica mentioned. I also was concerned about this, but was viewing this from a supervisor perspective, giving consideration to Jessica's already tight schedule and knowing that a TA may involve more appointments than we typically have for an psychological assessment. While Jessica and I figured it out, it took some conversations to ensure that we could provide the best TA possible for the client, while also ensuring Jessica was attending to her other demands and was not feeling overwhelmed.

In addition, since our site receives funding through government and private grants, we have various pieces of information that need to be included in our diagnostic assessments and psychological evaluations in order to comply with the stipulations outlined by our funding sources. As a result, Jessica also needed to complete a full psychological assessment report in addition to the TA letters to the client and her family. Jessica and I both agreed that the TA letter was more beneficial than the full report for answering the questions posited by the client and her family. Nevertheless, the extra work involved in having to write both the letters and the full evaluation represents a potential barrier for implementing this model in a setting like ours. Given this, one of the future goals for our site is to find a way to integrate the required assessment report elements for our grant funding into the TA letters in order to streamline this process.

While I was initially unsure what it would be like to co-supervise a psychological assessment case, which was interesting to me given that I have a lot of experience supervising therapy cases with multiple other supervisors, I was surprised by the ease of the process. I assume that a lot of the ease had to do with Jessica's superior assessment skills and Raja's expertise. I enjoyed learning about new measures with Jessica and hearing how she was able to use test results to talk and build insight with her client . Overall, I also could see the benefits of the model for the client, enjoyed collaborating with the others involved, and was direct witness to Jessica's good work.

Perspectives of a Training Director for Implementing TA

By Dr. Tina Shah

Much like Jessica and Christine, I was interested in the opportunity to determine the viability and potential benefits of implementing the TA model with the populations we serve. As the Training Director of our pre-doctoral internship program, I frequently explore ways to bring unique and innovative models of assessment and intervention to our trainees. This is particularly important as we are mandated to have our doctoral interns meet the Profession-Wide Competencies that are put forth by the APA Commission on Accreditation. However, as a CMHC with limited funding, bringing innovative approaches is always a difficult task.

For a number of years, Raja has been gracious to provide our trainee cohort with a didactic seminar on TA. With initial cohorts, most trainees had never heard of the model. However, in more recent years, trainees had some familiarity with TA. This past year, the stars aligned as we were not only lucky to have Raja provide a seminar about the model, but to actually have a postdoctoral fellow trainee that had taken Raja's course and who was eager to try out the model with a client. Our Training Supervisor team, as well as the doctoral intern and postdoctoral fellow cohort, were thrilled to have this unique training opportunity.

CMHC settings have unique barriers and systems that are often difficult to navigate and trying to implement the TA model magnified all of these as my colleagues have described. Oh, and not to mention, the new testing billing codes! However, the end result was well worth navigating these challenges. The trainees and the training team were able to learn a new approach, which they found inspiring. They also had heard about the client over the course of the year prior to the TA during group supervision as the assigned clinician had struggled with making progress. The trainees and training team were able to hear how TA was then utilized and what unfolded as a result. They were able to hear the insights the client gained, as well as how effective and efficient the model was, which are often things that are hard to see during the course of a training year in this type of setting. As a result, many of the trainees and training team members voiced a desire to attend additional trainings on TA and were inspired to find ways to integrate it into their future work. Overall, this process illustrated what a training director lives for: (1) significant progress for clients and (2) learning and inspiration for the trainees!

Perspectives of an Outside Consultant

By Dr. Raja M. David

As a clinician and educator, practicing and teaching about TA has been my passion for the past eight years. When I found out that Jessica was going to be a fellow at WCC, I recognized a possible opportunity for them to implement TA. Heretofore, I had conducted didactics with various cohorts at WCC, but I also recognized that it would be difficult for them to implement the TA model without having someone trained on site. I also knew Jessica as a skilled clinician, and believed she was up for the challenge of conducting this assessment and with some guidance from me, we could navigate the system.

For many months, Jessica and I were in contact about what was transpiring relative to starting the TA, while she, Christine, and Tina were all involved in the multiple discussions described above. Jessica and I connected about a client who was identified for TA and how to potentially work with the challenges they were facing, but I ultimately agreed that finding a difference client would be best. Eventually, the teen client was identified and a TA began.

