THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

Volume 12 Issue 1
Spring / Summer 2024

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TA Trainings Past and Future!

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One advantage of being the editor of *The TA Connection* is I have my finger on the pulse of TA related trainings, and 2024 may be the year of the most offerings ever. During the Society for Personality Assessment Annual Conference, there were nine C/TA presentations. At The International Society for the Rorschach and Projective Methods Congress in Copenhagen this July, there are eight. In addition, the TAI has offered monthly trainings and at the inaugural R-PAS conference in May there were opportunities to learn about the utility of the Rorschach in C/TA. It is exciting that interest in TA continues to grow and that there are so many opportunities to learn.

This leads to 2025 and the…

4th International Collaborative/ Therapeutic Assessment Conference

The TAI is thrilled to announce that dates are set for the 4th International Collaborative/Therapeutic Assessment Conference (CTAC)! We will meet June 12-14, 2025, in-person in Salt Lake City, Utah. Details are coming together, but the conference will be held at the University of Utah and is co-sponsored by The University of Denver Graduate School of Psychology and the Society for Personality Assessment (SPA). There will be some virtual offerings and some sessions will be translated for our international participants. On June 12th, there will be several half- and full-day workshops offered. On June 13th & 14th, there will be a plethora of presentations, symposiums, and posters. This will be a great opportunity to build your TA skills and connect with colleagues. As we get further organized, information will be shared through the TAI listserv, website, and our co-sponsors.

This Issue

Over the past couple of years, research on the efficacy of TA and collaborative assessment practices has grown incrementally because of Fillipo Aschieri and his colleagues' good work. Fil has written the first of two articles that summarize recent TA research. Often TA assessors need to demonstrate to workplace administrators the value of TA, so decisions can be made about assessment practices and policies. This article will help such professionals quickly grasp the most recent literature.

Second, Serena Messina has written a lovely article demonstrating how she used The Early Memories Procedure (EMP) to help shift a client's Internal Working Model of attachment. Serena presented this case at the 2024 Society for Personality Assessment Annual Conference, and it is a touching example of how exploring clients' memories can be an avenue for change.

Third, Abby Hughes-Scalise and I have pulled together our TAI presentation on somatization and dissociation in adolescents. This article is a must-read for TA assessors working with teens, as it is a resource for understanding how these issues can be both assessed and understood from a systemic conceptualization. The clinical case demonstrates how shifts can be made in the family system through both the individual and family Assessment Intervention Sessions.

TA Trainings

This past spring, the TAI offered monthly offerings on shame, systemic conceptualization, anti-racist assessment practices, the Millon Adolescent Clinical Inventory–II, and somatization and dissociation in adolescents. It was an exciting training season, with hundreds of participants attending. While we are on our summer break, we plan additional monthly trainings this fall. As described in the *Upcoming Trainings* section, there is a host of offerings at the International Rorschach Society Conference this July in Copenhagen.

Become a Member of the TAI

The Therapeutic Assessment Institute (TAI) began offering memberships in 2017 and currently has close to 300 members. Membership in the TAI gets you two issues a year of *The TA Connection*, access to the members-only listserv, discounts on trainings sponsored by the TAI, and discounts on Adult Attachment Project (AAP), Wartegg Drawing Completion Test (WDCT) Crisi Wartegg System (CWS), Rorschach Performance Assessment System (R-PAS), and workshops offered through the Minnesota Center for Collaborative/Therapeutic Assessment (MNCCTA). The membership fee is very reasonable, at $75 per year for professionals and $40 for students. Please consider joining to receive these benefits and to help support the TAI's mission.

The Leonard Handler Fund

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

Donate to TA

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

Future Issues of the TA Connection

The fall 2024 edition of The TA Connection will be focused on the use of the Rorschach during a TA. If you have an idea for an article, please reach out.

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

Therapeutic Assessment: A Review of Supporting Evidence (Part 1)

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The aim of this column is to provide a brief recap of research findings related to Collaborative/Therapeutic Assessment, summarizing results from three meta-analyses aggregating quantitative, randomized controlled trials investigating: (a) the effects of providing feedback to clients, (b) the positive impact of broadly defined collaborative assessment interventions; and c) the impact of TA as a specific approach.

Review of recent research literature also includes quasi-experimental repeated-measures single case studies, with different clients showing a variety of presenting problems, and qualitative, cross-sectional within-subject studies exploring the subjective experiences of participants to TA. Quasi-experimental, repeated measures single-case studies, and qualitative research designs will be covered in the Fall 2024 issue of *The TA Connection*.

The first meta-analysis from Poston and Hanson, published in 2010 in *Psychological Assessment,* investigated the therapeutic efficacy of psychological assessment procedures. It analyzed data from 17 published studies, encompassing 1,496 participants. The primary focus of the analysis was to examine the impact of psychological assessment as a therapeutic intervention, with the impact of personalized and collaborative feedback specifically considered.

The authors (Poston & Hanson, 2010) screened for studies published in English-language peer-reviewed journals that employed experimental designs suitable for calculating Cohen's d effect sizes, and that measured some aspect of therapeutic benefit, whether related to treatment processes or outcomes. The definition of therapeutic benefit was broad, encompassing any dependent variable designed to demonstrate potential client improvement or enhanced therapy process.

The researchers then conducted a systematic literature search using relevant keywords in the PsychINFO database, with their review occurring between September 2008 and February 2009. Poston and Hanson (2010) identified and included 17 studies published between 1954 and 2007, ensuring a diverse and representative sample. The researchers then coded various study characteristics, such as the type of dependent variable, research design, and effect size calculation method.

The meta-analysis revealed a significant overall effect size (Cohen's d) of 0.423, and approximately 66% of participants in the treatment groups demonstrated higher mean scores compared to control and comparison groups (Poston & Hanson, 2010). The meta-analysis included subgroup analyses based on categorical variables. Significant treatment effects were found for therapy process variables (d = 1.117), therapy outcomes (d = 0.367), and combined process/outcome variables (d = 0.547).

The authors concluded, based on these results, that psychological assessment procedures, when integrated into therapeutic interventions with personalized and collaborative feedback, have clinically meaningful effects on treatment outcomes (Poston & Hanson, 2010). Considering these results, this first meta-analysis highlighted the importance of incorporating assessment feedback practices into therapy and has implications for assessment practice, training, policy-making, and future research in the field.

The second meta-analysis reviewed for this article was performed to assess the effect of collaborative assessment methods (CAMs) in general (Aschieri et al., 2023). CAMs included clients' involvement in formulating the goals of the testing, collaborating with clients to expand the understanding of their results, and articulating new ways of understanding clients' presenting problems based on a shared understanding of their testing results. CAMs research included studies on the "bare bones" of assessment (e.g., testing and

some form of test feedback with therapeutic intent) as well as studies that examined the efficacy of a full model of assessment based on CAMs (i.e., aligning to TA).

In May 2021, a comprehensive search was conducted across PsycINFO, Web of Science, and PubMed databases, focusing on articles related to *assessment utility, Therapeutic Assessment, collaborative assessment, test feedback, assessment feedback, and test interpretation*. The search was restricted to studies involving adults and publications in languages known to at least two authors (English, French, Dutch, Italian). Additionally, an informal search was carried out based on recommendations from selected scholars and references of other seminal studies (Aschieri et al., 2023).

To be considered for inclusion in the meta-analytic review, studies needed to meet several criteria: (a) they must have evaluated Collaborative Assessment Methods with adult clients, excluding articles involving children and adolescents; (b) they must have assessed a form of psychological CAMs, excluding articles focusing on somatic or neuropsychological settings; (c) they must have been published in peer-reviewed journals, excluding dissertations, conference presentations, and book chapters; (d) they must have employed a suitable between-group design for calculating Cohen's d effect sizes, excluding studies without a control or comparison group; and (e) they must have measured therapeutic benefit or outcome in a clinical sample, excluding studies conducted with healthy students. Moreover, studies considered for the meta-analytic review were required to (f) use authentic test data, indicating that the data were derived from actual test interpretations rather than pre-canned statements (Aschieri et al., 2023).

This meta-analysis incorporated findings from 10 studies, comprising a total of 70 effect sizes and involving 444 patients (Aschieri et al., 2023). Among these, seven studies contributed 27 effect sizes with a participant pool of 320 for treatment process outcomes, while seven studies provided 32 effect sizes with a sample size of 332 for symptom-related outcomes. Additionally, five studies offered 11 effect sizes, representing 264 participants focused on personal growth outcomes. In total, 221 individuals engaged in CAMs interventions, while 223 were part of control or comparison groups.

Results demonstrated a notable medium effect size concerning treatment process ($d = 0.59$, $p = .021$), indicating a meaningful association between CAMs and a more favorable treatment process, as evaluated through client-reported post-session assessments, in contrast to the control condition (Aschieri et al., 2023). Also, a significant small effect size was observed regarding symptoms ($d = 0.19$, $p = .036$), implying that engagement in CAMs corresponded with symptom reduction compared to the control condition. Lastly, a significant small-to-medium effect size was identified concerning personal growth ($d = 0.42$, $p = .017$), indicating that CAMs fostered personal development to a greater extent than the control condition. Of interest, moderator analyses indicated that the level of structure included in the intervention (TA versus CAMs), clients' age, gender, or ethnicity, sample type, number of sessions, quality of the study, and time between CAMs and assessment did not moderate the effect of CAMs, with the exception of a greater effect of CAMs than TA on client's treatment process variables (e.g., alliance, hope in treatment, motivation for treatment). However, the authors warned that this observation is based on a limited number of studies, with only two exploring Collaborative Assessment and eight examining TA, potentially affecting the precision of the effect size estimate for Collaborative Assessment and suggesting that differences could be attributable to variations in study populations or other inherent characteristics of the studies rather than solely the disparities between the methods themselves.

The authors concluded that "based on this meta-analytic review, CAMs, consisting of on average 2.7 sessions (range from 1 to 4 sessions), exert significant positive distal effects on treatment process, patient symptoms, and personal growth compared to a control condition" (Aschieri et al., 2023, p. 364), suggesting that assessors should consider 1) employing CAMs which typically yield positive effects on distal treatment processes and outcomes; 2) encouraging clients to articulate personal questions related to their assessment and tailoring the assessment to align with their goals; 3) involving patients in interpreting assessment findings and providing collaborative feedback; and 4) utilizing test results collaboratively to assist clients in developing a more accurate, compassionate, and useful self-perception.

