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THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

TA Marches On

By Justin (J.D.) Smith, Ph.D.
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Greetings, friends and colleagues. I am delighted to bring you the second issue of the *TA Connection*. We have three excellent columns in this issue and some exciting news to announce about the next big events in TA and collaborative assessment.

This Issue

In this issue's research column, Steve Finn reviews recent empirical studies of narrative identity by Jonathan Adler and their relevance to TA. Adler's quantitative studies of clients' written accounts of their self-narratives during and after psychotherapy have important implications for why TA works to reduce clients' distress and helps them more effectively manage problematic affect states. Adler's work suggests that meaningful reductions in distress and disturbance can occur quite quickly after particularly impactful sessions that help the client develop more coherent narratives and experience themselves as more active, instrumental agents in their lives. These findings suggest important areas of future research on TA's mechanisms of therapeutic action.

Bill Hanson discusses the challenges and enjoyments of teaching a TA practicum in a doctoral training program. Bill describes the sequence and process of the practicum, the clinical work students conduct, and some preliminary outcomes based on student evaluations of their experiences during the past decade. Bill also presents what he has found to be some of the more challenging aspects of TA to teach and supervise. These areas of challenge will probably come as no surprise to any of us —gathering assessment questions, resolving discrepancies between the results of different tests, and presenting "hard to hear" findings to clients. Bill offers a number of successful tips and approaches to dealing with these challenges. And as Bill notes, students' reactions to the practicum and course evaluations truly are the proof in the pudding: Once you encounter TA, it becomes hard to consider conducting psychological assessment any other way, because of the many benefits to client and assessor alike.

In this issue's clinician's corner, Raja David tackles one of the most common and trickiest questions about TA: How am I going to get paid to do this? Raja describes the approach he has taken with managed care companies to successfully procure

In this issue:

reimbursement for TA. He presents a very useful example of a typical TA case and how it would be billed with current codes. He also takes it one step further and compares reimbursement for TA with a typical psychological assessment followed by psychotherapy. The monetary difference might be surprising but encouraging. Raja's article is an excellent tutorial that many of us could follow, and, perhaps more important, it inspires us to meet the financial challenges of the managed care environment head on and still provide the best possible services to our clients.

The Future

I am excited and energetic as I reflect on where the TA community is headed in the near future. Our group continues to grow and flourish around the world, and with that growth come new challenges and opportunities in research, training, teaching, and implementation. This past June the faculty of the Therapeutic Assessment Institute (TAI) convened to discuss our plans for training and dissemination of TA in the coming years. The immersion courses held in Austin the past 4 years have very successfully provided trainees with a unique and intensive experience. With attendance totaling more than 100 participants during those 4 years, there is an increasing need for somewhat advanced training opportunities. Workshops and live assessment conducted by TAI faculty around the world have served this purpose fairly well.

The annual meeting of the Society for Personality Assessment remains the predominant opportunity to attend workshops about specific topics and aspects of the TA model. This year is no different, with three TA workshops being offered. These workshops are listed on page 21 in this issue. As usual we also expect that there will be a number of TA-related symposia, paper presentations, and posters, as well as the Collaborative/ Therapeutic Assessment interest group meeting and many fun, informal gatherings. However, we realize that the SPA meeting is a significant commitment for many, as is the annual Advanced Training. Thus, we endeavored to provide the kind of intermediate and advanced training that would best serve the TA community at this time.

Inaugural CTA Conference

With these issues in mind, the TAI faculty decided to hold a conference devoted solely to Collaborative and Therapeutic Assessment (CTA). The inaugural conference will take place September 11–13, 2014, at the AT&T Conference Center in Austin, TX. Along with my fellow cochair Barton Evans and a committee comprising Steve Finn, Dale Rudin, Mary McCarthy, and Pamela Schaber, we are busily preparing a program of diverse and interesting offerings. I want to provide a taste of what is being planned, but note that the following schedule and specific workshops are subject to change.

Thursday will be devoted entirely to training workshops aimed at attendees having novice to advanced skills in CTA. Half-day and full-day workshops will focus on a variety of topics. Workshop offerings will be announced shortly.

Friday will begin with a plenary session with a number of speakers, including Steve Finn and cochairs Barton Evans and J.D. Smith. The remaining conference program on Friday and Saturday will comprise symposia, individual paper presentations, case discussions, round table discussions, and case consultation with CTA experts. We will release a call for proposals early in 2014, and I hope you will consider submitting and presenting the research and clinical work you are doing with CTA. We are interested in a mix of topics encompassing all aspects of CTA, from research findings to the practice, implementation, and teaching/ supervision/training. Sessions will be both large group (all attendees in one room) and breakouts, during which multiple presentations will occur simultaneously.

We have reserved a beautiful space at the new AT&T Executive Education and Conference Center in Austin, which is near the University of Texas campus and close to downtown. We have attempted to keep costs as low as possible while providing attendees with a comfortable space and plenty of amenities. Double occupancy rooms will be $169 per night. We have reserved a block of rooms and expect them to fill quickly. The conference center's location is highly desirable, and alternative accommodations might be difficult to procure, so reserve your room soon! Click here for the conference center's room reservation page.

Conference registration and workshops rates will be announced in early 2014 along with the workshops offered on Thursday. Continuing education cred-

its will be offered to psychologists for workshops and for the majority of the Friday and Saturday program.

We hope you will attend this exciting event and consider submitting a paper to present. We all have so much to learn from each other and so much wisdom to share!