As Jessica and her teen client were meeting, she and I had routine contact and I assisted her in interpreting test data and conceptualizing the client. The didactic occurred towards the end of the TA, after one discussion session had occurred but before the process was complete. Being able to discuss the TA enhanced the learning experience of the trainees, as they were already familiar with the client and how she was stuck, and thus they could see the significant changes the client experienced. This only further built their enthusiasm for the model and how it might be implemented in the future.

Overall, my experience as a consultant was quite positive. While I believe Jessica got the guidance she needed, in retrospect, I do believe it would have been even better if she had received consultation or

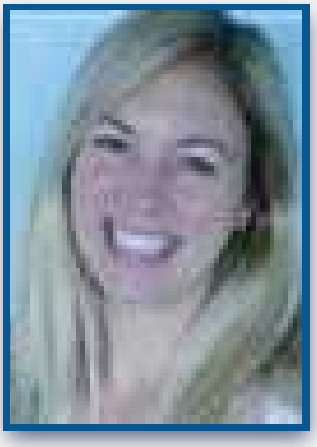
supervision from someone on-site. Even though I am familiar with CMHCs, each has their own nuances, so I had to make sure I understood their policies and system as well. Additionally, more routine conversation about the case would have only enhanced this TA. If I serve this role in the future, I believe I will establish a more defined meeting schedule with the consultee to ensure we maintain a strong connection on what is transpiring. Nonetheless, overall this experience was quite positive.

In summary, I think we can all speak to the power of the TA model for this client. She was truly stuck in therapy for many months, and the process she went through allowed her to make some strong gains fairly quickly. While it is true that implementing the model for the first time required consistent dedication on all of our parts, as well as time for conversations and problem solving, in the end those efforts were worth it. Additionally, our initial feelings about how difficult implementing a TA might be were not matched by what we found, and we'd encourage others at CMHCs to find ways to make TAs a routine part of the clinical work conducted.

Author Bios

Jessica D. Miller, Psy.D., recently completed her postdoctoral fellowship at Washburn Center for Children in Minneapolis, Minnesota. She graduated from the Minnesota School of Professional Psychology at Argosy University and completed her internship at Canvas Health in Oakdale, Minnesota. Before completing her doctoral degree in Clinical Psychology, Jessica worked as a mental health practitioner in community mental health, day treatment, group home, and inpatient behavioral health settings for 20 years. Her clinical interests include providing psychological assessment and outpatient therapy for children, adolescents, and their families with particular interests in trauma, Fetal Alcohol Spectrum Disorders, and Autism Spectrum Disorders.

Tina D. Shah, PsyD, LP received her doctorate in clinical psychology in 2007 from the Minnesota School of Professional Psychology after completing an APA-Accredited Doctoral Internship. She then completed a Postdoctoral Fellowship and became a Licensed Psychologist in 2008. She has been actively practicing, as well as providing clinical supervision and training since that time. Tina was most recently Director of Psychology Training at Washburn Center for Children prior to recently joining Morningsong Therapy Center as the Clinical Directo



Christine Brooks White, PsyD, LP completed her MA and PsyD in Clinical Psychology at The Chicago School of Professional Psychology-Chicago. She joined the Washburn Center for Children (WCC) Outpatient Department as a Postdoctoral Fellow in 2012 after completing her APA-Accredited Predoctoral Internship at The Help Group in Los Angeles, California. Christine has worked as a staff psychologist providing individual and family therapy and psychological testing at WCC since 2014. She also provided supervision to trainees within the Psychology Training Program and co-supervised the weekly psychological testing consultation group from 2014-2019. Christine is a Training Professional that provides training and consultation in Managing and Adapting Practice (MAP), an evidence-informed direct services model for youth presenting with a range of difficulties for clinicians in the state of Minnesota. Christine also has training in Trauma-Focused Cognitive Behavior Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR). Her clinical areas of interest include: psychological testing, evidence-based practices in community mental health settings, child trauma, parent-child therapy, cultural responsiveness, and clinical supervision and training.