The third reviewed meta-analysis, which captures more closely the effects of TA as objectively defined (Fantini et al., 2023), was published by Durosini and

Aschieri in 2021. For this study, the literature search was carried out in February 2020. Relevant studies were initially identified through the analysis of PsycINFO and PUBMED using *Therapeutic Assessment, collaborative assessment, test feedback,* and *assessment feedback* as keywords in the title and abstract of the studies. After consulting with Stephen Finn, Ph.D., to identify the variables that define "what TA is," the authors included identified studies: 1) involving the administration of at least one standardized test or psychological measure; 2) where assessors provided individualized, collaborative feedback to clients; 3) including clients with intrinsic motivation for the assessment; 4) documenting structured supervision, formal training, or detailed procedure descriptions; 5) including at least one of the following elements from the TA model: collecting clients' Assessment Questions, using Extended Inquiry or Assessment Intervention Sessions, providing feedback structured according to Finn's Levels of Information, providing oral or written feedback, or involving the client's larger system.

Durosini and Aschieri (2021) analyzed three types of effects of TA, pertaining to the effect of TA on treatment process (e.g., alliance, motivation for change, trust in treatment, and duration of treatment), the degree of symptom reduction among clients through TA (e.g., clients' demoralization, as well as self-reported internalizing and externalizing symptoms), and Clients' Self-Enhancement (e.g., clients' self-awareness, empathy, self-esteem, and self-efficacy).

Regarding the treatment process, the dataset included six out of nine studies and encompassed 18 dependent variables. A random effects three-level analysis revealed a statistically significant medium-to-large effect size (Glass *g*) of .46, with a 95% confidence interval of [0.33; 0.59] and $p < .001$. This indicates that TA leads to increases in variables such as alliance, motivation for change, trust in treatment, and length of stay in treatment (Durosini & Aschieri, 2021).

For the effect of TA on clients' symptoms, the dataset comprised six primary studies and 17 non-independent effect sizes. Analyses demonstrated that TA has a statistically significant small-to-moderate mean effect size ($g = .34$, 95% CI [0.06; 0.63], $p = .021$) on clients' symptomatology. There was substantial heterogeneity of effect sizes among studies, and moderator analysis indicated that TA provides a booster effect in reducing client symptoms, particularly when integrated with longer treatments (Durosini & Aschieri, 2021).

Regarding TA's effect on clients' self-growth, the dataset included five out of nine studies and seven dependent variables. The random effects three-level analysis demonstrated a statistically significant small-to-moderate effect size ($g = .37$, 95% CI [0.05; 0.69], $p = .029$), suggesting that TA positively affects variables, such as self-esteem, self-awareness, and empathy for others (Durosini & Aschieri, 2021).

Of interest, none of the additional moderator variables were influential on the effects of the intervention. Contrary to expectations, variables such as the overall length of the TA, the presence of supervision, and the clinical conditions of clients (i.e., inpatients or outpatients) did not increase its effect (Durosini & Aschieri, 2021).

In summary, the authors stressed these results indicate that TA, properly structured, is a resilient and effective intervention approach as these results were attained in three or

fewer sessions, including one session for the administration of testing, which does not include formal therapeutic interventions.

In conclusion, what can assessors and clinician "bring into their office" from these studies? My impression is that the main implications of these results are:

1. Strive to intervene on the client's personal stories using tests, and whenever the context allows is (i.e., when there are no forensic complications in the assessment) provide compassionate and coherent feedback to clients, with the aim of helping them understand themselves more.

2. The most visible outcome of using tests collaboratively may not be a change in clients' presenting symptoms; rather, a solid therapeutic alliance with the assessor and a change in how clients experience themselves may be more evident. Of note, a lack of change in the "level" of client's symptoms might not even be the primary goal of the assessment itself (Aschieri et al., 2023). Rather, the assessment generally helps clients to use their symptoms as "ostensive clues" of how other, deeper and more profound issues are being addressed.

3. There is still relatively little we can identify about "how" these changes are produced by assessors

doing Collaborative and Therapeutic Assessment. More information about these aspects can be drawn from studies which use different research designs (i.e., case studies and qualitative research). At this time, a systematic and empirical research on change mechanisms of TA has not been carried out and there is a relevant lack in the literature surrounding this aspect of our work.

I hope that once this gap is filled, the TAI could build a committee and evaluate TA through the lens of the Tolin Criteria (Tolin et al., 2015) as a candidate to be included in the list of Empirically Supported Treatments.

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Author Bio

Filippo Aschieri is an internationally renowned expert in the field of Collaborative/Therapeutic Assessment. He has extensively lectured on the use of the Rorschach and projective methods in Europe, the United States and Latin America and has written the two most relevant meta-analytic studies about the effects of Therapeutic Assessment (Durosini & Aschieri, 2021, in *Psychological Assessment*) and of Collaborative Assessment methods (Aschieri et al., 2023, in *Psychotherapy*). He has also co-authored the recently published manual of Therapeutic Assessment (Fantini et al. 2022, edited by Routledge). He serves as an Associate professor in Università Cattolica del Sacro Cuore, and he is the Director of the European Center for Therapeutic Assessment in the same University. For the International Society of the Rorschach, he serves as the Editor-in-Chief of *Rorschachiana*.

Superman Will Save Me: Working on Attachment and Social Anxiety through the Early Memories Procedure

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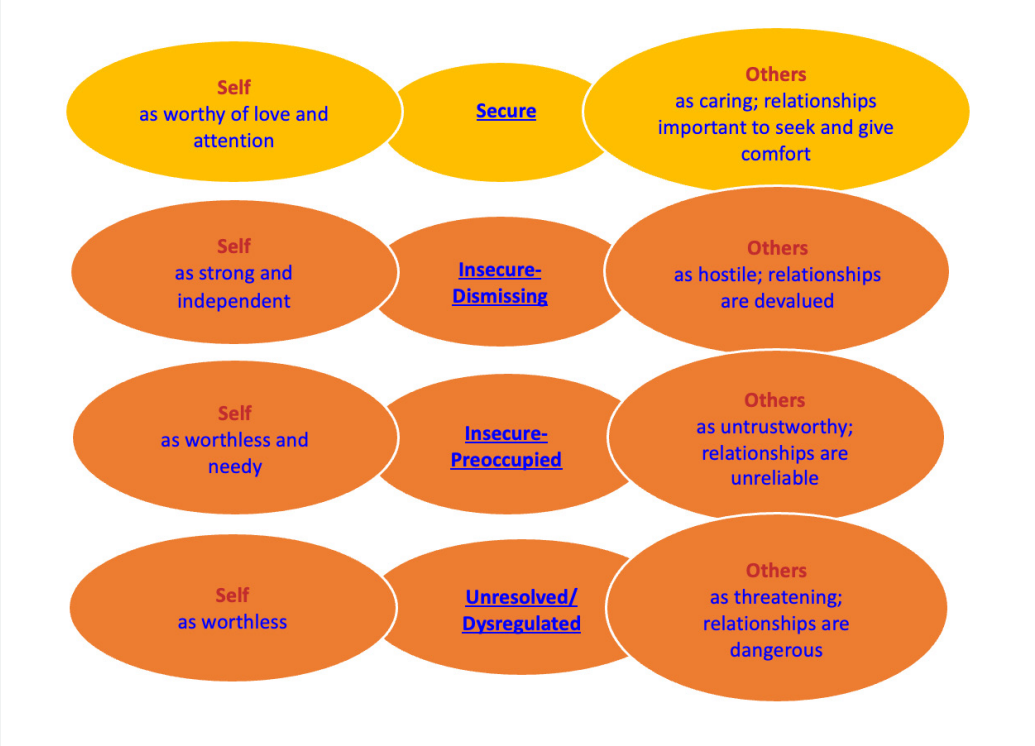
In Italian, we have a saying: "Il primo amore non si scorda mai" (You can never forget your first love) . Attachment theory definitely embraces such a saying, as this approach underscores how early interactions with our caregivers (our first love) shape the way we think about ourselves and our relationships, thus significantly affecting later emotional functioning.

To explain this mechanism, attachment theory refers to Internal Working Models (IWMs) of attachment, which are representations of the self, others, and the way relationships work. Attachment IWMs are created based on the internalization of repeated interactions with caregivers. IWMs allow children to know what to expect from their caregivers, and to develop adaptive strategies to preserve closeness to them. Such representations are fairly stable over time as they influence the selection and storage of social information. Individuals whose caregivers were "good enough" had their attachment needs of protection, safety and love mostly met during their childhood. Consequently, they came to view themselves as worthy of attention and love and relationships as a source of support. These are the hallmarks of a secure attachment, which makes individuals more resilient in the face of distressing events and more able to seek help from others when they need (Mikulincer and Shaver, 2016; Thompson, 2016). On the other hand, individuals with an insecure model of attachment had to develop different strategies to cope with emotional distress on their own, because their caregivers were unable to provide consistent, sensitive care. Figure 1 shows the main features of the IWMs of attachment

Figure 1: Internal Working Models of Attachment



in regard to self-perception, perceptions of others, and view of relationships. It is common for individuals to display features of different IWMs of attachment, but in moments of distress, they tend to adopt consistently prevalent strategies to cope with emotional pain.

There comes a point when the strategies that individuals developed to function within their early caregiving environment do not serve them well anymore. This is when clients seek help to understand and address issues with their self-view, with their relationships, and with intimacy. Our work as clinicians and assessors often revolves around helping clients frame their problems in these areas through their attachment history, so that they can gain self-compassion and an appreciation for the reasons these issues came to be.

Exploring autobiographical memories is a fundamental path to uncover the origins of our clients' attachment models, as well as the coping strategies associated with these models. With such a goal in mind, I have been struck by how the Early Memories Procedure (EMP, Bruhn, 1992a, 1992b) can be an effective and time-efficient technique to gather information about our clients' attachment history and to start a process of change in our clients' IWMs. Santas (2023) and Turret (2015) illustrated how the EMP is a powerful tool to foster therapeutic change in clients, particularly in the context of TA. I have used the EMP with many clients, but it was with a client I will call "Lance," that the EMP as an attachment intervention really came to light for me. Since then, I have been more intentional about using the EMP within an attachment perspective.

