THERAPEUTIC ASSESSMENT: USING PSYCHOLOGICAL TESTING AS BRIEF THERAPY

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The field of psychological assessment is undergoing dramatic change, perhaps even a paradigm shift. Traditionally, assessment has focused on gathering accurate data to use in clarifying diagnoses and developing treatment plans. Although largely retaining these goals, new approaches also emphasize the therapeutic effect assessment can have on clients and important others in their lives. Evidence accumulating over the past 20 years suggests that this effect can be substantial. On the basis of their meta-analysis of outcome studies investigating the therapeutic effect that assessment can have, Poston and Hanson (2010) contended that psychology needs to reconsider training in assessment to incorporate approaches that emphasize its therapeutic value. They even argued that managed care organizations need to reevaluate delivery of services in light of the efficacy of the new approaches to assessment. This chapter highlights the development of the therapeutic application of psychological assessment, examines its empirical support, discusses how assessment might produce therapeutic change, and outlines the Therapeutic Assessment (TA) approach and illustrates it through a case example.

WHAT IS TA?

TA is a semistructured approach to assessment that strives to maximize the likelihood of therapeutic change for the client. It has been developed largely through the efforts of Stephen Finn and his colleagues (Finn, 1996, 2007; Finn & Martin, 1997; Finn & Tonsager, 1997), building on the innovations

of collaborative assessment developed by Constance Fischer (1985/1994), Leonard Handler (2006); Caroline Purves (2002), and others. TA has incorporated knowledge from a range of psychology to produce an evidence-based approach to positive personal change through psychological assessment. It rests on the commonsense application of the powerful insights that are efficiently available through reliable and valid assessment tools and techniques to a collaborative, respectful, supportive, gentle, and ultimately experiential process of self-discovery.

DEVELOPMENT OF TA

The roots of TA are grounded in the early work of Constance Fisher. In 1978, she wrote that historically "psychology has assumed that people should be treated as objects amenable to measurement, prediction, and control" (p. 41), and argued that psychologists do not have to be restricted this way but rather can acknowledge that humans are purposeful and that the "the professional's understandings are not more real, valid, or influential within the client's life than are the client's" (p. 42). Fischer then defined collaborative assessment as assessment "in which the client and professional labor together toward mutually set goals, sharing their respective background information and emerging impression" (p. 42).

Fischer's work largely provoked resistance until Finn discovered it and saw that it fit nicely into his own understanding of the value of assessment. The collaborative/TA movement began in earnest in 1992 when Finn and his graduate

student, Mary Tonsager, published a randomized controlled study showing that a simple assessment involving only the Minnesota Multiphasic Personality Inventory—2 (MMPI–2)—but conducted in a collaborative manner—had powerful therapeutic benefits. Over succeeding years, Finn has developed the TA approach, incorporating evolving insights from other areas of psychology, including the idea that emotional experience rather than logical understanding is at the heart of therapeutic change (Fosha, 2000; Schore, 2009). As the case example in this chapter illustrates, TA involves structured experiential components that move assessment from an intellectual exercise to an experiential one.

Through these developments, TA has been applied to a range of assessment situations. Finn adapted the approach developed for adults to the assessment of children. He and his colleagues borrowed a practice from Fischer (1985/1994) and others and introduced the idea of writing fables or stories as age-appropriate feedback for children, offering new options and outcomes through stories (Tharinger, Finn, Wilkinson, et al., 2008). More recently, Deborah Tharinger, Finn, and their students at the University of Texas at Austin have further advanced the assessment of children to integrate the child's parents and support system into the process (Tharinger, Finn, Austin, et al., 2008; Tharinger, Finn, Hersh, et al., 2008). This same group is also researching applications of TA to adolescents (Tharinger, Finn, Gentry, & Matson, in press). Finn also pioneered the application of TA to couples' assessments; these often involve using a consensus Rorschach to help partners understand and undo projective identification (Finn, 2007). Others are applying TA to neuropsychological assessment (Gorske & Smith, 2008).

WHAT IS THE EVIDENCE BASE FOR TA?

As mentioned earlier, Finn and Tonsager (1992) were the first to document empirically the therapeutic effect an assessment can have. They studied students waiting for therapy at a university counseling center and randomly assigned them to two conditions. About half ($n = 32$) underwent a two-session

assessment in which they took the MMPI–2 and were given feedback according to a collaborative method developed by Finn (1996). The remaining students ($n = 29$) got equal clinical attention focused on their current concerns but no assessment. The effects were striking. The assessment group showed a significant drop in symptoms ($p < .01$; effect size $= .85$) and a significant increase in self-esteem ($p < .001$; effect size $= .46$), whereas both these variables remained unchanged in the nonassessment group across time. It is interesting that the two groups showed no differences in feelings about the therapist/assessor. This simple study provided powerful evidence that assessment can be therapeutic, and it fueled the movement to use assessment therapeutically.