Raja M. David, PsyD, LP received his Doctorate in Clinical Psychology (PsyD) at the Minnesota School of Professional Psychology in 2002. He is the founder and owner of the Minnesota Center for Collaborative/Therapeutic Assessment in St. Paul, MN. He is board certified in Child and Adolescent Clinical Psychology (ABPP) and specializes in working with adolescents and young adults. In 2015, he earned certification in the adult model of TA by the Therapeutic Assessment Institute, of which he is now a member. Raja is the former Program Dean of the Minnesota School of Professional Psychology, and as a faculty member he taught doctoral courses related to providing psychological services, including an elective course on TA. He has presented locally and nationally on TA, and in 2019, he recorded two podcasts on the model for the Testing Psychologist Podcast.

Incorporating TA in a Community Mental Health Clinic

Deana Smith, PhD
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The Center for Behavioral Health at the University of Missouri – St. Louis

The Center for Behavioral Health (CBH), based at the University of Missouri – St. Louis, was founded in 2014 by psychology faculty members with a passion for psychological assessment and a mission to provide cutting-edge evaluation services to the people of St. Louis and surrounding communities. CBH strives to be a center of excellence, bringing the best assessment approaches to the region and training upcoming psychologists to provide the highest quality services. As a result of many community partnerships, our clinic stays quite busy. In a given year, approximately 1,400 psychological evaluations are conducted by our staff of doctoral students, psychology interns, post-doctoral fellows, and licensed psychologists. Significant diversity in racial/ethnic and socio-economic backgrounds is represented in the clients with whom we have the privilege to work; almost half of our clients identify as racial/ethnic minorities and just as many have total household incomes below the median for the region. We are fortunate that our evaluation services are typically provided at no cost through service grant funding the Center receives from both private foundations and local government agencies.

Our "typical" client is an adolescent whose family has been struggling to understand them for some time and who otherwise would not have been able to afford an evaluation. Significant emotional, psychiatric, and/or behavioral difficulties are common, as is exposure to trauma or involvement in the juvenile justice system. Many of the cases referred to us are quite complex. Indeed, our services are often recommended by treating clinicians who are concerned that their client is continuing to experience significant difficulties despite treatment. It is also common for us to receive referrals for a second opinion from families who continue to seek answers to their child's difficulties. Our agency has always placed an emphasis on a collaborative approach to evaluations and engagement of the support system, working closely with parents and the child's current providers.

Implementing Therapeutic Assessment

Our clinic was drawn to the Therapeutic Assessment (TA) approach as we believed it to be a good fit with our historically collaborative stance to providing services. Our investigation into the TA model affirmed its position at the forefront of assessment practice, and we desired to become trained in the approach. We were highly fortunate to have Marita Frackowiak, faculty member of the Therapeutic Assessment Institute, visit our clinic in 2015 to provide a two-day introductory training. We were impressed by the model's robust ability to help clients and families understand their struggles, to leverage strengths to promote growth, and to foster acceptance of limitations or circumstances that cannot be changed. The combination of psychological testing and brief intervention seemed to hold the power to effect change in the lives of these families.

To advance our learning, we created an in-house TA study group during which we reviewed and discussed TA readings and role-played components of both the Child and Adolescent models. Thereafter, two of us attended the weeklong TA Immersion Course and a weeklong Advanced Training in Austin, TX, where we expanded our knowledge regarding the unique components of the model and how to implement them in a broad range of cases. Simultaneously, we began using the TA approach in our clinic and teaching what we knew to our

trainees. We found TA to be exceptionally helpful to our clients; parents reported enhanced understanding and empathy for their child's struggles; and, remarkably, we witnessed the sorts of therapeutic change typically seen after lengthy treatment. In 2017, Dr. Frackowiak provided a follow-up training during which we focused on implementation of the model across the clinic.

The next phase of our training came in the form of twice-monthly virtual meetings with Dr. Frackowiak, allowing us to receive tailored feedback regarding our skills in applying the model with our clients. These consultations included planning for upcoming sessions and then reviewing the video tapes of them, which proved to be invaluable, particularly given the challenging nature of some of the cases. Dr. Frackowiak made our consultations a collaborative process and promoted a growth-affirming space. She provided practical guidance while affording us opportunities to apply emerging skills in ways that felt natural to our clinical sensibilities. Reviewing videos, Dr. Frackowiak was encouraging as she cheered our successes and helped explore ways to amplify TA features. At times, our consultation meetings mirrored Assessment Intervention sessions, as we became curious about our stuck points and practiced new ways of engagement. Dr. Frackowiak led us in processing the experience and thinking about trying something new with our clients. We sometimes role played techniques we would later implement. In this thoroughly collaborative and affirming consultation process, we were able to immerse ourselves in the TA model and have a powerful learning experience.