Other Trainings

With the CTA Conference comprising the primary intensive training opportunity in the United States in 2014, the TA Immersion Course will be held on the stunning west coast of Italy (Massa Carrara) May 26–June 1. The course will be conducted in English and Italian and will focus exclusively on TA with adult clients. Training sessions will take place in the mornings, leaving attendees to participate in wonderful prearranged excursions in the afternoons. The 6-day Advanced Training will again be held November 10–15 in Austin. Other con-firmed opportunities for training in TA and related topics will be help in Denver, CO; Stockholm and Blekinge, Sweden; and Istan-bul, Turkey. A complete listing is provided on page 21. Photos from TA trainings and presentations held at SPA 2013 can be found on pages 18–19 in this issue.

Future Issues of the TA Connection

As always, I would love to hear your feedback and suggestions for the newsletter. If there is a topic you would like to see appear in an upcoming issue, please let me know. There is also a standing invitation to anyone who is interested in submitting a column for consideration. Email me at jd.smith@asu.edu with your ideas. A warm thank you to the contributors in this issue: Steve Finn, Bill Hanson, and Raja David. And a thank you to Barton Evans for helping with the description of the CTA Conference in this column. 2014 is shaping up to be a big year for TA!

Future Issues: If you would like to receive future issues of the *TA Connection*, please email me directly.

Please email questions or comments about this column to J.D. Smith at jd.smith@asu.edu

Jonathan Adler's Research on Narrative Identity and Psychotherapy

Implications for Therapeutic Assessment

By Stephen E. Finn, Ph.D.
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In this issue I want to use *The Researcher's Corner* to draw readers' attention to an interesting and relevant body of work by Johnathan Adler, a clinical psychologist at Franklin W. Olin College of Engineering in Massachusetts. Adler completed his Ph.D. in 2009 at Northwestern University under the guidance of Dan McAdams, a well-known researcher who has done groundbreaking work on the concept of *narrative identity*. Adler has extended McAdams' work to investigate changes in narrative identity during psychotherapy. Adler's research has important implications for understanding Therapeutic Assessment (TA).

Narrative Identity

Narrative identity is the "internalized, evolving story of the self that each person crafts to provide his or her life with a sense of purpose and unity" (Adler, 2012, p. 367). The theory of narrative identity starts with the belief that human beings are inherently "meaning makers." Beginning in adolescence and continuing over the course of our lifetimes, we all construct an ongoing "story" that makes sense of our past experiences, our current situations, and our anticipated futures (McAdams, 2001). This story serves several important purposes: (1) it provides us with a sense of internal coherence and meaning (i.e., that we know who we are and why we are that way), and (2) it gives us a sense of continuity across time and situations (i.e., that we know where we came from, where we are in life, and have some sense of where we are headed; Adler, 2012). It is important to note that our stories about ourselves are not always conscious, but they influence many aspects of our lives and are revealed through the choices we make, how we behave in relationships, and how we think and talk about our experiences. For example, McAdams has shown that major life events are understood on the basis of our existing stories and can produce important changes in those stories, which then shape our future behavior (McAdams, 2001). In previous writings (Finn, 2007) I have speculated that many clients have personal narratives that are problematic—in terms of being poorly formed, inaccurate, or self-blaming—and that TA can help clients develop more coherent, accurate, compassionate, and useful stories about themselves and the world.

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In their work, McAdams and others have convincingly demonstrated that personal narratives have implications for mental health, with well-functioning individuals having more coherent personal stories characterized by themes of agency and self-efficacy, while the narratives of individuals with mental health challenges are less coherent and more likely to contain themes of inefficacy and powerlessness (Adler, Skalina, & McAdams, 2008; McAdams, Hoffman, Mansfield, & Day, 1996; Woike & Polo, 2001). McAdams and others have also developed methods of assessing clients' narratives, by interviewing them or asking them to give written answers to certain questions and then looking for themes in those accounts. This is not far from deducing personal narratives from clients' stories to the TAT or Early Memory Procedure, and as all TA practitioners know, such indirect assessments yield very different results than if one were to ask clients to describe themselves on self-report tests of personality.

Narratives About Psychotherapy

As I mentioned earlier, Adler has been particularly focused on how people narrate the experience of being in psychotherapy and also

on how psychotherapy influences their stories about themselves and the world. Adler's work is also unique in that he has used quantitative methods to study narrative identity, while much of the early research relied on qualitative methods. Adler did use the prior qualitative research to identify themes and variables that he later targeted in his quantitative research.

For example, last year Adler (2012) published a remarkably ambitious study of 47 adult clients as they began and completed 12 sessions of psychotherapy at the Family Institute of Northwestern University (where TA friend Carol Middelberg was on faculty before moving to Austin). Therapists included students and senior staff, and they used a variety of therapeutic approaches with clients. Before beginning treatment and then again after each therapy session, clients completed a series of questionnaires and tests assessing their emotional distress and symptomatology and wrote extended accounts of their thoughts about psychotherapy and its impact on their lives. (Previous studies of psychotherapy narratives had used retrospective accounts rather than track clients while they were in treatment.) Adler coded each writing sample by using a detailed, reliable system developed in previous research. He was specifically interested in two variables: *agency* (the extent to which clients saw themselves as independent, powerful actors in their lives) and *coherence* (the degree to which clients felt clear versus confused about who they were and could answer questions about their lives in an orderly, consistent way). In short, he found that (1) agency, but not coherence, increased in most clients as they progressed through 12 sessions of psychotherapy; (2) the more clients saw themselves as having agency and self-efficacy, the less distressed and symptomatic they were; and (3) increases in clients' sense of agency directly preceded and predicted increases in their mental health. This latter finding was particularly intriguing in that it suggests a causal relationship between therapists' ability to help clients see themselves as independent, powerful actors in their own lives and their sense of well-being. Narrative coherence was not related to symptomatic distress is this study, but in fact, across 12 sessions of psychotherapy many clients did not show increases in the coherence of their narratives. I suspect changes in narrative coherence come only after more time passes in most psychotherapies.

