Volume 5 Number 1 | **Winter/Spring 2017**

THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

Excitement Abounds

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

This issue of the *TA Connection* marks the beginning of the fifth volume. I want to express my gratitude to current and former associate editors of the newsletter—Hale Martin, Deborah Tharinger, Pamela Schaber, and Steve Finn—for their support and contributions to making sure that each issue is rich in its content and free of glaring typos and mistakes that I would surely make if left solely to me. I also want to thank the many authors who have contributed articles and thought pieces. The TA com-munity benefits greatly from hearing from diverse and highly experienced practitioners and scholars of TA. Last, I want to extend a special thank you to Cher Mikkola, our technical editor, whose work on fine-tuning the newsletter goes a long way in creating a positive experience for the readership.

It has been a particularly exciting time for me as I witnessed the energy of the TA community in multiple ways. At this year's meeting of the Society for Personality Assessment (SPA) in San Francisco, California, Hale Martin and I co-chaired the Collaborative/Therapeutic Assessment Interest Group meeting. As has been the case for nearly a decade now, we had a tremendous turnout (about 70 people) and had an opportunity to hear about the amazing things people are doing with TA all over the world. It was particularly enjoyable to hear people share how they became interested in TA and connected to the community. Our network is spreading the word about TA everywhere and engaging new people. Amazing. Second, as the Chair of the 2nd International Collaborative/Therapeutic Assessment Conference that is set for September 21–23, 2017, in Austin, Texas, I have been invigorated by the interest in this event and the incredible ideas that people are already sharing about what they want to see and endeavor to present. It is sure to

In this issue:

Using the Thurston Cradock Test of Shame to Uncover Shame Dynamics in Therapy and Assessment, *Julie Cradock O'Leary,* page 4.

Using Advanced Training to Build Collegial Relationships in Therapeutic Assessment Practice, *Gay Deitrich-MacLean and Peter Jackson,* page 8.

Workshops at the 2nd International Collaborative/Therapeutic Assessment Conference, page 13.

Making Unbearable Feedback Bearable: You Can't "Half-Ass" Attachment, *Barbara Mercer*, page 14.

Proficiency in Personality Assessment: Why Should I Care?*, Hadas Pade and Stephen Finn*, page 19.

Photo Album, page 22.

Recent Publications in Therapeutic/Collaborative Assessment, page 25.

Upcoming Trainings in Therapeutic Assessment, page 26.

Call for Papers for the 2nd International Collaborative/Therapeutic Assessment Conference, page 27.

© Therapeutic Assessment Institute 2017

be a memorable and enjoyable event yet again. I will say more about the conference later in the introduction to this issue. This community is as inspiring as it is welcoming and supportive. It's a truly special group of people.

This Issue

This issue was a delight to put together. There are so many things to be excited about in the TA world that I have the pleasure of sharing with you, and our contributors for this issue pro-vided fantastic pieces that are a treat to read.

This issue's research column straddles both the research angle (a validated assessment instrument) and its clinical application to bring to life the results that an assessor may garner from using the Thurston Cradock Test of Shame. Test coauthor Julie Cradock O'Leary presents an overview of the reasons why assessing shame is important in TA, describes the test of shame that she helped develop, and provides enlightening examples of defenses against shame and the way shame manifests in the family system, by using responses to the test to illustrate these concepts. Any assessor interested in shame likely already knows that there are very few good instruments and procedures to actually assess shame. The Thurston Cradock Test of Shame is certainly near the top of the list.

The training column in this issue takes the reader along for a journey with Gay Deitrich-MacLean and Peter Jackson, practitioners in Madison, Wisconsin, who arranged a week-long, in-person advanced training on the use of TA with a couple. The training took place in Austin, Texas, under the mentorship of Steve Finn. Gay and Peter discuss how their professional lives have been changed by TA, which led them to participate in the advanced training as a means of furthering their learning in TA and forging a professional relationship that they are taking back to Madison. This piece is an honest and revealing look at the challenges and growth that come with the advanced training. I think many people will be in-spired to take on this unique training after reading the positive ways that it has affected Peter and Gay personally and profession-ally.

The third column is a clinically focused piece written by Barbara Mercer that concerns the challenges of discussing and presenting feedback about attachment dynamics within families. Barbara takes the reader through the case of Win, a 16-year-old Eurasian boy, and his mother. The crux of the case is the attachment relationship between the two; the clinicians, a two-person team, are challenged to consider how directly to approach these issues in the Summary and Discussion session of the TA. Given the nature of the attach-ment findings, coupled with other results of the assessment that included trauma, the clinicians felt a pull to "half-ass" the feed-back, or to pull their punch, so to speak. Barbara's retelling of the case is an excellent example of working with challenging find-ings in a productive way for our clients.

Last, Hadas Pade, the proficiency coordinator at SPA, and Steve Finn discuss the relatively new initiative between SPA and the American Psychological Association to recognize psychologists who are proficient in personality assessment. They provide information about the proficiency process and history, as well as some reasons why assessment psychologists might be interested in achieving proficiency. Steve talks about his positive experience going through the submission and review process and then describes the valuable feedback he received about the report he wrote.

2nd International Collaborative / Therapeutic Assessment Conference

It feels as though the 2nd International Collaborative/ Therapeutic Assessment Conference is right around the corner! The committee of myself (Chair), Steve Finn, Pamela Schaber, and Deborah Tharinger have been working to ensure that this conference exceeds the high bar that we set in 2014 at the inaugural conference. This year's gathering will occur September 22 and 23, 2017, at the well-appointed AT&T Executive Education and Conference Center in downtown Austin, which is close to the University of Texas, 6th Street, and the other attractions that make the city such a fun destination. A few important details about the conference are described here:

Workshops. As with the inaugural conference, we will be offering preconference workshops on Thursday, September 21. I am pleased to announce that the workshops have been selected and are listed on page 13 of the newsletter, complete with abstracts. We will again hold a daylong introduction to TA workshop offered by Steve Finn, which would be a perfect way for newcomers to TA to learn about

© Therapeutic Assessment Institute 2017

the model before the two days of presentations that follow. Four half-day workshops are also being offered that will be presented by Hilde De Saeger and Pamela Schaber, Melissa Lehmann and Carol George, Dale Rudin, and Filippo Aschieri and Francesca Fantini. These offerings will be beneficial for TA newbies as well as for seasoned practitioners of the model. I do hope you will choose to join us for this day of learning before the conference.

Call for Submissions. On Friday and Saturday, we will hold the scientific presentations and large-group plenary sessions. See page 27 for the Call for Submissions for symposia; individual, paper and case presentations; panel (round-table) discussions; and posters. There is an online form to complete for your submission to be considered. The link can be found on page 27. A helpful suggestion concerning symposia: The session time will be 100 minutes. We require a minimum of three presenters; you have the option of a Discussant or a fourth presenter, or both, but this will inevitably reduce the time available for each presenter.

Feedback we received from the conference in 2014 guided some changes to the schedule; namely, presenters will be given more time for each presentation. This means that individual paper sessions will contain two presentations rather than three or four, which translates to about 35 minutes to present and 10 minutes for questions and discussion for each presenter.

Happy Hour! We will have a happy hour on Friday evening from 5:00 to 6:00 pm at the conference center to facilitate socializing and getting to know one another.

Conference Registration. We are in the process of finalizing our on-line registration page and hope to have it up by June 1. There will be a reduced registration rate for attendees who register before August 7, 2017. Rates will in-crease modestly after that date.

Constance Fischer Scholarship. I am very excited to announce that we will be awarding the first Constance Fischer Scholarships for attendance at the conference. Connie is deeply passionate about providing students with opportunities to learn TA and contributed funds to the Therapeutic Assessment Institute to make this a reality. This year we will award two scholarships in the form of free registration to the conference and free admission to the workshops offered on September 21. Students in graduate training programs or trainees completing their post-doctoral training are eligible to apply. An application form will be available soon through the TA website and will be due July 15. It will be posted on around June 1, along with the registration page for the conference.

Donate to TA

The Constance Fischer Scholarship was made possible by a generous contribution from Connie to the TAI. To continue to offer scholarships to students and professionals, we rely on this kind of philanthropy. The TAI is a nonprofit organization 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.

Future Issues of the TA Connection

If you have feedback or suggestions for the newsletter, please send me an email. 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.

A warm thank you to the contributors in this issue: Julie Cradock O'Leary, Gay Deitrich-MacLean, Peter Jackson, Barbara Mercer, Hadas Pade, and Stephen Finn.

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

© Therapeutic Assessment Institute 2017

Using the Thurston Cradock Test of Shame to Uncover Shame Dynamics in Therapy and Assessment

By Julie Cradock O'Leary, Ph.D., Private Practice, Anchorage, AK

Therapeutic Assessment Is Inherently Developmental

I'm new to the Therapeutic Assessment (TA) community and am so pleased to have discovered a group that truly believes in the importance of meeting clients "where they are," embraces performance-based and stimulus-response measures, and naturally con-siders shame in clinical work. I attended Steve Finn's workshop about shame in Austin this past February and was thrilled to find that others "get it." My husband jokes that I see shame everywhere. While that's not quite true, I have become increasingly adept at identifying the smoke screens shielding shame. As coauthor of a shame test, I'm certainly biased, but I can't see doing therapy or assessment without sleuthing for shame dynamics. For this column, I've been asked to introduce you to my measure, the Thurston Cradock Test of Shame (TCTS; Thurston and Cradock O'Leary, 2009), and its utility for assessment and therapy.

It's odd to say that I have a favorite definition of shame, but I do. The following provides a rich description of the emotion and experience of shame. It's admittedly hard to read—I simultaneously say "yes!" for its accuracy while wincing at its sadness.

> "Shame is an inner sense of being completely diminished or insufficient as a person. It is the self judging the self. A moment of shame may be humiliation so painful or an indignity so profound, one feels one has been robbed of her or his dignity, or exposed as basically inadequate, bad, or worthy of rejection. A pervasive sense of shame is the ongoing premise that one is fundamentally bad, inadequate, unworthy, or not fully valid as a human being" (Fossum & Mason, 1986, p. 5).