The Finn and Tonsager (1992) research was replicated by Newman and Greenway (1997), who conducted a similar study with some refinements. In their investigation, both groups took the MMPI–2, although the control group received feedback after the outcome measures were completed. Their results were similar to those in the Finn and Tonsager study, but the effect sizes were smaller. Subsequently, a growing number of studies have investigated various effects of TA. The research that has been done is intriguing and largely supports the contention that TA is an effective therapeutic intervention. Ackerman, Hilsenroth, Baity, and Blagys (2000) showed that TA was better than traditional assessment in insuring compliance with treatment recommendations (effect size $= .42$). Ougrin, Ng, and Low (2008) found that TA was superior to "assessment as usual" in getting adolescents admitted to emergency rooms for self-harm to attend follow-up appointments ($p < .05$) and engage with services ($p < .05$). Hilsenroth, Peters, and Ackerman (2004) demonstrated that TA was better than traditional information gathering assessment in strengthening clients' therapeutic alliance with a subsequent psychotherapist (effect size $= 1.02$).

Little and Smith (2008) studied psychiatric inpatients, showing that TA was more effective than structured supportive therapy or standard psychiatric treatment and milieu therapy on several factors, including facilitating treatment alliance, cooperation with treatment, and satisfaction with treatment, and

that it also promoted lower distress and an increased sense of well-being. Morey, Lowmaster, and Hopwood (2010) showed that a brief (two-session) TA improved therapeutic outcomes in a group of women diagnosed with borderline personality disorder who were undergoing a brief, manualized form of cognitive therapy. Tharinger, Finn, Gentry, Hamilton, et al. (2009) showed decreased symptomatology in both latency-aged children and their mothers, decreased family conflict, and better family communication after a nine-session TA. Finally, a study by Smith, Handler, and Nash (2010) used a time-series analysis to reveal improvement in symptomatology and family relationships in latency-aged males with oppositional defiant disorder who underwent a TA with their caregivers.

The most telling study of collaborative/TA is a meta-analysis by Poston and Hanson (2010). They identified 17 published studies (with a total 1,496 participants) that used psychological assessment as a therapeutic intervention. They defined therapeutic intervention "broadly as the process of completing any formal psychological test/measure and receiving feedback on the results . . . with therapeutic intent" (p. 205). Thus, many of the studies they included only examined the therapeutic effects of feedback.

The results showed an overall effect size of .423, which was significant at the .01 level. Poston and Hanson (2010) compared this with the effect sizes of various psychotherapy approaches and found it comparable with substance abuse treatment (effect size = .45) and "approaching" cognitive–behavioral treatment for anxiety disorders (effect size ranged from .89 to 2.59) and general psychotherapy (effect size = .80). This is an impressive showing for TA, given that some of the assessments in the study involved as few as two sessions.

From these results, Poston and Hanson (2010) concluded that "those who engage in assessment and testing as usual may miss out, it seems, on a golden opportunity to effect client change and enhance clinically important treatment processes" (p. 210). Furthermore, they asserted that (a) training programs should include therapeutic assessment models, (b) competency benchmarks should include aspects of TA, and (c) managed care managers should consider TA in future policies.

HOW CAN SUCH A BRIEF INTERVENTION BE EFFECTIVE?

There are several ingredients of TA that may help explain why such a brief intervention can have powerful therapeutic effects. Different therapeutic elements fit nicely into the assessment situation and in that context likely potentiate change.

Changing a Client's Self-Narrative

TA changes the narrative clients have developed about themselves or about their children or spouses. Effectively changing how people view themselves in the world opens new possibilities in their lives. For example, certain clients who have always thought of themselves as "stupid" may discover through a TA that they are intelligent but have a specific learning disability that impeded them in school. Learning this information may dramatically change the way the clients view themselves and the choices they make after the TA.

Walking the Line Between Self-Verification and Disintegration

One of the challenges in creating change in any therapeutic process is walking the line between self-verification and the potential for disintegration. Self-verification is the powerful human tendency to seek and attend to information that supports established ways one understands oneself (Swann, 1997). Even when this view is negative and self-limiting, a person will hold on to it in the face of more favorable understandings (Swann, Wenzlaff, Krull, & Pelham, 1992). Practicing psychologists have historically labeled such attachment to old ways of thinking as "resistance." Research in social psychology has helped determine that reliance on established self-views serves to "predict the reactions of others, to guide behavior, and to organize one's conceptions of reality" (Swann, 1997, p. 177). If these established patterns of understanding oneself in the world are changed too abruptly, the person risks feelings of disintegration, an experience of emotional distress, disorientation, and fear that can result when an individual is unable to refute evidence that some central and tightly held belief about the self is wrong (Kohut, 1984). The balance between self-verification

and disintegration is central in promoting change. The focus on empathy and relationship in TA—as well as specific TA techniques such as involving clients in setting the goals for an assessment and in interpreting test results—enables the assessor to facilitate change without overwhelming the client.

