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THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

Happy Holidays

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We are in the midst of the busy holiday season and the end of the academic term for many of us. Due to the 2nd International Collaborative/Therapeutic Assessment Conference (CTAC) that was held in Austin, TX in late September, I was delayed in completing this issue of the newsletter. However, this allowed me and the editorial board, Associate Editors Hale Martin, Deborah Tharinger, and Pamela Schaber, to select from among many, many interesting and deserving presentations at the conference for inclusion in this issue. Other presentations will appear in the subsequent issues as well. If we were to include all of those presentations that we wanted to, we would have compiled a book! If anyone has the energy to do so, let me know!

There are many exciting events and news items to share with the TA community in addition to the wonderfully informative and engaging columns in this issue. Before I get to the contents, I want to wish you all a very fulfilling and relaxing holiday season with family, friends, and loved ones. At this time of year, it is customary to reflect on the successes and trials of the previous year, to gather with loved ones, and to prepare for the start of the coming new year. The image of being snuggled under a blanket in a chair, next to a crackling fire, with a warm mug of coffee in my hands comes to mind. I hope you all can find a comforting place such as this over the next few weeks.

This Issue

As I mentioned, this issue follows on the heels of the CTAC, which was an invigorating experience despite the immense amount of energy it took to pull together and pull off. We diverge somewhat from the typical format of the newsletter by including four columns that cross-cut the usual themes of research, training, and clinical practice of TA. Each column was presented in some form at the conference.

This issue's first column has an applied focus on the use of the Adult Attachment Projective Picture System (AAP) in a TA of an adolescent who had intense shame and failed mourning.

In this issue:

AAP developer Carol George and AAP trainer and TAI faculty member Melissa Lehmann discuss the way that this test is uniquely positioned to identify these two issues in adolescents (and adults) and how doing so in the context of TA can help achieve therapeutic aims. Carol and Melissa's column weaves attachment theory in with TA practice, techniques, and core values. The result is a compelling illustration of the need to assess for shame and failed mourning, and how the AAP can be used for this as well as beginning a therapeutic dialogue with the client about the meaning of these issues in their world.

The second column also diverges somewhat from the typical direct focus on teaching, training, and supervising by presenting a discussion of a potentially thorny ethical issue—practicing TA in a rural community. This is one of many ethical issues that a TA practitioner might encounter. Sara Boilen discusses how she has successfully navigated the ethical responsibility of providing quality TA to a rural community in northwest Montana.

The third column is a clinically-focused piece written by Caroline Purves on the use of collaborative and TA methods in juvenile court. Caroline's years of experience in this setting come through in her description of this work and the short case vignettes included in her column.

Finally, we have a fourth substantive contribution for this issue on the Crisi Wartegg written by Jacob Palm. Jacob has been working diligently with Alessandro Crisi on the English translation of the CWS manual for some time and it is finally (to his great relief!) set to be released early in 2018. Jacob's column discusses the value of integrating the Wartegg into TA. Among the test's many qualities are the ease and breadth of administration and the wealth of information provided by scoring protocols using the Crisi Wartegg System.

2nd International Collaborative/Therapeutic Assessment Conference

I want to take a moment to recap the CTAC, which was a huge success. The conference was attended by 112 people hailing from 7 countries around the world. Nearly 50 of those presented their work—and the talks and posters were fantastic! The scientific and social events were thought provoking, inspiring, and fun. It was great to catch up with long-time friends and to meet and welcome new members to the TA community. We are very excited for the next opportunity to all get together again.

Upcoming TA Trainings

Speaking of opportunities to gather, there are a few upcoming trainings I wanted to highlight. As is usually the case, TA will be represented at the annual meeting of the Society for Personality Assessment (SPA). This year's meeting takes place in downtown Washington, DC from March 14th to 18th. There are two TA workshops being offered. Jan Kamphuis, Hilde de Saeger, and Pamela Schaber will conduct a workshop on the 14th titled, "TA in Clients with Personality Disorder." Then on the 18th, Filippo Aschieri and Francesca Fantini will conduct a workshop on "Missteps and Repairs in TA." These full-day workshops are sure to be well attended and of excellent quality so make your travel plans accordingly.

There will also be a number of symposia, paper presentations, and posters presented during the main conference on TA. We will also convene the Collaborative/Therapeutic Assessment Interest Group, which is a time where we can all get together to socialize and learn about what this great community is doing all around the world.

Also check out the upcoming international offerings, which include a week-long Immersion Course in the beautiful seaside town of Massa, Italy from June 26–30, 2018. The course is designed to allow time for participants to visit the nearby attracttions of Pisa, Florence, and Cinque Terre. It will be a one-of-a-kind professional experience.

Become a Member of the TAI

As many of you already know, the Therapeutic Assessment Institute (TAI) recently began offering membership, which gets you two issues a year of this lovely newsletter, access to the members only listserv, and discounts on trainings hosted by the TAI, and discounts on AAP trainings. The membership fee is very reasonable at $75 per year for professionals and $40 for students. Please consider joining to receive these benefits and to help support the TAI's mission.

Donate to TA

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. We currently use the majority of donations to support training for students and professionals in need of financial assistance in the form of travel and registration scholarships. We count on your generosity to be able to do this.

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: Carol George, Melissa Lehmann, Sara Boilen, Caroline Purves, and Jacob Palm.

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

Using the Adult Attachment Projective Picture System in Therapeutic Assessment

Adolescent Shame and Failed Mourning

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Attachment ensures that humans universally seek and find fundamental protection in intimate, caring relationships. Human biology is so powerful that we cling physically and psychologically to these relationships, despite potential harm and destruction. Parent-child attunement shapes the development and structuralization of right brain emotion centers; thus, early attachment relationships are the foundation of self-regulation and emotional well-being (Schore, 2001). Empathy, shame, the desire and ability to seek care from caregivers, and core features of personality and functioning are grounded in childhood attachment patterns. Mental representations of attachment gained through assessment provide clinicians with clients' personal stories and a "map" for exploring the WHY behind their questions and the other assessment results that emerge during Therapeutic Assessment (TA; Finn, 2007).

Our clients' stories may be used for protection, survival, and functionality, even if they are self-destructive or painful. One of the greatest things we can provide to our clients is an understanding of what their stories are, how they were created, and how to initiate shifts in the ways they see themselves. The understanding that we co-create in the context of the therapeutic relationship can help our clients shift from feeling they are bad or damaged to understanding ways of being or relating as "tools" they developed to cope with distress and significant disruptions in early attachment relationships.

From an attachment perspective, significant disruptions are likely traumatic, even though these experiences may not necessarily be viewed by our clients, their families, or the outside world as trauma. Attachment trauma is defined as "assaults" that threaten the integrity of the caregiving-attachment relationship or the self (George & West, 2012; Solomon & George, 2011). This view would include childhood bullying, chronic or frightening parental separation, or parents' unpredictable rage, and especially events in which parents are the source of fear or danger or fail to protect (Solomon & George,

2011). All attachment trauma, not only loss or maltreatment, must be mourned (George & West, 2012). If not mourned, trauma undermines emotion regulation and blocks our clients' abilities to trust others and function in everyday life. As clinicians, we are detectives and collaboratively uncover with our clients their personal traumas and search for meaning, understanding, and the co-creation of a new story. This co-creation requires facilitating and supporting our clients as they engage in mourning.

We describe here how we used the Adult Attachment Projective Picture System (AAP, George & West, 2012) to uncover attachment trauma and initiate mourning in an adolescent client named Zoey who was referred by her parents for a TA. The AAP is a free-response method that assesses current representation of attachment (see George & West, 2012, for complete details). Attachment classifications and mourning patterns are derived from an individual's narrative responses when asked to tell a story about the people, events, and feelings associated with seven line drawings that depict a range of attachment contexts. Attachment patterns are differentiated based on the story content and defenses revealed during the storytelling process. A description of all of the attachment patterns revealed using the AAP is beyond the scope of the current discussion. Here we focus on failed mourning, a particular form of dysregulated mourning uncovered in Zoey's AAP responses.

Zoey was 17 and a high school senior at the time of the TA. She had a history of severe depression, anxiety, and panic attacks, and her acute emotional dysregulation undermined her daily activities, such as homework, chores, and going to school. She was hospitalized in the 9th grade for suicidal ideation, the catalyst for which was severe academic stress. At the time, Zoey was socially anxious and isolated, which were chronic, long-standing feelings for her. She was bothered by how hard it was to make friends and described being severely bullied by her peers throughout childhood.

A TA of a family with an adolescent uses aspects from both the child and adult models (Tharinger, Gentry, & Finn, 2013). Parents are included in the process while at the same time the adolescent is given a sense of control and independence. The first part of the initial session involved formulating assessment questions and getting background information from Zoey's parents with Zoey present to hear her parents' concerns. They were concerned about Zoey developing the organizational and social skills that she would need in adulthood. Like other worried parents, Zoey's parents tried to disentangle her emotional and behavioral disturbances from parental defiance. Their overarching question was, "How much of this is related to Zoey's emotional state versus her unwillingness to do something?"

Zoey also had "private" assessment questions, which were generated in the initial session without her parents present, and would be kept confidential unless she decided to share them. Her main concerns addressed ongoing struggles with social anxiety, being unable to make friends, and fitting in. She revealed her overarching concerns, however, when she asked, "How can I get my parents to understand what is going on with me mentally?"