It's no wonder people go to great lengths to push shame away. Helen Block Lewis (1987) called shame the "sleeper in psychopathology." It can underlie a variety of diagnoses and struggles (e.g., depression, substance abuse, eating disorders). I also view shame as the sleeper in many of the interpersonal dynamics (e.g., parental, marital, workplace) that cause stress for our clients. Shame is so excruciating that we humans scramble to defend against it. Often, the very defenses we use are labeled as the "presenting problem." For example, anger, excessive drinking, depression, and perfectionism can all be used to shield one from shame. To make things more complicated and yet clearer (if we can uncover them), we must consider the intrapsychic dynamics (e.g., self-critic, a shaming teacher's voice from childhood) and interpersonal dynamics of real people around that shamed individual. Those voices can trigger shame and related defenses at unexpected times. Even well-meaning clinicians can inadvertently trigger shame via slight misattunement, disruptions in frame, or a clinical interpretation taken as criticism. In a similar way, clients can trigger a therapist's own shame and defenses, which necessitates doing our own work in that area. Imagine a clinical situation in which the therapist gets something wrong, the client feels rejected, and the therapist realizes he/she evoked shame. It's messy work, but well worth it if we can bravely jump into the muck and help.

Thurston Cradock Test of Shame

With this complexity in mind, Nancy Thurston and I developed the Thurston Cradock Test of Shame (TCTS; 2009). All other shame measures are traditional paper-and-pencil, self-report instruments requiring an individual to be somewhat aware of their shame and also willing to acknowledge it on a piece of paper that would be handed to a therapist or evaluator. It's a tall order, particularly for someone who is prone to feeling profoundly inadequate! Also,

© Therapeutic Assessment Institute 2017

paper-and-pencil measures elicit limited information because of their forced-choice true/false or Likert scale response formats. As a stimulus-based storytelling task, the TCTS can better capture both the intrapsychic and interpersonal dynamics, which are known to be present in shame (Morrison, 1987; Nathanson, 1987).

The TCTS is a card-based storytelling measure, similar in style to the TAT (Murray, 1943), with a structured scoring system. Individuals are asked to look at the 10 picture cards and tell stories with a beginning, a middle, and an end. They are asked to include what characters are thinking and feeling. Six of the cards have overt shame themes and four do not. The stories are then scored and interpreted. If shame is present in the story, it is rated as direct ("she felt mortified") or indirect (such as a description of a rejecting or shame-based behavior). Story content that suggests possible embedded shame content through vague affective statements, such as "she felt bad," is also scored. Shame defenses (deflation, aggression, inflation/ contempt) are scored according to the degree (mild, moderate, severe) they are used by characters. The type of story resolution provided (adaptive, maladaptive, unresolved/ambivalent) is also rated. Additional scoring variables can be found in the TCTS manual.

Results from the TCTS can also be examined to clarify the dynamics and catalysts that trigger, exacerbate, or alleviate shame. Analysis of the responses across all 10 TCTS card stories can provide information about the words the client uses to describe affect, which types of characters tend to experience or create shame, and how an individual uses shame defenses. For example, one client (often depressed or therapy-experienced clients) may express a variety of emotions and defenses in a story in their effort to work through painful, shame-related affect and reach a healthy resolution. Another client's stories may include the same number and variety of defenses, but the defenses may be more reactive (aggressive) in nature and fail to facilitate resolution of the emotion in the story.

It is helpful to view a client's experience of shame thematically across TCTS cards. This can occur, for example, when there is a tendency for characters to feel victimized by shame from an authority figure, a trend of characters engaging in a shame–rage spiral, chronic experiences of shame regarding personal appearance, or a pattern of children seeking adult help with painful affect, and others. The pattern of responses across cards and over time is also important because some people improve in their ability to articulate and resolve shame, while others begin to decompensate and need to stop the test altogether as they encounter shame repeatedly without resolution.

Defenses Against Shame

Shame defenses are often the first clues that shame is present. The TCTS defenses are based on Morrison's (1989) work and have similarities to the Compass of Shame model (Nathanson, 1992). They include deflation (withdrawal in the face of shame), aggression (an expression of anger), and inflation/contempt (a classic bullying dynamic of discharging one's shame into another to temporarily feel better). Each of these defenses is scored based on the degree to which a character engages in the defense.

The following example of an adolescent TCTS response includes a variety of defenses. Examples of defenses are illustrated with the boldface text and initials indicating the defense: (D) = deflation, (A) = aggression, (I/C) = inflation/contempt. In the interest of brevity, I didn't include the degree of each defense.

> So it's like this championship game. The player is doing his best and yet it doesn't seem like enough. He is the son of the man—the coach—and he is **harder on him** (I/C) than the rest of the team because he is family. He missed a really important rebound and he was supposed to intercept and take it to the other side. So he took him out and does a "player trade" and **yells at him** (A), "Why did you miss the play? Why didn't you do it right? **It was so easy and you screwed it up."** (I/C) Um, this assistant coach doesn't do anything. He doesn't want to interfere with the coach, doesn't feel like it's his place. Fans are cheering for the home team and they are disappointed because it is starting to appear that they aren't going to win the game. Time is running out. When people yell, a lot of **people hide and ignore** (D). So the coach is **threatening to throw the guy out** (A) of the game. So **the guy runs off** (D), out of the gym. And the coach is **so angry and fuming** (A) he can't see straight, so he puts in one of his favorite players because he knew he wouldn't mess it up. And he wished it was his son instead, because college scouts are there. So then they, um, the team wins the game. They bring it back in the last 2 minutes. The guy helps lead the team to win. The son who ran out is off and gone, packing his stuff to leave the house. And I guess then he does. **He leaves** (D). The team goes out and celebrates and everybody is like "Yeah!" And dad

© Therapeutic Assessment Institute 2017

doesn't see the guy again because he is gone. He doesn't leave a note or anything.

This is a complicated story, full of family shame dynamics. A harsh, critical father uses anger and threats when upset with his son's athletic performance. The son, in response, first flees the game, and then his home. The context of the father's response appears to be his wish for college scouts to see his son play, but the player in the story does not appear to know this. The characters do not resolve the conflict, and the son leaves home.

This is just one story out of 10, and a mere snapshot of what the TCTS can elicit. The story may or not be typical of real life or an autobiographical scene for the client. Naturally, you'd want to review all TCTS cards, clinical sessions, and other testing to better understand a client's shame dynamics. In the interest of space, I have addressed a few of the clinically relevant questions I'd have in the back of my mind, based on this story. Does the teen experience others (interpersonally) as critical or aggressively harsh, or is the teen critical of himself (intrapsychically)? Why doesn't the assistant coach intervene? Does this teen have "trusted others" who can help him, if needed? Why might the father have responded that way? The teen clearly interjects a positive reason for the father's reaction. In the teen's mind, is there more to the story that could be parsed out? Finally, the phrase "When people yell, a lot of people hide and ignore" seems out of place, and is perhaps more of a reflection on the client's life rather than the story being told to the card itself.

Shame Defenses Within Families

The complexity of shame dynamics within couples and families can be difficult to unpack. Often, the shame defenses of one person trigger shame in another. It is in this painful intersection that we can begin to help family members understand how and why each member reacts. I think of this scenario in terms of the "old math" long division. If you simply provide an answer of 12 without "showing your work," and 12 is incorrect, you receive no credit. If you "show your work," but get an incorrect answer, you still get some credit for the parts you got right. We cannot simply accept as a final answer that one family member criticizes, one yells, one runs away, and everyone is miserable. Watching it unfold allows us to make corrections before we have our final answer. If shame dynamics do not unfold in therapy, they may be illuminated by the TCTS. Let's consider the following case, for which I served as a consultant:

The Smith family consists of a mid-40s married couple, Marie and Luke, and their 11-year-old son Bill. Marie and Luke are concerned that Bill is overweight, doesn't complete homework assignments, and is teased by classmates. Marie presents as well dressed, fit, and articulate. She is eager to point out how and when Bill misses the mark with chores and school assignments. Marie is a teacher herself and explains to her therapist how she has been able to successfully help her students, but that she cannot seem to help Bill. She openly wonders if she shouldn't have gone back to work when Bill was 3 months old and had to attend daycare. Luke is a successful lawyer who reports often feeling "out of the loop," explaining that he can't be home much in order to support the family's lavish lifestyle. Luke reports feeling underappreciated by Marie and Bill and resentful of "the disgusting state of the house" when he comes home. Luke believes Marie isn't doing her job with Bill, pointing out that weight is easy to control if you serve children the right kinds of food. He states that Bill has gotten good grades in the past and should be able to do it again. As Luke expresses his frustration in session, Marie withdraws and becomes quiet. In a separate session, Bill presents as disengaged and has trouble articulating why he isn't able to do his schoolwork. He struggles to express emotion, vaguely reporting that he feels "bad" or "down." Bill reports enjoying videogames because they're "easier than hanging out with people." He wishes his mom would leave him alone.

Shame dynamics are plentiful with this family. Further clinical work and evaluation revealed that underneath Marie's professional teacher façade was a woman with deep shame stemming from being overweight as a child. Her own father was very critical, and Marie coped by withdrawing and engaging in comfort eating. As she began to excel in school, she found perfectionism as a temporary way to feel good about herself. When Bill's weight struggle began, Marie's past shame experiences came to the foreground. Her attempts to help Bill avoid the same childhood struggles she had faced, by asking about food intake and reminding him not to eat sweets, ended up making Bill feel ashamed. His increasing weight and difficulty with school made her feel like a failure at home, and she stopped tending to housekeeping tasks. In her vulnerability, Luke's tendency toward anger felt sharp and shaming, compounding her self-criticism. As a result, Marie withdrew physically. Luke, in turn, experienced Marie's withdrawal of intimacy as rejection, prompting his attempts to help her via telling her "what to do" about

© Therapeutic Assessment Institute 2017

laundry, dishes, and Bill's weight, so, in his words, she could get "back on track." His efforts merely compounded her shame.

By understanding Marie's overidentification with Bill, how Bill experiences shame despite being unable to clearly articulate it, and the dance of withdrawal, aggression, and criticism between the couple, this family began to notice shame more quickly and was able to verbally toss up "white flags," which signaled everyone to step back and take a break before the shame was compounded. Over time and with therapy, they were better able to prevent triggers in one another and experience a greater sense of connection and understanding.