The Case of Marcus

We use the case of Marcus, an 11-year-old boy whose family was struggling to understand him, to illustrate how TA yields unique and powerful outcomes. Dr. Frackowiak provided consultation from the time of the initial session to the follow-up. Marcus was referred for a comprehensive psychological assessment by his counselor and his mother. He had been involved in therapy services for more than year, but progress was minimal. Marcus had limited peer relationships, was underperforming in the classroom, and voiced a painfully negative self-concept. Marcus was out of step with the world around him. His actions appeared odd and immature, leaving him lonely and lost in the hypercritical middle school environment. Although both of his parents recognized that their son was drowning in everyday responsibilities, they were lost in how to help. Financial hardships, limited transportation, and strained communication between the parents impeded therapeutic progress and contributed to feelings of frustration.

During the Initial Session, Marcus' mother offered the following assessment questions: 1.) Does Marcus have traits of Autism? 2.) What can be done to support Marcus' social relationships? 3.) Why is Marcus' self-esteem so low? and 4.) What would improve the way he sees himself and his depression? Marcus' father indicated he did not share his wife's question of Autism, explaining that he already "knew" his son had Autism. However, Marcus' father communicated an earnest desire to learn what he could do to support his son.

The examiner utilized the Child Model to answer these assessment questions. Not only did the Child Model seem more consistent with Marcus' maturity level, but the examiner believed that the parents would benefit from the regular opportunity to observe Marcus' assessment sessions and generate hypotheses regarding what they were seeing. An additional benefit of watching video recordings with the family was the examiner's opportunity to learn more about the potential cultural implications of Marcus' behavior. For example, Marcus' father shared how Marcus' ways of interacting likely would be interpreted within the Black community. Marcus' father provided invaluable insights based upon his lived cultural experience and enriched the understanding of the assessment data in ways that the examiner, a White woman, simply could not.

Although ASD was a plausible hypothesis in this case, as the assessment progressed, another picture emerged. Rather than a developmental disorder, data suggested Marcus was experiencing extreme deficits in reality testing. Of course, Marcus could not connect with his peers—he could not connect with reality! Watching the recorded ADOS-2 administration with his parents, they clearly noted their son's appropriate social skills while also witnessing the looseness of his thinking. Marcus skillfully engaged in reciprocal conversation. He was lively and charming in easy back-and-forth discussions with the examiner. However, there was a startling rupture when the examiner inquired about his experiences, his feelings, and his relationships. As Marcus tried to share his internal world, his psychological resources were overwhelmed and the quality of his thinking declined.

The connection was lost, leaving Marcus alone in the chaos of his thoughts and producing great feelings of helplessness in the examiner. As Marcus seemed to spiral into confusion on the screen, his mother described him as a "Picasso painting," explaining that all the essentials seemed present, but they were disorganized and the picture was obscured. She articulated that the viewer had to work exceptionally hard to see the image.

This finding was revisited when we reviewed Marcus' idiosyncratic and distorted Rorschach responses during the Summary and Discussion session. Looking at the percepts, his parents were pained by Marcus' obvious confusion and isolation. It became clear to them that others likely were perplexed by their son and pulled away from him, and they recognized how Marcus could be left feeling rejected and dejected. Marcus' parents realized their son's disorganized thinking was at the root of his social difficulties, academic struggles, and low self-esteem. The examiner and Marcus' parents talked at length about ways to bolster his reality testing by exploring psychiatric interventions, school-based supports, and psychosocial skills building. Ending the session, the family was confident in the plan they had developed to support their son. No longer confused and frustrated, the family felt hopeful. In addition, the therapist created a fable for Marcus, capturing his "story" in ways that made him feel understood and supported. Marcus smiled and told the examiner, "I liked it."

A follow-up with th e family revealed that Marcus had begun psychotropic medication, which was proving to be highly beneficial to him. His mother indicated that, when the school expressed surprise that Marcus was not diagnosed with Autism, she had replied, "I trust her," referring to the examiner. The school then implemented a plan to support his unique social, emotional, and educational needs based upon the evaluation.