To the extent that we can help clients develop more coherent stories about themselves and the world and to see themselves as active, instrumental agents in their lives, the less emotional distress and disturbance they will show.

In a second project published earlier this year (Adler, Harmeling, & Walder-Biesanz, 2013) Adler did an even more detailed study of how 54 clients' narratives were related to improvements during therapy. Again Adler studied how clients' thoughts about themselves and their lives developed over 12 sessions of therapy, as reflected in their writing. Also, as before, clients completed a standardized measure of distress and disturbance each week (the Systemic Therapy Inventory of Change [STIC]; Pinsof et al., 2009). The STIC was then used to identify what psychotherapy researchers call *sudden gains* (SGs) in psychotherapy, that is, periods following therapy sessions when clients' distress and disturbance suddenly improved dramatically. I have long been interested in SGs during Therapeutic Assessment, which many of us witness fairly frequently following assessment intervention and summary/discussion sessions.

In Adler's study, sizeable SGs occurred fairly often (after 24% of psychotherapy sessions), and the median session in which they occurred was session number 5 (of 12). These results are in line with those of other studies of SGs. It is important to note that clients who did and did not have SGs during their psychotherapies did *not* differ in their levels of functioning before beginning treatment. What was striking was the timing of sudden improve-ments in clients' functioning in relationship to their personal narratives. By carefully tracking clients' written accounts following each therapy session and comparing those to symptom ratings after sessions, Adler showed that SGs were preceded by changes in clients' narratives. Those clients whose personal stories changed in the direction of being more coherent and less avoidant of emotions and who came to see themselves as having more agency and self-efficacy in their lives, tended to show

sudden improvements in their mental health functioning. This is one of the most convincing pieces of evidence in the research literature that helping clients change their narrative identities can have an immediate, profound effect on their well-being.

Implications for Therapeutic Assessment

In TA, we use psychological tests to (1) help identify clients' narratives, (2) help clients become aware of and understand their *own* narrative identities, and (3) help clients "rewrite" their narrative identities. Adler's work testifies to how important such narrative shifts can be in terms of clients' mental health functioning. To the extent that we can help clients develop more coherent stories about themselves and the world and to see themselves as active, instrumental agents in their lives, the less emotional distress and disturbance they will show. Also, such changes can happen fairly quickly—sometimes after a single impactful session—and often persist over long periods of time.

What Adler has not studied, and where current theory and practice in TA are focused, is on *how* to help clients change their narrative identities in a positive way. At this point in time, several major factors seem important. First, when clients feel emotionally supported and respected by the assessor, they can risk giving up old ways of thinking about themselves and try on new ones. Second, when we affirm and validate some of clients' existing views and perceptions, they are more open to revising other aspects of their narrative identities. Third, when clients believe that editing their narrative identities will help them achieve their current life goals, they are more receptive to making changes. Fourth, psychological tests provide an external "screen" on which clients' narratives are reflected and through which they can be analyzed; this is often less threatening than examining thoughts, actions, or behavior directly. And finally, when we involve clients as active participants in examining and rethinking their existing narratives, we foster their self-efficacy, which in itself is related to positive outcomes.

A fruitful line of future research would be for someone to apply Adler's established methods for studying narrative changes in psychotherapy to Therapeutic Assessment. Any students looking for a dissertation topic?

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Author

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Please email questions or comments about this column to Stephen Finn at sefinn@mail.utexas.edu

Teaching Therapeutic Assessment Practica

By William E. Hanson, Ph.D.
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In my first doctoral practicum, I was not allowed to use psychological tests. This was disappointing. I was fascinated by tests such as the MMPI-2 and wanted to use them with clients. Alas, my supervisor did not believe they were clinically useful, so I relied mostly on structured interviews and observations. In the years since, I have used tests extensively with clients, studied their utility (e.g., Poston & Hanson, 2010), and taught Therapeutic Assessment (TA) courses, including practica. All along, I have been interested in assessment and testing, process-outcome research, and mixed methods. TA combines these interests beautifully! Here, in this column, I discuss three aspects of the *TA Practicum*, namely, its overall structure, content, and process; challenges and special considerations; and preliminary outcomes and evaluation. I want to say, upfront, that I am indebted to Ken Keith, Chuck Claiborn, John Creswell, Clara Hill, Mike Lambert, Steve Finn, and Connie Fischer. They are intellectual heroes of mine and have influenced my assessment research and practice. I am also indebted to hundreds of graduate students who, likewise, have influenced my work. Many, many thanks! Now to the course.

Structure, Content, and Process

To begin with, I thoroughly enjoyed Hale Martin's (2013) inaugural teaching column. His experiences and sentiments resonate strongly with me, as I first taught TA theory and research at the University of Nebraska-Lincoln (UNL) and subsequently at Purdue University. Both courses mirrored Martin's, structurally and content-wise, and were based on Finn's (1998) teaching suggestions. At UNL, I also incorporated TA into general practicum courses and Career Exploration Workshops.

At Purdue, I taught TA theory/research once and *TA Practicum* (TAP) three times. TAP was a traditional, semester-long springtime course that evolved out of a joint service-learning collaboration between Educational Psychology and the Student Access, Transition, and Success (SATS) Office. As such, SATS referred clients to us, and the majority of them were on academic probation and struggling emotionally. Some had bona fide Axis I and II issues and near-debilitating distress levels, but most had less-severe adjustment problems. SATS paid for testing and associated clinic materials, as well as an adjunct instructor to cover my regular course. To take TAP, student assessors had to be in our APA-accredited doctoral program, have basic psychometric/measurement knowledge, and advanced practicum

and assessment skills. They also had to have traditional quantitative and qualitative data collection and analysis skills, preferably formal research training. I required the latter because, in addition to being potentially multimethod (Smith & Finn, in press), TA is also inherently "*mixed* methods," in which clinicians collect, analyze, and integrate quantitative and qualitative data (Hanson, in preparation; Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005). The intentional mixing of quantitative test scores and qualitative client narratives enhances meaning-making and, ultimately, understanding of the results (Fischer & Finn, 2008; Hanson, Leighton, Donaldson, Oakland, & Shealy, in press).