How to Use the TCTS Clinically

TCTS cards can be used to educate clients about shame dynamics. Most people can identify the "classic" shamed reactions of someone averting their gaze or a bully situation, but less obvious shame dynamics can be identified and explored by viewing TCTS cards. It is often easier for clients to initially talk about the picture cards and the stories elicited before moving on to more personal, and inevitably more painful, real-life stories of experiencing shame.

Comparing family or couple stories for the same card can be very useful in promoting an understanding of how family members interpret the same situation differently. Like the Smith family, sharing family TCTS stories can provide a way to illustrate how one situation can elicit a variety of defenses, and help explain why family members react the way they do.

The presence of an intentionally benignly depicted "competent adult" in several TCTS cards provides a great discussion point. Some clients don't even realize the adult is present, while others describe the adult as similarly rendered mute (via shame) or as another shaming figure. Being able to discuss that someone could intervene and provide assistance or empathy is valuable. Many parents are able to help their kids with bullying situations, but cannot harness that same strength and compassion for themselves. If a client is unable to access their "parent self" for help, I sometimes jokingly refer to the old bumper sticker, "What Would Jesus Do?," and ask, "What Would Julie Say?" By borrowing the idea of me, some clients are able to be kinder to themselves, and—in time—need my imagined words less as they strengthen their own ability to kindly talk themselves through a painful shame experience.

Clearly, I'm a big believer in better understanding shame dynamics and helping alleviate some of the pain of shame in others. I'm thrilled that my test is being used within the TA community. I look forward to hearing more from you about how it has helped in your work.

References

Fossum, M. A., & Mason, M. J. (1986). *Facing shame: Families in recovery*. New York, NY: Norton.

Lewis, H. B. (Ed.). (1987). *The role of shame in symptom formation*. Hillsdale, NJ: Erlbaum.

Morrison, A. P. (1989). *Shame: The underside of narcissism.* Hillsdale, NJ: Analytic Press.

Morrison, N. K. (1987). The role of shame in schizophrenia. In H. B. Lewis (Ed.), *The role of shame in symptom formation* (pp. 51–87). Hillsdale, NJ: Erlbaum.

Murray, H. A. (1943). *Manual of the Thematic Apperception Test*. Cambridge, MA: Harvard.

Nathanson, D. L. (1987). Shaming systems in couples, families and institutions. In D. L. Nathanson (Ed.), *The many faces of shame* (pp. 246–270). New York, NY: Guilford.

Nathanson, D. L. (1992). *Shame and pride: Affect, sex and the birth of the self.* New York, NY: Norton.

Thurston, N. S., & Cradock O'Leary, J. (2009). *The Thurston-Cradock Test of Shame (TCTS).* Los Angeles, CA: Western Psychological Services.

Author

© Therapeutic Assessment Institute 2017

Julie Cradock O'Leary, Ph.D., is a licensed clinical psychologist in private practice in Anchorage, Alaska. She provides therapy and assessments to children, adolescents, and adults. She has a psychodynamic approach, influenced by self psychology. She is coauthor of the Thurston Cradock Test of Shame. In addition to clinical work, she enjoys giving workshops and conducting research about shame.

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

Using Advanced Training to Build Collegial Relationships in Therapeutic Assessment Practice

By Gay Deitrich-MacLean, Ph.D.
Private Practice, Madison, WI

Peter Jackson, Psy.D.
Private Practice, Madison, WI

Many of us who are learning Therapeutic Assessment (TA) can attest to the power of the method to help clients recognize their dilemmas of change, to loosen the barriers to healing, and to elicit the profound pleasure of connecting with clients at a deep level in a relatively brief time period. Yet, many of us also recognize the challenges in developing a practice devoted to TA in our "far from Austin" communities. For mid-career psychologists, it is challenging to transform one's practice from a traditional assessment model to the TA model, in terms of both the business and practice prototypes. If one wants to practice the full TA model, the business and therapeutic aspects are intricately tied together, and many of us have puzzled about how to make this a stepwise transition. Another challenge in doing the full TA model is the relative paucity of like-minded or trained clinicians in comm-unities outside of Austin. This article describes how advanced training in couples TA has facilitated the initial process of Gay and Peter moving from traditional to TA-focused practices in Madison, Wisconsin.

Gay had been practicing a partial form of TA in rural Wyoming after having attended her first immersion course in 2011. By using the adolescent TA model and substituting treatment center staff for parents in the model, she found her consultations to be much more effective and meaningful for the clients and for the staff. To deepen her TA work with the adolescent residential treatment clients, Gay attended an in-person advanced training in working with adolescents and families. Gay was impressed not only with all that she learned about conducting TA, but also with how one learns about oneself and one's colleagues in the process of the advanced training.

Despite considerable TA training and visiting Austin so often that it was like a second professional home,

Donate to Therapeutic Assessment

The **Therapeutic Assessment Institute** recently obtained nonprofit status as a 501c3. As such, we are able to accept donations to support scholarships to our more costly TA trainings and to fund research studies. All donations to the TAI are tax deductible and can be given in any amount. Checks can be sent to Dale Rudin, TAI Treasurer, 4310 Medical Parkway, Suite 100, Austin, TX 78756. If you have questions about donations to the TAI, please email Dale at drudin@gmail.com. Your generous support will help us fulfill the mission of the TAI and the clients served by psychologists all around the world.

© Therapeutic Assessment Institute 2017

Gay was practicing this partial model of TA alone. This solo practice of TA was less than ideal, because Gay had always valued working as a team with like-minded colleagues. As the Therapeutic Assessment Institute faculty often say, having supportive colleagues is important to practicing TA effectively! A move from rural Wyoming to Madison, Wisconsin, fortuitously afforded her the opportunity to develop a collegial relationship with a fellow TA trainee, Peter Jackson.

Peter is a staple of the Madison psychological community, and Gay heard from many colleagues that he was the "go-to" assessment person in town and a gifted clinician in both assessment and therapy. However, prior to Gay's move to Madison, Peter had found himself professionally with few colleagues in the area with training, experience, and interest in psychological assessment. With Gay's move to the community, he found a colleague also well trained and interested in assessment, but better yet, also trained in TA. For Gay, it was a stroke of luck that this icon of her new community was also a TA trainee!

Peter's doctoral degree from Widener University afforded him a strong background in psychological assessment and led to a thriving assessment practice in Madison. Yet, he had always felt that there was something missing in the assessment methods he had been taught. In 2010, he discovered TA and attended the first offering of the immersion course. After this initial powerful exposure to TA, Peter knew immediately that this was where he wanted to be in terms of his assessment practice. He also realized that in many ways he was already doing many of the pieces of TA through the use of empathic attunement, thinking about assessment collaboratively, and using assessment as an avenue for therapeutic change. He began using some of the TA strategies in his practice and continued to participate in other TA workshops. However, he knew that unless he received a more direct and advanced experience, he was not going to receive the full impact that this training had to offer. He had been waiting for the right time to extend his skills. The right time came when Gay moved to Madison and their collegial relationship began.

With their shared passion for the TA model, Gay, Peter, and another colleague, Elizabeth Winston, had been meeting regularly to discuss pursuing TA as a specialty in the Madison community. This further spurred them to avail themselves of opportunities to enhance skills and learn more about individual styles as they might relate to how they would build a collaborative practice. For example, Peter and Gay attended the three levels of training and were certified in the Wartegg together. Elizabeth and Peter attended Steve's shame workshop (in Austin, Texas, in 2017), and Elizabeth attended the recent skill-building workshop in Austin. Gay and Peter worked as coassessors with an adult in a TA process supervised by Steve Finn.

To jumpstart the new business and clinical model, Gay pestered the very busy Peter into joining her in the in-depth learning afforded by the TA advanced training. Peter realized that this was an opportunity to gain valuable in-depth, experiential learning of the TA model with a colleague equally eager to develop TA in Madison. Thus, it suddenly seemed more possible to change from a traditional assessment practice to a TA-oriented practice.

With this backdrop, Peter and Gay decided to pursue an individualized advanced training with Steve Finn. Both Peter and Gay enjoyed providing couples therapy and decided to see if Steve would be willing to do an advanced training in couples TA with them. Doing this training jointly was particularly advantageous. At a practical level, the training cost could be split in half. In addition, by doing the training together, they could learn more about how they worked together, what their strengths and weaknesses were in the assessment process, and what their dynamics might be in building a practice together.

For those of you who have not completed an advanced training, the Therapeutic Assessment Institute offers the opportunity to work with clients as a co-therapist with one or more of the training faculty. In the process, the trainees both observe and "try out" their skills with master TA colleagues in the room. The training Gay and Peter participated in spanned 11 days and involved hours of case consultation, supervision, and, of course, in-session work. During the course of the training, their skills were enhanced, blind spots were addressed, and they received the support needed to attempt new skills and shed less productive patterns of practice that interfere with practicing the TA model.

Individual Professional Development in the Advanced Training

Of course, personal experiences of the advanced training differed between us, so we discuss our experiences separately:

Peter. My own professional development grew exponentially during the 11 days of the advanced training. While observing my colleagues—Steve, the founder of TA and a master at his craft, and Gay, a highly skilled, dedicated, and empathically attuned clinician—I was initially awe-struck. It was amazing to observe how my esteemed colleagues responded to the events that unfolded within the session. Equally valuable were our meetings before and after the sessions and our lunches and dinners together.

In my case, I experienced an initial hesitancy to "jump into the fire." I was encouraged by Steve's support and constant refrain to put it all out there, and his reminding me that we were fortunate to be working with a couple we could act more forcefully with. I also observed Gay's willingness and desire to take a leadership role in the sessions. From the get-go, she was jumping in and making important connections, always using the power of her empathy to lead the way. This challenged me to also find my voice. It felt daunting at first, but with both Steve's and Gay's encouragement, I suddenly and rather spontaneously found myself jumping in as well. As I engaged more and more with the couple, my confidence grew, and I was learning that I had a voice and that with the support of my colleagues I had ample room to find it in this clinical setting.