The role of attachment and relationship regulation unfolded over the course of the TA. The parent-child relationships were tense. Zoey's father, a logical man who focused on achievement and problem solving, was unsympathetic regarding Zoey's failure to complete tasks. He attributed her problems to procrastination, laziness, or playing the "victim." Zoey's mother was more sensitive to Zoey's overwhelm because of her own struggle with emotional issues. However, Zoey's mother was depressed and could also become unpredictably enraged by minor infractions

The results of the TA also revealed that Zoey was distressed and ashamed of her emotional and social difficulties. She blamed herself for many of her chronic struggles. She felt isolated and blocked from seeking understanding or comfort from her parents because they reacted to her behavior by either becoming frustrated and angry or overprotective and stifling. As a result, Zoey had become caught in a cycle of pathological shame, and was traumatized by parent abdication and failed protection, and trapped in desperate "protective" immobilization or unleashed emotional dysregulation (Finn, 2011; George & Solomon, 2008; Schore, 1998).

Failed protection is associated with the most extreme forms of attachment and emotional dysregulation (George & Solomon, 2008). Finn (2011) explained that children's developmental inability to self-regulate or tolerate the "painful disorganizing state" produced by feelings of shame creates a sense of isolation, interrupts the development of self-regulation processes, and are associated with a range of psychological problems later on in life, including depression, anxiety, and difficulties with affect regulation (see also Schore, 1998). These symptoms and behaviors had been chronic problems throughout Zoey's life.

Zoey's personality testing, including the MMPI-A and Rorschach, elucidated the WHAT – the feelings that Zoey had cut off an attempt to cope with her emotional pain. Her test results also indicated trauma. Feelings and symptoms do not develop in a vacuum. Pathological shame surrounding experience and associated affect develops in the context of attachment. Shame is co-created, and in order to address it, we must understand the relationship context in which it developed. The AAP uncovered the WHY — the nature of Zoey's attachment trauma, shame and inability to grieve.

Failed mourning is a traumatic form of attachment that on the surface appears as dismissing attachment (George & West, 2012). Dismissing attachment and the processes associated with rejecting or neutralizing attachment needs and caregivers contributes to an overarching sense of mistrust, distress, and anger that must be "cooled down" (i.e., deactivated) to be tolerable. Deactivating forms of defensive exclusion shifts attention away from intimacy, vulnerability, and the need for comfort and care; story themes emphasize rejection (i.e., pushing others away or self as pushed away), personal strength, the desire to solve problems, and the importance of following social rules and expectations. Because the AAP is not a biographical (i.e., tell me your life story) task, it has the potential to unlock trauma that may not be described in interviews. The AAP stories that evidence failed mourning demonstrate how the affect associated with trauma — fear and helplessness — are isolated and walled off for self-protection. In failed mourning, attempts to dismiss attachment are brittle; when attachment "is activated," behavior and emotions become volcanic, incoherent, and extreme (Bowlby, 1980).

The last picture in the AAP is "Corner," a scene that portrays a child facing a corner with hands extended outward away from the corner. Zoey immediately started her story by describing a "kid" who is pushing someone away (i.e., rejection). Throughout the remainder of her story, she repeatedly described the kid as being helpless and trapped, endangered, and frightened. The immediate rejection reveals Zoey's representation of self as attempting to block these feelings, pushing them away to neutralize their impact. It is here, through Zoey's own words, that we begin to see why she has developed pathological shame around her emotional pain. We described earlier how Zoey's parents overreacted; she has learned that it is risky to share painful feelings with her parents. Therefore, Zoey cuts off her feelings and her parents in order to cope.

What is Zoey's attachment trauma? What exactly needs to be mourned? It is in addressing these questions that we see how beautifully the TA process and the AAP work together. One of the tools used in TA is extended inquiry, which allows us to start talking with clients about their responses to specific tests. By asking what the clients see first, we help them make their own connections, thereby helping them increase their sense of self-efficacy and self-esteem. Helping clients "observe" what is going on is integrative, connecting left and right brain

The first picture Zoey talked about during the extended inquiry of the AAP was "Bench," a scene that depicts a lone adolescent figure huddled up on a bench. As with Corner, Zoey revealed walled off intrusive feelings of panic and isolation. This picture reminded Zoey of her hospitalization, the conditions leading up to it (i.e., suicidal ideation, frequent panic attacks) and the isolating separation from her parents she experienced during this time. For the first time in her life, Zoey openly described the hospitalization as traumatizing. She spoke about her feelings of sadness and anxiety, as well as the shame she felt for what she had put her parents through. In fact, it became clear during this discussion that nobody in her family had ever talked about the hospitalization or the effects it had on them as individuals and as a family. Zoey was isolated and left alone with the memory of the hospitalization and the pain that surrounded it, which included an immense amount of pathological shame.

It was during the extended inquiry that Zoey and her assessor began weaving a new story, helping her see how this was a traumatic experience for her, and how it had come to shape her thinking, feeling, and behavior. As Zoey began to let go of some of her pathological shame, she was able to identify and elaborate on other attachment traumas and parental failed protection, including peer bullying, her mother's depression, and her maternal grandmother's death. The experience that happened between Zoey and her assessor during the extended inquiry of the AAP illustrates how shame can, in fact, be healed in a dyadic relationship in which the "bigger, stronger, wiser, and kind" one is comforting, supportive and emotionally attuned.

The extended inquiry also paved the way for the Summary/Discussion session during which Zoey was able to understand the concept of failed mourning without shame overwhelm. She was beginning to

understand why she was the way she was in relationships. She was beginning to understand that mourning was too much to do on her own and that without attachment figure support, her perception of self and others, thinking, and behavior became dysregulated and disturbed when she emotionally aroused.

Zoey's case is but one example of our many clients whose distress is rooted in early childhood attachment relationships. The incorporation of the AAP in a TA helped Zoey and her assessor identify WHY she was feeling and behaving the way she was. The designation of failed mourning combined with the extended inquiry of the AAP helped Zoey articulate and reduce her shame by providing the relationship context for her feelings and behavior. The sessions that followed gave Zoey the "okay" to be angry and not be ashamed of her anger. These sessions also increased her parents' empathy for her difficulties and gave the whole family hope by providing suggestions about next steps and how to begin the grieving process.

This case also demonstrates that "seeing" a person's mind through the lens of a storytelling task, such as the AAP, or other projective or free response measures, can elucidate clinically relevant material that may otherwise take much longer to uncover if it is uncovered at all. Other tests in a TA battery uncover the WHAT. The AAP uncovers the WHY and gives words to our clients' personal stories that were created many years ago in early attachment relationships.

Additional Resources

For interested readers, there are published papers demonstrating the unique and central role that the findings from the AAP can play when used within a TA. Smith and George (2012) discuss the way an unresolved attachment, identified on the AAP during a TA, was impacting a woman's adaptation after entering remission for a stage IV cancer from which she was told would take her life. Smith and Finn (2014) illustrate the TA process of conducting a Summary/Discussion session with a woman judged to be unresolved with failed mourning, which was exacerbating her symptoms of OCD and interfering with her psychotherapy. Third, in the very first issue of the *TA Connection*, Tharinger (2013) illustrated the use of the AAP in the TA of an adolescent and the parents.

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Melissa Lehmann, Ph.D., received her degree in August 2008 from the Counseling Psychology program at the University of Texas at Austin. Dr. Lehmann is a founding member of the Therapeutic Assessment Institute. She is currently in private practice at the Center for Therapeutic Assessment in Austin, Texas. Dr. Lehmann is also trained in the Adult Attachment Projective Picture System (AAP) and achieved AAP coding reliability in 2006. In her current practice, she codes AAPs for other professionals from around the world. Beginning in the summer of 2013, Dr. Lehmann became a trainer of this particular measure under the supervision of Carol George, Ph.D., and Malcolm West, Ph.D., the developers of the AAP. She is certified in TA with adults.

Please email questions or comments about this column to *george@mills.edu*

Therapeutic Assessment in Rural America

Our Ethical Responsibility?

By Sara Boilen, PsyD
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I live down a dirt road off a two-lane highway that leads south to Whitefish, Montana, an idyllic

mountain town, and north to Canada. When I first moved to this road, some 15 years ago, I noticed that drivers would subtly wave their hands as I drove by. The strategy was fairly predictable – with one's hand at twelve o'clock on the steering wheel, a driver could lift a few fingers in a cordial but casual acknowledgement. The dirt road wave (as I called it), a phenomenon consistent across the region, was, as far as I could tell, a way for drivers to acknowledge one another, humanizing the driving experience and thanking each other for sharing the road.

There was an intimacy to sharing the road I had not previously experienced. Driving, I quickly realized, was not the only aspect of rural life I was unprepared for. I learned, as I trained myself to rest my arm upon my steering wheel when driving on a gravel road, that the small community in which I had embedded myself as a psychologist would bring with it fierce ethical challenges.

What began as a study in survival – neighbors who wished to be clients, clients who were friends of friends – quickly evolved into an exploration into how the ethical dilemmas facing rural America might offer a window into how we all might practice more ethically. I would suggest, as a working hypothesis, that the practice of Therapeutic Assessment (TA) provides us with a stone path amongst the ethical muck in which many of us – rural providers or not – find ourselves.