Using Psychological Tests as "Empathy Magnifiers"

Another aspect of psychological change that TA harnesses is the power of empathy. The client is changed by the experience of being deeply seen and understood (Kohut 1982). Psychological tests are excellent "empathy magnifiers" (Finn, 2007) and, thus, perfectly suited to maximize the empathy experience. Using empathic understanding gently and with compassion creates a unique experience of being seen that is healing in itself for many clients (Finn, 2009).

Involving the Entire System With Children and Families

TA is a family-systems intervention with children and families. Thus, caretakers observe or participate in each step in the assessment process and are included in discussions during or after each assessment session. During these discussions, the parents are led by the data and their interactions to see their child more accurately and understand what the child needs. The assessor also helps parents deal with their own pain and limitations. Thus, TA addresses the child's most important interpersonal environment to create opportunity for growth and therapeutic change.

Undoing Projective Identification With Couples

The challenge in couples treatment is often exposing and diminishing the relationship patterns rooted in childhood that guide expectations, reactions, and behavior with one's spouse or partner. These patterns are often deeply entrenched and completely ego-syntonic. TA approaches couples work by first assessing the partners independently to gain an understanding of each person's underlying dynamics that influence the couple's relationship. By beginning to understand how each partner imposes his or

her relationship history on the other, the assessor can move the couple to relate more from accurate, present-day reality than from projection of past relationship patterns, which are often shaded with hurts and failures. Often, when each spouse begins to understand the reasons why the other acts in certain ways, repair and healing can begin.

STEPS IN THE TA PROCESS ILLUSTRATED THROUGH AN ADULT CASE

Finn and Tonsager (1997) articulated the semistructured approach of TA in sequential steps, and these were expanded by Finn (2007). In this section, we briefly discuss each step and use a case example to illustrate each of the steps in practice.

Initial Contact

The assessment begins with the initial contact with the referring professional and later with the client. Usually these both happen by telephone. Questions and information are sought from the referring professional, and he or she is encouraged to share the questions with the client.

The initial phone contact with clients and sometimes even the recorded message encountered convey a wealth of information: how they present themselves, what concerns they might have, their tone of voice, and how open they are to the assessment. A collaborative assessor–client relationship is begun in the initial phone contact by asking clients to think of questions they would like the assessment to answer. The assessor also answers practical questions and schedules the first meeting.

Initial Contact: Case Illustration

A well-respected therapist, Sarah, contacted Steve for a TA to aid in outpatient therapy with Luanne, a 26-year-old woman who had been working with Sarah in therapy for about 9 months. Sarah explained that Luanne was having trouble "settling in" to therapy because of her loyalty to her previous therapist, Mary, whom she had seen for 6 years. Luanne had begun therapy with Sarah immediately after relocating for school. Sarah reported that Luanne still talked to Mary several times a week by phone. The focus of Luanne's treatment was her

recovery from childhood sexual abuse by her father. This abuse had gone on for many years, and Luanne's mother had apparently known about or suspected the abuse but had done nothing.

Sarah explained that in Luanne's previous treatment, Luanne had done a great deal of emotionally intense "reliving" of past traumas and psychodrama enactments of confrontations with family members. Sarah felt that such a therapeutic approach was not what Luanne needed currently, and she wanted to work with Luanne on experiencing her emotions in a "modulated way" that was less disruptive to her life. Sarah said that Luanne perceived this approach as a message of "You have to stuff your feelings." Sarah had two questions she wanted the assessment to address: "What will help Luanne shift her alliance more from her previous therapist to me?" and "How can I avoid getting in a power struggle with her about how to work on feelings in therapy?"

Initial Session

The initial session is very important as it sets the frame in which the assessment will occur. The assessor tries to convey authentic warmth, respect, compassion, and curiosity and to engage the client as a collaborator. Sometimes clients are taken aback by the expectation that their questions will drive the assessment and that they will play an active role. They may need help understanding that psychological tests are not "oracles" and that their coparticipation is essential for the assessment to be valid and useful. Sometimes clients need help formulating questions. If so, to the assessor can encourage them to talk about the problems they are having in life and then listen carefully for potential questions to bring to their attention.