Gay. Having been out of graduate school and internship/postdoc experiences for so long meant that until I began doing TA trainings, I had not been directly observed in my work, except in co-therapy situations, since 1990. I had to deal with the anxiety and doubt that comes from thinking that maybe I had deluded myself into thinking I was a good psychologist and was about to be confronted with the extent of my delusion. Thus, I had to desensitize myself to being observed and to the expectation of negative judgment by colleagues. This desensitization began even in the role-plays at the first TA immersion course I attended in 2011 and has continued throughout my training in TA. At this point I am much more comfortable and I genuinely value the opportunity to get feedback based on direct observation of my work. I have found that feedback from Steve and other TA faculty is always supportive. It is often very positive and affirming. In the advanced training, I learned that what I thought were my strengths were indeed affirmed by Steve and Peter. In some ways, however, the gentle critiques of my work by TA colleagues have been even more valuable. For example, although I have found a way to work with many avoidant, traumatized, and conduct-disordered adolescents, I have not been as consistently effective in working with adult male versions of these kids. It was a profound experience to watch Steve and Peter help the male member of the couple we were working with, to access his deep pain. Following up on that learning in subsequent supervision with Steve has been quite powerful for me. I have been better able to transfer my skills with adolescents to working with adult men with similar dynamics. Specifically, my approach tends to be very emotionally focused with clients. Although this can be beneficial once a client with an avoidant style is ready to open up, at times one must be more direct in confronting dysfunctional and even abusive patterns that cover the underlying vulnerability. Steve has helped me gain courage in being more direct with these highly defended men.

Personal Growth as a Result of the Advanced Training

Peter. In the advanced training, I gained a newfound confidence as I began to recognize and appreciate my own talents as a clinician. Through gentle nudging from Steve and the process itself, I also began to examine areas in which I still needed to develop. My challenges have always been about being observed by colleagues whom I highly value as clinicians and the fear that I might not "measure up." Through Steve and Gay's empathic and nonjudgmental attitude and their abundant use of humor in encouraging me and all of us to laugh at ourselves, I received exactly what was needed to successfully move through this training in a way that supported my personal and professional growth. It was a deeply moving and rewarding experience that not only strengthened professional bonds, but also forged friendships to last far beyond this training.

The psychological processes that particularly faced the male member of our TA couple were centered around shame. Because shame has been a theme in my own life, I found that there were strong countertransference patterns at work for me as I worked with the couple, which, in some ways, forced me to face my own shame. Even though my shame is about things that are different than those of the male member of the couple, the experience of shame is similar. Specifically, the male member of the couple had significant shame that he was a "bad person" because of some of his behaviors over time. My own shame centers more on a sense of adequacy rather than goodness, but feeling the tendencies to defend against shame and the difficulties expressing my own vulnerability helped me appreciate the dilemma our

client felt in his relationship with his wife. During our "huddles" in between sessions, Steve, Gay, and I discussed these processes and the impact of our own experiences. As we talked, I could see how using my own personal experiences helped bring about greater awareness of the defenses that the couple used with their own shame. By the end of the advanced training, I experienced a sense of lightness and confidence. I felt motivated to learn more about shame and the centrality this core experience had on many of our clients seen in the mental health field, and how TA could play an important, if not essential, role in bringing about change. As it happened, Steve had a workshop, Working with Shame in Psychotherapy & in Psychological Assessment coming up the following February (in Austin, Texas, 2017), which proved to be a serendipitous offering for my further development in working with shame in TA.

Gay. I tend to be an over-incorporator, in Rorschach terminology. I get lost in the forest for the trees, and it often takes me longer than I would like to get to the point or see the overarching theme. These tendencies get much more pronounced when I am anxious or confused. I have been aware of this tendency for years, but have realized with the help of Steve and Peter that I have used this as a (dysfunctional) coping strategy. For one thing, I saw in both Steve and Peter a more fluid ability to get the gist of a situation, as in writing reports. I was aware of this tendency in writing our feedback to the couple.

In my subsequent supervision with Steve, he pointed out this over-incorporator tendency in me. For the first time, I am seeing the dilemma of this strategy for me. Although I know that it can be a problem for me, I choose to do it anyway because I am afraid I might miss something and experience shame as a result. But this causes me to take too long to get to the main point and actually hinders my ability to communicate effectively. As a result of our work in the advanced training and since then, I am now much more likely to ask myself if I really need this kind of detail. I more quickly look for the main point and am trying to become more comfortable with not having to integrate every detail in my thinking.

Learning more about this tendency in myself is well worth the time and money spent on the advanced training. I am working on discussing the anxiety I feel rather than trying to cope using my "don't miss anything" style. In addition, at a deeper level my over-incorporating tendency has its root in shame. (Does everything?) As such, I have been working to be more open with others about the experiences that led to shame about my own competence, because as we know, a major cure for shame is to tell someone.

As a result of the very profound experience of advanced training in couples TA, both Peter and Gay are pursuing certification in TA through individual supervision with TA faculty and preparing for the certification process. In addition, we are moving toward marketing collaborative assessment in Madison and have even hired a marketing firm to help us in this process. We have recently found office space that we will jointly occupy and we are negotiating to secure it. Our marketing team is in the initial stages of building a website and a marketing plan for us. At this early stage, we are emphasizing to the marketing team our commitment to using psychological assessment as a foundation for a deep understanding of our clients and the extent to which we value the research basis for our work.

Considerations for Others Pondering Doing an Advanced Training

The advanced training was an incredibly valuable experience for Gay and Peter. Being in the TA community likely means that you value learning about your own process as it affects your clients. We cannot think of a more effective and efficient way to learn about your process than through the advanced training. Even if you are not pursuing the development of a full-on TA practice or preparing for certification in TA, participating in the advanced training will most definitely help you grow more as a professional than will any other activity you might choose to do. Dollar for dollar, minute for minute, the advanced training is well worth it!

Authors

For the past two years, **Gay Deitrich-MacLean, Ph.D.,** has been in independent practice in Madison, Wisconsin. She has previously practiced in Laramie, Wyoming (18 years) and in Nashville, Tennessee (six years). She graduated from Vanderbilt University in child clinical and developmental psychology and completed her internship training at Boston Children's Hospital, Harvard Medical School. She specializes in therapy of couples and families and psychological assessment of children, adolescents, and parents. She also enjoys individual therapy with adults. She is working toward certification in adult Therapeutic Assessment.

Peter C. Jackson, Psy.D., is a clinical psychologist who has been in private practice in Madison, Wisconsin, for more than 23 years. He graduated from the Institute for Graduate Clinical Psychology, Widener University, and completed his internship within this program at Swarthmore College and Hahnemann University Hospital. He completed his postdoctoral fellowship at the Franklin Medical Center in Greenfield, Massachusetts. His specialty in the Madison community is psychological assessment of children, adolescents, and adults in both outpatient and inpatient settings while also maintaining a psychotherapy practice with adults and adolescents and their families. Dr. Jackson, with two of his like-minded colleagues, is forming a collaborative psychological assessment center in Madison and is preparing for the certification process in Therapeutic Assessment.

Please email questions or comments about this column to ***g.demac@hotmail.com*** *or* ***pjacksonpsyd@gmail.com***

2nd International Collaborative/Therapeutic Assessment Conference

Preconference Workshops, September 21, 2017

Full-day, 9:00 AM – 5:00 PM

How and Why Therapeutic Assessment Works

Stephen Finn, Ph.D.

Many studies now support the efficacy of Therapeutic Assessment (TA) with a variety of clients, and during the past 20 years a working theory has emerged about why and how TA works. In this introductory workshop, Dr. Finn will summarize the research on TA and explain current thinking about the therapeutic elements. Dr. Finn will then review the basic steps in TA and illustrate each with "classic" videos of him working with actual clients. This training will focus mainly on TA with adults, but will also include case examples and discussions of TA with children, adolescents, and couples.

Half-day 9:00 AM – 12:30 PM

Ultra-Brief Therapeutic Assessment: Simplicity is the Ultimate Sophistication

Hilde De Saeger, M.A. & Pamela Schaber, Ph.D.

The presenters will discuss the application of an ultra-brief (i.e., 2–3 hours) empirically supported model of Therapeutic Assessment (TA) with adult clients and illustrate it with video clip and role plays. This training is intended for clinicians who are interested in TA but are limited to implement the full model in their settings. The ultra-brief version of TA is most applicable to distressed, help-seeking clients in inpatient and outpatient treatment settings. Participants will learn how to conduct focused initial interviews; do optional, effective brief assessment intervention sessions; and give focused feedback. It requires expertise in one valid adult self-report inventory (MMPI-2, MMPI-2-RF, PAI, or MCMI-III).

Using the AAP in Therapeutic Assessment: Addressing the Origins of Adolescent Shame

Melissa Lehmann, Ph.D. & Carol George, Ph.D.

This workshop will demonstrate how to integrate the Adult Attachment Projective Picture System (AAP, George & West, 2012) in Therapeutic Assessment with an adolescent in order to reduce shame. A specific focus will be paid to how this semistructured assessment model can provide a supportive and therapeutic environment in which to talk about attachment information in order to increase a client's understanding of her emotional difficulties and reduce shame attached to her lifelong struggles. The workshop will begin with an introduction to the case in regard to relevant background information and family relationships. This will be followed by a brief discussion of shame and a summary of the client's MMPI-A and Rorschach testing results. The presenters will then discuss attachment theory constructs, highlighting the use of the AAP within the Therapeutic Assessment model, and how understanding a client's specific attachment pattern can help direct the therapeutic agenda and enhance the client–assessor relationship. The workshop will then return to the case example and demonstrate how an extended inquiry of the client's AAP stories helped initiate a discussion about shame, which allowed the client to begin seeing her difficulties in a new light. The presenters will then highlight how Therapeutic Assessment can help reduce shame and provide the assessor and client with an opportunity to begin weaving a new, more compassionate, life story.

Half-day 1:30 – 5:00 PM

Using a Collaborative/Therapeutic Assessment Model in Diagnosing Adults with an Autism Spectrum Disorder

Dale Rudin, Ph.D.