The Landscape

Montana, with a population that hovers around 1 million has approximately 240 licensed psychologists. Many of these practitioners are in the "urban" centers of Bozeman, Helena, Billings, and Missoula. This leaves huge swaths of land under- or unserved. Between the cities of Montana lie open, beautiful, rugged landscapes, speckled with sprawling farms, pastures, and dirt roads. Signs at local businesses in the autumn read 'welcome, hunters,' and there is a Cowboy church that hosts services after dusk to allow the ranchers to complete their chores before prayer. Despite the beauty surrounding the small towns, the landscape of Montana's mental health is bleak. Our suicide rate is currently third in the nation– with 25.2 of 100,000 people committing suicide annually (Suicide, 2017) – and veterans here are more likely to die by suicide than their matched peers elsewhere (Veteran Suicide Data Sheet, 2016). Research suggests that this is due to greater access to lethal means (Higher Rural, 2017), poor access to adequate health care, and what Herbert Hoover called "rugged individualism" (Sotille, 2013).

The People

There is s a saying, "The nice part about living in a small town is that when you don't know what you are doing, someone else does." Gossip, a core component of many rural communities, is a way to associate with others over common ground without revealing too much about ourselves.

While our country is facing a crisis of vulnerability and power, the Rural West has been long familiar with this formidable predicament. Montanans are frontiersmen by lineage. Those who made it far enough to stake their claim on a piece of land during western expansion are hardier than most. Rugged individualism, an ethos consistent with the forefathers of the American West, has persisted. The same mentality that drove men and women from their safe urban havens to pan for gold on the banks of the rivers or drill for oil in otherwise desolate areas, is the same mentality that shapes the modern-day ethos of every one for him(her)self (Sotille, 2013). To ask for help in Montana is to admit one is not as tough as one is expected to be. With military style bunkers, arsenals of weapons, and a boot straps mentality, Montanans in need of help are faced with the dilemma of admitting they were not as strong as their ancestors.

Montana is currently facing a major budget shortfall due to the diversion of funds to fight this summer's intense wildfire season. While Montanans are quick to request funding from Federal Emergency Management Association (FEMA), they are equally as likely to reject intrusions of the federal government. To say that Westerners have a complicated relationship with asking for help would be an understatement. The Western spirit also creates a wariness of authority. Flags proclaiming, "Don't tread on me" are a common sight in Northwest Montana. This flag, a symbol of protest of the government's overreach, reveals a central distrust for authority. The Native Americans in the region carry this distrust in spades because of their extensive history of abuse at the hands of the American government.

Thus, the cultural structure that affirms power and suppresses vulnerability persists. I recently asked a mother what had caused her to wait so long before reaching out for help regarding her abusive husband. In graduate school, we learned that abusive relationships were often hard to leave due to alienation and

isolation in addition to mechanisms of power and control. I expected an answer along these lines. Instead, she informed me that her now ex-husband maintained an arsenal of military style weapons. She feared that calling the authorities would trigger him to "go out in a blaze of glory." She tearfully explained that she didn't want to prevent her son from knowing his father. From my chair in the consultation room, it does not seem like a stretch to say that people in my community would rather risk death than be vulnerable. The line I am permitted to walk as a helping professional is thin and tenuous.

The Dilemmas

In addition to working within a cultural context different from those commonly seen in urban centers, providers in rural communities also face ethical challenges not common to their metropolitan counterparts. Frequently, these dilemmas center around preserving the dignity of our clients, which include issues of privacy, competency of the therapist, and dual relationships.

Tasked with upholding our clients' sense of dignity, providers in rural communities face a plethora of challenges that often serve to undermine our best intentions. Given the burden created by ample gossip, privacy is of the utmost importance. It is also incredibly challenging to mitigate. The building in which I see clients offers parking in rear. In a town where people are easily identified by the truck they drive, a client's identity is difficult to protect. The teller at our local bank knows my name and my profession. While I enjoy the comfort and connection this affords me, it means that she could likely tell you the name of many of my clients, simply by the inscription on the checks I deposit.

Common practice (and ethical guidelines) encourage us to mind our scope of practice and work within our competencies. As the only psychologist working with the community, I am often faced with the dilemma of turning people away – without a referral option – or learning as fast as I can to provide them with the services they require. Further, our professional community is as small and tightly knit as the larger community into which it is embedded. Thus, we tend to maintain the same characteristics of their non-professional neighbors. They are hardy, independently minded, and reluctant to ask for help. Our competency is threatened not only by our remoteness and access issues pertaining to training, but also by our own pride and stoicism.

Dual relationships are inevitable in any insular community. I have been asked to assess my husband's boss's child. I have been asked to see my dog sitter's daughter for therapy. I provide trainings at a school where my clients are employed. I have ridden the chair lift at the ski resort with former clients and once returned from the bathroom at a bar to find my spouse talking to a client I had seen for an intake that very day.

Privacy, competency (or lack thereof), and dual relationships threaten the rural provider's ability to uphold a client's dignity. Moreover, while the Western landscape and ethos complicate access to mental health, there is also a high demand for our services. With thirty people presently waiting for an assessment, my practice struggles to keep up. The demands on rural providers is often great and is frequently coupled with little access to support, training, and supervision. Navigating this complicated landscape requires careful attention to the ethical potholes scattered along the way. I suggest that on the path toward ethical excellence, particularly in rural America, one would find Therapeutic Assessment (TA) as a viable means of mitigating many of the ethical dilemmas encountered.

Therapeutic Assessment

TA is a brief intervention that uses psychological assessment to help people change their lives in positive ways (Finn, 2007). The practice is rooted in five core principles: Collaboration, respect, humility, compassion, openness, and curiosity.

Collaboration aims to engage clients in the entire assessment process, thus producing more useful and accurate results. TA clients are to be treated with respect. Assessors are the experts on the assessment instruments while clients are the "experts on themselves." By treating our clients as we would like to be treated, we hold space for their limitations, strengths, vulnerabilities, and shame. With humility, therapeutic assessors remain vigilant about their own limitations, biases, and perspectives, never failing to forget the power and limits of empathy. Therapeutic assessors develop hypotheses, not conclusions, as they aid their clients in rewriting their self-narrative. Compassion becomes the container in which the client can explore new solutions to old problems. The antidote to judgment, compassion, helps assessor remember the humanness of their clients, and their own. Finally, as therapeutic assessors, we are tasked with remaining open and curious about our clients and ourselves. (Finn, 2009). While these principles

guide professionals toward a more ethical model of assessment, I believe they also afford providers in rural and other insulated communities a path toward highly ethical clinical behavior. Koocher and Keith-Speigel (2016) proclaim "Thinking positively about ethics by aspiring to the highest professional standards should always guide our actions." Simply put, to uphold our greatest ethical aspirational guideline is to do good for our clients.

As an assessor, and as a practitioner in the Rural West, there are several likely impediments to attaining these goals. When conducting psychological or neuropsychological assessments, common ethical issues concern competence, dignity of our clients, informed consent, reliability and validity of the assessment measures, and providing feedback in appropriate terms to our clients and referral sources (Graham, Naglieri, & Weiner, 2013). In the Rural West, avoiding ethical pitfalls such as dual relationships, maintaining our clients' integrity and privacy and competence remain significant barriers to ethical triumph.

Our Ethical Responsibility

I use the case of Darlene, a 31-year-old mother of two, to illustrate how TA might guide us toward ethically sound behavior, particularly in a rural community. Darlene was referred to Sweetgrass Psychological Services by her caseworker at the Department of Public Health and Human Services DPHHS). Darlene's children had recently been removed from her home and placed with a foster family following a home visit that yielded findings of severe neglect. Darlene had experienced a Traumatic Brain Injury (TBI) following a car accident several years earlier and since that time, had struggled with executive functioning problems. Due to her injuries, and subsequent deficits, Darlene experienced impairments rendering her incapable of gainful employment. Her children had been removed from the home on two previous occasions, and her case worker was requesting a psychological evaluation to determine if Darlene could parent her children safely and effectively and what, if any, resources and assistance she would require should her children be permitted to live with her again.

Despite the debate in the psychological community about its applicability to forensic cases, I elected to proceed with a TA. My reasoning for this was two-fold. First, policy dictates that DPHHS makes "reasonable efforts" (Reasonable Efforts, 2016) to preserve and reunify parents. Second, the services in the valley in which Darlene resides are limited. Her therapist and caseworker both indicated a sense that they were stretched beyond their competencies in their efforts to aid Darlene. A TA, in my opinion, seemed like the most productive means of helping Darlene and her caseworker better understand her dilemmas while readying her for the change necessary to engage in the inevitable reunification process.

Further, while individuals around the world are often skeptical or disdainful of institutions that interfere in the functioning of the family unit, individuals in the Rural West are often incredibly wary of such intrusions. Darlene's address alerted me to her membership in a community particularly known for their disdain for authority figures. The "Canyon Critters" as they call themselves, are an informal group of anti-establishment outdoorsmen and women.