Between 2010 and 2012, 13 doctoral students took *TAP*, seeing more than 100 clients. Taking the course was not easy. Students' schedules were already filled with three to four required courses a semester. So, typically, advanced, internship-ready students took the course, which was rigorous but manageable, with three texts (Finn, 1996, 2007; Levak, Siegel, & Nichols, 2011), 20–25 supplemental readings, and a three- to five-page end-of-course self-assessment. Students saw two to three clients per week, maintained all records, and obtained approximately 40 direct assessment/intervention hours during the semester. Course goals and objectives related to collaborative, humanistically oriented assessment generally and TA-based theory, research, and practice specifically. My assigned readings largely paralleled Martin's (2013). In addition, I also included Binderman, Fretz, Scott, and Abrams (1972); Claiborn, Goodyear, and Horner (2001); Holm-Denoma and colleagues (2008); Lafferty, Beutler, and Crager (1989); Schafer (1954); and Worthington and colleagues (1995), plus a few more.

From a process standpoint, the course embodied TA as Finn (1998) described it. That is, core principles were applied to teaching and course management. For example, on the first day we discussed how advanced, in-house practica can be unsettling, even anxiety provoking. We also discussed past assessment- and testing-related courses. As much as possible, I validated students' experiences, both good and bad, and processed past hurts. Then, students generated three to five personal and professional questions they had, not only about TA, but also about themselves. As a group, we collaboratively explored individual questions in depth, encouraging elaboration and additional discussion/consideration. Course expectations and evaluations were also explored collaboratively and, in effect, co-constructed, with students determining their final grades. Students received additional, competency-based feedback/evaluation as well (Fouad et al., 2009).

Clients were seen in the department's training clinic, which has 10 individual therapy rooms, two group rooms, a play therapy room, and two observation decks with one-way mirrors and audio-video capacity. Upon arrival, clients completed standard intake paperwork, a handful of pretest measures, and an assessment-oriented informed consent form. Virtually all clients completed three, 50-minute sessions. On rare occasions they completed a fourth intervention/*in vivo* session. To reduce paperwork and, in particular, serve as a reminder of TA's basic steps/techniques, checklist progress notes were developed. Each note contained essential elements of Finn's model (Finn, 1996). Regarding the feedback session, for example, notes had boxes for setting the client at ease, reestablishing the collaborative tone of the process, and discussing the client's test-taking experience. As an aside, students documented the most important therapeutic interaction regarding the feedback process. Interestingly enough, this tended to be "making the implicit explicit" and tying one's past to the present. Finally, to facilitate test interpretation, students completed Test Summary Worksheets and Preparatory Notes for each client. Of note, clients took the OQ, MMPI-2, Strong Interest Inventory (SII), and a values inventory. Supervision occurred weekly via live observation

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of sessions, individual case consultations, and in-class group supervision.

Challenges and Special Considerations

As we know, TA is challenging and requires the utmost skill and clinical acumen. Although students did remarkably well, generally speaking, they consistently struggled with three aspects of the model and process: (1) helping clients generate questions; (2) discussing discrepant results, that is, those that do not align fully with clients' self-perceptions; and (3) discussing potentially negative, "hard to hear" feedback. Over the years, we discussed these issues at length. Regarding the first, which students repeatedly said was the single most challenging aspect of TA, we developed prompts (e.g., "Amongst everything else going on in your life right now, you seem to be struggling academically. I wonder if you have questions about that?"). We also developed fallback questions, such as "How do you typically handle stress?" and linked clients' questions to their presenting problem(s). Thus, special consideration was given to this issue.

Special consideration was also given to discussing discrepant results. Discrepancy is, after all, a critical message variable in attitude and behavior change, with moderate discrepancies being optimal (Claiborn & Hanson, 1999; McGuire, 1985). Finn (1996) specified three levels of discrepant information, which is a helpful conceptualization. For TAP students and clients, I wanted these levels to be determined empirically, somehow, someway, so I developed a crude, 20-item, "work-in-progress" (pretesting) measure of MMPI-2 and SII test scores. MMPI-2 preestimates focused on clients' personality, emotional well-being, and psychological vital signs (i.e., mood, anxiety, and anger; Spielberger & Reheiser, 2009). SII preestimates focused on clients' career interests. Thus, to operationalize discrepancy and give students a sense of clients' prevailing self-perceptions, their actual test scores were compared and contrasted with preestimates, with scores being plotted together. Though it was an imperfect system, it highlighted complexities of this critical variable and facilitated in-class discussions that transferred to in-session application (e.g., ordering of Level 1, 2, and 3 information).

Finally, special consideration was given to potentially negative, "hard to hear" feedback. Oftentimes, after seeing clients' MMPI-2 profiles, students felt anxious. This is understandable because some profiles look more challenging than others. To study this issue directly, we conducted a national survey of clinical, counseling, and school psychology doctoral students. Turns out, they were significantly more reluctant to share 6-8/8-6 MMPI-2 feedback with hypothetical clients than 2-7/7-2 feedback (Peltier & Hanson, 2010), further underscoring the point. To address it in class, anxious feelings were normalized, attention was paid to the *MUM Effect* (i.e., the tendency to withhold negative information; Merker, Hanson, & Poston, 2010), and prefeedback role-plays were conducted (Hanson & Claiborn, 2006; Lillie, 2007). Moreover, students were encouraged to approach all feedback sessions openly, not assuming they would have deleterious effects. As expected, clients invariably felt validated and understood, some for the very first time. Speaking of validation, my official, oft-repeated course mantra was "soothe before you move." It is, in most clinical instances, a helpful, therapeutic first step. In closing, I want to shift gears and highlight some preliminary course outcomes.