Dr. Rudin will discuss how to use a Therapeutic Assessment approach in the assessment of adults who present with behaviors and concerns that are consistent with an autism spectrum disorder. She will discuss differential diagnoses, useful assessment tools, and how to involve clients as collaborators in the assessment process. A key message will be that clinical judgment is essential in making a diagnosis of an ASD. Points will be illustrated with videos of actual clients, and participants will be actively involved in the workshop.

Missteps and Repairs in TA: Learning from Past Errors and Raising Awareness About Their Potential

Filippo Aschieri, Ph.D. & Francesca Fantini, Ph.D.

Missteps in Therapeutic Assessment (TA) can result in negative reactions to the assessor, experiences of misattunement, and even drop out. They can also hinder the achievement of the goals of TA, making it impossible to respond therapeutically to a client's assessment questions and affect as it arises. Missteps are often bound to assessors' personality characteristics, misunderstandings about their role as a TA practitioner, and incomplete or inaccurate case conceptualizations. Each can negatively affect various TA steps and lessen the potential effectiveness of the model. Therefore, missteps can be important learning and growth opportunities that can increase self-awareness about how to provide responsive and effective professional help to clients and enhance capacity to integrate data to form more complete and accurate case conceptualizations about a client's personality, needs, and struggles. This workshop will focus on missteps in initial sessions, in assessment intervention sessions, and in summary and discussion sessions. During initial sessions, participants will focus on missteps in negotiating the framework of the assessment (e.g., What does collaboration mean? What are the assessor's responsibilities? What are the responsibilities of the client?), and on balancing hope in the treatment and humility (i.e., How to cope with idealizing and devaluing transferences to the assessor). In intervention sessions, participants learn how to avoid missteps in their attempts to modulate the level of emotional arousal (i.e., Determining when the target of the intervention session is adequately arousing. Repairing when the session is too "challenging" for the client.). Finally, participants will learn about problems is writing fables for children at the end of the assessment and how to avoid overwhelming or hurting either the child or his or her parents. For each step of the TA, the workshop leaders will provide case scenarios and will lead small group discussion about the variables to take into account in avoiding the missteps that actually occurred in real TAs. Attending this workshop will be valuable for clinicians interested in fine-tuning their TA skills by reflecting on the rationale of different clinical choices and techniques with TA clients.

Making Unbearable Feedback Bearable

You Can't "Half-Ass" Attachment

By Barbara L. Mercer, Ph.D.
WestCoast Children's Clinic, Oakland, CA

"Nothing is more difficult than to know precisely what we see," said the French philosopher Merleau-Ponty in 1962. In 2008, Michelle Obama followed up on this, saying in an interview, *"Real change comes from having enough comfort to be really honest and say something very uncomfortable."*

Thinking over the hundreds of feedback sessions we as clinicians and trainees have given in a Therapeutic Assessment (TA) model (Finn & Tonsager, 1997) in our Oakland, California, community child and family clinic, I realize that it is hard to recall a feedback that's been easy and that didn't involve imparting painful-to-hear information. Some of our more difficult sum-maries to parents have included what most of us might consider positive feedback: "Your teenage son is *not* autistic" when a parent is certain their child is autistic, or, "Your adopted daughter is troubled from early abandonment. I know you are thinking about putting her back in foster care because of her difficult behavior, but not only does she need parents, she needs YOU." In some assessments, the data remind us to raise the issue of a child's racial identity that is different from his adopted parents, even though the parents have not asked specifically about it or may be resistant to acknowledging it.

Because we work with both biological and foster families, we see the behavior problems of children in the context of loss, social and economic suffering, community violence, and intergenerational assaults. A clinician working with people who have suffered trauma and loss must not be detached and must be engaged enough to "hold" a portion of the feelings communicated by the child or parent, the feelings required to begin to transform raw, traumatic, and "unthinkable" thoughts and emotions (Bion, 1962). It was hard for one mother, for example, to hear that her daughter witnessing her mother being mugged on an Oakland street had shaken the girl to the core. In a recent TA of a 6-year-old boy from Guatemala, who lived with his aunt and uncle, we found that he was rejected for his gender nonconformity. Uncovering and communicating a child's identity to caretakers can be risky. In this case, the feedback story written for the boy about a butterfly showing his many colors spoke powerfully to the caregivers and they recalled their own gay brother and their cultural dilemmas about masculinity. In this way, they were able to loosen their fixed perspective about the boy and show compassion.

Another layer in all the layers of presenting difficult feedback arises during the training of TA and collaborative assessment (Haydel, Mercer, & Rosenblatt, 2011). In our commitment to train students in both the community and collaborative/therapeutic models at WestCoast Children's Clinic, a few times a year we bravely, or foolishly, embark in having two therapists and two supervisors—one assessor works with the youth, another with the parent—and two supervisors watch the process live on a video screen. The team then processes each session and gives feedback to the clinicians. Steve Finn's training emphasizes the importance of assessors handling their own anxieties and reactions by checking in with themselves and each other to figure out their less-than-comfortable countertransference.

In the following case of a 16-year-old youth and his mother, a team of two clinicians, Frank and Anna, and two supervisors were challenged to hold the disparate pieces of their personal reactions and ultimately put them together as a whole in the process of giving feedback to the mother, Lauren, and her son, Win. Win is a 16-year-old Eurasian American adolescent who had been in individual or family therapy at our clinic with different therapists for several years. Lauren, a White professional woman, had persisted with his treatment and sought parental support despite the transitions of clinicians or the family taking a break. The most recent departing therapist suggested that a TA might help shift the family system because, despite interventions to help the mother increase consistency and limit setting, their relationship was stuck. When the mom was

unable to enlist cooperation from her son, or he was dismissive of her, palpable disengagement would occur. This disruption often came in the form of sending Win off to camp, Lauren going on exciting vacations without Win, or lack of follow-through of plans to be together.

Win exhibited depression, anxiety, and school refusal. He was avoidant and withdrawn at home and in social situations. He had recently begun therapy with a male clinician. Win's primary question for the assessment was, "Why does my mother always want me to see a therapist?" His mother's questions were comprehensive and insightful but overwhelming in number; we asked her to consolidate her 13 questions into four:

- How has his relationship to his father impacted his ability to relate to others and myself, and can he form an attachment?
- How has his understanding of mom and dad's trauma impacted him?
- How have any of my decisions impacted him?
- How do we help him develop and move forward?

In addition to Win's question about seeing a therapist, he wanted to know:

- Why do I sleep all the time?
- Why don't I want to go to school?
- Why am I so sad?
- Everyone tells me I'm smart. Am I smart enough to go to University?

In exploring his questions about being sad, Win told Frank, his assessor, that he was definitely *not* depressed, that he just preferred to stay in his room and play video games. He didn't want to be called "depressed" because he didn't want people to take care of him. He wanted to be self-sufficient.

Win had ongoing trouble in school. He was kicked out of middle school for angry outbursts and behavioral problems. In response, his mother moved them to a new city because he was refusing to go to school and had severe social anxiety, although he reported having missed his friends in the old city.

Lauren grew up in an abusive cult, which was later investigated by a state attorney general. She reported that in the cult if children didn't obey, they had to leave the house, and that she was ostracized, beaten, and shut out of her own home in the middle of winter. A cult practice was to trade children to another parent so as not to become too attached. As a toddler, Lauren was given to a Native American mother, to whom she felt more connected than to her own mother. Lauren was sexually abused in adolescence by her father, who didn't live in the home. When the sexual abuse was discovered, she was sent away to a parochial school where she continued to rebel, but eventually made her way, went to college, and earned a law degree.

We came to see that Lauren's survival was tied to escape; for example, her travels around the world involving herself in humanitarian projects in Asia and Central America. She traveled to Burma and there in a Buddhist monastery met Win's father, a charismatic spiritual activist who was a supporter of Aung San Suu Kyi. She reported coming to realize that her husband had bipolar disorder; she left him when he became physically abusive when Win was 1 year old. Although Win has never known his father, Lauren continued to tell him that his father was a great man, psychic and spiritual, but later dropped hints that he was not as great as all that. She came into the knowledge that the father was deceased and she had only recently told Win. She was still grieving this loss.

Lauren has continued to travel over the years, once leaving Win with her friends in Central America for the summer. Only recently did she acknowledge her surprise in finding out that her son hates traveling. Win confided to the assessor that he has not forgiven his mother for leaving him in Central America when he didn't want to go.

Lauren reported she often leaves Win in the house alone, puts food in the refrigerator for him, and goes off overnight to visit friends or goes to work for days at a time, telling him she is leaving at the last minute. It was apparent that Lauren loves her son, but vacillates between trying to elicit his affection or, when she feels shut out, just leaving. Win stated that he used to fight with his mother, but now is resigned.

This mother and son case brought up countertransference reactions among our assessment team. Win's current therapist wondered if he might be on the autistic spectrum because he seemed so aloof. Lauren, who is highly intelligent, talked to Anna, the second assessor, about her horrific history as if it were all a dream, in a matter-of-fact manner. In the first phase of the assessment, in our team of four, two of us were

skeptical about the truth of some of her horrific events recounted in such a mundane way, while the other two on the team thought trauma had confused and numbed her. We knew in the feedback we would have to figure out how our countertransference responses could con-tribute to our understanding (or misunderstanding) of the complex relationship between mother and son.

The Assessment Results

An underlying question from Lauren was, "How can I understand my son?" While she was shocked to hear that he didn't like traveling, we hypothesized she would be uncomfortable if she realized he actually needed her. Her MMPI-2 (Butcher et al., 2009) profile was an emotional and PTSD profile. Her major defense against her own fatigue, depression, and pain is action or an impulsive fleeing, a survival strategy requiring her *to not hold* her child in mind. If she stays and makes more connection with him, she has to feel painful and destabilizing emotions. She wants to be a good mother, but affecting this uncovers her fragility. The proactive woman she is covers a sense of helplessness and feeling alone without support.

Lauren's responses to the Adult Attachment Projective (George & West, 2012) point to a dismissive attachment style in which she uses a deactivation strategy that Carol George describes as a way to neutralize or minimize the attachment relationship to avoid past painful and care-taking realities. We see in her stories (see Figure 1) the person in the "Departure" going on an "*awe-some adventurous trip,*" and the mother in "Bed" trying to "*inch her way out of the room"* so he can go to sleep, and only eventually is the mother willing to soothe him (see Figure 2 for picture of "Bed" card).