Darlene's initial skepticism and defensiveness dissolved as I implemented strategies rooted in TA principles. Within the first session, I subtly and directly demonstrated respect, humility, collaboration, and compassion. I asked that she call me Sara, instead of Dr. Boilen, while allowing her some precious moments to share some pictures of her children she kept on her phone. While demonstrating empathy, I encouraged her to become an active collaborator in the process, moving her from the role of the disenfranchised, defensive victim of the system to an active participant in her therapeutic process. Darlene quickly followed my curiosity and openness, acknowledging within the first 20 minutes her failings as a parent. In addition to her caseworker's questions, Darlene asked, "What gets in the way of me being a better parent?"

Prior to beginning the data collection phase, I reminded Darlene of the nature of the assessment, the steps we would take and the tests we would complete, and set forth to secure informed consent, or in this case (because of the court mandate) ascent. In TA, the power differential is reduced, as compared to traditional models (Finn, 2007) and I would posit that this allows for greater access to true informed consent. Again, Darlene, now committed to generating good data in the spirit of getting some answers to her questions, agreed. We proceeded with the assessment and Darlene completed a D-KEFS, MMPI-RF, the R-PAS, WMS-III, and a WAIS-IV. Additionally, I conducted observations and spoke with her mother, therapist, caseworker, and primary medical care provider.

As a psychologist, with minimal training in neuropsychology, I reached out to a colleague to under-

stand more the nature of Darlene's TBI. In other communities, I might have the liberty of referring Darlene for a neuropsychological evaluation with a Board Certified professional. In Whitefish, MT, if Darlene wanted her children back, I was her only option. Guided by the TA principle of humility, I sought consultation and engaged in some reading to bring myself up to speed.

Upon the data completion phase, I generated several working hypotheses. One of these hypotheses was that, in addition to the complex injuries resulting from her TBI, Darlene was suffering from significant depression that rendered her unable to adequately generate empathy for her children, attune to their needs, or maintain an energy level sufficient for parenting two small children. Our Assessment Intervention Session made use of the Thematic Apperception Test (TAT) story cards to help Darlene understand how her exhaustion impacted her decision making. By the end of the task, Darlene (and her caseworker who had elected to be present) came to understand a new narrative about herself. Darlene's TBI had rendered her incapable of managing daily tasks with the unconscious ease of days prior. This, combined with her significant depression, left her exhausted and depleted, often before the children had finished their breakfast. Further, Darlene helped me understand an integral piece of the puzzle. Her mother had instilled in her an ethos around never asking for, or receiving, help. As Canyon Critters, they had a long-standing mistrust for authority figures. What's more, the rampant drug abuse and domestic violence in their community left most individuals shamed, isolated, and hopeless. The shame that permeated her culture, coupled with a sort of individualism similar, but different from the ranchers with whom I had grown so familiar, dissuaded her from receiving the help she had been offered by DPHHS. The caseworkers, therapists, and in-home parent coaches had been needling Darlene's self-esteem and sense of efficacy. They were, inadvertently, causing her shame that was, in turn, worsening her depressive experience and her treatment outcomes.

We then turned back to the TAT cards to co-create a new potential narrative in which Darlene could give herself some compassion (which was overflowing in both the caseworker and myself) in the spirit of allowing herself to receive some help. By acknowledging her depression, her shame diminished. Her new narrative regarded a person with a disability (her TBI) and a mental illness, for which she needed treatment. She began to give herself some grace and shift her expectations.

The caseworker later shared that Darlene's engagement in the parenting plan and interventions offered by DPHHS had changed dramatically following feedback from the TA. The subtle resistance and lack of progress had been replaced with engagement and openness. She disclosed that their previous observations of Darlene's defensiveness had led them to believe she would not be a successful parent. By participating in the Assessment Intervention Session, she had seen a possible alternative path toward better parenting.

Discussion

The benefits of a TA in Darlene's case were evident to both myself and the DPHHS case worker. There were also benefits to me as a provider, which aid in my longevity and the sustainability of my work. While work in the forensic field of child protection can be taxing and disheartening, the outcome of this assessment left me feeling the hope so common amongst TA clients (Finn & Tonsager, 1997). In addition to the therapeutic and programmatic gains, TA provided a path toward mitigating some of the ethical risks inherent in the work I do. Allow me to review how TA, in the case of Darlene, provided me with a means of practicing more ethically.

As a provider in a rural community, I am often practicing at the edge of my competency comfort zone. TA, with its values of humility and curiosity, not only permits, but encouraged me to seek out support and approach my limits and bounds to Darlene's case without ego. We must always be careful to not become emboldened to take on that which is beyond the scope of our practice. I would suggest that if we remain humble, we are less likely to stumble into that unethical territory. This is likely because we have either received the support and supervision required or because we knew when to admit to our shortcomings. Further, with adherence to the value of humility, TA directs the forensic assessor to remember that they are human and that the objectivity and impartiality our scientific craft is, indeed, limited (Katz, 1992).

Much has been stated on the ethical conflicts faced by those conducting forensic assessments, particularly those conducting TA in the forensic setting and this is, to some extent, beyond the purview of this discussion. However, Child Protective Services has a dual mission of providing safety for children and

supporting parents (DePanfilis & Salus, 2003). To this end, TA can provide robust evaluative findings *and* readiness for change (Finn, 2007), thus wholly supporting the mission of Child Protective Services and helping Darlene and her referring professionals simultaneously.

In Darlene's case, while our vastly different social networks left me with little worry of the existence of a dual relationship, the nature of the assessment allowed for a positive dual relationship in and of itself. The collaborative model of assessment, employing humility, openness, respect, and compassion, allowed for Darlene to leave the consultation room with her pride intact and an openness between us that would allow us to sort out any future run-ins.

TA tasks the assessor with seeking out, and perhaps drawing out, the inherent strength, wisdom, and capabilities in our clients. By enlisting them in collaboration throughout the process, we reduce our clients' shame, increase their hope, and empower them to shift their narratives and/or ways of being. In the case of Darlene, once hopeless about her efficacy as a parent, a TA allowed her to acknowledge her limitations and need for support without relinquishing her pride.

In addition to the noticeable positive outcomes for the referral source and client, utilizing a TA model also may have mitigated many of the ethical threats while allowing me, as the assessor, to uphold a high ethical standard, perhaps, the ultimate ethical standard: Doing good.

Final Thoughts

"One purpose of an ethics code is to establish and maintain the viability of a profession," in this case, the practice of psychology (Fisher, 2017, p. 3). Ethics provide us with a tool by which we can measure what is morally acceptable. Ethical guidelines typically promote the fulfillment of moral obligations to do good, to avoid harm for our clients, and to treat others with respect, dignity, fairness, and honesty (Fisher, 2017). Discussions centering around ethical behavior frequently focus on infractions, violations, or abuses. However, at the core of an ethical imperative is a guide toward better behavior. Here, I have posited that to act ethically, in the field of psychological assessment, particularly in the Rural West, is to practice TA.

The research on the benefits of TA is clear: it works as both an effective means of performing psychological assessment and as a means of improving the lives of our clients (Finn & Tonsager, 1997). Clients in Northwest Montana face numerous cultural barriers to achieving mental health and accessing and utilizing mental health services. Further, geographic barriers and a dearth of providers limit an individual's access to mental health care. TA offers a model to address these impediments. By making psychological services (particularly assessment) approachable and collaborative, our clients are more likely to reap the benefits. Further, we can create change in our clients that is likely to persist and promote better outcomes (Finn & Tonsager, 1997). Finally, practicing in rural America is lonely. With few opportunities for consultation and the clinical needs of any insular community invariably challenging a clinician's competence, the principles TA offers guidelines for engaging ethically with our clients. Burnout, a real risk amongst rural providers, is mitigated by the rewards reaped by the clinician through the process of TA (S. Finn, personal communication, November 1, 2017).

In short, I would contend that TA is the "dirt road wave" of the assessment world. It's an opportunity to humanize our brethren while honoring their autonomy and staying out of their way.

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Collaborative Assessment with Adolescents in Juvenile Hall and Group Homes

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Though there are no bars on the windows, there is no mistaking the jail–like atmosphere of Juvenile Hall. The grey concrete walls, furniture bolted to the floor, and the endless maze of hallways are constant reminders of its grim purpose—incarceration and punishment. When directed to the homey–labelled 'cottages' to pick up a youth for her assessment, one

walks through gray bare corridors to a locked area which is even more like a jail than the rest of the building. This is the surrounding in which a young person awaits the psychologist, if he or she has even been told that one is coming. If the youth is being kept at home, the specter of a stay in the Hall hangs over the family like the sword of Damocles.

In the person of the psychologist, the youngster faces yet another adult who has power to judge and criticise, pry into his mind, ask painful questions and undermine yet further his already low self–esteem. Whatever defenses are in the arsenal are brought to bear so that he can manage this new challenge. The distrust of the "system" is mobilized in the face of the demands of the assessment. In these circumstances, the contributions of a collaborative or Therapeutic Assessment are particularly valuable. A subtle sense of agency along with a glimmer of hope that the mental health world does offer real help are no small gains with which to come away from an unwanted assessment.

What does using a collaborative/therapeutic approach mean? First, while Therapeutic Assessment in its fully developed form is a marvel, both to participate in and to watch, we practitioners do not always have the luxury, (i.e., the time and clients who can afford it), to follow all those elegant steps. Usually there is a two-week deadline, and secondly, the remuneration does not justify extra trips to the Hall for the feedback session. On the surface, these referrals have all the earmarks of a 'get in, do the job, and get out' 'type of deal.' But just as beauty is in the eye of the beholder, so TA is in the mind of the psychologist. My belief, born out by years of working in different settings, is that one can bring an attitude to the evaluation that honors the foundations of C/TA while working within the practical bounds that each setting demands.