A collaborative approach was fundamental to the outcome in this case. While the parents had been "sure" that their child had Autism in the initial session, they were able to relax, become curious, investigate the data with the examiner, and piece together a newly emerging picture during this assessment process. Their understanding of their child shifted and they were able to support him with their new understanding. It was a privilege to work with this family.

From Therapeutic Assessment to Collaborative Supervision

Our passion for TA has been mirrored in our trainees, many of whom had not been exposed to the model prior to joining our Center. Trainees have shared their appreciation for the emphasis TA places on client's engagement in the process as well as the encouragement to help clients make sense of their own stories. One trainee commented, "Most important, in my experience, is transitioning my clinical approach toward the development of a collaborative relationship with the client, such that the client is continuously engaged in reflective self-discovery alongside the clinician, rather than providing information and awaiting diagnosis in a manner akin to traditional medical assessment." This trainee went on to say, "In this way, the client is able to compare their responses and performance during the assessment to their lived experience outside the assessment office, re-contextualizing, restructuring, and illuminating their understanding of their presenting concerns with considerably more independence and autonomy than in the traditional diagnostic assessment approaches I was trained on in graduate school." Other trainees have noted the impressive therapeutic impact of "putting the client in the driver's seat" and allowing them to discover unconsidered facets of their lives and problems independently, in much the same way a good therapist facilitates clients' self-exploration. Even when trainees have not been able to implement the full TA model, their exposure to it has greatly influenced how they now approach the initial interviews, feedback, and report writing.

Four Years of Collaboration: From the Perspective of Marita Frackowiak Supervision

Working with CBH has been exciting, fulfilling, challenging, and always interesting. I have appreciated very much each opportunity to visit the clinic to offer a workshop as the interest and enthusiasm for TA was always energizing and very rewarding. Just as much, I enjoyed offering individual consultation to Drs. Ashley Darling and Deana Smith. Not only did I look forward to hearing about the new developments in their cases or their internship interview process, but also how they continued to incorporate TA in the supervision of their trainees. It felt like a gift that kept on giving.

Reflecting on those years of collaboration, I wondered what turned the training in 2015 into a long-term relationship (besides the shared sense of humor between the three of us). What can we learn from this experience and how could we replicate this in other, similar settings? It's clear to me that several factors are

involved. First, and most of all, CBH showed a strong interest and willingness to learn and practice the TA model and had wonderful support from Dr. Steve Bourne, Director of the Clinic, and Dr. Deana Smith, Training Director. Such solid leadership is invaluable as obstacles inevitably come up. Second, openness to change was essential, as well as openly dealing with the resistance of those who were not interested in changing the way they worked. While many people were very interested in TA from the beginning, not everyone was willing to change how they practiced. The strength of the group allowed for both approaches to co-exist. It was a great reminder that TA is not for every clinician, and shouldn't be required. Third, there was financial support available to try out TA while collecting satisfaction data to offer concrete feedback as to how the model was working out with the CBH's population. And fourth, there was support to incorporate the model gradually over time.

It's been an absolute pleasure to work so closely with CBH, and Drs. Darling and Smith. I have enjoyed learning from both of them and the wonderful, complex families they serve.

Author Bios

Deana Smith, PhD is an Associate Clinical Professor in the Department of Psychological Sciences at the University of Missouri – St. Louis where she serves as the Training Director for University's Center for Behavioral Health. Dr. Smith is also the Training Director for the St. Louis Psychology Internship Consortium, an internship program accredited by APA. Dr. Smith, a licensed psychologist, provides psychotherapy and assessment supervision to doctoral students, interns and post-docs; teaches undergraduate and doctoral level courses; and conducts psychological evaluations. She has worked in inpatient and outpatient settings with children, adolescents and adults. Her clinical interests include therapeutic/collaborative assessment and emotion-focused approaches to psychotherapy with individuals and couples.

Ashley Darling, PsyD is a Staff Psychologist and Intern Training Coordinator at the University of Missouri – St. Louis – Center for Behavioral Health and specializes in psychological assessment. She earned her Psy.D. from Xavier University in Cincinnati, Ohio. She completed her doctoral internship at Family Service and Guidance Center in Topeka, Kansas. Dr. Darling has experience completing psychological assessments of children who have been prenatally exposed to substances/alcohol, as well as children with traumatic histories. Her clinical interests include early childhood development, play therapy, and therapeutic/collaborative assessment procedures.