Figure 1. ***Adult Attachment Projective Stories***

Departure (Mother)
They are about to go on a trip and they're waiting on the platform to the train. And they're feeling excited because they are going to go somewhere far away… and have an awesome adventurous trip.

Bed (Son)
She is trying to put her son to bed and he wants to stay up longer, and so he's reaching for a hug. What led up to it is that she had already read him like three stories and now she's trying to inch her way out of the room so that he can go to sleep….

Cemetery (Son)
A man is visiting his father's grave. I don't know I guess he is just remembering his memories. He also feels some, a little bit of grief. Then he's just gonna go home after. *(What do you think led up to that scene?)* Maybe something happened that he would always do with his dad or something that reminded him of his dad, so he wanted to go visit his grave.

Win's stories in the Attachment Projective show that despite a tendency to dismiss attachment needs, there is a desire for comfort in the face of extreme distress. In "Cemetery," he tells about grief about a deceased father (Figure 1). In "Ambulance," the boy goes to visit an injured father in the hospital. In the Sentence Completion he said, My father …"was never here"; A mother …"should put her child over herself"; and What pains me …"is fighting with people I care about."

In the presence of his mother, we observed Win to say nothing and put his sweatshirt hood over his face. His testing profile showed depression on both the MACI (Millon, 1993) and the Rorschach. Using the Comprehensive System (Exner. 2001), positive Coping Deficit and Depression Indexes reflect overwhelm and a double dose of depression that has gone on for so long he forgets it is even there. This is why he says, "I'm not depressed, I'm just sad." The R-PAS (Meyer, Viglione, Mihura, Erard, & Erdberg, 2011) indicated that Win is exhibiting high anxiety, feelings of low self-worth, shame, and a struggle to function daily, all of which belie his mother's conceptualization of him as mature and independent.

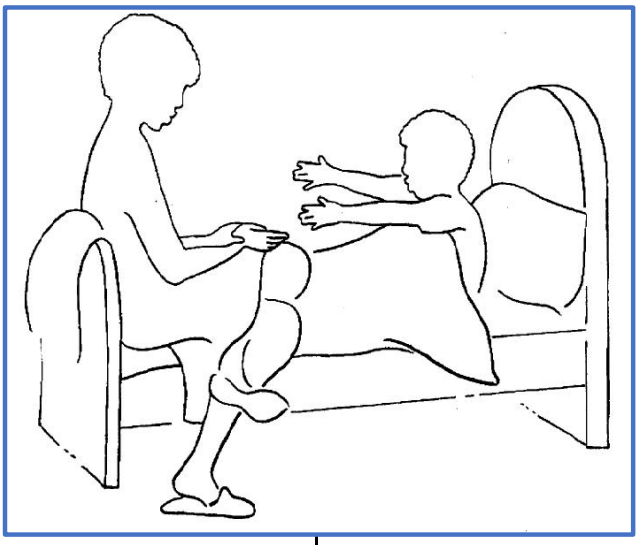
Despite pervasive depressive indicators, Win showed strengths and hopefulness for growth. He exhibited a sense of agency in his attachment stories. On the WISC Block Design he insisted on completing the final difficult design. On the Sentence Completion, Win revealed a sociable part of himself: The greatest thing is … "being with friends"; I'm best when … "I'm with close friends." His Rorschach responses began with either distanced, defended, or damaged responses: "A mask, an alien helmet (CARD I), an ant torn in half" (Card III), but migrated on the Color cards to images of portals opening (Card IX), a jeweled interior (Card IX), animals walking together (Card VIII), insects working together (Card XX), and a warrior's face paint (Card XX). This fit with the assessor's clinical observations of Win, that he could be walled off, and resistant, yet over time, in the right situation, become open to connection. Win hinted at the loss and

mystery of his father on Card IV ("a ghost, a slender man in the shadows") and Card VII ("a man, a dark figure standing at the shore of the water moving or disappearing").

Feedback: Gentle or Tough?

We surmised that the heart of Lauren and Win's dilemma was their attachment. The challenge was how to help them navigate between the detached mother and orphan child on one hand, and on the other, their longstanding entanglement so tied to the mother's traumatic history that Win knew about, the loss of her husband and Win's loss of his father. We did not want to overwhelm Lauren by bringing her terrible past to the fore-front, but we needed to infuse life into her desire to flee, to resist the pull to go to sleep. The heart of our feedback had to be, "Your 16-year-old son still needs you, and you *do* have to sacrifice something in order to help him and make your relationship better." At the same time, we knew she would need assistance to not take his seemingly indifferent responses as rejection.

Figure 2. Bed Card



The Family Intervention Session served as the introduction to our delivery of our feedback. This session was slow and tedious. The team presented them with TAT cards (Murray, 1943) and asked them to create a story together. Lauren took the lead in Card 6BM, the Mother/Son card, and Win participated only because his mother interrogated him. Win said the "mother has Alzheimer's and doesn't remember him, so the son may never come back." This was difficult for us to hear because it reflected their core dilemma: He thinks his mother doesn't keep him in mind, and he wants to get away. In the second story, Card 13B, the little boy in the doorway, Win was able to create a story about a boy waiting at the barn with impatience for his turn to ride a horse. Lauren added that he wanted to ride the horse into the Copper Canyon, but Win said, "No, to the field, because the Copper Canyon is too far away." This brought up the discussion about how his mother thinks Win rejects her advice or ideas, and she gives up. They said it was hard to create something together because their ideas were so different. "Was this always the case?" Frank and Anna asked, and mother and son replied that they used to read Buddhist fables and actually created stories together. Win said, "I would take my knowledge from a game and my mom would draw the pictures."

"This was something you have succeeded at in the past," Frank and Anna said. Lauren was able to say, "Now he's bigger and our roles need to change, but we don't have an agreement on how."

In the final TAT Card I, the Violin, Win said, "He's being forced to play the violin. Lauren added, "He's going to break the violin because he doesn't like to be forced." Win says, "No, he just seems really lost. He wants to break it but he's not going to. … He's going to 'half-ass it'." Lauren said, "Yes, his mom just gives up."

The assessors talked about how the notion of comings and goings came up a lot in their stories. Lauren talked about how she goes away for a couple of days when it seems like Win doesn't even notice if she is around. Win piped up, correcting her and saying, "*No it wasn't a couple of days, you were gone for five days.* … She says she doesn't want to be home if she thinks I don't want her around…"

This was the *opening* to talk to them about how kids like Win pull for dismissing behaviors and rejection from their parent; they make you think you should go away. We explained that because of your own history of being dismissed yourself, you are especially prone to fall into that.

The final feedback session with the mother focused on telling her the findings from Win's data: "He's been depressed for a long time but doesn't use his words, which makes a parent think he can get along better by himself than he really can. He's like a younger child and acts like he doesn't need you, but he really does need you. It's hard not to take this personally. This is a sacrifice for a parent. He feels worthless and terrible about himself, but his testing shows he very much wants connection but acts like he doesn't because he's afraid of rejection. Anna had to tell the mother, using Win's own words, "You just can't half-ass" your attachment to each other. Because their family history had been uncovered during the assessment, Lauren

reported how the two of them had located Win's Burmese uncle, had talked with him on Skype, and were going to visit him. We told her that her question about Win's father pointed to how important it was to work on their connection to his father together. We validated how this connection, despite it bringing up grief, guilt, and anger for both of them, was vital to healing.

The feedback to Win was that "you don't want people to feel sorry for you, but depression is getting the best of you." As for his questions about his academic future, Frank told him that "some of your scores are off the charts, some are average. But we see in the testing that depression and anxiety are in the way. We don't know about attending university, but this is why therapy would help. The testing shows you have some pretty big strengths you would like the world to see; the testing tells us that you want to come alive. You are depressed—but there is fire inside—the warrior part in you has to take up the depression." By the end of the assessment, Win asked to make up his missing therapy session.

Trauma and loss make attachment fragile. Feedback was a tiring and frustrating balance, to make something half-assed into something uncomfortably genuine and lively. While the demons of grief and guilt are difficult, they are less demonic than a walled-off in-difference. Quoting Joan Didion, a reviewer (Wilner, 2017) wrote, "'There is no real way to deal with every-thing we lose.' But it may be that what we make of that loss is what makes everything matter."

Our challenge was to "not half-ass" our feedback. We wanted to help them locate the strands that could strengthen their relationship, for them to talk about the loss of the father together. Lauren talked about hoping that if Win moves out, he would agree to see her for dinner sometimes like she sees her friends. Win rep-lied, "But I'm not like your friends, I'm your son." The goal of our work was to convince Lauren that she should be Win's mother, that mother and son, together in a new way, could face both their loss and their future.

References

Bion, W. R. (1962). *Learning from experience*. London: Marsfield.

Butcher, J. N., Graham, J. R., Ben-Porath, Y. S., Tellegen, A., Dahlstrom, G., & Kaemmer, B. (2009). *Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Manual for administration, scoring and interpretation* (rev. ed.). Minneapolis, MN: University of Minnesota Press.

Exner, J. E., Jr. (2001). *The Rorschach workbook for the comprehensive system* (5th ed.). Ashville, NC: Rorschach Workshops.

Finn, S. E., & Tonsager, M. E. (1997). Information-gathering and therapeutic models of assessment: Complimentary paradigms. *Psychological Assessment, 9,* 374–385.

George, C., & West, M. L. (2012). *The Adult Attachment Projective Picture System.* New York, NY: Guilford Press.

Haydel, M., Mercer, B. L., & Rosenblatt, E. (2011). Training assessors in collaborative assessment. *Journal of Personality Assessment, 93*(1), 16–22.

Merleau-Ponty, M. (1962). *Phenomenology of perception*. London, UK: Routledge.

Meyer, G. J., Viglione, D. J., Mihura, J. I., Erard, R. E., & Erdberg, P. (2011). *Rorschach Performance Assessment System: Administration, coding, interpretation, and technical manual*. Toledo, OH: Rorschach Performance Assessment System.

Millon, T. (1993). *Millon Adolescent Clinical Inventory: Manual*. Minneapolis, MN: National Computer System.