The EMP prompts clients to produce their earliest memories and assess these memories on two Likert scales, one about clarity (from very unclear to exceptionally clear) and one about the emotional tone of the memory (from very negative to very positive). According to Bruhn's (1992a, 1992b) Cognitive-Perceptual theory, the clients' early memories can be viewed as the product of a creative process within the individual, with the goal of reminding the self what work is most pressing. The memories that the client deems as the most negative and clear are believed to represent what Gestalt theory calls "unfinished business," or sources of current internal conflict and pain. Memories that are evaluated as most positive and clear represent clients' coping strategies and situations when their emotional needs were met. Bruhn believes these memories do not refer only to an isolated specific event, but they are also "screen memories" of interactions that might have happened many times in the clients' lives.

Issues around intimacy, need for support, and emotion regulation are often part of the "pressing work" (Bruhn, 1992a, 1992b) and they are rooted in our clients' attachment history. For this reason, although the EMP is not a test of attachment, it often produces memories that shed light on a client's attachment wounds. Our clients' positive memories, on the other hand, show ways in which clients address their needs. Such positive memories frequently illuminate the adaptations that clients developed to survive within their attachment landscape and how they still use these strategies with their current significant relationships.

Clinical Case-Lance

I will now describe my experience using the EMP with Lance. Personal details have been deidentified but his memories are reported verbatim.

Lance sought treatment to address anxiety, irritability, and a lack of focus. The psychiatric medications he was taking did not seem effective at improving these issues. He was a 40-year-old Caucasian straight white male who lived with his partner and worked in the tech industry. Lance appeared as a handsome, muscular, and successful man. He had a loving partner and was well respected by his colleagues. He enjoyed his job but was often excessively worried about his performance and dwelled for days on any feedback that he perceived as slightly negative. In social situations, Lance struggled to be present and was often consumed by concerns about the way others perceived him. Large gatherings and meeting new people were particularly painful for him, and Lance often avoided these situations. His social distress caused conflict between him and his partner, who enjoyed participating in social events. Another significant cause of conflict, was related to Lance's tendency to become angry and withdraw whenever he felt emotionally distressed. Lance was invested in his relationship and wanted to change this pattern of behavior but felt incapable of acting differently.

Lance grew up with his parents and an older brother. His mother was very emotionally volatile, which caused stress for the whole family and, in particular,

to Lance's father, whom Lance perceived as stable and reliable. Lance's parents divorced a few years before Lance started therapy. The divorce was highly conflictual, and Lance stayed close to his father and became estranged from his mother. Therapy lasted for two years and was conducted virtually because of Lance's busy schedule.

This was Lance's first time working with a therapist, and although he did not know what to expect, from the very beginning he was motivated to better understand the behaviors and thought patterns that were creating distress in his life and specifically in his partnership. A significant source of Lance's emotional pain was related to strong self-blaming thoughts that were triggered whenever he worried about negative feedback from others (whether real or imagined), when things did not go as expected, or when he did not act as he would have liked to. I quickly realized that building self-compassion was going to be the first important step in our work. I started by adopting an Acceptance and Commitment Therapy approach (ACT, Hayes; Strosahl, & Wilson, 2012), as I believed that the emphasis on accepting thoughts and feelings with an open mind while gaining distance from them could be beneficial for Lance. In line with the ACT theory, I wanted to help Lance see his struggles in a more compassionate way, while focusing on his values and the type of life he wanted for himself. Lance resonated with the idea that thoughts are stories we create about ourselves and successfully executed ACT exercises to acquire some distance from his thoughts. However, when on his own and in the heat of the moment, Lance struggled with the emotional impact of the self-blaming thoughts and with believing that these thoughts could be accurate. At this point, I decided to explore the origins of Lance's negative thoughts, thus working more intentionally from an attachment perspective. To do so, I asked Lance to complete the EMP.

Lance's Early Memories

Lance was motivated to engage in the EMP task. I expected him to complete it without feeling excessively overwhelmed, so I asked him to do the EMP at home on his own. During the following session, I explored with Lance his experience of the EMP. He shared that at the end of the task he was surprised by some of the memories that came to his mind. I commented that his sense of surprise was a sign of how open he was in approaching the task, as well as his authentic desire to better comprehend himself.

As mentioned above, when working with the EMP, the clearest most negative memory and the clearest most positive memory are particularly important, as they point to sources of distress (and possible attachment wounds) and coping strategies in our clients' lives, respectively.

Given the importance of clients' clearest and most negative memory, I often begin discussing the EMP from that memory (see Box 1). I start by mentioning the memory and asking the client to share more about it, to see if the client will add relevant details, and to observe the feelings that the client experiences while talking about the memory.

Box 1: Lance's Most Negative Memory

I remember I was in middle school, and we had just finished physical education. We went to the locker room and some of the other male students started to team up against me. I had no idea why, but after I was beaten by some of them, I realized it was because of my weight. My eyes were filled with tears, and I was trying my hardest not to cry. After I changed clothes, I went to my next class and acted like nothing happened.

What is the clearest part of the memory?
The physical beatings.

What is the strongest feeling in the memory? What thought or action is this connected with?
Anger, confusion, depressed, retaliation. How people perceive me.

If you could change the memory in any way, what would that be?
For me to have stood up to them and made them feel the same way.

Your approximate age at the time of the memory?
11 or 12

My conversation with Lance was as follow:

Serena: *So, Lance, I noticed that your clearest and most negative memory is your fourth memory, which describes a situation when you were a victim of bullying in middle school. Can you tell me a bit more about that memory?*

Lance: *Middle school was terrible for me…That was such an awful period in my life…I was overweight and other students bullied me all the time. That time was one of the worst…*

Serena: *That must have been so hard for you… I can see how many painful feelings you have related to that memory, and they all make sense to me. I, too, would feel angry, depressed and unsure about what to do in such a scary situation.*

Lance: *Yeah…I wish I had been able to stand up for myself…but I wasn't that type of kid then*

Serena: *I can see that you really wished you were able to defend yourself. You wrote this also in the test, when the test asked how you would like to change your memory.*

Exploring this memory from an attachment perspective proved to be instrumental in helping Lance develop a more compassionate narrative about himself and start intervening with his IWMs of attachment. Some questions that I find useful to investigate memories from an attachment point of view are:

1. Does the memory depict an attachment need? If so, what is it?
2. What is the view of the self that is implied in the memory?
3. How are others seen?
4. What is the strategy used to cope with emotional distress?

Using this framework to analyze Lance's memory, I hypothesized that Lance was describing a strong (and unaddressed) need for protection and safety, one of the most important attachment needs. I also made inferences on some important features of Lance's IWM of attachment. This memory suggested that Lance may have viewed himself as powerless and lacking agency. He described himself as unable to react to the bullying and to take action to protect himself in the moment and later on. His memory is colored by feelings of shame. The shame is evident in the way Lance referred to his weight and his inability to stand up for himself *(I wish I had been able to stand up for myself…but I wasn't that type of kid then*).

Other parts of the memory illuminated how Lance perceived others, who were seen either as dangerous as the bullies or at best unsupportive (there is nobody that noticed what was happening and nobody to whom Lance reached out to share his traumatic experience). Lance viewed relationships as something that could not be relied on in moments of emotional distress. His descriptions suggested a *dismissing* attachment strategy, which dictates that he is the only one who can take care of his emotional needs. Thinking about Lance's memory from this point of view, I was struck by how well the memory explained his current way of functioning. It made sense why Lance was hypervigilant to any possible negative feedback and worried about the way others perceived him. Being disliked had been dangerous for him in the past! It was also clear to me why it was hard for Lance to be open with his partner when he was upset. Lance learned that relationships are not a place to seek comfort and he had to rely on himself.

Based on these hypotheses, I worked with Lance and his memory to shift aspects of his IWM of attachment related to his sense of self. I started by helping Lance *get into the shoes* of his 11-year-old self, who was victimized by a group of peers. I tried to address Lance's shame and helplessness by exploring the idea that being passive in that moment may have been a survival strategy and standing up for himself could have been a dangerous choice. Lance seemed able to take in some of this perspective, and I hoped he was building self-compassion, and his feelings of shame would be decreased.

Serena: *You were 11 or 12 then, right?* (Lance nods) *What do you think would have happened if you had tried to say something or hit back while these students were beating you up?*

Lance: *Uhm…I was 1 and there were 5 of them…and nobody else was in the locker room…I don't think I could have made them stop…and maybe they would have hit me even more.*

Serena: *Uhm…I think so too. I wonder if in that moment, standing up for yourself could have been even more dangerous.*

Lance: *I guess probably so.*

Serena: *So maybe standing up for yourself could have made things even worse in that moment.*

Lance: *Yeah…that's true.*

It is paramount when working with clients' IWM of attachment, to first focus on building compassion and understanding for these models that are affecting our clients' behaviors and causing distress. The next step in the exploration of Lance's memory was to *plant the seeds* for a shift both the strategies Lance assumed needed to be used to address his attachment needs and his view of relationships. To do so, I first helped Lance acknowledge his attachment need of protection and support. I asked Lance, "Can you think of any other way to change this memory?" but he was unable to formulate a response.

Lance had trouble getting in touch with his attachment needs, and it might have been too painful to let himself feel the depth of pain connected to the lack of protection and support. When this happens, I try to activate the client's caregiving system, and ask them to think about someone in their life in a similar situation; someone whose attachment needs the client may more easily identify. If the client is a parent, asking about what they would like their child to do in a similar situation is often a good way to accomplish this result. Lance did not have children, but he was close to his brother's son, Jack, who was attending 5th grade. So, I asked him to imagine that Jack was going through the same bullying experience.

Serena: *If something like this happened to your nephew Jack, what would you like him to do?*

Lance: *Oh, I'd want him to tell his parents…or me…or maybe a teacher at school*

Lance seemed ready to recognize that it would be good and important to share such traumatic experiences with a trusted and supportive adult.