Student Reaction is the Proof in the Pudding

Since the mid-1990s, I have asked students to collect process-outcome data in practicum, including TAP. Normally, in traditional practica, they collect alliance, hope, and therapist-credibility data and periodically plot, share, and discuss it with clients and supervisors. This is done in the spirit of Practice-Based Evidence (PBE; Barkham et al., 2001; Duncan, Miller, & Sparks, 2004; Lambert, 2010), of which I am an adherent and proponent. TAP is no different, and preliminary data look promising. Clients benefited greatly. For example, on average, their distress levels decreased, hopefulness increased, and perceived social support increased. Moreover, clients learned about themselves, based on AQ New Self-Awareness/Understanding subscale scores, and valued the experience overall, perceiving it as helpful and highly satisfying and seeing their assessors as highly credible (i.e., expert, trustworthy, and interpersonally attractive). Course-wise, evaluations were positive and, per students' reports, they achieved

their goals, increased their confidence in TA, and, it seems, increased their internship competitiveness. Of the 13 students, most got their first or second choice. It is exciting to note that at least one APA-accredited site (Albany Medical College/Psychology Internship Consortium) has a TA-based clinical rotation! John Poston, my former advisee, interned there and is now a post-doctoral fellow.

To be sure, I believe in the power and potential of psychological testing, and I enjoy discussing its merits with former supervisors, psychologists in the community, and academic scholars alike (Hanson & Poston, 2011; Lilienfeld, Garb, & Wood, 2011). TA, in particular, can be clinically useful, and TA practica can be beneficial for all involved. Personally, I look forward to teaching TAP next year, this time at the University of Alberta! As a faculty, we added it to our accredited program's curriculum and annual course schedule. If you would like copies of the syllabus, intake, informed consent, pretest estimates, progress notes, test summary worksheet, pre- and post-measures, or final evaluation form, please let me know. I will happily pass them along. Following the list of references, please find the Student Self-Assessment Form.

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William E. Hanson, Ph.D., is an associate professor at the University of Alberta. He teaches in the accredited Counseling Psychology Program, Department of Educational Psychology. At heart, he is keenly interested in "what works," assessment- and therapy-wise, and "why." Currently, in addition to assessment-based feedback studies, he is working on an edited book: *The Deliberate Therapist: Using Process-Outcome Feedback to Enhance Treatment*.

Please email questions or comments about this column to Bill Hanson at whanson@ualberta.ca

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Student Self-Assessment Form

Therapeutic Assessment Practicum

What did you learn about "Therapeutic Assessment?"

What did you learn about yourself?

What were your personal & professional goals/individualized questions for the course?

Personal:

Professional:

To what extent did you meet them?

1 2 3 4 5 6 7 8 9 10

To a Little extent — To a Great Extent

What, in your opinion, were the most *interesting* and *compelling* aspects of the course?

As far as therapeutic assessment goes, what are your strengths and weaknesses?

Strengths:

Weaknesses:

How confident are you, right now, in your ability to assess a client therapeutically, following the principles/techniques of Finn's model?

1 2 3 4 5 6 7 8 9 10

Not Very Very

What's the easiest aspect of Finn's model? Hardest/most challenging?

If you were to conduct research in this area, what would you study? What (seemingly) are the most important client variables to consider? Therapist variables? Therapist-client interactional variables? Other variables?

Plot your **Outcome Data** – by client (and measure [AQ *New Self-Awareness* and *Total* scores and *Helpfulness* and *Satisfaction* ratings] – on a separate page.

Billing Health Insurance for Therapeutic Assessments

By Raja M. David, PsyD
Minnesota School of Professional Psychology at Argosy University

I suspect the two thoughts that ran through my mind when I attended the Therapeutic Assessment Immersion Training were common experiences: "This approach looks very promising!" and, "How am I going to get paid for this?" Fortunately, my excitement about the model won out, and I returned home and began sharing with colleagues about TA and finding potential clients. To date, I have performed about 10 TAs, and all have included billing health insurance. In this article, I describe how I approach billing managed care for TAs and provide an example of such a case.

Although I hope this article will help psychologists understand how to bill insurance for TAs, given the complexities of working with insurance companies, a few caveats are offered. Foremost, you are strongly encouraged to review the policy and procedures manuals for the insurance companies you work with to get a "lay of the land" when it comes to billing for psychological testing. Second, I have a small private practice in St. Paul, Minnesota, and largely provide therapy and forensic evaluations. During the past couple of years I have completed about four TAs a year. I primarily work with adolescents and young adults, and all my TAs have followed the adolescent and adult models; I have not done a TA following the child or couple model. Third, insurance plans vary greatly within states and even more so across states, so some of what may be covered and easily billable in Minnesota may not be elsewhere. A few of the largest insurance companies in Minnesota adopted the test administration and interpretation times outlined in the Camara, Nathan, and Puente (2000) article, and I have used those guidelines when billing for any testing I do. Last, as I think about the different types of clinical activities I perform and what I get paid for them, there is quite a variety in the reimbursement rate I receive and in my level of interest and satisfaction in the job tasks. Although it would be great to be paid the most for the work that is most difficult or enjoyable, and is most beneficial to our clients, that is not always the case, and I am okay with that.