As questions that the client sees as central come into focus, the assessor gathers relevant background for each. It is also helpful to inquire about past assessments and any hurts they might have caused. This can be an important step in insuring that the assessor and the client will not repeat those injuries. In TA, the assessor also asks clients if they have questions about the assessor. This simple act conveys that the relationship is open both ways. Rarely do clients ask anything inappropriate, but they do have a chance to address any concerns or fears they have about the assessor or the assessment. Before parting, the assessor and client review the client's questions and the plan of work and agree on fees and the schedule of future sessions.

Initial Session: Case Illustration

Luanne was a tall, handsome, athletic-looking woman, who greeted Steve in the waiting room with direct eye contact and a firm handshake. Luanne seemed very comfortable and fairly quickly articulated her first question for the assessment: "Is there a way for me to not be as controlled as I am by shame?" Luanne explained that she felt held back in many situations—with friends, in school, in social situations—by the fear that she would do something "wrong" and "look like a fool." She said she had always had intense shame but that it was worse in her relationships with men, where she rarely spoke up and had a very difficult time "holding on to herself." She explained that she had not dated for 7 years.

This led Luanne to pose a second question: "What still gets in the way of my dating?" She briefly mentioned her childhood sexual abuse and said that as an adolescent and adult, she had dated abusive men who "treated her like dirt." Luanne said that currently, she was longing to start dating again but was also "terrified" that she would get back into old patterns. She and Steve agreed to see what the testing could help her understand about her fear.

Steve then asked Luanne if she and Sarah had a game plan for working on the dating, and Luanne finally began talking about her ambivalence regarding the therapy with Sarah. Luanne explained that the therapy she had done with Mary was very different. The philosophy had been "all feelings should be felt," and "if it doesn't hurt, you're not working." Luanne said Sarah's goal of helping her develop affect regulation seemed like a "waste of time" and that she feared she wasn't going to "get all her feelings out" so she could go on and lead a normal life. Steve asked Luanne if she felt she was making changes in her life as a result of her work with Sarah. She said she was and that actually she was functioning better than she had in years. This seemed to surprise her and led Luanne to pose her first question about the therapy: "What's the best approach for me in therapy: pushing for lots of

feeling versus a more paced, controlled approach?" When Steve asked, "Does it have to be either/or?" Luanne admitted that she tended to think in "black-and-white terms" and asked another question: "Is it possible and/or desirable to integrate these two approaches to treatment?"

Toward the end of the meeting, Steve and Luanne talked about practical aspects of the assessment. Her funds were limited, so they agreed to use the MMPI–2 (Butcher et al, 1989) as the main assessment instrument and made arrangements for Luanne to take the test at Steve's office before their next meeting. Steve asked Luanne what it had been like to talk together that day, and Luanne said, "More comfortable than I thought it would be. I've never had a male therapist before. But you were easy to talk to, and I feel excited about doing the testing together."

After Luanne left, Steve was aware of feeling somewhat sad. He wondered if Luanne needed to understand that even after successful treatment, her sexual abuse would always play some role in her life. It seemed possible that part of Luanne's dilemma about therapy was her fantasy that if she just worked on her trauma enough and "got her feelings out," it would be as if she were "washed clean" and it had never happened. Steve knew this was not possible and wondered if her previous therapy had reinforced Luanne's fantasy.

Steve also noticed how much Luanne seemed to look to external sources to guide her decision making. Luanne had talked as if she had little choice about the pacing of her therapy rather than exploring her own mixed feelings about going fast or slow. Steve decided to pay special attention to helping Luanne make her own choices during the assessment, remembering that she said she tended to "give herself away" in relationships, especially with men.

Standardized Testing Sessions

Testing typically begins at the next session. Tests are administered in standardized ways to gather information that will inform the answers to the questions. To begin, the assessor often chooses tests that are more clearly related to the client's questions. This conveys that the assessor is indeed focusing on issues the client has identified. One technique that has become increasingly valued in TA is the extended inquiry (Handler, 1999). This technique involves the assessor asking about the client's experience of a test or the client's thoughts about certain test responses.

Standardized Testing Sessions: Case Illustration

Luanne's MMPI–2 showed no signs of invalidity, and it appeared that she approached the test in a very unguarded manner (Variable Response Inconsistency [VRIN] = 46T; True Response Inconsistency [TRIN] = 65T; Infrequency Psychopathology [Fp] = 49T; Lie [L] = 42T; and Defensiveness [K] = 37T). This kind of openness is not uncommon in clients voluntarily taking part in TA who have defined personal questions they want to have answered using the MMPI–2. The moderate elevation on F (Infrequency; 79T) was higher than that found in most outpatient therapy clients and indicated that Luanne was in a significant amount of distress, more than Steve had picked up on in the initial interview.