Serena: *Yeah, I think that would be good, telling something like that to an adult. Seeing if anybody could help. Did you tell anybody about what happened?*

I was hinting here at the idea that wanting support is the expected and healthy thing to do, as solving things on his own would not have been realistic or possible. Sadly, asking for support was not an option for Lance.

Lance: *No. I just tried hard not to cry and not to let anybody know what happened* (Lance becomes teary). I *didn't like any of my teachers…and my parents…my mother, you never knew what she would do…and my dad…he was too stressed with my mom* (Lance starts silently crying)

Lance's tears indicated that some of the pain from his attachment wound around feeling so deeply unsupported was coming to the surface. I tried to strike a balance. I did not want Lance to feel too overwhelmed with painful emotions, but I also wanted to ask about his pain, to show that I noticed it, and to provide an *emotionally corrective* experience, a time where for once he was not left alone with his emotional distress.

Serena: *How are you feeling right now?*

Lance: *This is hard…I feel so stupid, but this memory comes to my mind often.*

Serena: *This is so painful for you. It must have been so scary, and you were feeling alone and overwhelmed. You were just a child and needed someone protecting you.*

Lance nodded in agreement and slowly his crying subsided.

As demonstrated, I validated Lance's need for protection and described his attachment wound, giving words to his feelings and helping him mentalize his emotions. This seemed to have a soothing effect on Lance, who slowly stopped crying and appeared more settled. From a countertransference perspective, I felt a wave of tender feelings towards Lance because he presented as such a successful person, and yet there was so much vulnerability and suffering underneath that façade. I was also struck by how powerfully haunting this memory was for Lance.

To help Lance process the memory and cope with the painful feelings associated with it, I worked with him on developing an *internal secure base*, a place in his mind where he could feel safe and soothed. Individuals with a secure attachment developed an internal secure base as the product of the interactions with their caregivers during childhood. Sensitive caregivers can acknowledge and soothe their children's emotional distress. The child, in turn, learns from these interactions how to comfort themselves and acquires the confidence that emotions do not need to be suppressed but can be faced. Further, for securely attached individuals, emotional distress feels more manageable, as

they assume that if the distress is too overwhelming the significant relationships in their life will offer relief and support. Lance did not have this experience growing up, and so I explored with him if he could envision feeling protected and safe by imagining a different ending to his memory. This way of helping clients develop self-regulation skills through imagining a soothing attachment figure is often employed by clinicians working within an attachment perspective, and it is at the center of approaches such as the *Ideal Parent Protocol* (Brown & Elliott, 2016).

Serena: *I know you did not have anybody supporting you at the time, but sometimes it is helpful to imagine a different ending for a painful memory, even if we know things didn't go that way.*

Lance: *A different ending…like what?*

Serena: *What about an ending in which someone comes and helps you? Someone stronger and protective?*

Lance: *I really cannot think of anyone who could have helped me then.*

It was hard for Lance to imagine a supportive figure during his childhood, which highlighted his experiences of a lack of emotional support. Lance could not conceive of a world where an adult in his life would have come to help and soothe him; it just did not feel like a remotely possible option. I felt a bit stuck. I believed that imagining a more soothing ending for his memory would have been beneficial for Lance in order to cope with the feelings that the memory evoked in him. On the other hand, if I created an alternative ending and just "fed it" to him, the process would have felt inauthentic and ineffective for Lance. So, I went a slightly different route. If nobody from this world could have helped him, could Lance imagine receiving protection from an entity that was not of this world? I had this idea based on my experience working with clients who struggle with recurrent nightmares. I often ask such clients to imagine a different ending for their dreams where someone comes to rescue them. Since these are dreams, clients often find it soothing to imagine spiritual or fantastic entities coming to save them. These experiences inspired me to try a similar strategy with Lance, who could not imagine a human helping him, but could picture a superhero.

Serena: *You know, I get it, at the time there was nobody that was supportive to you. I can see why you said that was the hardest time in your life! If you cannot think of a real person, you can make up one. It could be a person, or even an imaginary character.*

Serena: *You know, this is silly, but I was really into Superman at the time, I wish he could have come and scared the crap out of those guys!*

Serena: *That is perfect! I want you to close your eyes and imagine you are in the locker room. These students are about to beat you up but BOOM! Superman is right there. What does he do?*

Lance: *Oh, he will be right there next to me, grab these guys by the collar one by one and throw them out of the window! And tell them to never bother me again!* (Lance smiled)

Lance and I spent time exploring how this new ending made him feel. He appeared to enjoy this conversation, which made me hopeful that he was slowly starting to feel soothed, less alone, and less powerless when facing difficult emotions.

What Happened Next?

The work Lance and I did with this memory proved instrumental for him. In the following weeks, whenever this memory came back to his mind, or whenever he was about to face socially stressful situations, Lance thought about Superman coming to protect him. This both amused him and gave him some sense of peace. Once he felt calmer, Lance was more able to use the ACT techniques that we practiced together and he had an easier time distancing himself from his self-blaming thoughts.

Although this was certainly Lance's most significant memory for our clinical work, exploring his other EMP memories was also very effective. For example, he was surprised by the first memory that came to his mind, which was his most positive memory (Box 2). Lance had a difficult relationship with his mother, and little recollection of positive interactions with her when he was a child. Delving into this memory, Lance realized he may have experienced some emotional closeness with his mother, although fleeting. He became curious about events that may have affected his mother's mental health and decided to reconnect with her, though with infrequent contact. Through these realizations, Lance developed a more nuanced view of his parents. As he became more able to acknowledge

the lack of emotional support he experienced during his childhood, with my help, he also became able to express both anger and compassion for each one of his parents.

Little by little, Lance started building an internal secure base, which gave him some confidence that he could cope with his emotions without shutting down. Lance also started allowing himself to experience important people in his life as a secure base and a source of support. Without my prompting, Lance opened up with his brother about his work in therapy and his childhood struggles.

Box 2 Lance's Most Positive Memory

I was maybe 3 or 4 years old. We were at my grandmother's house on my mom's side. My grandmother has a bench swing in her backyard and my mother was holding me, cradling me and singing a song. I don't remember the specifics of the song. I just remember her singing and the swing moving forwards and backward.

What is the clearest part of the memory?
My mother holding me and the swing moving. She seemed happy at the time.

What is the strongest feeling in the memory? What thought or action is this connected with?
That I was happy and so was my mother. One of the few times I remember her being happy.

If you could change the memory in any way, what would that be?
I wouldn't because it's one of the few good memories I have of my mother.

Lance's brother reacted by sharing some of his own emotional difficulties during childhood, difficulties Lance was not aware of. As a result, Lance felt less alone with his experiences and closer to his brother. Lance also shared his internal struggles with his partner, who gained a better understanding of the reasons he withdrew during moments of emotional pain. While his partner showed more patience and compassion towards Lance's defense mechanisms in moments of distress, Lance felt ready to practice new ways of reacting, and slowly was more open with his partner when he was upset.

My work with Lance highlighted how the EMP can be a powerful tool to foster therapeutic change in our clients' internal attachment representations. The memories that emerge during the task (and the healing that the process sparks), can become "anchors" that clients call to mind whenever their IWMs are activated in order to cope with their painful affects in a more adaptive way. The EMP is effective because it is both an intellectual and an emotional enterprise for the client and the clinician. On an intellectual level, the clinician and the client are working as a team, using the power of their left brains to investigate aspects of the client's past that may contribute to the client's current functioning. At the same time, the clinician and client are also experiencing an emotional connection, as learning about the client's early memories helps the clinician feel closeness and compassion towards the client. The client, on their side, feels the support of a secure base when the clinician validates and holds their painful emotions. This allows the client to start creating a secure base in their mind. After all, we will probably never forget our first love, but we can definitely grow from it.

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Author Bio

Serena Messina, PhD works as a licensed psychologist in Austin, Texas, practicing TA and therapy with children, adolescents, families, and adults. She is certified in the Adult TA model, and she offers therapy and assessment services in English, Spanish, and Italian. She has published peer-reviewed articles and chapters about attachment, psychopathology, assessment, and trauma. Serena gave national and international presentations on attachment and related assessment measures, as well as risk and protective factors for emotional wellbeing, from an attachment perspective.

When the Body Tells the Story: Understanding Dissociative and Somatic Presentations in Adolescent Assessment

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Julia was a 17-year-old, cisgender female who presented with a high level of dissociation that was confusing to herself, her therapist, her parents, and eventually me (Raja) when I was conducting a TA with her. I consulted with Abby, because I knew she specialized in somatic and dissociative experiences in children and adolescents, and our conversation was enlightening. I recall after our discussion thinking, "Every clinician needs to understand these elements of dissociation, somatization, and how family dynamics can be contributors to this type of clinical presentation." That conversation was the impetus for our presentation of the same title (Therapeutic Assessment Institute, webinar, February 23, 2024), and this article.

We begin by defining and describing key terms and associated issues to ground the reader in the dissociation and somatization literature, and how to conceptualize these symptoms when conducting psychological assessments. Next, ways to evaluate and measure dissociation and somatic symptoms are described, including the utility of commonly used broad-based measures as well as discrete measures of these symptoms. Next, Julia's case is presented to illustrate how these ideas were incorporated into her TA to build insight and understanding, and to help her parents better understand how to shift contributing communication patterns in the family. Last, we describe some of the current best practices for treating these issues.

Dissociation and Somatization Defined

Dissociation is conceptualized as an inability to integrate consciousness, memory, or identity into one's awareness of the present moment (American Psychiatric Association [APA], 2022). Symptoms can present in several ways, including: loss of time (amnesia), having "out of body" experiences (depersonalization), or feeling as though one is still dreaming, despite maintaining awareness that one is awake (derealization). Unlike psychotic symptoms, in which an individual might actually believe that their spirit has left their body, the individual experiencing dissociation is aware of a disconnect between the sensations they are experiencing and what is actually occurring. While dissociative symptoms are commonly associated with trauma, dissociation can be considered transdiagnostic (Ellickson-Larew et al., 2020), and occurs in a variety of psychiatric disorders, including eating disorders, somatic disorders, substance use disorders, and depression (Lyssenko et al., 2018). Dissociative experiences are common in adolescents, with up to 45% of adolescent psychiatric inpatients meeting criteria for dissociative disorders in a recent study (Goffinet & Beine, 2018). Experiencing dissociation is associated with increased risk of psychiatric comorbidities (Bozkurt et al., 2015), self-harm (Tanaka et al., 2024), and family dysfunction (Thayyil & Rani, 2020).