I want to share a few points I have found both helpful and comforting. Some years ago, Judith Armstrong gave a talk on the shifts of balance of power created by our approach. Traditionally, the power in assessment is held by the psychologist, as recognized in a chapter by Shafer (1954) in which he describes a kind of cat and mouse game between subject and tester. Of course, there is a power imbalance, but we acknowledge it and invite our clients to, as it were, join us. Thus, it's important to be transparent to our juvenile clients, when we explain the purpose of our meeting, discuss the possible outcomes, while still acknowledging that, yes, the judge will read the final report.

Secondly, even more years ago, when family therapists were on the presentation circuit, I heard Carl Whitaker say to a family, "Let's have fun. If I'm not having fun with you, I'm not going to be of any use." Of course, he didn't mean that he was going to joke around and that it was all games. I understood it to mean an attitude that was open to possibility. To take a chance by taking seriously what the client says; to be open to different understandings of the information offered; to not be fearful of exploring and following through on what the client says and demonstrates in the testing and in the interaction.

My attitude to these ideas translated into the idea that the next few hours will be a voyage of discovery for both the youth and myself. For me, of course, will emerge the data that will allow some reasonable recommendations. For the person being tested a chance to voice some of her concerns and to learn something about herself that she may not have expected. For example, 13-year-old Crystal came to be tested from her group home. At first she barely spoke to me, adopted a tough persona and hinted that she had gang affiliations. I let her know what the social worker wanted to find out and l suggested that she come up with questions. To my surprise, Crystal eagerly said that she wanted to know why she couldn't remember what she read. When we were finished, I was able to tell her that it looked as if she did not have any neurological damage, but that the amount of marijuana she was smoking was probably affecting her short–term memory.

When working with young people in the Juvenile Justice System there are several elements working in our favor that can be used to facilitate the collaborative process. Assessment referrals are not routine. Rather, an assessment is asked for because there is some ambiguity about the case. A request for treatment recommendations, or level of control, as well as risk to the community are often the key questions indicating that there are resources somewhere that can be tapped to aid the youngster. Rarely was I asked to evaluate a young person already enveloped in a criminal career. (Though once, determined to finish a session with a high school drug dealer, the final parts of the assessment involved us leaning against his school window, outside, completing the Rorschach, which had a certain frisson of drama.) Furthermore, "Juvie "can be both terrifying or boring, so a break in the routine, even if initially scary, can be a welcome diversion!

Thus, by presenting the court's puzzle to the child some curiosity or beginning engagement can occur.

For instance, after explaining who I am, I will explain the dilemma the judge wants help with. There is no beating around the bush. If it is a question of a group home versus California Youth Authority, (i.e. jail), for example, or home versus out of home placement, the youngster is asked for her input. Often, the resistances already mentioned are in full play, so at first a mumbled "I don't know" is the response. Once the issues are on the table, no matter how little response, she knows that this is both serious and she will not be lied to. As the work continues I find that the initial comments have been heard and can be digested bit by bit. In one instance, Eduardo could barely speak to me and only mumbled when told the point of the evaluation. I had explained to him that his placement, either home or foster care, was part of the question the judge wanted some ideas about, which led to no response at all. Furthermore, he had been offered counseling several times in the past and had never shown up.

We were well into the Wechsler Intelligence Scales for Children, version 4 (WISC; Wechsler, 2003) when he stopped and said clearly. "I don't want to go to a foster home." What to do? Should one continue with the testing or stop abruptly and respond to Eduardo. His impulsive bursting of the dam of resistance seemed tenuous…if I didn't respond to the pain immediately, it felt as if the opportunity would be lost. Perhaps the door would again slam shut. On the other hand, disrupting the flow of testing could invalidate the scores. The question in my mind, then, was: who was the evaluation for, the test makers or the client. Once that was clear in my mind, we agreed to take a break, and return to the WISC in a few minutes.

At that point we were able to discuss his home life and some self–perceptions that negatively shaped his behavior. He told me that he thought that he was dumb and ugly. He was also terribly worried that his girlfriend would find someone else. We spent some time discussing this; as we had the Intelligence scale in front of us we were able to see realistically where he wasn't dumb and where his real learning problems were. He told me about his older brother who was critical of him, but whom he admired. He made it clear that he wanted to stay at home. After this was clarified, we returned to complete the testing elements of the evaluation.

At the end, I asked him how he had found our time together. He liked it. I told him he could have this every week; it was actually like counseling. He left with the thought that maybe he could give counseling a try after all.

(As a personal aside, this case was my "gateway drug" to collaborative assessment. I was in a psycho-analytic writing group with nothing to say! In desperation, I wrote about Eduardo. The group was intrigued and encouraged me to write more. I sent the resultant paper, which referenced Constance Fischer's paper, the "The Testee as Co–Evaluator" (in Fischer, 2017), for presentation to the Society of Personality Assessment where it was accepted. There I met Connie, Len Handler, and Steve Finn and found a lifelong coterie of like–minded friends.)

Van: An Unwilling Client

The following case is a rather dramatic example of how a most unpromising situation ended up with happy results for both the youth and myself. Van was referred by his probation officer to help in under-standing his criminal behavior and to come up with a treatment plan. From the beginning a pall was placed over the assessment. First a supervising probation officer told me that "the kid was really weird—don't meet with him in your office." His own probation officer warned me that he "didn't like white people; why on earth did they give this referral to you!" When I phoned to make the appointment (he was at home after having spent several weeks in Juvenile Hall), he hung up on me. His mother groaned, when I finally was able to speak with her to arrange the appointment, "Oh, no, a white lady!" So expecting the worst, I arranged for a space with colleagues nearby and set to. Van arrived with his mother, who was charming. He wasn't, pointedly refused to shake my hand and looked away. I brought the both of them in the room, assuming that she would keep some control should he become aggressive. After a few minutes of explanation, he said abruptly, "I ain't doing it," and got up to leave. That was certainly a possibility for Van, so I did not try to prevent him, but merely remarked that it was his choice. I noted that he sat back down, and while sullen, did not leave.

I took out the 'Bender Gestalt Test (Hutt & Briskin, 1960; Connie Fischer has helped me see the value of this instrument in terms of its therapeutic potential beyond its standard use) and, to my surprise, he became quite active. He also responded to my comment about how hard he was trying. We eased into the WISC as his mother watched. I noticed that Van was invested in the task. Turning to her I asked if she wouldn't mind leaving as I found it hard to concentrate with her there. She left, and Van and I

kept on working. Through his mumbled, brief replies, his fears began to emerge. I asked him why he did bad things. He said that he didn't know yet. He admitted that he wanted to live "normal" and be a mechanic. His drawing of a boy was "someone you wouldn't want to know— he's a crazy person." All this allowed for a discussion about his criminal behavior. I suggested that perhaps he should give it up, because he really was a good person inside and he was worried. He was pleased by this idea. Being talked with seriously, and insisting on some response from him seemed to create a feeling that he was someone worth considering. Then, adding to the now positive feeling, the colleague from whom I borrowed the office, (also white) came in (I have now become used to these interruptions and even welcome them.) He expressed great interest in Van, offering him something to drink. Once Van had a cup of cocoa, he really settled in. Finally, I had to send him home this boy who "hated white people." His mother phoned later to say how happy he was with the experience.

While there was not a formal feedback session and our interaction was limited to one session, there was clearly a positive, therapeutic impact on this teenager. The longer-term benefit of this approach is that by finding the hopefulness, the wish the youngster has to find another way to live his life, one can present the court with more alternatives than incarceration. He or she feels that more has been seen than just his/her "badness" or "craziness", feelings that usually fuel the resistance in the first place. They begin to have a glimmer of curiosity about their behavior because of my curiosity. I am not taking for granted the story given by the court report or whatever else has been said about them. The notion that Van was not cut out for a life of crime actually seemed a surprise to him (there were family dynamics at work here which I will not go into), and one that offered a glimpse into the self that wanted to be "normal."

Lorinda: Lonely and Bad

Now, let me give another example, one where, unlike Van, I didn't have to work so hard just to get her cooperation. Lorinda Jones was a 14–year–old girl in Juvenile Hall on charges of assault. She had beaten up several girls, either by herself or in groups, sometimes stealing their belongings, sometimes not. The referral question addressed the risk factors for the community and the type of program that would best suit her needs. Lorinda appeared in one of the interview rooms, insisting that she had not been told of the appointment, that she had never met with a "psychiatrist person" before and was worried that she might be "crazy." In fact, this family had been referred for counselling over a year ago after a previous assault charge but had never followed through with appointments. I asked Lorinda what she might want to learn from her assessment. After much hesitancy on her part, and encouragement on mine, she said. "I want the evilness to go out of me. If it go away, I be fine. I'm not sure how." The origin of this understanding of her behavior was somewhat illuminated when she described what her mother did when Lorinda got in trouble. "She prays over me. She reads the Bible to me to get Satan out." As we worked through the various tests Lorinda was forthcoming about her loneliness, some of which was self–imposed. She had to dump many friends, for example, because of their betrayals of her. It was better to be alone than to be with deceitful people. The sense of isolation from her own family was graphically portrayed when she described how they all ate dinner in separate rooms watching their own televisions. Whether true or not, her sense of bleakness was vividly conveyed.