Basic Steps Taken When Billing Insurance

Before I saw my first TA client, I read about dealing with managed care (Finn, 2007; Finn & Martin,

1997) and consulted with two colleagues who review testing authorizations for an insurance company. They helped me think about the biomedical perspective insurance companies use when reviewing psychological work and how to use terms that are part of that philosophy. Those seeking to enhance their ability to do this may wish to consider reading texts such as Maruish (2002). Generally speaking, services are authorized based on medical necessity, and when it comes to testing, that means there is a need for additional, objective data that will assist with diagnostic clarification and treatment planning. After these conversations, I also crafted a letter with research citations to use in the case of a needed authorization. This letter contained space for me to talk about the client and their difficulties, but I also referenced some of the major studies that demonstrated the therapeutic impact of TAs, because I wanted it to be clear that testing could be valuable to a client for reasons other than clarifying diagnoses and determining treatment.

When I have referrals for a TA, I take a few steps at the onset in order to be transparent with clients and hopefully set the stage for a successful experience, both clinically and with regard to insurance. During the initial telephone conversation, I inquire about their health plan and provide information about what the process might be like, given their insurance. For example, I let clients know if an authorization will be required for testing units and how that might lead to delays in the process. In addition, I let them know what types of testing are commonly covered (e.g., personality measures) and not covered (e.g., achievement testing). I also ask about any past evaluations, because some insurance companies will not pay if testing has been completed recently. This discussion continues during the first session, and I let clients know how many units are likely to be billed, so those with copays or partial payments can estimate what their costs might be. If past testing has been completed, I always try to obtain a copy and review the report, as I would do for any evaluation.

After the initial session, during which assessment questions are established, I create a treatment plan. The plan typically lists the client's basic difficulties as the problems (e.g., anxiety). The goal often is alleviation of symptoms (e.g., "Client's anxiety will decrease, as indicated by…") and the TA is listed as the intervention. This appears to be a prudent step in that insurance companies require treatment plans for therapy—which TAs clearly are. This also illustrates the artificial distinction that most insurance companies and many psychologists make between testing and therapy. Because TA is "ahead of the curve" in integrating testing and therapy, it is necessary for a TA treatment plan to describe how the combination of services will benefit the client. In other words, the challenge is to document how a TA fits with the medical necessity criteria for both testing and therapy.

Because TA is "ahead of the curve" in integrating testing and therapy, it is necessary for a TA treatment plan to describe how the combination of services will benefit the client.

Similar to what others have described (Finn, 2007), I bill a mix of testing units (96101) and therapy units (90834/37) during the TA. As elaborated below, the therapy units typically are used for extended inquiries (EI) after testing, the assessment intervention (AI) session, and the discussion session. I complete progress notes for all therapy sessions, with the therapeutic aspects of the EI, AI, and discussion sessions clearly identified. For example, "After completion of the TAT, the client and I explored responses that seemed relevant to her relationship difficulties. The client identified a tendency for characters to act passively in her stories and I helped the client recognize how this mirrored her own tendencies. We connected this back to social anxiety, and I helped the client see how developing assertiveness skills could improve her relationships."

Example

This is the case of a young woman who presented with mood and relationship difficulties. From the onset, I knew her insurance company would require an authorization, and I informed her about this requirement upfront. During our first meeting we established questions to be addressed

Table 1

Summary of Services and Billing Rates for TA

Service	Time	CPT	Reimbursement[1]
Initial interview	60 mins	90791	$145.00
Early Memory Procedure (EMP)	60 mins	96101	$86.00
EI on EMP	45 mins	90834	$89.00
MMPI-2	60 mins	96101	$86.00
EI on MMPI-2	45 mins	90834	$89.00
TAT	60 mins	96101	$86.00
EI on TAT	45 mins	90834	$89.00
Rorschach	120 mins	96101*2	$172.00
EI on Rorschach	45 mins	90834	$89.00
Assessment intervention	60 mins	90837	$117.00
Discussion sessions	120 mins (2 separate days)	90837	$234.00
Report writing	60 mins	96101	86.00
Total	780 mins (13 hours)		$1368.00

Note. EI = Extended inquiry. [1]This rate was determined by identifying the median rate of reimbursement I receive for these services. The median appeared to be a more useful number due to a large standard of deviation. Codes: 90791, Psychiatric Diagnostic Evaluation; 96101, Psychological Testing; 90834, Individual Therapy–45 minutes; and 90837, Individual Therapy–60 minutes.

through the TA, and this session was billed as diagnostic interviewing (97901). This client's questions were narrow in focus, so I requested only six units of testing (one unit each for the Early Memory Procedures, MMPI-2, TAT, and report writing, and two for the Rorschach). I completed the insurance company's authorization form and submitted it with the aforementioned letter. In hindsight, this letter may have been too lengthy. However, I wanted to make sure I received an authorization, and I also saw this as an opportunity to educate the reviewers about this approach. In addition, I had some concern about getting approval, because none of the client's questions was about diagnostic clarification. Regardless, I received authorization and proceeded to conduct the TA.

During the course of seven weeks, I completed the different parts of the TA with the client. This TA occurred prior to the 2013 change in CPT codes, but Table 1 shows how this TA would have been billed with the current codes. The client completed the Early Memory Procedures (EMP) at home and brought it back the next session. I conducted an EI on the EMP and billed one unit of therapy. After that session, the client completed the MMPI-2 on her own in an adjacent office. The client returned the following week; I conducted more interviewing, and we completed the EI on her MMPI-2 responses, which was billed as therapy. The next week the client returned, and I booked two hours for this appointment. We initially completed the TAT, then an EI was conducted on her responses (one unit of testing and one unit of therapy). The following week she

returned to complete the Rorschach, and I followed the same protocol. Next the client returned for what was billed as a therapy session, and the AI was conducted. Last, the discussion session occurred during the course of two meetings, each of which was billed as therapy.