This distress was confirmed by the profile of clinical scales, where Luanne had seven scales with significant elevations: Scale 1 (Hypochondriasis; 69T), Scale 2 (Depression; 68T), Scale 4 (Psychopathic Deviate; 85T), Scale 6 (Paranoia; 74T), Scale 7 (Psychasthenia; 76T), Scale 8 (Schizophrenia; 77T), and Scale 0 (Social Introversion; 77T). Scale 3 (Hysteria; 56T) was slightly elevated, while Scale 5 (Masculinity-Femininity; 45T), and Scale 9 (Mania; 54T) were not elevated. This "gull-wing" configuration is not unusual among women with histories of trauma and current difficulties with relationships (Graham, 2006). According to Caldwell's (2001) theory, Luanne's profile suggested that she was a "sturdy survivor" with a traumatic childhood who had been exposed to humiliating and shocking events without adequate support and who had coped by "pulling herself up by her "bootstraps," focusing on achievement and avoiding intimacy. Steve hypothesized that this coping strategy was one reason Luanne did not seem as distressed in person as she appeared on the MMPI–2.

Apart from distress, the MMPI–2 profile indicated problems in a number of areas. Women with similar profiles have identity confusion, histories of

drug and alcohol abuse, and tumultuous relationships. They have problems with emotion regulation and emotional flooding, tend to engage in splitting and "black-and-white thinking," and can go through periods—particularly when emotionally aroused—when their thinking is illogical and distorted, especially in the area of interpersonal relationships. Steve was surprised by the elevation on Scale 0 (Social Introversion) because it did not fit his picture of Luanne having been deeply embedded in her previous therapeutic community. Further examination of the subscales for Scale 0 (Ben-Porath, Hostetler, et al., 1989) showed that Luanne was a "sociable introvert"; that is, she desired contact with other people but tended to avoid social situations and relationships because of her anxiety and low self-esteem. Regarding low-self esteem and shame, Luanne had a high score (84T) on the Low Self-Esteem scale of the MMPI–2, suggesting that she was self-critical and often felt worthless and insignificant.

On the basis of this information, Steve believed that he had an understanding of Luanne's struggle with shame (her first question), that there were many good reasons why she was avoiding dating (her second question), and that a more paced therapeutic approach was likely to be the most beneficial (her third question). In general, however, Steve wanted to avoid imposing this understanding on Luanne, with the hope that Luanne could take more of her own authority in choosing how to pace her treatment. If Luanne could feel more in charge, it might make her feel less afraid of the world. With these goals in mind, Steve planned an assessment intervention.

Assessment Intervention Session

Perhaps the most innovative step in TA is the assessment intervention session. In this session, the assessor uses the information gathered up to that point to elicit an analogue of the client's main difficulties in vivo. If this is successful, the assessor invites the client to observe the problem behavior, understand it, and then solve it in the assessment session. Meanwhile, the assessor and client relate their discussions to the client's daily life. The assessment intervention session is a stepping stone to answers that will be discussed in the upcoming summary/discussion session.

Assessment Intervention Session: Case Illustration

In short, Steve's plan for an assessment intervention was to arouse Luanne emotionally in a controlled fashion while keeping close tabs on her level of distress and to put her in the driver's seat about whether she wanted to "push for more feelings" or "slow things down." In preparation, Steve selected cards from a number of picture story tests and ordered them according to his sense of their emotional difficulty for Luanne. Steve introduced the session to Luanne as follows: "Today I want to do another test with you that I hope will help us explore your question, 'What's the best approach for me in therapy: pushing for lots of feeling vs. a more paced, controlled approach?'" Steve explained that the test they would be working with might be emotionally arousing and asked if Luanne was OK with that. She said she was, and Steve then gave the standard instructions for the Thematic Apperception Test (TAT; Murray, 1943).

In order, Steve then asked Luanne to tell stories to pictures of a woman sitting, resting on the back of chair while looking off into the distance (TAT card 8GF); of a young teenage girl sitting on a curb in front of a house looking at her hands (Card 2F of the Adolescent Apperception Cards; Silverton, 1993); and of an androgynous-looking teen sitting up in bed under the covers while an adult man sits at the foot of the bed with his hand on the teen's thigh (Card 2 of the Family Apperception Test; Sotile, Henry, & Sotile, 1988). Luanne easily told stories to the first two cards, and each contained themes of the characters being "bored and lonely." Steve chose the third card because it could suggest sexual abuse. Luanne told a story of a father tucking in his child who, for some reason, did not "feel safe" because "it's hard to predict how the dad is going to be at any moment." She said the child "wished the dad would go away." There was no explicit mention of sexual abuse or violence, but Luanne looked quite uncomfortable as she told the story. Afterward, Steve asked how Luanne was doing, and she said, "Fine. I can do more." He then presented her with