Murray, H. A. (1943). *The Thematic Apperception Test.* Cambridge, MA: Harvard University Press.

Wilner, P. (2017, March 12). Road Warrior. *San Francisco Chronicle,* Q38.

Author

Barbara L. Mercer, Ph.D., has been the assessment program director and clinical supervisor at WestCoast Children's Clinic, a community psychology clinic in Oakland, California, since 1986. She has worked in community mental health throughout her career. She has been on the faculty of California School of Professional Psychology and the Wright Institute in the San Francisco Bay Area, where she taught psychological assessment and child therapy and chaired a number of dissertations at both schools.

Please email questions or comments about this column to bmercer@westcoastcc.org

Proficiency in Personality Assessment
Why Should I Care?

By Hadas Pade, Psy.D.
and Stephen E. Finn, Ph.D.

"*The BDI and BAI tests showed little of depression and anxiety. It showed self-dislike, criticism, problems with stress and sleep. But in contrast, her MMPI tests showed that she has a lot of physical complaints. There is more worry about her health and a lot of obsessive thinking about her state. Family problems can create her physical problems as well. Since Mrs. X went through a traumatic injury in her childhood, this could be why she still has issues today with how she physically feels. The way she deals with anxiety and conflict converts into difficulties in her body. The physical complaints show an indirect expression of these conflicts. There is a possibility for a histrionic personality since she needs affection and social support. On the positive side, Mrs. X tends to be agreeable, sentimental, and romantic and yearns for people who are kind and loving toward one another.*

The VRIN is not average and showed a moderate elevation with a lot of random responding, most likely because she rushed through the exam. The tree drawing showed her feelings of insecurity, like the BDI, and her need for social connection, like the MMPI. The tree also showed feelings of anxiety, which MMPI analyzed that her anxieties come out physically. The person drawing showed that Mrs. X has a need to control things, which shows in her personality, and the person drawing showed that she is not open to criticism, which showed in the MMPI as well. The house drawing showed obsessive compulsiveness and that she has a hard time getting close to others, like the MMPI as well."

Why Do We Need Basic Standards for Personality Assessment?

We can only hope and assume that you were as bothered by this real example as we were and thus already answered the question above. Just in case . . . this is just one example as to why we need clear and well-established standards ensuring that licensed psychologists conducting assessments in the field are, at the very least, proficient. Most of us conduct our work the way we were taught, not necessarily stopping to question whether this is best practice or what the basis is for our format and approach. Unfortunately, we have scant data in our field about effective reports and the frequency of incidents in which we may cause harm. Our reports are often used in high-stakes situations (custody evaluations, law

enforcement selection, placement and availability of services, etc.). Even when not in high-stakes contexts, reports can have an enormous impact on clients and their families. Why do we assume that our work is good or even proficient? Our clients are certainly not trained to let us know. Often, they accept our reports and feedback whether they are accurate or not.

From Hadas, the SPA Proficiency Coordinator. Dear *TA Connection* readers. I am thrilled to have this opportunity to reach out to you as the proficiency coordinator for SPA and share a bit about the Proficiency in Personality Assessment. It's even more exciting to do so alongside Steve Finn. Some of you may already be familiar with the proficiency through your involvement with SPA. Either way, we hope you find the information presented here useful and give some thought to applying for recognition.

From Steve. I am joining Hadas in writing this article because I am concerned that substandard personality assessment is hurting every one of us who does good work, and because I am impressed with the procedures that the SPA Proficiency Committee and the SPA Board have put in place for reviewing and approving proficient practitioners. I know that you, like me and Hadas, are busy people, and that you don't have time to waste on meaningless self-aggrandizement. We hope to explain how proficiency can be good for you and for our field.

Proficiency Overview

The proficiency entails a basic (rather than advanced) standard for clearly established expectations for personality assessments in the field. Such a standard has not existed before. Applications for most psychologists include a basic application form with demographics, a current CV, and a written report with testing data. Each application is reviewed by three psychologists who have established expertise in assessment. A Proficiency Report Review Form is used to evaluate each report, and feedback is provided to each applicant regardless of recognition status. All application materials, including the review form, are available on the SPA website:

http://www.personality.org/about/proficiency-application/

The Report Review Form was developed and edited by quite a few SPA members, many of whom have been leaders in the field of personality assessment. The form addresses five main components that are considered integral to effective assessment reports: Comprehensiveness, validity, integration, client-centered, and overall writing. Each category includes several items, for a total of 22 items for the entire review form. There are also several items that are considered critical, and applicants must meet proficiency on those in order to meet overall proficiency. These categories and included items are relevant across settings and populations, with perhaps some slight variation. Thus far, interrater reliability using the form has been consistently high.

If reviewers determine that an applicant meets proficiency, he or she is then endorsed for approval vote by the SPA Board of Trustees. Regardless of recognition status, applicants receive detailed feedback, including reviewers' ratings and comments, in the hope that such information helps enhance their level of skill. Applicants are offered an opportunity to provide feedback about the application and recognition process via a brief and anonymous online survey. Applicants are welcome to contact the proficiency coordinator with questions or concerns at any time before, during, and after the process. The proficiency coordinator often consults with members of the proficiency committee to further ensure the process is useful and fair.

Applying for Proficiency Recognition

Most psychologists seem to agree that the proficiency is a positive step in our field. They feel strongly that those we teach and train need to become competent in assessment as they progress through their training and work toward producing meaningful and helpful re-ports. However, this has not necessarily translated to a steady flow of applications. We currently have about 60 or so psychologists recognized as proficient. We'd like to have more. We are not sure what gets in the way of people applying. A few possible reasons to consider in terms of applying or not, follow:

Top Reasons You May Have for Applying for Proficiency Recognition

1. It's a great opportunity to get feedback on my work post-licensure.

2. I would be supporting a field of work that I care about.

3. I would be modeling good practice to the next generation of assessment psychologists.

4. I want to ensure that my work is, at the very least, proficient.

Top Reasons You May Have for NOT Applying for Proficiency Recognition

1. I don't have enough time to put together my application.

2. I'm not sure I will get recognized (isn't this a reason to apply?).

3. I'm sure I'm proficient and don't need to prove it.

4. I don't think recognition will do anything for my career.

So Why Should I Apply?

We want to address the latter arguments that may get in the way of applying. There is never enough time to do anything, really. If we let that get in the way, we'd accomplish very little. The application process is not that time consuming. Completing the online application form takes a few minutes, as does uploading necessary documents. Taking out all identifying information from a report is probably the most time-consuming aspect, but the "Replace All" function on your word processing program, or a black indelible marker, make it fairly easy. As noted above, any concern about possibly not getting recognized as proficient is a great reason to apply. Most of us experience a sense of doubt at some point in our career, no matter how experienced we might be. Obtaining feedback about our work is a part of ethical and responsible practice. It's as simple as that. The worst that can happen is not getting recognized and getting feedback about reports. Such information is not shared beyond reviewers and the proficiency coordinator and has no direct impact on one's practice. Hopefully, such an outcome would lead to some self-reflection and enhancement of skills in necessary areas, also known as personal and professional growth.

If you are confident about your level of proficiency, the process can be a validation that your self-evaluation is correct. You can sleep better at night knowing that you supported your field of practice and are a role model to fellow colleagues and the next generation of psychologists. It is true that being recognized as proficient probably will not significantly change your practice at this time. It will, however, allow you to advertise your proficiency status to further enhance your marketing, and as the public becomes more and more aware about such standards, this may be advantageous. Finally, if you have already demonstrated an advanced level of skill in personality assessment, including an SPA Fellow or ABAP Diplomate, the process is simplified (check our website) and you can potentially become a reviewer for recognition of others. Again, this is a remarkable opportunity to contribute to your field of work.

One last point germane to readers of the *TA Connection*: the proficiency reviewers are open to Collaborative/Therapeutic Assessment and will take your context into account if you send in a collaborative report or feedback letter to a client. Steve tested this himself before becoming a reviewer, by sending in a collaborative report to be rated by other reviewers. They were very comfortable with the usual TA format (e.g., written in first person, all tests explained in detail, organized by findings rather than tests) and praised the client-centered approach. They also offered other useful comments and questions, and Steve really felt that he learned from the process.

Conclusions

To conclude, we chose to share feedback from a recent applicant who was recognized as proficient. The comments below illustrate what we hope to achieve with the proficiency process and what we addressed throughout this article. Although of course not all applicants will feel this way, this is absolutely our intention and goal for everyone.

I wanted to thank the SPA reviewers for the thoughtful and valuable feedback on my report. I didn't realize I would be getting such a great bonus as part of this process! The feedback was so interesting, helpful, and on point—and I really appreciated that. It was also very consistent with the direction I have been going with tightening up my reports and making them shorter. It's important to have feedback articulated so clearly from highly skillful reviewers and colleagues and nice to not just be thinking my own thoughts! I regularly get feedback from parents (the target audience) and referring therapists, but this is different and a unique opportunity. Feedback like this also helps me in my supervision work with students when I need to scaffold and edit their reports.