Lorinda told me that her mother had not yet come to see her in the Hall, and that she did not want her to. (She had been there for four weeks.) If her mother came all she would do is cry, and Lorinda couldn't stand that. Here I put on my therapist hat and explored it with her. Why was it so hard to see her mother cry? Could she do anything about it, as it seemed that she really missed her? Lorinda's shame about being there, and her real longing for her mother was apparent. She agreed that I could call her mother and tell her that Lorinda would prefer her not to cry.

In this instance, Lorinda was not really interested in feedback from me. What seemed helpful was an opportunity to talk about her family, her sense of injustice from the outside world, and her feelings of sadness and loneliness. We left on good terms, and Lorinda seemed not to be quite so worried about being crazy. However, the phone call to her mother did provide the chance to give her some of my understandings of her daughter. She had gone to see Lorinda and was eager to hear what had come out of the assessment.

Mrs. Jones' first response to each idea offered was to sound puzzled and surprised. This was then followed by a corroborating statement. For example, I wondered if she had noticed that Lorinda was depressed. "Depressed?" she responded in a shocked tone. Then she began to give evidence from her own observations, such as Lorinda staying alone in the house

and not having friends. It was as if hearing her own fears expressed by someone else allowed her to recognize them. She was also able to hear that Lorinda worried about her—not wanting to see her mother cry, for instance. We talked about the failed counseling and her importance to Lorinda's well–being. She began to see other ways in which her daughter's needs had been overlooked, and how she had paid more attention to other relatives at the expense of Lorinda. For example, for many months, various cousins had been staying at their house, always sharing Lorinda's room, without even discussing it with her. A couple of weeks later, she called me asking for referrals to counselling and we discussed the pros and cons of residential treatment.

Summary

The approach that I bring to the evaluations in Juvenile Hall mirrors many of the other collaborative/therapeutic assessment thinkers. (See Finn, Fischer, and Handler for further elaboration.) For example, the work is not about reporting how someone does on various instruments—the instruments are a means for both myself and the person being assessed to get at aspects of their world that are not obvious. Their idiosyncratic responses to standardized tests can give me a clue to their thinking or emotive issues that is not otherwise immediately accessible. Part of my job is to translate these new awarenesses into immediate use for the adolescent as well as the later translation for the judge. Thus, when someone is receiving low scores on Picture Arrangement, for example, we might explore how she misinterprets what her peers are doing. In Lorinda‘s case, her suspicious mistrust of others led her to think they were attacking her. Or, it might be a lead–in to explore other career choices for kids who really can't hack it as criminals. With Eduardo, mentioned earlier, his belief that he was stupid was a beginning for him to tell me how this came about. With test data in front of us, we could counter these negative perceptions.

I do not want to give the impression that the testing procedures are compromised by the rather meandering approach. Once a test is underway, we abide by the rules. The built–in structure contributes to lessening the anxiety, and for the oppositional youngster, gives them something to fight other than the assessor. And it is the rare person who does not feel a sense of accomplishment upon completion of a test. My belief is that she will enjoy being challenged, and will do her best. It is unusual that a youngster will not respond to the respect implicit in this attitude. For example, I recently worked with an 11-year-old boy who was in the Juvenile Hall shelter located in a city neighborhood. After an hour of temper, crying, and refusal, once he finally got going, he tried his hardest to do well, and was very interested in his results. What strikes me as the essence of this way of thinking, is making a true connection with the client, and using this connection for our mutual benefit.

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Caroline Purves, Ph.D. At age 14, after reading *Can This Marriage be Saved*, by Dr. Paul Popinoe, in the

Ladies Home Journal, I decided to become a psychologist—the one where you don't have to go to medical school! I took the Honours course at the University of British Columbia in Vancouver, and then moved to Berkeley, CA where I earned my Master's at San Francisco State College (as it was then). Deciding I had had enough of classes, I worked as a master's level psychologist running a local Head Start program and seeing children at a special school for youth diagnosed with ADD. In London, I studied at the Tavistock Clinic for 2 years and ended up working at Roffey Park, an old mansion in the country where folks with neurotic disorders and work-related problems were treated at the expense of the National Health Service! LSD was one of the meds they were offered. My job was to do the short assessments. After my children were at the beginning of their school lives, I went back for my doctorate at the California School of Professional Psychology. Since then I have had a very general practice, both in Canada (the only psychologist in the phone book in Nanaimo, B.C.) and Berkeley. My love of assessment grew, and once in the C/TA fold, I became a staunch advocate, which position I hold dearly even in my "retirement stage" of development!

Please email questions or comments about this column to ***cpurves@earthlink.net***

Testing Without an Eraser

Integrating the Wartegg Drawing Completion Test with Therapeutic Assessment

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American educator John W. Gardner is said to have remarked, "Life is the art of drawing without an eraser" (Radmanesh, 2006, p. 269). Dr. Gardner used these words while speaking on the topic of personal renewal, risk-taking, interpersonal vulnerability, compassion, overcoming obstacles, and active self-discovery—all endeavors that allow an individual to continuing writing his or her personal story in an active and growth-promoting manner (Gardner, 1990). This sentiment resonates well with the tenets and goals of Therapeutic Assessment (TA), including shared bi-directional learning between client and assessor, self-evaluation and empathy, collaborative vulnerability, and use of the assessment process to begin rewriting a client's personal story (Finn, 2007). While there are many tools available to clinicians to facilitate these goals in the course of TA, the Wartegg Drawing Completion Test (WDCT) is particularly well-suited to the processes of creation and self-reflection, insight-development through metaphor and shared language, and empathy magnification. In fact, the simple task of drawing without an eraser—a requirement for those completing the WDCT—magnifies the vulnerability and self-empathy of the client from a process perspective, just as the assessor's personal vulnerability and empathy for the client is magnified through genuine engagement in the TA process; that is, as much as our clients are changed by the work undertaken collaboratively, we as assessors are also changed by our clients and the process of collaboration; if we allow ourselves to be, and "test without an eraser". In both cases, Dr. Gardner's quotation appears an apt reflection on the personal and shared self-discovery that can occur in TA work utilizing empirically validated and sensitive tools.

While use of the WDCT is growing, it remains less well known to many clinicians as compared to other performance-based personality measures. The goal of this article is to provide a brief overview of the WDCT, as well as an introduction to the normed, standardized, and empirically validated method of scoring and interpretation created by Dr. Alessandro Crisi, the Crisi Wartegg System (Crisi, 1998, 2007). Next, integration of the WDCT into collaborative and therapeutic assessments will be briefly discussed. Last, updates on developments in the Crisi Wartegg System, including the publication of the English-language test manual and upcoming clinical training opportunities will be provided.

The Wartegg Drawing Completion Test

The WDCT, known historically as the *Wartegg Zeichen Test*, WZT, or simply the Wartegg Test, is a

semi-structured, graphic, performance-based personality test. Created in 1926 by German psychologist Ehrig Wartegg (1897-1983), the first text related to the test was published by Wartegg in 1939, and the first test manual in 1953. Belgian humanistic psychologist Mariam Kinget (1952), who first brought the WDCT to the United States, asserted, a "merit of the test lies in the fact that the material used does not threaten the subject by the strangeness of its appearance or by its emotional implications, but rather appeals to him by its simple and neutral character" (p. xiv). Schwartz (2016) further reflected, "…myriad clinical examples of the usefulness in under-standing individual personality adds to the potential useful-ness of this curious and interesting new (old) measure" (p. 12).

Despite first appearing in United States publications in the 1950's, the WDCT has remained mostly unknown to psychologists in North America until quite recently. However, it has a long and rich history of use throughout the world, and is currently widely used in Northern European countries (i.e., Sweden, Finland, Denmark, Norway), Germany, Spain, Italy, Japan, and South America. In these countries, the test is widely used in the field of clinical evaluation, occupational selection, and educational and vocational screening and placement.