Somatic symptoms can be understood as prominent physical symptoms, such as chronic pain, physical weakness, or shortness of breath, which are distressing to the individual and typically do not have a clear medical origin (APA, 2022). In a recent population-based study of 2,476 adolescents in Sweden, 22.7% of adolescents reported experiencing persistent distressing somatic symptoms, and nearly half of those adolescents reported significant associated psychological distress (van Geelen et al., 2015). Somat-

ic disorders in adolescents are also on the rise in the United States, with a recent national study showing a prevalence rate of 8.2% for chronic pain (Groenewald et al., 2020). Adolescents who experience distressing somatic symptoms are at an increased risk of comorbid pathology (van Geelen et al., 2015) and being admitted for hospital-based psychiatric care in adulthood (Bohman et al., 2018).

While somatic and dissociative symptoms are often thought of as distinct experiences, somatic symptoms in functional neurological symptom disorder (FND; APA, 2022), formerly known as conversion disorder, can be conceptualized as "somatoform dissociation" (Nijenjuis, 1998). In FND, it has historically been hypothesized that the body converts emotional distress into physical symptoms, in order to protect the self from aversive feelings and memories that are too difficult for the individual to confront (LaFrance et al., 2018). Recent research further asserts that these difficult events lead to biological changes in the physical management of stress (e.g., changes in cortisol or heart rate variability), and that these changes underlie an individual's vulnerability to experiencing conversion episodes (Cretton et al., 2020). FND can range from physical tremors to temporary paralysis to non-epileptic seizures (APA, 2022). Importantly, FND episodes share common characteristics with dissociative episodes: both involve an individual's perceived lack of control over their physical functioning, and in some instances, amnesia during the episodes.

Centering Dissociative and Soma ic Symptoms: Case Conceptualization

When conceptualizing the shared features of somatization, FND, and dissociation in psychological assessment, physical causes of these symptoms must be ruled out. Following this necessary step, an important diagnostic consideration is the extent to which the client is aware of the connection between their psychological stress and their physical symptoms. For example, in illness anxiety disorder, the client is keenly aware of the connection between their mild physical symptoms and their health-related anxiety (APA, 2022). However, in somatic symptom disorder (SSD), awareness is less strong. The client often asserts that their somatic symptoms are the only reason for their distress, and if the somatic symptoms dissipate, their mental health symptoms would improve. However, research suggests that psychological factors such as health anxiety, catastrophizing, depression, and a strong self-image of bodily weakness all contribute to the development of this SSD (Limburg et al., 2017). As such, a narrow focus on improving physical symptoms does not fully alleviate the mental and emotional distress of SSD, and a psychological approach is needed.

Clients with FND or dissociative disorders typically demonstrate the lowest awareness of a connection between their physical symptoms and their emotional distress. In these presentations, physical symptoms typically represent an unwanted, difficult, or intolerable emotional life (LaFrance et al., 2018). As certain emotions are outside of the client's awareness, the stress is instead experienced physically to protect the client from awareness of those unsafe feelings. Many assert that trauma underlies the experience of certain feelings staying outside of one's awareness. However, the most common pre-stressors for teens who present with FND or dissociative disorders are related to school and family life (Fang et al., 2021). Family conflict, parental divorce, learning problems, school refusal, and bullying are common. During an intake, the teen may state that these types of stressors are occurring but will often fail to recognize that these stressors are affecting them emotionally. They will instead become overattentive to their somatic and dissociative symptoms. Assessment and treatment of these symptoms is further complicated by the family, who are often inadvertently rewarding the teen's expression of physical distress at the detriment of the client's emotional well-being (Thayyil & Rani, 2020).

One consequence of not fully experiencing one's emotional life is a diffuse sense of self, (Krivzov et al., 2020). Identity development is a cornerstone of the adolescent period (Broderick & Blewitt, 2020), and as such, difficulties with connecting to one's sense of self during this time are especially concerning. This diffuse sense of self has multiple presentations in the context of dissociative and somatic symptoms, from meeting criteria for dissociative identity disorder (APA, 2022) to presenting with a "sick child" identity, where the individual has no sense of self beyond their somatic experiences (Tharinger et al., 2022).

Clients with primary FND or dissociative symptoms also report actively concealing feelings that arise, with an emphasis on presenting as "fine" and not generating more distress for others (Moyon et al., 2021). Fur-

ther, these clients perceive others as unreliable and/or unavailable in their support, and in response, attempt to meet the needs and expectations of others to maintain relationships (Krivzov et al., 2020). As such, these clients often present as people-pleasing, exerting themselves beyond their capacities and to the point of exhaustion to engage in exaggerated and compulsive caretaking. They are also more vulnerable to repeated victimization across home and school contexts (Kouri et al., 2024).

Dissociation and Somatization: Psychological Assessment Tools

It can be difficult to effectively identify dissociative and somatic symptoms in a psychological assessment. Dissociation and somatization are often mis-labeled as symptoms of some other form of pathology. For example, instead of seeing dissociation, clinicians may assume that the client is experiencing inattention associated with ADHD. A second example might be that instead of seeing somatization, clinicians label the client's experience as representative of panic symptoms associated with anxiety. Further, individuals who present with dissociation and somatization often assume that the cause of these symptoms is medical, and as such do not recognize their episodes as a potential indicator of psychological distress. Many clients initially present in a neurologist's office for help. They rarely discuss these symptoms at length during a psychological assessment, particularly if medical tests to determine the cause of these episodes are ongoing.

Dissociative and somatic symptoms are not typically screened for in the beginning stages of a psychological assessment, though recent research suggests early screening of these symptoms may be beneficial given their transdiagnostic nature (Ellickson-Larew et al., 2020). Depression and anxiety are frequent differentials in context of adolescent assessment, and self-report mood screeners for these symptoms are commonly included in an assessment battery. However, if an adolescent is presenting with primary dissociation or somatization, mood screeners will typically show minimal elevations. This is in line with the client's active suppression of emotion, and the client's lack of understanding that their emotional life is being converted into physical distress (LaFrance et al., 2018). If elevations on depression screeners do occur in the context of primary dissociation or somatization, adolescents are more likely to endorse physical symptoms of depression, such as fatigue, low energy, difficulty with concentration, and psychomotor retardation, rather than depressed mood or feelings of guilt. Similarly, on anxiety measures, adolescents with primary somatic/dissociative presentations are more likely to report physiological symptoms of anxiety, rather than worry or fear.

Caregiver rating scales of adolescent concerns are another common element of a psychological assessment. As many families initially conceptualize dissociation and somatization as medical rather than psychological, these symptoms are often not considered by caregivers as they are completing rating scales. Further, caregivers themselves may be avoidant of emotion, and therefore less likely to report emotional concerns in their children. As such, for adolescents with primary dissociative or somatic symptoms, caregiver rating scales will often show minimal elevations. One notable exception is the Behavior Assessment System for Children (3rd ed.) (BASC-3; Reynolds & Kamphaus, 2015), which includes a Somatization subscale. However, if an adolescent's caregivers perceive that the adolescent's somatic symptoms are appropriate to whatever they believe is impacting their child physically, this scale can also show minimal elevation.

Compared to mood symptom inventories, objective personality measures are more likely to detect somatic complaints, as well as interpersonal patterns associated with dissociation and somatization. This is another argument for the importance of a multi-method assessment approach, which aligns with common practice in TA (Fantini et al., 2022). The Minnesota Multiphasic Personality Inventory–Adolescent–Restructured Form (MMPI-A-RF; Archer et al., 2016) includes a Somatic Complaints scale (RC1), and this scale is often elevated in individuals with primary somatic/dissociative concerns. In addition, elevations may occur on the Interpersonal Passivity, Social Avoidance, and Disaffiliativeness scales, in line with these clients' vulnerability to victimization (Kouri et al., 2024), as well as their tendency to engage in people pleasing (Krivzov et al., 2020). Similar Personality Pattern scales on the Millon Adolescent Clinical Inventory-II (MACI-II; Millon et al., 2020) are likely to be elevated, including Introversive, Inhibited, and Submissive subscales. Further, an elevation on the Identity Diffusion subscale of the MACI-II is likely, in line with an increased vulnerability to a diffuse sense

of self secondary to emotional suppression and people pleasing (Krivzov et al., 2020).

To explore dissociation or somatization more directly with teens during a TA, well-validated self-report measures exist. Specific information on each measure is included in Table 1 below. Regarding dissociation, the most used and psychometrically sound is the Adolescent Dissociative Experiences Scale (A-DES; Armstrong et al., 1997). Another commonly used measure is The Cambridge Depersonalization Scale (Sierra & Berrios, 2000), which assesses both the frequency and duration of the individual's depersonalization experiences. Item examples from these two measures are included in the following section on Julia's case.

Regarding somatization, the most robust measure in circulation is the Children's Somatic Symptoms Inventory (CSSI; Walker et al., 2009). The CSSI is popular due to its flexibility and breadth: there are both 24- and 8-item versions, and both versions include a youth self-report and a parent-proxy report. This measure is helpful in assessments, as it allows you to compare the experience of adolescent somatic symptoms across the adolescent and their caregivers.To explain this mechanism, attachment theory refers to Internal Working Models (IWMs) of attachment, which are representations of the self, others, and the way relationships work. Attachment IWMs are created based on the internalization of repeated interactions with

Table 1:
Characteristics of Dissociation and Somatization Measures

Name	Measure	Questions	Item Style	Age Range
Adolescent Dissociative Experiences Scale (A-DES; Armstrong et al., 1997)	Dissociation	30	Likert Scale from 0 (never) to 10 (always)	11-18
Cambridge Depersonalization Scale (Sierra & Berrios, 2000)	Dissociation	29	Likert Scale: • Frequency from 0 (never) to 4 (all the time) • Duration from 1 (a few seconds) to 6 (more than a week)	13+
Severity of Dissociative Symptoms (APA, 2022)	Dissociation	8	Likert Scale from 0 (not at all) to 4 (more than once a day)	11-17
Children's Somatic Symptom Inventory (CSSI; Walker et al., 2009)	Somatization	24 and 8 item versions	Likert Scale from 0 (not at all) to 4 (a whole lot)	8-17
Somatic Symptom Scale (SSS-8; Gierk et al., 2014)	Somatization	8	Likert Scale from 0 (not at all) to 4 (very much)	13+
LEVEL 2 – Somatic Symptom – Child (APA, 2022)	Somatization	13	Likert Scale from 0 (not bothered at all) to 2 (bothered a lot)	11-17

Clinical Case

17-year-old Julia was referred by her individual therapist and her parents for a TA. Diversity factors for her are presented in Box 1 following Hays' ADDRESSING Model (Hays, 2001). Julia was a junior at a public high school and had a fairly typical Minnesota middle class family. She had a younger sister and was raised by her parents (Matt and Sue), who were married.