About two weeks into this TA, I received a letter from the insurance company requesting that I submit a copy of the psychological testing results prior to payment. I had not expected this, and it was unclear to me if my different approach prompted this request or if this was random sampling. I completed the TA with the client and wrote a personal letter that follows the model (i.e., informal language, the client's questions are answered directly, no diagnoses are listed, and test results are in an appendix). I contemplated whether this would be sufficient, given how different a TA letter is from a standard psychological report. However, I submitted it, thinking this would be another opportunity to educate reviewers about the model. Insurance paid with no questions asked.

A comparison of this example with a traditional evaluation and pure individual therapy further shed light on the reimbursement rate. If this had been a traditional evaluation, the units billed for testing and report writing would be the same. I would have likely completed a second day of interviewing and billed an additional 90791 code if that were allowed, and additional report writing would have taken two hours. Thus, I would have billed $806.00 for 10 hours of work, equaling $80.60 an hour.

In addition to what is outlined above, this TA took longer because deeply exploring the test data to prepare for the AI and writing the letter were more time consuming. I suspect that process added an additional five hours of time to what is listed in Table 1. Thus, all my time for this TA (13 hours outlined in Table 1 plus an additional five hours) amounts to $76.00 an hour. Although this number is not too dissimilar from the hourly rate described above, it is also recognized that I could have completed the interview and simply begun individual therapy with this client, which would have led to a better rate of pay. More specifically, one unit of 90791 plus 10 units of 90834 equals $1035.00, or $94.00 an hour, adding an additional hour for writing up the initial assessment. However, given I now write TA letters more quickly than what is described in the example, my hourly pay on my most recent TAs is at least equivalent to traditional psychological evaluations and approaches the amount paid for therapy, given the higher rate of reimbursement on 90834/37 versus 96101.

This example illustrates my typical experience conducting TAs and billing insurance. There have been a few other situations that I managed differently. For example, one adolescent TA had a question that required achievement testing to answer, and I knew insurance would not pay for it. I discussed with the client and parents the type of test needed and how this would help answer their question. I also explained why insurance companies do not pay for tests they view as educational. The client and parents believed it was worthwhile to obtain these test results and agreed to pay out of pocket. I have encountered a similar situation in another adolescent-TA in which MMPI-2s completed by the parents would help answer a question. I consulted with my aforementioned colleagues about this matter, and they suggested that I open a new chart under each parent and bill the testing in their name. However, so far I have found it simpler to discuss with the parents the benefits of the testing and the complexities of billing and privacy matters. To date, all have agreed to pay cash for the noncovered testing.

There have been challenges in implementing the TA model, some of which I have overcome and others that I have not solved. My first few TA letters took a significant amount of time to craft, more so than a typical psychological report. However, I now find that I can write most letters in a timely fashion, and my last few were easier to write than a report, because I had a much better understanding of the client after having completed the procedures of a TA. The 2013 change in CPT codes was unfortunate because of the loss of the 90808 code (outpatient psychotherapy 75–80 minutes). The steps in the model that take the most time are the AI and discussion sessions, and I used the 90808 code for some of those sessions. Doing the AI in two separate sessions would not work in most situations, but I have conducted discussion sessions across multiple appointments. However, I also have participated in some discussion sessions in which it was in the client's best interest to be finished in two consecutive hours, which is what I did. I did not bill for that second hour, but the clinical value of conducting these sessions in that time period outweighed the financial loss.

Last, use of a therapy code for the discussion sessions may be of some concern to professionals, given there is a CPT code for providing feedback (90887). However, I think the biomedical perspective helps us see how different discussion sessions are from standard feedback. If you get an x-ray on an injured leg and receive feedback that your leg is broken, this information does not lead to healing. In contrast, the individualized, collaborative nature of the discussion session has been proven to lead to change (Poston & Hanson, 2010). In my example, during the discussion sessions my client gained insight into those situations that are difficult for her, and she began to see how some of her relationship tendencies were connected to experiences with her family of origin. Realizing this, we identified new ways of healing the wounds from her past and practiced new ways of responding in those interpersonal situations that were most difficult for her. I would posit that this is therapy.

In summary, I hope this article sheds some light on how you might apply TAs in settings where insurance is billed. Aspects of how the mental health system works can make TAs a challenge to adopt. The billing issues described are some of those challenges. Creating a schedule that allows for flexibility in time spent with clients is another challenge. However, given the benefits TAs provide to our clients, I believe we need to educate other professionals and stakeholders about the model, and think about adapting our systems to meet the model rather than changing the model to conform to our systems.

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Therapeutic Assessment Workshops and Presentations at SPA 201

Symposium at SPA entitled, "*Therapeutic Assessment Around the World*" conducted by (left to right) Stephen Finn (USA), Filippo Aschieri (Italy), Hilde de Saeger (The Netherlands), Lena Lillieroth (Sweden), and Lionel Chudzik (France).

Presenters (back, from left) Diane Engelman, J.B. Allyn, Deborah Tharinger, and Marita Frackowiak (seated) of the workshop, "*Making Meaning from Assessment Findings: Writing Therapeutic Stories for Children, Adolescents, and Adults*" at the SPA meeting in San Diego.

The presenters of a symposium at SPA in 2013 entitled "*The Alchemy of Collaborative/Therapeutic Assessment: Integrating Science and Art*": (back row, from left) Diane Engelman, Caroline Purvis, Phil Erdberg, J.D. Smith, Deborah Tharinger; (front row) Filippo Aschieri, J.B. Allyn, Constance Fischer.

Filippo Aschieri and J.D. Smith accepting the Martin Mayman Award from Greg Meyer, outgoing editor of the *Journal of Personality Assessment* for their article, "The Effectiveness of an Adult Therapeutic Assessment: A Single-Case Time-Series Experiment."