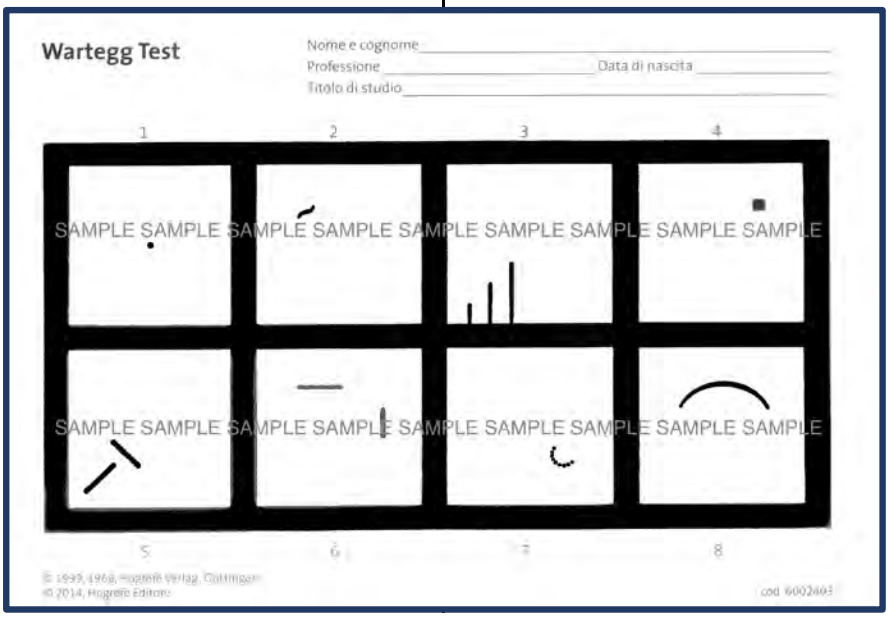

Figure 1. Sample Wartegg Test

While several versions of the Wartegg Test exist, the most common consists of eight boxes, labeled 1 to 8, displayed in two parallel rows, with each row consisting of four boxes. Each box is delineated by a thick black margin and contains a unique graphic stimulus or "mark" (see Figure 1). The client is asked to make a drawing in each box that incorporates the mark, avoids abstract designs, and "means something." Most clients, regardless of age, immediately grasp the instructional set and engage in this disarmingly simple art task in a non-defensive manner. Following completion of the drawings, the examiner asks the client to describe what has been drawn in each box, as well as to select which drawings and marks he or she likes most and least. On average, administration of the test requires only 10-15 minutes, can be used with children as young as 5 years old, and is appropriate for use with individuals demonstrating cognitive or developmental delays, speech or hearing reductions, or language challenges (Palm & Crisi, in press-a).

The Crisi Wartegg System (CWS)

The Crisi Wartegg System (CWS), which emanated from Crisi's years of research and clinical experience with the Wartegg (including collection of over 3,000 Wartegg and Rorschach tests for comparative purposes), is both a scoring and normative interpretive system akin to scoring systems dev-eloped for the Rorschach Inkblot Test. Client responses are scored across a wide range of variables at the graphic, verbal, and conceptual le-vel. In creating the CWS, Crisi established a standardized administration procedure, collected a large normative sample, researched reliability and validity, and developed a computerized scoring system (see Crisi, 1998; Crisi, 2007).

CWS codes are similar to those found in Rorschach scoring systems, including Form Quality, Popular responses, Content Categories, movement responses (both human and inanimate), and Special Scores related to morbidity, personalized answers, and thought disturbance. The CWS further adds two additional unique scoring elements, Evocative Character (a client's response to the "pull" of each stimulus) and Affective Quality (a standardized rating of the positive, neutral, or negative valence of client responses). Following standardized scoring, several pages of ratios, percentages, and indices are computed which allow for comparison of the client's performance to the normative sample in personality, emotional, and functional domains. From this normative interpretation approach, description of the client's ego functioning, cognitive processes and org-

anization, reality testing, personality integration, consistency of motivation and energy, approach to social relationships, and affective functioning can be generated.

In considering the CWS guidelines for the WDCT, several benefits of the test have been noted. First, test instructions are easily understood by examinees of all ages and cognitive abilities, making it a useful test for assessment across the lifespan (both child and adult norms are available), including with those who demonstrate cognitive or developmental delays. Second, the WDCT is quick to administer, with most subjects completing the test in 5–10 minutes. Third, the WDCT provides exceptional clinical efficiency, able to be scored in approximately 10–15 minutes by a proficient examiner, and taking only 30 additional minutes for interpretation. Fourth, a computer-scoring program is available to facilitate reliable calculation of scores and indices (*Istituto Italiano Wartegg,* 1997, 2013). Fifth, the test may be administered in both individual and group administration formats (Crisi, 2014). Sixth, the CWS has demonstrated effectiveness in a variety of settings including utility in screening and identification of the need for further assessment (for review of research on use in screening, see Palm & Crisi, in press-a). Seventh, the WDCT is particularly useful in cases where other performance-based measures yield coarcted or overly defensive protocols. As no-ted above, the simplicity of the test stimuli oftentimes circumvents examinees' defenses. Last, the WDCT is less affectively overwhelming for most clients, compared to other performance-based measures of personality, lending itself well to most assessment situations, including TA (Finn, 2014).

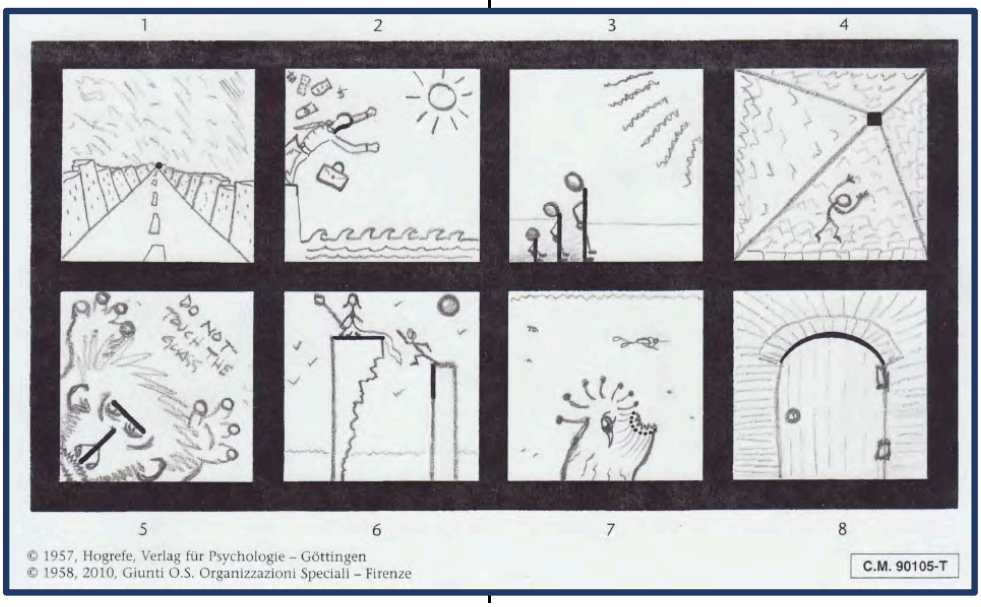

Figure 2. Completed Wartegg Test

Concerning psychometrics, a meta-analysis of 37 Wartegg studies from various countries established preliminary evidence for the validity of the measure (Soilevuo Grønnerød & Grønnerød, 2012). It should be noted, however, that CWS was included in only one study in this meta-analysis, given that the majority of CWS research has historically been conducted and published in Italian. When the complete body of three decades worth of CWS-related research is considered, as summarized in the upcoming English-language manual (see Palm & Crisi, in press-b), the CWS demonstrates well-established interrater reliability, adequate test-retest reliability, and convergent validity with other measures (including the MMPI-2, Rorschach, and Adult Attachment Projective Picture System). Moreover, as Finn (2014) wrote, the incremental validity of the Wartegg lies in its power to access the internal world of clients without emotionally overwhelming them, and is particularly helpful for children or clients with severe emotional regulation challenges.

Integration of the CWS into TA

As discussed above, the graphic quality of the WDCT and the creative process of drawing facilitate easy integration of the Wartegg into TA. This is particularly the case in considering the common TA practice of "Extended Inquiry," a process in which clients are asked to reflect on produced test materials as related to their personal assessment questions (Finn, 2007). The CWS has been noted as especially effecttive in this intervention given the client's direct role in the production of their drawings, the evocative nature of the stimuli, the ease of drawings in the creation of metaphor, and the simple, non-thr-eatening nature of the test (Crisi & Palm, 2016). Per Crisi (2011), it is the evocative nature of drawings as metaphor that allows deeper understanding of a client's personality and internal world, as well as the presence of psychopathology. As described by Palm (2017), this is true for several reasons. First, the built-in imagery contained in graphic drawing tests that

lends itself well to the metaphorical manner of conceptualization widely used in TA. For example (see Figure 2), the illustration of "*A scuba diver. He is swimming in a lovely setting and a very beautiful large underwater sea creature is coming out of the depths… most likely to drown him.*" In Box 7, the WDCT box closely related to intimacy in relationships; or *"This is an ape-type man obviously, looking out from a window with his fingers and hands plastered to the glass. The sign says: DO NOT TOUCH THE GLASS"* in Box 5, the WDCT box related to integration and regulation of aggressive energies and anger, yielded powerful thematic and visual concepts with which to raise insight and build resonance with the process of assessment in a particularly defended and depressed physician. Moreover, as the client has produced the images by his or her own hand, they are less likely to dismiss or disregard the produced content. Rather, the imagery must be considered an extension of the self, and therefore, personally relevant. That is, where it may be easy for some clients to deny earlier responses on the Rorschach, for example (stating, "It looks exactly like that," "I just didn't know what to say," or "I don't see that anymore!") it is much less common (or even impossible) for clients to offer these distancing or minimizing statements in reference to Wartegg drawings. It is hard to deny what you have produced yourself!

Additionally, the imagery in the Wartegg lends it-self well to cre-ating a common language or "sh-orthand" specific to the client and the assessment, which then wea-ves a thread of connectivity thr-ough the remainder of the assessment pro-cess; this may include future Extended Inqui-ries with other measures, language and metaphor used in feedback sessions, and power-fully personal verbiage integrated into and inspiring written materials, including therapeutic letters, stories, or fables. For example, in the published case of Pippa, the client wrote of a therapeutic letter written by Dr. Crisi, "I've been giving a lot of thought to the Wartegg boxes and to the letter you shared with me. I'm amazed with his assessment of my drawings and the accuracy of what he said has unfolded gradually." (Engelman, Allyn, Crisi, Finn, Fisher, & Nakamura, 2016, p. 371).