Box1: Julia's Diversity Factors following the ADDRESSING Model (Hays, 2001)

A: Adolescent-17

D: No developmental disability

D: No acquired disability

R: Christian, Protestant, practicing

E: Caucasian (parents both from mid-west U.S.)

S: Middle class

S: Heterosexual

I: Non-indigenous

N: Born in U.S.; always lived in upper mid-west

G: Cisfemale

The impetus for the referral was Julia's therapist's concerns about dissociative symptoms. Julia had a history of anxiety and depression, which dated back to elementary school, and these symptoms seemed connected to difficulties forming healthy friendships. In the months before the TA, Julia and her therapist explored moments of dissociation and depersonalization, during which Julia felt herself floating above the ground. These symptoms had been shared with Julia's parents, and so for this case, the family arrived at the TA with an understanding that these issues were occurring, but they were perplexed about causative factors and the best treatment path. Julia previously participated in a traditional psychological evaluation, which ruled out ADHD, and clarified some of her anxiety and depression symptoms. The family entered the TA curious, motivated, and open to exploring themselves and family dynamics. Julia wanted to know more about dissociation, and all were interested in figuring out how to decrease her anxiety so Julia could be less avoidant of school and peers. The family's Assessment Questions (AQs) are presented in Box 2, and Julia's parents were aware of her questions.

Box 2: Julia, Matt, and Sue's Assessment Questions (AQ)

- How can I make school a better place for me and feel ok about being in school and going to school?
- How do I prevent these swings or find a balance between always feeling awful and always feeling great?
- What is the depersonalization and dissociation connected to?
- Is there more I can understand about my anxiety and depression and what would help?
- What will help me have more positive emotions—joy without thinking about stressful things?
- Matt & Sue's question--How can we find a balance about how to parent around school and cleaning her room when we also consider Julia's anxiety?

Julia's father, Matt, was a nurse in an emergency room, and her mother, Sue, was a social worker at a nursing home. Julia had a typical development, had not faced medical issues, and earned good grades, even during times of school refusal. During her middle school years, she was ostracized by some peers, and during her first year of high school, was heartbroken after a boyfriend ended a relationship. When Julia was born, Matt was the primary caretaker, with help from his parents, and his mother specifically, who was a primary attachment figure for Julia. This grandmother passed away when Julia was 12 and this was a significant loss for her; she reported feeling as if she had lost her biological mother.

I met with Julia and her parents for 10 sessions, with two of those being sessions with the parents alone. Julia completed the tests listed in Box 3 and her parents

completed the Personality Assessment Inventory (PAI) to shed light on their personality functioning. They were open to the idea of parent testing, and I explained how having their test results would help us understand where they might align and mis-align with Julia.

Box 3: Tests Administered for Julia's TA

- Minnesota Multiphasic Personality Inventory-Adolescent-Revised Form (MMPI-A-RF)
- Millon Adolescent Clinical Inventory (MACI)
- Wartegg Drawing Completion Test (WDCT) Crisi Wartegg System (CWS)
- Individualized Sentence Completions [Individual-AIS]
- Cambridge Depersonalization Scale (CDS)
- Adolescent Dissociative Experiences Scale (A-DES)
- Personality Assessment Inventory (PAI)—completed by parents.

Julia's Test Results

Across Julia's self-report measures, there was a high endorsement of symptoms, almost to the point of invalidating some measures. Julia was feeling a great deal of distress and overwhelm, and she did not have the psychological resources to manage. Some of the test scales previously mentioned were elevated. For example, on the MMPI-A-RF (Archer et al., 2016), there were elevations on the Somatic Complaints (RC1, T = 97), Gastrointestinal Complaints (GIC, T = 86), Head Pain Complaints (HPC, T = 78) and Cognitive Complaints (COG, T = 72) scales. In sum, Julia endorsed a significant level of health-related concerns, fatigue, and general physical symptoms. In addition, there were signs of anxiety, depression, self-doubt, insecurity, low self-worth, and shame about herself. Julia tended to be passive and submissive in relationships, and she didn't feel confident asserting herself or relying on herself, and I hypothesized she organized herself around these somatic complaints.

During the different Extended Inquiry (EI) following the self-report measures we reviewed items such as, "I often have to yell to get my point across," (true) and Julia said, "I feel like I've always been someone who struggles a lot with how I feel." Later in the discussion, she said, "I get frustrated easily, but I don't have an outlet for it, which frustrates me even more." One of my favorite questions to ask clients like Julia is, "If I were around when you were experiencing a hard emotion, would I be able to tell?" Often clients like Julia reply as she did, "No. I keep it together, so others see me in a people pleasing kind of way." These responses highlight the typical pattern we see in adolescents with dissociation: that the client's focus on people pleasing and emotional suppression increases their vulnerability to expressing emotions physically through dissociation or somatization (Krivzov et al., 2020).

Exploration of endorsed items on the self-report measures was an entryway to important conversations. Julia and I explored questions such as, 'What's it like to have a lot of feelings but keep them all in?' and, 'What do you think happens to those feelings? Where do they go?', and eventually, 'Do you think holding all of these feelings in impacts what happens in your relationships, and with your parents specifically?' These questions helped Julia begin to see how her over-control of emotions was not helpful and contributed to physical symptoms and dissociation. She also began to think systemically and stated, "Maybe my parents don't respond to my feelings because they don't know."

Julia's Wartegg (Crisi & Palm, 2018) results added incremental validity to the objective test results, while contributing important elements that led to a more nuanced case conceptualization. Her Wartegg results indicated she was working hard to make sure everything appeared the 'right way' and had perfectionistic tendencies. Further, she was prone to an intellectual response to emotions, but avoided recognizing and expressing her feelings. Discomfort with anger was indicated, and she relied on oppositional avoidance to cope, which aligned with her history of school and social refusal. Julia clearly desired connection and wanted better relationships, but her Wartegg results indicated that her desire for closeness clashed with her need for self-protection.

Julia completed the Adolescent Dissociative Experiences Scale (A-DES; Armstrong et al., 1997) and the Cambridge Depersonalization Scale (Sierra & Berri-

os, 2000). Some of the items she endorsed as most frequent are presented in Box 4. Much like what occurred with the objective personality measures, Julia endorsed a high level of difficulties on these measures, making the quantitative data less useful than the qualitative data.

Box 4: Selected Items that Julia Endorsed as Quite Frequent from the Dissociation Measures

Adolescent Dissociative Experiences Scale (A-DES; Armstrong et al., 1997)

- I get confused about whether I have done something or only thought about doing it.
- I feel like I am in a fog or spaced out and things around me seem unreal.
- I get back tests or homework that I don't remember doing.
- When I am somewhere that I don't want to be, I can go away in my mind.
- I am so good at lying and acting that I believe it myself.

The Cambridge Depersonalization Scale (Sierra & Berrios, 2000)

- Out of the blue, I feel strange, as if I were not real or as if I were cut off from the world.
- Parts of my body feel as if they didn't belong to me.
- Whilst doing something I have the feeling of being a 'detached observer' of myself.
- My surroundings feel detached or unreal, as if there were a veil between me and the outside world.

During the EI on these measures, we reviewed the experiences she endorsed as most frequent. This allowed me to gain a greater perspective of her experiences, while also having an opportunity to validate her. The level of dissociation, anxiety, and depression she experienced would make it quite difficult for most teens to achieve good grades, but, her high striving, perfectionistic style allowed her some success, albeit at the cost of fatigue.

Parent Testing and a Growing Conceptualization

Often as part of Therapeutic Assessment-Adolescent (TA-A), parents complete testing, and in this case, I had each complete the Personality Assessment Inventory (PAI, Morey, 1991). Both parents had similar profiles, with no significant elevations. Neither endorsed difficulties with anxiety, depression, the expression of anger, or emotion dysregulation. Dad's profile was notable for a slight elevation on the Positive Impression Management (PIM) scale, suggesting it was difficult for him to admit even common human issues or foibles. Further, his profile suggested that he was emotionally constricted, highly organized, perfectionistic, and liked to have control over things. Recall, Matt worked in a hospital emergency room, and this is the type of personality style that likely works well there—organized, detail oriented, meets demands efficiently, and emotionally equanimous. Mom's profile was similar in its lack of negative emotions, although her PIM was not elevated, and there was less rigidity and a need for structure in her profile.

Importantly, I wanted to ensure I held empathy for everyone in the family to maintain rapport with each of them. When considering everyone's test results, Julia's sense of confusion about her emotions became clearer. There must have been times she felt confused about her emotions and that she was different from her parents who were less emotional. I envisioned Julia moving through the world, thinking, "I'm a mess, and my parents are perfect and so put together. I must be disappointing them." These differences likely produced shame in her, as she wasn't moving through the world as they were. When I stepped into her parents' shoes, I could see how Julia's big emotions might be hard for them to understand and be empathic with, and perhaps they wondered, "Why can't she let little things go? Why does everything have to be a big deal?" However, they also likely felt confused and perhaps shameful about their parenting. Holding all three family members, I recognized everyone needed to shift and find different language, with Matt and Sue sharing more of themselves and their feelings, and Julia recognizing and expressing what she feels and needs.

Assessment Intervention Sessions (AIS)—Individual and Family

As the testing phase ended, my conceptualization

built (See box 5) and I began planning the Assessment Intervention Sessions (AIS).