TAT Card 13MF (a woman lying on a bed with a man standing nearby), and Luanne told the following story:

> Wow. I thought I didn't like the lonely female pictures, but this is the worst. This is a couple and she looks passed out, like she's spent a lot of time that night running from herself and from reality and is out of it. Her husband or boyfriend is tired of seeing this again. He has come home from work and can't stand seeing this again. He doesn't think about why she did this, just about how hard it is to deal with. He doesn't cover her up, he covers his eyes and thinks about himself. He'll probably go have a drink afterwards and not realize he's doing just what she does. [Steve: How does she run away from reality?] Through drugs and alcohol. It's really a shame. She looks really hungry for love and he's not available for it.

Afterward, Luanne looked somewhat "blank" to Steve, so he immediately asked how she was doing. The following conversation ensued:

Steve: How are you?

Luanne: [*pause*] I'm feeling frightened and vulnerable, and like you're learning more about me than I realized I would be sharing today.

Steve: OK, I'm so glad you said that. So before we do any more, let's regroup. Is the level of feeling pretty intense right now?

Luanne: It's escalating, but that feels appropriate given the four pictures you showed me.

Steve: Exactly. I gave them in that order because I imagined that might happen.

Luanne: Yes, I thought so.

Steve: So, I know this is different than in therapy, but is what's happening now relevant to your question about which therapy approach is best for you?

Luanne: Hmmm . . . I'm not making the mental connection. I don't get the analogy.

Steve: OK . . . let me explain more. It's like we've got some different options here. We could keep going, with some harder cards, and intensify the feelings even more, or we could stop here, and

call it a day, or perhaps talk some more about what we've already done. And that choice seems similar to me to your question about what therapy approach is best for you. I know it's a different situation, but it seems related to me. Does it to you?

At that point, Luanne confessed that she did not see it as a real option to stop. She just assumed that she had to go on, no matter how difficult it was. Stopping would feel like "weakness." Steve asked if stopping could be "a kindness to oneself" instead of weakness, and Luanne confessed that was a whole new way of thinking for her.

This interchange then led to a long discussion about the pros and cons of "pushing for feelings" versus "pacing oneself." Steve asked if there were unpleasant feelings that came up if Luanne gave herself breaks and didn't push so hard. She said, "There's sadness, and I'm more in touch with what I missed out on and what I long for." Steve asked her what she longed for, and Luanne paused before saying, "Love and support." Steve put his hand over his heart and made a sympathetic noise, and Luanne became tearful and looked away. Steve waited a moment and then said,

> Luanne, that makes so much sense. And yet, I have to tell you . . . when you were pushing ahead just now with the early cards, I had no idea how hard it was for you. It didn't occur to me to offer you any support. It was only when we stopped and you told me how vulnerable you felt that I had any inkling that you were in distress.

Luanne nodded and said that friends often told her that they could not tell when she was upset. Steve said,

> Well, I think it was unsafe growing up to show any weakness, and also you figured out you got more for yourself by just soldiering on. But now, in a way, when you do that, you miss out on what you most long for, because no one can even tell that you need support.

Luanne, sat quietly at that point for several minutes and said she had never thought about things that

way. Steve asked how she was feeling and she said, "Excited. Less frightened. I've got some options here that feel good to me."

At that point, Steve asked Luanne if she would like to look at more picture story cards or stop where they were. He warned her that the next cards were "even harder hitting emotionally" and might be difficult. Luanne said it was virtually impossible for her to imagine *not* going forward unless Steve had the sense that it would be bad for her and made the decision to stop. Steve felt the temptation to decide but declined, saying that he did not know what was best for Luanne at the moment. Instead, he asked if she wanted help "thinking through how to make such a decision." She said she definitely needed help, as she had no idea how to choose. Steve then shared several questions that he might ask himself in making such a decision, such as "How close am I to my emotional limit?" "What do I need to do after this—do I need to be 'on'?" and "How safe do I feel?" Luanne listened and answered each question for herself. She then paused and said, "I would like to do another card." Steve agreed and gave her a card showing a person kneeling, bent over on some kind of couch or cushion (TAT card 3BM). Luanne told a story of a woman who had been robbed and was terrified but who went to the police and got help. She started to blame herself, but the police reassured her she was not at fault. Eventually, she got the things back that had been stolen from her.

Steve asked Luanne what she noticed, and she said that the woman started out terrified but then ended up taking action and getting support and that made her feel better. Steve asked how Luanne was feeling, and she said "Good. I feel I learned a lot here today. And I've had enough now. I want to stop." Steve commended her for knowing that, and they ended.