Marita Frackowiak, PhD is a licensed psychologist in private practice at the Center for Therapeutic Assessment in Austin, TX. She is a founding member of the Therapeutic Assessment Institute. Dr. Frackowiak has worked with Dr. Stephen Finn for almost two decades providing clinical services, conducting research, writing, and providing trainings on Therapeutic Assessment. She is an author of a therapeutic fable "Little Bear's Cup and Saucer" as well as many chapters and articles on Therapeutic Assessment. Her current focus, in addition to clinical work, is lecturing internationally and offering consultation for clinicians wanting to learn the model. Dr. Frackowiak is certified in Therapeutic Assessment with adults, children, adolescents,

Photo Album

Stephen Finn and attendees at his workshop in Buenos Aires, August 10, 2019, "Therapeutic Uses of the Rorschach and Other Projective Tests." This was sponsored by the Asociación Argentina de Estudio y Investigación en Psicodiagnóstico (ADEIP).

Members of the Asian-Pacific Center for Therapeutic Assessment, November 3, 2019, at workshop in Tokyo: "Restoring Epistemic Trust Through Therapeutic Assessment." Front row (left to right): Shin-ichi Nakamura, Jan H. Kamphuis (Guest Discussant), Stephen Finn, Noriko Nakamura; Back row (left to right): Hisako Hoshide, Yasuko Nishida, Mitsugu Murakami, Fumi Imamura, Seiji Mabuchi, Sho Yabugaki, Sachiyo Mizuno, Masamichi Noda, Mitsue Tomura, Naoko Ogura, Satoko Yamada (translator), Mikako Ohzeki, and Ryuko Shinzaki (translator).

Members of The Therapeutic Assessment Institute Board of Directors enjoying dinner in New Orleans during their March 2019 board meeting. From left around the table are J.D. Smith, Pamela Schaber, Dale Rudin, Marita Frackowiak, Hilde De Saeger, Deborah Tharinger, Lionel Chudzik, Stephen Finn, Hale Martin, Filippo Aschieri, Francesca Fantini, and Jan Kamphuis

Stephen Finn and Anna Elisa Villemor de Amaral, with her graduate students at the University of San Franciso in Campinas, Brazil before his workshop on "Introduction to Therapeutic Assessment" in São Paolo on August 14, 2019. From left to right: Gabrel Acioly Gomes, Juliana Araújo, Leilane Henriette Chiappetta Santan, Anna Elisa, Steve, Lucila Moraes Cardoso, Ruam de Assis Pimentel, Mayara Salgado de Moraes, and Luiz Manoel Paiva Jr.

3RD INTERNATIONAL COLLABORATIVE/THERAPEUTIC ASSESSMENT CONFERENCE

CALL FOR PAPERS

PRE-CONFERENCE WORKSHOPS:
June 18, 2020

SCIENTIFIC SECTIONS:
June 19th & 20th, 2020

LOCATION:
University of Denver

The Therapeutic Assessment Institute (TAI) is delighted to distribute this call for submissions for the **3rd International Collaborative/Therapeutic Assessment Conference (CTAC)** to be held at the beautiful University of Denver campus in Colorado on June 19th and 20th, 2020 with preconference workshops to occur on Thursday, September 18th, 2020. All topics pertaining to collaborative and therapeutic assessment are welcome in any of the following formats. Notification of acceptance will be sent by June 15th, 2020.

The inaugural CTAC in 2014 and 2nd CTAC in 2017 were a great success and served as an opportunity for members of the CTA community to learn and to socialize with colleagues from around the country and the world.

SYMPOSIA, INTEGRATED PAPER SESSIONS, ROUNDTABLES:
https://www.memberleap.com/members/form.php?orgcode=TAI&fid=3971179
A 300-400 word abstract on the overall session theme is required for submission. Please also include a list of presenters (including affiliations and contact information) and the titles of each individual presentation (this information does not count toward the 300 word limit). A minimum of 3 presenters is required in each submission in this category. These sessions are allowed 1 hour and 40 minutes, which is to include time for discussion and questions from the audience. Inclusion of a Discussant is optional for symposia but is not allowed for Integrated Paper Sessions or Roundtables.