Box 5: Julia's Case Conceptualization and Levels of Information

Julia feels deep shame about herself and her feelings, and likely has a dismissive attachment status. She often feels confused about herself, is too passive, and works hard to be seen positively. She struggles with emotional regulation and has had moments of activation, but manic symptoms were not indicated. Her parents are more emotionally contained, if not constricted, and in the family, Julia hasn't felt safe to be vulnerable. This, combined with unresolved grief, contributes to her anxiety, depression, dissociation, and somatic symptoms.

Level 1—Depression, anxiety (social), dissociation.

Level 2—Family struggles with communication about emotions. Julia still grieving the death of grandmother.

Level 3—Impact of early experiences with father and paternal grandmother.

For Julia, it would be helpful to continue building her systemic thinking and my understanding of her experiences in the family. I considered targeting her split-off anger and difficulties being assertive but wanted to set the stage for the Family AIS. I chose the Individualized Sentence Completions method (Tharinger et al., 2022) and edited stems to pull in systemic elements and language. Some of the more important sentences are presented in Box 6. Her responses allowed us to further explore some of what occurred in the family. We discussed the items related to communication with her parents (e.g., My parents…*don't understand my feelings*.). Julia said, "Sometimes when I'm anxious, they are dismissive. I don't know how to express to them what I'm thinking and feeling. I say it in a way that's more pleasant to hear." Her *problems in living* (difficulties with emotion expression and her tendencies towards people-pleasing) were in the room, and these aligned with what is commonly seen in teens who somaticize. She seemed to hold everyone's emotions as a result of the projective identification that occurred, and it was not enough to target building her parents' acceptance of her emotions. Julia also needed to be more comfortable with recognizing and expressing her feelings assertively, otherwise even if her parents shifted their style, she would bring the family back to homeostasis.

Box 6: Selected Items from Julia's Individualized Sentence Completions

Mother should…*be caring.*

Father should…*think about others.*

Communicating with my parents…*is really hard sometimes.*

Parents…*are most helpful when they just listen.*

My parents…*don't understand my feelings.* The worst thing that ever happened to me…*was my grandma dying.* [dad's mom]

Another important part of Julia's story also became clearer as part of her AIS. We discussed what it was like for her when her paternal grandmother died, and her deep connection with her during her early childhood. The grandmother's death was unexpected and appeared to leave her parents managing their own grief and Matt's father's well-being. However, this left Julia sad, confused, and uncertain. Julia said, "I still don't know why she passed—I'm guessing a heart attack. It felt like losing a mom and it felt too uncomfortable to bring it up." My conceptualization further grew, as I could see how some of her depression was connected to unresolved grief.

For the Family Intervention Session, I decided it would be helpful to build connections and explore what occurs when various emotions are experienced by each family member. I had developed trusting relationships with each of them and felt I could bring them towards more difficult feelings. I chose the Consensus Storytelling approach (Tharinger et al., 2022), and selected cards from various storytelling tests that have teen and adult characters interacting, as well

as some cards with characters experiencing difficult emotions. The family participated well in this process; there were some moments of levity, and other moments that were difficult.

The most impactful part of the Family Intervention Session was the conversation that occurred after the family created a story for Bench from the Adult Attachment Projective (AAP; George & West, 2012). This stimulus involves a young person sitting alone on a bench, with their arms crossed over their knees which are curled up, and their head down in their arms. The young person looks like they are experiencing a hard emotion, and Julia's family created a story that captured the card pull with a character who was sad, lonely, and overwhelmed. After reflecting on the story with them, I asked each of them if they could think of a time in their life when they felt like the character in the story. Sue shared about what it was like for her when her parents died, which was before Julia was born. Julia then had the opportunity to share what it was like for her when her grandmother died. I allowed her to speak freely and guided her towards some of the story she previously shared with me, while encouraging Matt and Sue to be open to the fact that they may have missed supporting Julia during that time. They all stepped into this difficult conversation well, and Matt and Sue clearly had not realized that Julia was still struggling with that grief. It was a tender and supportive moment for all of them.

I next turned to Matt and asked him if he could resonate with a character who felt like the person on the bench. The silence and discomfort that followed made it feel like many minutes had passed. While it was briefer than that, Matt struggled to identify and articulate such an experience. Recall, Matt worked in an emergency room and routinely dealt with patients and their family members who were facing significant medical issues and death. Of all of us present, Matt has likely had the most experiences that would produce sadness and overwhelm, but it was extremely difficult for him to step into those emotions. I was attentive to his shame rising, and I helped him get out of the situation and normalized how it's hard to identify tough experiences. After briefly processing what occurred, I split them up and with Julia we discussed what it was like to see her dad struggle, while also validating her experiences of living with a parent who struggled with his emotions. With Matt and Sue, I gathered their perspectives on what occurred, validated them for stepping into a hard situation, and encouraged them to consider how to support Julia and her grief, and how their communication styles might need to shift.

Summary/Discussion Session and Letter

I held two Summary/Discussion Sessions: one with Julia and her therapist, and one with Matt and Sue. Julia was invited to attend the parents' session but declined. During her session, we reviewed the test data described; I encouraged Julia and her therapist to focus on many of the recommendations outlined in the next section. During the parents' session, we also talked about some of the family dynamics that were present during the Family Intervention Session, and they both remarked, "We can see more clearly how it's difficult for our family to talk about feelings." I strongly encouraged the family to participate in some family therapy to build more open communication. These themes were present in the TA letters sent to Julia and her parents. Some years later, I crossed paths with Sue, and she reported Julia had successfully graduated high school, was engaged in higher education, had improved her friendships, and overall, they were all more connected.

Treatment Recommendations

When clients present with a primary somatic or dissociative disorder, an important first step is to help the client and their family to view the teen as physically healthy. The stronger the client and family's belief in the teen's physical health, the better their engagement in therapy and their prognosis for symptom reduction (Williams & Zahka, 2017). Another key intervention is to normalize the physical expression of distress. There are many examples of dissociative and somatic reactions to stress in everyday life: most people have felt their stomach flip at least once when they were feeling nervous, or have driven from home to work having no memory of the drive itself. The emphasis should be on how, while these types of body responses are normal, the frequency and the functional impact of these symptoms are creating problems for the teen.

Given that the functional impact of these symptoms is the most important, treatment should focus on a return to function, rather than an exclusive focus on symptom reduction. Treatment goals in the early stages should emphasize activities that increase the

client's engagement in their life, even in the presence of ongoing somatic or dissociative experiences. This approach challenges the frequent narrative of "once my symptoms are gone, then I'll be able to do things again." This is important, as treatment studies of adolescents with somatic symptoms show that a return to function typically precedes symptom reduction, rather than the other way around (Williams & Zahka, 2017).

While a focus on increased engagement in a life worth living is important across somatic and dissociative presentations, management of somatic and dissociative episodes can benefit from a direct behavioral approach in the early stages of treatment. As previously mentioned, these episodes serve a specific purpose for the client (and that purpose is typically connected to suppression of unwanted emotions), though the teen is often not consciously aware of that purpose at the onset of treatment. As such, the role of the therapist is to adjust environmental consequences and rewards surrounding the episodes. Perhaps the client is being taken out of school every time the episodes occur or is let out of household chores by their parents. Stopping these rewards will decrease episode reinforcement. In addition, the therapist can work with the teen to identify other physical sensations that occur prior to the episode. As these are identified, the therapist can help the teen engage in relaxation strategies when early physical sensations arise, to lengthen the time between early awareness of the episode and the episode itself. This behavioral approach, adjusted over time as behavioral antecedents and consequences shift, can eventually eliminate and end dissociative episodes altogether.

As somatic and dissociative symptoms decrease, however, it is very common for experienced emotional distress to increase. This is because the client's physical symptoms are no longer the method of expressing emotion. Teens may report increased depression or anxiety or disclose difficult family dynamics that were not previously verbalized. This can be destabilizing for the family, as many clients with this presentation have learned that emotions are not safe to express in the family environment (Thayyil & Rani, 2020). Therefore, experiencing emotion is often associated with shame, both for the adolescent and for others in the family system. As the experience of shame around emotions can lead to those emotions becoming "split off" or dissociated (Fantini et al., 2023), a key goal when working with clients with primary conversion or dissociative symptoms is to decrease shame associated with emotional expression. Ultimately, the hope is that decreasing shame will allow an increase in and acceptance of appropriate emotional expression within the family system.

In summary, we strongly encourage assessors to incorporate some of the dissociation and somatic measures described to their battery and to use them routinely with clients of all ages. Equally important is to consider how these maladaptive ways of being may have been adaptive responses to the environment. While our focus has been on children and adolescents, many of the systems ideas presented apply to adults. Elevations on somatic scales can help us, and the client, get curious about whether emotions were accepted in the family of origin. This cluster of symptoms requires specific treatment approaches, as outlined, and for children and adolescents, family therapy should be prioritized. As hopefully demonstrated, a TA not only allows these experiences to be understood with compassion, but the family's narrative can also shift.

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Author Bio's

Abby Hughes-Scalise is the Program Director for Augsburg University's Clinical PsyD Program in Minneapolis, MN. She began her career investigating relationships between child psychopathology and family systems. As her interests in health psychology grew, she shifted to working with family systems in the context of com-plex illnesses requiring multidisciplinary care, such as chronic pain, conversion disorder, and epilepsy. Her publication history includes co-authoring a chapter in the *Handbook of Cognitive-Behavioral Therapy for Pediat-ric Medical Conditions* (2019; R. Friedberg & J. Paternostro, editors) on intervention approaches for psychogenic non-epileptic seizures and multiple journal articles on parent-child relationships in the context of mood disorders. She is on the Editorial Board for the *Journal of Child and Family Behavior Therapy.*

Raja M. David is the founder and owner of the Minnesota Center for Collaborative/Therapeutic Assessment. He has written various chapters and articles on Therapeutic Assessment (TA), and is co-author of the "TA man-ual," *Therapeutic Assessment with Adults: Using Psycho-logical Testing to Help Clients Change* (Routledge, 2022). Raja routinely consults with clinicians and organiza-tions looking to implement the TA model and teach-es TA through workshops and graduate courses. In 2022, he joined the Therapeutic Assessment Institute (TAI) board of directors.