Summary/Discussion Session

The summary/discussion session provides the opportunity for the client and assessor to collaboratively discuss the findings of the assessment. The assessor first contacts the referring professional to discuss the findings and plan the summary/discussion session together. Whenever possible, the referring therapist attends the summary/discussion session, and it is held at the therapist's office. The therapist sits with the client during the session, hears what the client hears, asks questions for the client, and "holds" the client emotionally during the process.

During the session, the assessor sets the client at ease as much as possible. Then the assessor takes each of the client's questions and proposes tentative answers based on the testing and previous discussions with the client. After each point, the assessor asks how the client understands the finding. If it seems to fit, the client is asked to provide examples of it in his or her life. The assessor stays attuned to any clue that the client is not following the discussion or that the test results do not seem accurate. The assessor is also attentive to the client going into shame or becoming overwhelmed. Often, the session ends with the client and therapist discussing viable next steps that the client can take to address the problems focused on in the assessment and talking about what it was like to do the assessment together.

Summary/Discussion Session: Case Illustration—Consultation Meeting With Sarah

Steve met with Sarah several days after the assessment intervention session with Luanne to bring her up to date, review the MMPI–2 results, answer Sarah's questions, and get her input on what he proposed to say to Luanne. Steve showed Sarah Luanne's MMPI–2 and shared his conceptualization of Sarah as a "sturdy survivor" who had to "shut off weakness" and "keep plunging ahead." Sarah, like Steve, was surprised at the level of distress Luanne revealed through the MMPI–2. Steve suggested that Luanne might shift her alliance more from Mary to Sarah if she felt that Sarah both recognized her distress and was attentive to Luanne's shame about appearing "weak." They both agreed that Sarah could avoid power struggles over the pacing of therapy by emphasizing that only Luanne could really know what was best for her in a given session but that Sarah could ask helpful questions and share her own impressions how to proceed. They agreed that Sarah's job was to help Luanne learn how to make

Exhibit 26.1
Excerpts From Written Feedback to Luanne at the End of the Assessment

Dear Luanne,

This is the letter I promised you, summarizing the results of the recent psychological assessment we did together. . . . I'll structure this letter as I did that session by addressing the questions you posed at the beginning of the assessment.

Before getting to the results, I want to thank you again for letting me get to know you through the assessment. I really enjoyed working with you and I appreciated the openness with which you approached the assessment. . . .

Now to your questions:

What still gets in my way of dating?

You told me that you have a lot of fear when you contemplate dating, and your MMPI–2 profile helps us understand that. Your test results showed that you often feel inferior, self-doubting, and are very self-critical. Although you are aware of your shame, and recognize it as a problem, at this point you still tend to believe it. This suggests that a part of you thinks you will be rejected by desirable men, which gets you to avoid dating or to pursue men who are unavailable—in a way taking control of the rejection.

There may even be some very practical reasons that dating is scary for you. Your MMPI–2 results suggest that you don't feel comfortable being assertive (more than the average woman psychotherapy client). People with scores like yours "lose their power" in relationships and have difficulty setting and maintaining appropriate boundaries. . . . So until you're able to be assertive and hold your own, you'll want to be cautious about whom you date. . . .

We also discussed your being a *sociable introvert* and how that complicates dating. You like and enjoy being around people, but are shy and can get anxious in social situations. You also need and cherish time alone. You might get along best with a partner who is similar to you in this regard (which is fairly rare) or at least you will need a partner who understands when you need time alone or are exhausted by lots of social contact.

Last we talked about how all the difficult feelings you are managing—of anxiety, depression, and shame—can make it difficult to date. We agreed that if you're able to date now, that's great. But if you can't, perhaps you can have compassion for yourself right now, and believe that as you feel better, dating could be a lot easier.

Is there a way for me to not be as controlled as I am by shame?

As mentioned earlier, the MMPI–2 does confirm that you feel bad about yourself and are very self-critical. In my experience, healing from shame involves the following steps: 1) being able to identify and label shame, especially when it is happening, and being curious about it; 2) learning about how your shame got there, what purposes it served, and developing compassion for yourself, especially so you don't feel shame about having shame; 3) letting yourself feel grief (including anger and sadness) about the circumstances that led you to feel shame, and the opportunities you've missed because of your shame; and 4) finding more and more skepticism for the self-critical thoughts and inner voices, so they no longer have much power over you.

From what you told me, it seems that you're currently working on step 2 and have a good handle on step 1. As we discussed, this entire process can take a long time, and in many ways is never done, so you'll need to be tender and patient with yourself.

What's the best approach for me in therapy, pushing for lots of feeling or a more paced, controlled approach? Is it possible and/or desirable to integrate these two approaches to treatment?