Developments in the Crisi Wartegg System

Over the past five years, interest in the CWS has grown, with six English-language training sequences completed during that time. Additional resources have been put in place for English-language users of the measure, including on-going consultation groups, individual clinical consultation opportunities, online scoring assistance in English, and development of English training materials. Most importantly, the second edition of Crisi's Italian-language CWS Manual has been translated, adapted, and expanded for English-speaking clinicians (Crisi, in press) and will be available to clinicians for purchase in early 2018.

The process of adaptation is a complex mix of translation, creation, and cultural considerations, including adjustment of content and presentational format to reflect cultural learning styles, focus on clinical utility, and analysis of the needs and expectations of the intended audience. In this case, the process of adaptation further included creation of two new chapters, the first providing a contextual history for the CWS (Chapter 1, as it is less well-known to English speaking clinicians), as well as thorough review of three decades of reliability and validity research, most of which is previously unpublished in the English language (Chapter 2). The remainder of the manual provides step-by-step administration, scoring, calculation, interpretation, and conceptualization guidelines, presented in the order in which clinicians will typically utilize the measure. These chapters contain new examples of clinical cases to assist clinicians in applying the material to their daily work. In addition, seven appendices provide relevant statistical information (including review of statistics related to the CWS normative samples and analyses of the Order of Sequence), as well as other relevant data. To facilitate ease of use, two appendices at the conclusion of the manual present scoring tables for each of the eight primary scoring categories contained in the CWS, and interpretive tables with applicable normative ranges. Information related to purchase of *The Crisi Wartegg System (CWS): Manual for Administration, Scoring, and Interpretation* is provided at the conclusion of this article.

In addition to published resources, several opportunities to learn more about the CWS are upcoming. First, Crisi and Palm will facilitate a full-day workshop at the 2018 Society for Personality Assessment (SPA) Convention in Washington, D.C. titled, "An Applied Introduction to the Crisi Wartegg System." In this workshop, participants will learn administration of the measure, review statistical foundations, become familiar with major scoring categories, review clinical examples, and take the Wartegg for themselves! Additional symposia and papers focusing on the CWS will be offered at SPA, including a symposium on the use of the CWS in C/TA Extended Inquiry presented by Palm, Pamela Schaber, Finn, and Crisi (originally presented at the 2nd International

Conference on Collaborative/Therapeutic Assessment, September 2017, Austin, TX). In terms of formal training sequences, a new CWS Level 1 training (3 days) will begin in April 2018 in the San Francisco Bay area. For more information on this training sequence, please contact the author.

Conclusion

In conclusion, the WDCT provides the clinician a novel tool to engage with clients, foster courageous creativity (in the absence of Gardner's "eraser"), circumvent a client's defenses, and enter into his or her internal world. The act of drawing allows the creation of shared experience, fostering self-discovery, collaborative engagement (and vulnerability), and the re-writing of personal stories. With the standardization of the CWS, the qualitative aspects of the drawing process are made quantitative, balancing the art and science of assessment. Given the Wartegg's efficiency, applicability to multiple populations, smooth integration into TA, and increasing availability of English-language resources, training opportunities, and publications, it is a useful addition to the clinician's arsenal of assessment tools… and with all those advantages, why would you need an eraser?

To purchase *The Crisi Wartegg System (CWS): Manual for Administration, Scoring, and Interpretation,* visit Routledge publishers online at: https://www.routledge.com/The-Crisi-Wartegg-System-CWS-Manual-for-Administration-Scoring-and/Crisi-Palm/p/book/9781138566880.

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Author

Jacob A. Palm, Ph.D., is a clinical psychologist and founder of the Southern California Center for Collaborative Assessment in Long Beach, California. Dr. Palm earned his doctorate at Fordham University, and completed his internship training at The Guidance Center, a community mental health center providing services to underserved children and families in Southern California. Dr. Palm maintains an assessment-focused practice, utilizing the collaborative/therapeutic assessment model, with children, adolescents, adults, couples, and families. He is on staff at both Miller Children's Hospital (Long Beach) and Hoag Presbyterian Hospital (Newport Beach). Dr. Palm integrates collaborative assessment approaches into his work with various agencies, including the Professionals Treatment Program-Santa Monica, where he conducts evaluations with impaired professionals; the Gateway to Success Program at Alhambra Unified School District, where he supervises doctoral interns; and the Hoag Neurosciences Institute, where he provides assessment services to the multidisciplinary "Teen Brain" team. Dr. Palm is the United States representative of the *Istituto Italiano Wartegg,* training and consulting with clinicians in the use of the Wartegg Drawing Completion Test (according to the Crisi Wartegg System). He is the English adaptor of the upcoming publication, *Crisi Wartegg System (CWS): Manual for Administration, Scoring, and Interpretation.*

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

Photo Album

Above: Members of the Asian-Pacific Center for TA and guests, at dinner after the highly successful workshop in Tokyo, November 2017, on "Working with Shame in Psychological Assessment and Psychotherapy." Left to right, top row: Naoko Ogura, Hisako Nakagawa, Noriko Nakamura, Toshiko Sato (student helper), Sho Yabugaki, Seiji Mabuchi, Mikako Ohzeki, Masamichi Noda, Mitsugu Mirakami, Yasuko Nishida; bottom row: Tamami Kumagai (translator), Shin-ichi Nakamura, Julie Cradock-O'Leary, Hal Richardson, Judith Reyes, Arnold Reyes, Tomoko Miwa (translator), Mitsue Tomura, Sachiyo Mizuno.

Above: Steve Finn giving the opening presentation at the 2017 CTA Conference in Austin, TX, entitled, "Let Down Your Tap Root: Leonard Handler's Enduring Contributions to Therapeutic Assessment."

Left: Jacob Palm, Raja David, and Filippo Aschieri at the 2017 CTA Conference in Austin, TX.

Right: A roundtable discussion at the 2017 CTA Conference in Austin, TX entitled, "How to use TA in the real world: Integrating TA into various settings." Left to right: Julie Robinson (just her left arm, sorry!), Margaret Lanca, Tracy Zemansky, Hilde de Saeger, Casey O'Neal, Lindsey Hogan, Raja David, and Pamela Schaber.

Recent Publications in Therapeutic/Collaborative Assessment

Aschieri, F., Chinaglia, A., & Kiss, A. (2017). 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.), *Using the Rorschach Performance Assessment System* (pp. 158–184). New York: Guilford.

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Upcoming Trainings in Therapeutic Assessment

March 14, 2018: Washington, DC

Title: "Therapeutic Assessment in Clients with Personality Disorder"
Presenters: Jan Kamphuis, Hilde de Saeger, & Pamela Schaber
Sponsor: Annual meeting of the Society for Personality Assessment
Schedule: 8:00 AM – 5:00 PM
Information: www.personality.org/annual-convention/general-information/

March 18, 2018: Washington, DC

Title: "Missteps and Repairs in Therapeutic Assessment"
Presenters: Filippo Aschieri & Francesca Fantini
Sponsor: Annual meeting of the Society for Personality Assessment
Schedule: 8:00 AM – 5:00 PM
Information: www.personality.org/annual-convention/general-information/

April 28, 2018: Tokyo, Japan

Title: "Using the Early Memory Procedure (EMP) in Psychological Assessment and Psychotherapy"
Presenters: Stephen E. Finn
Sponsors: Asian-Pacific Center for Therapeutic Assessment and Therapeutic Assessment Institute
Language: Japanese
Schedule: 9:00 – 18:00
Information: asiancta@gmail.com

April 29–30, 2018: Tokyo, Japan

Title: "Using Psychological Tests as Doors into Clients Lives: The Extended Inquiry Technique"
Presenters: Stephen E. Finn, Noriko Nakamura, and members of the Asian-Pacific Center for Therapeutic Assessment
Sponsors: Asian-Pacific Center for Therapeutic Assessment and Therapeutic Assessment Institute
Languag: Japanese
Schedule: 10:00-17:00 (4/29) and 9:30-16:00 (4/30)
Information: asiancta@gmail.com

June 26-30, 2018: Massa, Italy

Title: "Immersion Course in Therapeutic Assessment with Adult Clients"
Presenters: Stephen Finn and faculty of the TAI
Sponsor: European Center for Therapeutic Assessment and the Therapeutic Assessment Institute
Location: The Immersion course is held on the seaside, at the Casa per ferie del Sacro Cuore, with a private beach for participants
Schedule: Tuesday, Thursday, & Saturday 8:30 AM – 4:00 PM; Wednesday & Friday 8:30 – 12.30
Optional excursions: Attendees and their guests can elect to visit nearby Pisa or Cinque Terre on Wednesday and Friday afternoons and Florence on Sunday for the entire day
Language: Lectures will be in English (with translation into Italian); videotapes will be in English or in Italian with English subtitles; role-play groups will be in English and in Italian.
Information: filippo.aschieri@unicatt.it

Below: The beautiful private beach in Massa.