Society for Personality Assessment (SPA) Annual Conference

March 13-17, 2024
San Diego, CA

This year's SPA Conference was in sunny San Diego, with seals gathering nearby! There were nine C/TA offerings, but the highlight was the SPA C/TA Interest Group gathering during which Hale Martin's retirement from the University of Denver was celebrated. Hale also stepped out of his role as co-chair of the C/TA Interest Group and his former student, Krista Brittain, stepped into that role and read Hale a TA letter describing highlights of his career.

Krista reads Hale's TA letter.

Participants brainstorm ideas about how best to support the TA community.

Steve Finn and Noriko Nakamura describe the utility of a consensus Rorschach in a couples TA.

Krista Brittain, Sarah Bharier, & Elizabeth Winston meet up during a happy hour.

SPA President and TAI Board Member Jan Kamphuis enjoys a laugh with Steve.

Recent Publications

- Aschieri, F., Fantini, F., Antonelli, A., Van Ryzin, M., & Smith, J. D. (2023). Therapeutic Assessment in a university counseling center: A replicated single-case time-series pilot study. *Journal of Personality Assessment*, DOI: 10.1080/00223891.2023.2296065.
- Aschieri, F., van Emmerik, A. A. P., Wibbelink, C. J. M., & Kamphuis, J. H. (2023). Collaborative assessment methods. In C. E. Hill & J. C. Norcross (Eds.), *Psychotherapy skills and methods that work* (pp. 399-428). Oxford University Press.
- Barbosa, L. L. P. & Faiad, C. (2023). Análise do feedback escrito da Avaliação Terapêutica: uma revisão sistemática [Analysis of written feedback from Therapeutic Assessment: A systematic review]. *Revista Meta Avaliação*, December 2023, DOI: 10.22347/2175-2753v15i49.4207.
- Da Fonseca Glasson, F., Cardoso Ribeiro, L., & Morales Cardoso, L. (2023). O florir da violeta: Um estudo de caso em Avaliação Terapêutica [Violet blossom: A case study in Therapeutic Assessment]. *Psicologica: Ciência e Profissão, 43*, 1-15.
- Huprich, S. K., Roelk, B. C., & Poppe, T. (2024). Enhancing diabetes management through personality assessment: A pilot study. *Journal of Clinical Psychology in Medical Settings*, DOI: 10.1007/s10880-024-10002-y.
- Kpassagou, L. B. (2023). The contribution of the collaborative use of the Rorschach test in Togo. *Rorschachiana, 44*(1), 84-98.
- Stolberg, R. A., Bongar, B., & Thach, T. (2024). Assessment of suicide risk. In J. L. Mihura (Ed.), *The Oxford handbook of personality and psychopathology assessment* (2nd Ed.). Oxford Handbooks Online. DOI: 10.1093/oxfordhb/9780190092689.013.22.
- Taknint, J. T., Depestre, S., Alshabani, N., Martin, A. M., Virkar, S., & Milord, J. (2024). Assessing psychotic spectrum disorders in partnership with patients: Three culturally Responsive Therapeutic Assessment cases. *Practice Innovations*. Advance online publication. https://dx.doi.

Upcoming Trainings

July 8, 2024-Copenhagen, Denmark; In-Person (The International Society for the Rorschach and Projective Methods XXIV Congress)

Title: **The Rorschach Test as an Intervention: Using the Test to Change Individuals, Couples, Families and Groups**

Presenter: Filippo Aschieri

Sponsor: The International Society for the Rorschach and Projective Methods Language: English

Schedule: July 8, 9:00 AM – 5:00 PM (Copenhagen time)

Information: **https://rorschachcph2024.dk/en/**

July 9, 2024-Copenhagen, Denmark; In-Person (The International Society for the Rorschach and Projective Methods XXIV Congress)

Title: Changes in Children's Mental Representations as Noted in their TAT Stories During Collaborative/Therapeutic Assessments

Presenters: Catherine Gosselin-Leclerc, J. Éric Dubé, & Raphaële Noël

Sponsor: The International Society for the Rorschach and Projective Methods Language: English

Schedule: July 9, 1:30 PM - 3:00 PM (Copenhagen time)

Information: **https://rorschachcph2024.dk/en/**

Upcoming Trainings: Continued

July 9, 2024-Copenhagen, Denmark; In-Person (The International Society for the Rorschach and Projective Methods XXIV Congress)

Title: **How the Collaborative Use of Performance-based Personality Tests Engenders Hope**

Presenters: Stephen E. Finn, Hilde De Saeger, Mitsugu Murakami, Serena Messina, Melinda Glass, & Barbara Mercer

Sponsor: The International Society for the Rorschach and Projective Methods Language: English

Schedule: July 9, 3:30 PM - 5:00 PM (Copenhagen time)

Information: **https://rorschachcph2024.dk/en/**

July 10, 2024-Copenhagen, Denmark; In-Person (The International Society for the Rorschach and Projective Methods XXIV Congress)

Title: **Multi-method Collaborative Assessment of a Client with Severe Shame**

Presenters: Stephen E. Finn, Yutaka Sato, Noriko Nakamura, Jule Cradock O'Leary, & Filippo Aschieri

Sponsor: The International Society for the Rorschach and Projective Methods Language: English

Schedule: July 10, 9:00 AM - 10:30 AM (Copenhagen time)

Information: **https://rorschachcph2024.dk/en/**

July 10, 2024-Copenhagen, Denmark; In-Person (The International Society for the Rorschach and Projective Methods XXIV Congress)

Title: **The Pfister Test in a Therapeutic Assessment with Children**

Presenters: Camila Grillo Santos, Anna Elisa Villemor-Amaral, Camila Paixão Câmara Juntolli, Juliana De Almeida Araujo, Mayara Salgado de Moraes, & Scarlett Borges Fernandes

Sponsor: The International Society for the Rorschach and Projective Methods Language: English

Schedule: July 10, 3:30 PM - 5:00 PM (Copenhagen time)

Information: **https://rorschachcph2024.dk/en/**

July 11, 2024-Copenhagen, Denmark; In-Person (The International Society for the Rorschach and Projective Methods XXIV Congress)

Title: **Analysis of the Impact of the Rorschach and the Extended Inquiry Technique in a Therapeutic Assessment Process with Adolescents**

Presenters: Scarlett Fernandes, Anna Elisa Villemor-Amaral, Juliana Araújo, Mayara de Moraes, & Camila Santos

Sponsor: The International Society for the Rorschach and Projective Methods Language: English

Schedule: July 11, 3:30 PM - 5:00 PM (Copenhagen time)

Information: **https://rorschachcph2024.dk/en/**

Upcoming Trainings: Continued

July 12, 2024-Copenhagen, Denmark; In-Person (The International Society for the Rorschach and Projective Methods XXIV Congress)

Title: **"We Both Identify with Survival Mode": How a Couple's Collaborative Assessment Illuminated the Intricate Dance of Attachment and Shame**

Presenters: Cassandra Parrish & Edward Jenny

Sponsor: The International Society for the Rorschach and Projective Methods Language: English

Schedule: July 12, 9:00 AM - 10:30 AM (Copenhagen time)

Information: **https://rorschachcph2024.dk/en/**

July 12, 2024-Copenhagen, Denmark- In-Person (The International Society for the Rorschach and Projective Methods XXIV Congress)

Title: **Using the Rorschach to Help Clients Heal from Unresolved Trauma**

Presenter: Stephen E. Finn

Sponsor: The International Society for the Rorschach and Projective Methods Language: English

Schedule: July 12, 9:00 AM - 10:30 AM (Copenhagen time)

Information: **https://rorschachcph2024.dk/en/**

October 11-13; Tokyo, Japan; In-Person

Title: Live Therapeutic Assessment of a Client with Severe Shame

Presenters: **Mitsugu Murakami, Stephen E. Finn, & Noriko Nakamura**

Sponsor: Asian-Pacific Center for Therapeutic Assessment and Therapeutic Assessment Institute

Language: Japanese & English

Schedule: October 11 (10:00am – 6:00pm) October 12 & 13 (9:30 am – 5:30pm Japan Standard Time)

Information: **asiancta@gmail.com**

June 12-14, 2025; Salt Lake City, Utah; In-Person & Virtual

Title: **4th International Collaborative/Therapeutic Assessment Conference**

Presenters: tbd

Sponsor: Society for Personality Assessment, University of Denver, & Therapeutic Assessment Institute

Language: English with some offerings translated

Schedule: tbd

Information: **www.therapeuticassessment.com**

Upcoming Psychological Test Trainings

J uly 11, 2024-Copenhagen, Denmark; In-Person (The International Society for the Rorschach and Projective Methods XXIV Congress)

Title: **An Introduction to the Thurston Cradock Test of Shame (TCTS)**

Presenter: Julie Cradock O'Leary

Sponsor: The International Society for the Rorschach and Projective Methods Language: English

Schedule: July 11, 3:30 PM - 5:00 PM (Copenhagen time)

Information: **https://rorschachcph2024.dk/en/**

October-Virtual

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

Presenters: Melissa Lehmann, Caroline Lee, and Carol George

Sponsor: Alliant University

Language: English

Schedule: October 1, 11:00am – 7:00pm, October 11-14, 18, & 20, (11:00am – 3:00pm Central Time Zone)

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

Upcoming Trainings: Continued

Fall-Virtual

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

Presenter: Jacob A. Palm

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

Language: English

Schedule: September 20, October 4, 18, & 25, November 8 (9:00 AM – 12:30 PM Central Time Zone)

Information: **http://www.sc-cca.com/CWS-Trainings.html**

Summer & Fall-Virtual

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

Presenter: Jacob A. Palm

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

Language: English

Schedule: July 26, August 16, 30, & September 13 & 27 (9:00 AM – 12:30 PM Central Time Zone)

Information: http://www.sc-cca.com/CWS-Trainings.html

November-Virtual

Title: **Introduction to R-PAS: Rationale, Administration, Coding, and Interpretation (27 CE Credits)**

Presenters: Gregory J. Meyer & Joni L. Mihura

Sponsor: R-PAS

Language: English

Schedule: November 7 & 8 (8:00am – 4:00 pm), 9, 10, 15 & 16 (10:00am – 2:00pm Central Time)

Information: **r-pas.org/#Trainings**

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