As we discussed and practiced in our second session (where we used the picture-story cards), there probably is no therapy approach that is best for you on every day and in every situation. Instead, the optimal pacing for your work will vary from day to day, depending on such factors as 1) your level of general emotional distress, 2) the demands of your life at the time, 3) the amount of support that is available to you, and 4) how much you want to push vs. give yourself a break. By giving yourself permission each day to decide how fast and deeply you want to delve, you'll best meet your goal of working as rapidly as you can, without getting disorganized or threatening your sobriety. And remember, this approach does NOT mean that you have to make these decisions all alone. . . .

In closing, thank you again, Luanne, for letting me get to know through the assessment, and I hope it is helpful to you in your future work with Sarah. If you have any questions about the assessment or about this letter, please feel free to call or email me, or to pass on the questions to me through Sarah.

Best wishes,
Steve
Stephen E. Finn, PhD
Licensed Psychologist

such decisions and to accept that Luanne might make some mistakes along the way.

The content of what Steve told Luanne is reflected in the letter he sent to her after the session was completed (see Exhibit 26.1). Here we describe the flow and process of the session.

Steve began the session by asking how Luanne felt after the assessment intervention session. Luanne said she was exhausted immediately afterward but since then had been feeling, "joyful," "more connected to herself," and that she "was going somewhere emotionally."

As can be seen in the letter to Luanne, Steve used Luanne's question about why she was not dating to talk about the large amount of distress shown on her MMPI–2, including the intense shame. He said that it was remarkable that Luanne was doing all she was doing and that this showed a lot of psychological strength. Luanne confirmed that she was struggling with very painful feelings and that she did not know what else to do besides "carry on." At that point, Sarah said that she thought Luanne often underestimated the amount of energy it was taking to keep going. Luanne responded that she felt like crying but did not want to. She then said she was glad that Sarah understood the effort she was making.

Steve then addressed Luanne's question about shame. Luanne listened intently as he described steps involved in healing from shame and said she did not have much experience "grieving what had happened to her." Steve asked if the good feelings Luanne had experienced since the previous session might be related to her having felt the sadness. Luanne said that might be true and that she felt more alive for having "come close to the edge and survived."

Next, Steve summarized the work he and Luanne had done about the best way to approach her therapy, reminding Luanne of the questions she might need to ask herself before and during each session. Sarah said she thought such questions were an excellent guide and that she could assume the role of helping Luanne "make her own decision." Steve got the sense that Luanne and Sarah were finally on the same page about the treatment. At the end of the session, Luanne said that the assessment

had been a very "rich experience" and that she would be "feeding off it" for a very long time. Steve asked about what she felt she had learned, and Luanne said that "in complex situations, no one can decide what's best for me, but that doesn't mean I am all alone."

Written Feedback

After the summary/discussion session, the assessor writes a letter to the client that outlines the findings of the assessment that were discussed in the last session. Typically, it is in the form of a personal letter, which restates each question and summarizes the answer. This letter is an enduring documentation of the assessment findings and of the client's connection with the assessor.

Written Feedback: Case Illustration

The letter Steve sent to Luanne is excerpted in Exhibit 26.1.

Follow-Up Session

A follow-up session is typically scheduled 3 to 6 months after the summary/discussion session. It offers the opportunity for assessor and client to check in with each other and clarify or deepen what the assessment results indicate and how they might bear on recent questions and concerns. The follow-up serves as a mechanism to keep the client on track with the important results of the assessment. Sometimes the client requests additional follow-up sessions, and in some instances they become an annual occurrence.

Follow-Up Session: Case Illustration

Because of her busy school schedule, Luanne apologetically declined to come for a follow-up session. However, she returned a set of client feedback forms that Steve sent with the feedback letter and rated herself as highly satisfied with the assessment. When Steve checked with Sarah several months after the assessment, she told him that Luanne and she were working well together and that Luanne had recently been having almost no contact with her previous therapist, Mary. Sarah said she felt the assessment had helped her and Luanne bond in new and important ways.

CONCLUSIONS

We hope that this overview of TA and our case illustration convey the power and potential value of TA to psychological assessment and to clinical work in general. At this point, TA shows enormous promise to "breathe new life" into psychological assessment and to enhance our understanding of psychotherapy. Future research and clinical experience will determine whether TA lives up to this promise. Current research is focused on exploring TA's usefulness with different types of clients in diverse settings and in understanding why and for whom TA is most useful.

There is a vibrant assessment community that continues to explore TA's value, its applications, and ways to make it even more effective. Many members of this community are active in the Society for Personality Assessment (http://www.personality.org) and come together at its annual meeting. The TA website (http://www.therapeuticassessment.com) also contains more information about TA and lists of upcoming trainings.

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