For questions about the proficiency, please contact us at proficiency@spaonline.org

Photo Album

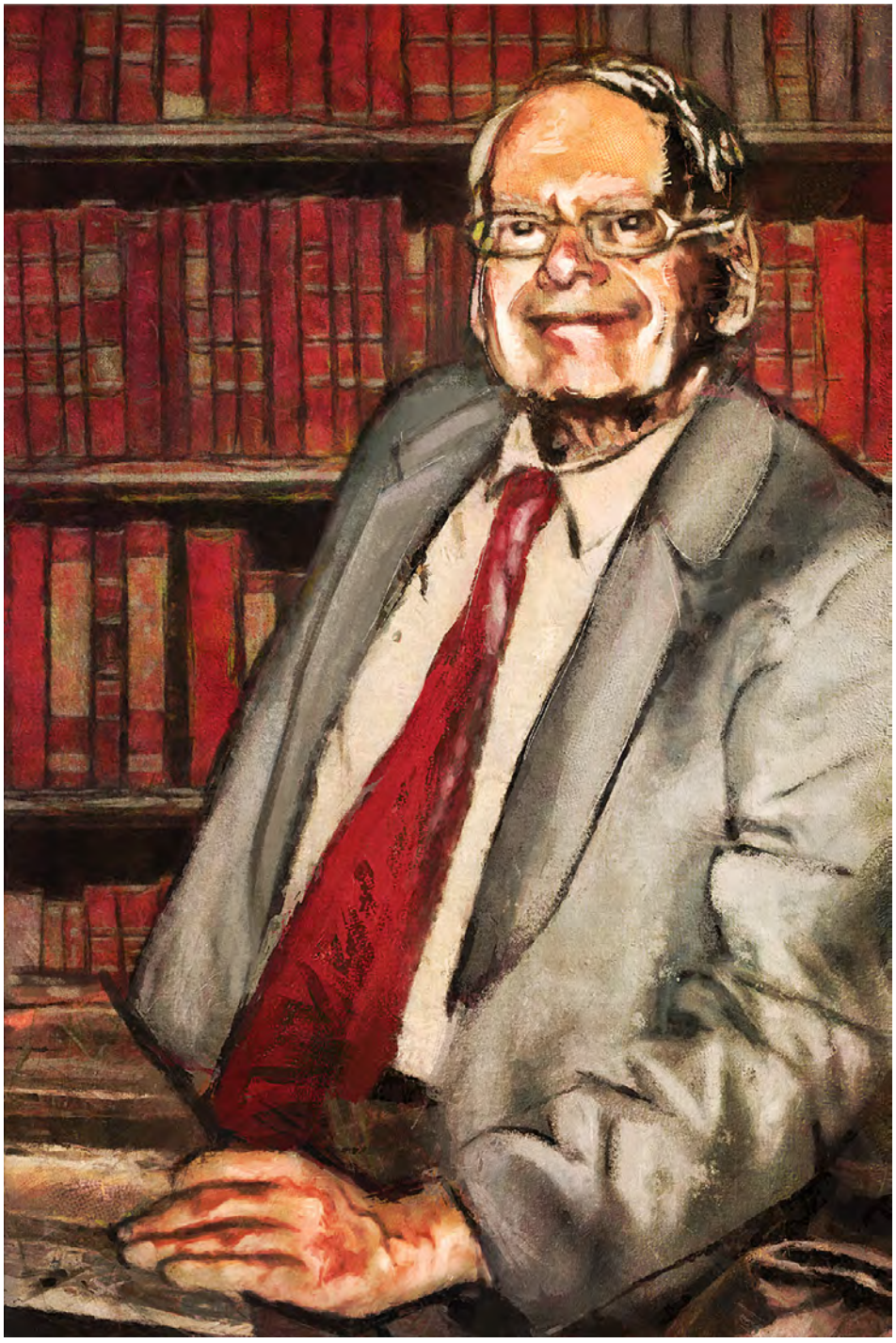
Above: Staff from the Asian-Pacific Center for Therapeutic Assessment celebrate in Tokyo in April 2017 following their successful training on case conceptualization in Therapeutic Assessment. Standing from left to right: Mitsugu Mirakami, Noriko Nakamura, Sho Yabugaki, Seiji Mabuchi; middle row: Yasuko Nishida, Naoko Ogura, Mikako Ohzeki, Tamami (translator), Sachiyo Mizuno; front row: Shin-Ichi Nakamura, Mitsue Tomura, Steve Finn, Tomoko Miwa (translator), Hisako Nakagawa.

Left: Dale Rudin conducting a workshop at the 2017 meeting of the Society for Personality Assessment titled "Using Clinical Judgment in the Therapeutic Assessment of Adults Who May or May Not Have an Autism Spectrum Disorder." For those of you who missed it, this workshop will be offered at the CTA Conference in September in Austin. (See p. 14.)

Above: Attendees of the 2017 Marguerite Hertz Memorial Presentation in honor of Dr. Leonard Handler gather for a photo, each wearing one of his neckties given as a remembrance. Leonard had more than 200 neckties.

Above: Attendees and presenter Steve Finn at a training on shame in Uppsala, Sweden, in fall 2016.

Right: A digital painting of Leonard Handler by Scott Gregory, commissioned by J.D. Smith.



Recent Publications in Therapeutic/Collaborative Assessment

Aschieri, F., Chinaglia, A., & Kiss, A. (in press). How individual R-PAS protocols illuminate couples' relationships: The role of a performance-based test in Therapeutic Assessment with couples. In J. Mihura & G. Meyer (Eds.), *Applications of the Rorschach Performance Assessment System.* New York, NY: Guilford.

Aschieri, F., Fantini, F., & Finn, S. E. (in press). Incorporation of Therapeutic Assessment into treatment with clients in mental health programming. In J. Butcher (Ed.), *APA Handbook of Psychopathology*. Washington, DC: American Psychological Association.

Chen, J. A., Gilmore, A. K., Wilson, N. L., Smith, R. E., Quinn, K., Peterson, A. P., ... Shoda, Y. (2017). Enhancing stress management coping skills using induced affect and collaborative daily assessment. *Cognitive and Behavioral Practice*, *24*(2), 226–244. doi: 10.1016/j.cbpra.2016.04.001

Durosini, I., Tarocchi, A., & Aschieri, F. (2017). Therapeutic Assessment with a client with persistent complex bereavement disorder: A single-case time-series design. *Clinical Case Studies*. doi:1534650117693942. Available ahead of print.

Evans, B. F., & Finn, S. E. (2017). Training and consultation in psychological assessment with professional psychologists: Suggestions for enhancing the profession and individual practices. *Journal of Personality Assessment, 99*(2), 175–185. doi:10.1080/00223891.2016.1187156

Fantini, F., & Smith, J. D. (in press). Using R-PAS in the Therapeutic Assessment of a university student with emotional disconnection: A single-case study. In J. Mihura & G. Meyer (Eds.), *Applications of the Rorschach Performance Assessment System.* New York, NY: Guilford.

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

Kaslow, N. J., & Egan, G. J. (2017). A competency-focused commentary on the special section on teaching, training, and supervision in personality and psychological assessment. *Journal of Personality Assessment, 99*(2), 189–191.

Nakamura, N. (2017). Therapeutic use of the Rorschach. *Psychometry, 2*, 12–17.

Provenzi, L., Menichetti, J., Coin, R., & Aschieri, F. (2017). Psychological assessment as an intervention with couples: Single case application of collaborative techniques in clinical practice. *Professional Psychology: Research and Practice*, *48*(2), 90–97. doi: 10.1037/pro0000076

Smith, J. D., & Egan, K. N. (2017). Trainee and client experiences of Therapeutic Assessment in a required graduate course: A qualitative analysis. *Journal of Personality Assessment*, *99*(2), 126–135. doi:10.1080/00223891.2015.1077336

Upcoming Trainings in Therapeutic Assessment

June 15–17, 2017: Milan, Italy
Title: Live Therapeutic Assessment of a Couple
Presenters: Filippo Aschieri, Francesca Fantini, and Stephen E. Finn
Sponsor: European Center for Therapeutic Assessment, Catholic University of the Sacred Heart, Milan
Language: Italian
Information: http://asag.unicatt.it/asag-assessment-terapeutico-di-coppia-dal-vivo-presentazione

July 17, 2017: Paris, France
Title: Working with Shame in Psychological Assessment
Presenters: Stephen E. Finn, Marita Frackowiak, and Pamela Schaber
Sponsor: International Society of Rorschach and Projective Methods
Language: English
Information: http://www.rorschachparis2017.org/Workshops/en

July 17, 2017: Paris, France
Title: Utilisation des techniques projectives comme outils thérapeutiques [Using projective techniques as therapeutic tools]
Presenters: Lionel Chudzik and Filippo Aschieri
Sponsor: International Society of Rorschach and Projective Methods
Language: French
Information: http://www.rorschachparis2017.org/Workshops/en

September 21–23, 2017: Austin, TX, USA
Title: 2nd International Collaborative/Therapeutic Assessment Conference
Chair: J.D. Smith
Preconference workshops on September 21 presented by: Stephen Finn; Filippo Aschieri & Francesca Fantini; Hilde De Saeger & Pamela Schaber; Melissa Lehmann & Carol George; and Dale Rudin
Sponsor: Therapeutic Assessment Institute and Society for Personality Assessment
Information: jd.smith@northwestern.edu
Online registration information coming soon!

November 2, 2017: Tokyo, Japan
Title: Introduction to Therapeutic Assessment: Using Psychological Testing as Brief Psychotherapy
Presenters: Stephen E. Finn, Noriko Nakamura, and members of the Asian-Pacific Center for Therapeutic Assessment
Sponsor: Asian-Pacific Center for Therapeutic Assessment
Languages: English and Japanese
Information: asiancta@gmail.com

November 3–5, 2017: Tokyo, Japan
Title: Working with Shame in Psychological Assessment and Psychotherapy
Presenters: Stephen E. Finn, Noriko Nakamura, and members of the Asian-Pacific Center for Therapeutic Assessment
Sponsor: Asian-Pacific Center for Therapeutic Assessment
Languages: English and Japanese
Information: asiancta@gmail.com

Call for Proposals
2nd International
Collaborative/Therapeutic Assessment Conference

The Therapeutic Assessment Institute (TAI) is delighted to invite proposal submissions in the following formats. All topics pertaining to collaborative and therapeutic assessment are welcome. Notification of acceptance will be sent by June 15th, 2017. **PROPOSAL SUBMISSIONS ARE DUE JUNE 1st, 2017**

SYMPOSIA, INTEGRATED PAPER SESSIONS, ROUNDTABLES

These events are continuing education (CE) bearing. Although they are open to all attendees, they are approved for their appropriateness in satisfying the continuing education needs of doctoral-level psychologists as defined by the American Psychological Association. 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 for symposia and integrated paper sessions (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.

INDIVIDUAL PAPERS/CASE PRESENTATIONS

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. Presenters can be students to seasoned professionals. Each paper is allowed 40 minutes for presentation, and 10 additional minutes for questions, to allow greater depth of presentation. A title and 200-300 word abstract is required for submission.

POSTERS

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.

Submissions by email will not be accepted. Please complete this Google Form to submit proposals for all formats: https://goo.gl/forms/unmsdk0OzXWPKD7I1

Questions can be directed to the conference Chair, J.D. Smith at jd.smith@northwestern.edu