INDIVIDUAL PAPERS/CASE PRESENTATIONS:
https://www.memberleap.com/members/form.php?orgcode=TAI&fid=3972401
Individual papers and case presentations can focus on research, clinical cases, or other topics germane to CTA, such as implementation, reimbursement, etc. The Conference committee or Chair will group papers and case presentations into a topic area. Each paper is allowed 40 minutes for presentation, and 10 additional minutes for questions, to allow greater depth of presentation. A title and 300 word abstract is required for submission.

POSTERS:
https://www.memberleap.com/members/form.php?orgcode=TAI&fid=3973623
Presenters will prepare a visual depiction of a study, case analysis, or other type of material relevant to CTA. Posters should be no larger than 36" X 48". A 200-300 word abstract is required. We urge presenters to consider presenting papers in lieu of posters as few poster submissions can be accommodated.

ALL PROPOSALS MUST BE SUBMITTED THROUGH THE TAI WEBSITE AT:
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Questions can be directed to the conference Co-Chairs,
Pamela Schaber at drpamelaschaber@gmail.com or J.D.Smith at jd.smith@northwestern.edu

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Recent Publications in Therapeutic/ Collaborative Assessment

Finn, S. E. (2019). (2019). Supervising Therapeutic Assessment. In A. J. Wright (Ed.), *Essentials of psychological assessment supervision* (pp. 221-242). Hoboken, NJ: Wiley.

Foster, E. E., Kelley, S., & Brooks Holliday, S. (2019). Feedback in Forensic Mental Health Assessment: A Preliminary Review of Ethics, Research, and Practice. *Journal of Forensic Psychology Research and Practice,* 1-14.

Hopwood, C. J., Pincus, A. L., & Wright, A. G. (2019). The interpersonal situation: Integrating personality assessment, case formulation, and intervention. In *Purdue symposium on psychological science. New York, NY: Oxford.*

Hopwood, C. J., & Waugh, M. H. (in press). *Personality assessment paradigms and methods: A collaborative reassessment of Madeline G.* New York: Routledge.

Edited book contains two chapters by Stephen E. Finn describing the TA of Madeline. The book can be preordered at this link: https://www.routledge.com/Personality-Assessment-Paradigms-and-Methods-A-Collaborative-Reassessment/Hopwood-Waugh/p/book/9781138310162

Mayer, J. D. (2019). An Integrated Approach to Personality Assessment Based on the Personality Systems Framework. *Journal of personality assessment,* 1-14.

Piotrowski, C. (2019). Contemporary Research Emphasis in Personality Assessment: A Bibliometric Analysis Mapping Investigatory Domain (2009-2018). *Journal of Projective Psychology & Mental Health,* 26(2), 1-6.

Sweeney, A., Clement, S., Gribble, K., Jackson, E., Carr, S., Catty, J., & Gillard, S. (2019). A systematic review of qualitative studies of adults' experiences of being assessed for psychological therapies. *Health Expectations, 22*(2), 133-148.

Upcoming Trainings in Therapeutic Assessment

March 25, 2020; San Diego, CA
Title: Restoring Epistemic Trust through Therapeutic *Assessment:* Building a Relationship "Superhighway" with Difficult-to-Treat Clients
Presenters: Stephen E. Finn, Hilde de Saeger, Jan H. Kamphuis
Sponsor: Society for Personality Assessment
Language: English
Schedule: 8:00 AM – 5:00 PM
Information: www.personality.org

March 29, 2020; San Diego, CA
Title: Introduction to Therapeutic Assessment: Using Psychological Testing as Brief Psychotherapy
Presenters: Pamela Schaber & Filippo Aschieri
Sponsor: Society for Personality Assessment
Language: English
Schedule: 8:00 AM – 5:00 PM
Information: www.personality.org

May 3-4, 2020; Tokyo, Japan
Title: Introduction to Therapeutic Assessment with Couples
Presenters: Stephen E. Finn and Noriko Nakamura
Sponsor: Asian-Pacific Center for Therapeutic Assessment
Language: Japanese and English
Schedule: 10:00 AM – 6:00 PM, May 3; 9:30 AM – 4:00 PM, May 4.
Information: www.asiancta.com

November 21-23, 2020; Tokyo, Japan
Title: Live Therapeutic Assessment of a Couple
Presenters: Noriko Nakamura and Stephen E. Finn
Sponsor: Asian-Pacific Center for Therapeutic Assessment
Language: Japanese
Information: www.asiancta.com

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