Recent Publications in Therapeutic/Collaborative Assessment

Chudzik, L., & Aschieri, F. (in press). Clinical relationships with forensic clients: A three-dimensional model. *Aggression and Violent Behavior*. Available online ahead of print.

de Saeger, H., Kamphuis, J. H., Finn, S. E., Verhuel, R., Smith, J. D., van Busschbach, J. J. V., Feenstra, D., & Horn, E. (in press). Therapeutic Assessment promotes treatment readiness but does not effect symptom change in patients with personality disorders: Findings from a randomized controlled trial. *Psychological Assessment*.

Fantini, F., Aschieri, F., & Bertrando, P. (2013). "Is our daughter crazy or bad?" A case study of Therapeutic Assessment with children. *Contemporary Family Therapy*, 35, 731–744.

Finn, S. E., & Martin, H. (2013). Therapeutic Assessment: Using psychological testing as brief therapy. In K. F. Geisinger, B. A. Bracken, J. F. Carlson, J. I. C. Hansen, N. R. Kuncel, S. P. Reise, & M. C. Rodriguez (Eds.), *APA handbook of testing and assessment in psychology, Vol. 2: Testing and assessment in clinical and counseling psychology* (pp. 453–465). Washington, DC, US: American Psychological Association.

Miller, L. R., Cano, A., & Wurm, L. H. (in press). A motivational therapeutic assessment improves pain, mood, and relationship satisfaction in couples with chronic pain. *The Journal of Pain*.

Smith, J. D. (2013). Book review: Finn, S. E., Fischer, C. T., & Handler, L. (Eds.). (2012). Collaborative/ Therapeutic Assessment: A casebook and guide. Hoboken, NJ. John Wiley & Sons, Inc. *Journal of Personality Assessment, 95*(2), 234–235.

Smith, J. D., Erard, R. E, & Handler, L. (2013). An updated statement for the Clinical Case Applications Section: Suggestions for clinical and empirical case reports. *Journal of Personality Assessment, 95*(5), 437–443.

Smith, J. D., & Finn, S. E. (in press). Therapeutic presentation of multimethod assessment results: Empirically supported guiding framework and case example. In C. J. Hopwood & R. F. Bornstein (Eds.), *Multimethod clinical assessment of personality and psychopathology*. New York, NY: Guilford Press.

Tarocchi, A., Aschieri, F., Fantini, F., & Smith, J. D. (2013). Therapeutic Assessment of complex trauma: A single-case time–series study. *Clinical Case Studies, 12*(3), 228–245.

Tharinger, Deborah J., Gentry, L. B., & Finn, S. E. (in press). Therapeutic Assessment with adolescents and their parents: A comprehensive model. In C. R. Reynolds (Ed.), *Oxford Press handbook of psychological assessment of children and adolescents*. New York, NY: University Press.

Upcoming Trainings in Therapeutic Assessment

Workshops at the Annual Meeting of the Society for Personality Assessment
March 19–23, 2014, Arlington, VA, USA

Title: "Developing Supportive Relationships with Referring Professionals"
Presenters: Filippo Aschieri and Mary McCarthy

Title: "Working with Shame in Psychotherapy and Psychological Assessment"
Presenter: Stephen E. Finn

Title: "Using Stories to Communicate Assessment Findings with Children, Adolescents, and Adults"
Presenters: Diane Engelman, Marita Frackowiak, and Deborah Tharinger
Information: www.personality.org

April 9–10, 2014, Blekinge, Sweden

Title: "Therapeutic Assessment with Children: Using Psychological Assessment to Change the Family Story"
Presenter: Stephen E. Finn
Sponsor: BUP Blekinge
Information: Lena Lillieroth at lena.lillieroth@sll.se

April 11, 2014, Stockholm, Sweden

Title: "Integrating the Wartegg and Rorschach"
Presenters: Stephen E. Finn and Alessandro Crisi
Sponsor: Therapeutic Assessment Institute and Instituto Italiano Wartegg
Information: Lena Lillieroth at lena.lillieroth@sll.se

April 11, 2014, Stockholm, Sweden

Title: "Introduction to Therapeutic Assessment"
Presenter: Stephen E. Finn
Sponsor: Therapeutic Assessment Institute
Information: Lena Lillieroth at lena.lillieroth@sll.se

April 25–26, 2014, Denver, CO, USA

Title: "Working with Shame in Psychotherapy and Psychological Assessment"
Presenter: Stephen E. Finn
Sponsor: University of Denver and Colorado Assessment Society
Information: Hale Martin at halmarti@du.edu

May 16, 2014, Tokyo, Japan

Title: "Using the Rorschach and Other Projective Tests in Therapeutic Assessment"
Presenters: Stephen E. Finn
Sponsor: Japanese Society for the Comprehensive System
Information: Tomoko Muramatsu at ttomotomo@aol.com

May 26–30, 2014, Massa Carrara, Italy

Title: "Therapeutic Assessment Immersion Course"
Presenters: Stephen E. Finn and members of the Therapeutic Assessment Institute
Sponsor: Therapeutic Assessment Institute
Information: www.therapeuticassessment.com

July 15–19, 2014, Istanbul, Turkey

Title: "Therapeutic Assessment of Psychological Trauma" workshop at the XXI International Congress of the Rorschach and Projective Methods
Presenters: Stephen E. Finn and Barton Evans
Information: www.rorschach2014.org

September 11–13, 2014, Austin, TX, USA

Title: "Collaborative/Therapeutic Assessment Conference"
Co-Chairs: J.D. Smith and Barton Evans
Sponsor: Therapeutic Assessment Institute
Information: Coming soon!

November 10–15, 2014, Austin, TX, USA

Title: "Therapeutic Assessment Advanced Training"
Presenters: Stephen E. Finn and members of the Therapeutic Assessment Institute
Sponsor: Therapeutic Assessment Institute
Information: www.therapeuticassessment.com