

Shame as a Cultural Artifact: A Call for Self-Awareness and Reflexivity in Personality Assessment

Filippo Aschieri

European Center for Therapeutic Assessment, Catholic University of the Sacred Heart, Milan, Italy

ABSTRACT

It has become common for assessors to face therapeutic impasses and dilemmas when practicing within the Therapeutic Assessment (TA) model. This is due to the explicit goal of producing therapeutic changes in clients. In this article the author discusses the importance of assessors being aware of how their clinical practices relate to their assessment outcomes. To enhance such awareness, the author reviews the characteristics of psychological assessment practices as derived from 3 paradigms developed almost 1.5 centuries ago in Europe by the forefathers of psychology as a scientific discipline. Current assessment practices are deeply ingrained in specific cultural, social, and political frameworks originating in these paradigms. Being aware of such a historical and cultural background might help the assessor avoid blindly reenacting the values, norms, and latent relational schemas implied by different assessment methods, and instead use assessment tools as potent aids in the service of clients' change. Finally, the author illustrates how the experience of clients' shame in psychological assessment might also be understood as a by-product of the specific cultural and historical background of certain common assessment practices.

ARTICLE HISTORY

Received 14 August 2015
Revised 27 November 2015

Personal values, subjective experiences, individual beliefs, and our understanding of reality are inevitably interwoven (Mahoney & Granvold, 2005). Reflexivity, intended as a deliberate attempt to increase awareness of the resulting personal biases (Schön, 1983), has been applied in various domains of clinical psychology, from research to psychotherapy and psychological assessment.

Quintana (2007) provided an example of how scrutinizing scientific results with a self-reflexive attitude is crucial for advancing reliable knowledge. Specifically, Quintana contrasted several theoretical assumptions about racial and ethnic identity development with data from cross-sectional and longitudinal studies. His paper contains several examples of bias in the definition of identity development models. Working only within specific settings can lead the psychologist to falsely extend a narrow set of observations into general models or theories. For example, scholars working with disturbed populations (e.g., Erickson) promoted models on adolescent identity development that included a normal "storm and stress" crisis. A second source of bias in developing theories and models based on empirical data is the sociopolitical environment. For example, models of identity development based on turbulent developmental transitions, proposed between 1960 and 1970 (Cross, 1971; Thomas, 1971), paralleled the cultural and political struggles in society in general at that time. A final source of bias comes from specifying a model based on information from a single source of data. In fact, models of racial-ethnic identity development based on the results of a single instrument (e.g., Multigroup Ethnic Identity Measure; Phinney, 1992) are

limited as "the validity of the psychometric properties of an instrument may be confused with the validity of the theory on which the instrument is based" (Quintana, 2007, p. 268).

The ideas of both intersubjective (Stolorow, Brandchaft, & Atwood, 1987) and systemic scholars (Cecchin, Lane, & Ray, 1994) are relevant to the need for psychotherapists to be reflexive and aware of one's own contributions in creating clients' ways of thinking, feeling, and behaving during therapy and in shaping therapeutic phenomena in general. Not only should therapists become observers of their own beliefs, but they should evaluate the course of the therapy as indicative of the interplay between their beliefs and assumptions and those of their clients.

A deeper examination of the role of assessors' personal values and biases has become increasingly emphasized in psychological assessment as well. The literature in psychological assessment discusses the effect of assessors' personal motives (Finn, 2007; Lerner, 1998), the effect of their implicit epistemic view of reality (Aschieri, 2012), and their emotional reactions to clients' problems (Chudzik & Aschieri, 2013). Increasing interest is being devoted to awareness of the assessors' personal values, awareness of social and cultural values and practices in clinical decision making (Evans, 2015), interpretation of assessment findings (Chudzik, 2015), and therapeutic processes (Fantini, 2015).

Clinicians' biases affect their relationship with clients and despite the good intentions of the helping profession in building "safeguards against prejudice and discrimination, the reality is that they continue to be manifested through the therapeutic

process” (Sue et al., 2007, p. 280). Studies in multicultural psychology point out that clinicians’ biases and prejudices are acted out through microaggressions; that is, “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative . . . slights and insults to the target person or group” (Sue et al., 2007, p. 273). Such microaggressions are “often unconsciously delivered in the form of subtle snubs or dismissive looks, gestures, and tones. These exchanges are so pervasive and automatic in daily conversations and interactions that they are often dismissed and glossed over as being innocent and innocuous” (p. 273). As stressed by Sue and colleagues (2007), microaggressions can be extended beyond discrimination based on race or ethnic differences to any human relationship involving any difference in status, power, or culture. As such, implicit, automatic, unintentional communication processes such as microaggression could contribute to clients experiencing shame.

This article shows that understanding the historical roots of assessment practices could help clarify—at least to a certain extent—how our standard ways of working with clients might create the context for microaggressions to occur and shame to be instilled in clients. Within this framework, understanding the historical roots of the assessment practices might enhance assessors’ awareness of the potential consequences of their clinical choices and help them adjust their behaviors to the clients’ needs.

The birth of psychology as a science

According to Danziger (1990), three research methods that appeared at the beginning of the last century in Europe conferred on psychology the status of a scientific discipline. The first research method was used in the clinic for diseases of the nervous system founded by Jean-Martin Charcot at the Salpêtrière Hospital in Paris. Starting in 1870, Charcot studied the functioning of the nervous system with patients who were exposed to hypnosis. The automatic, mechanical reactions of patients exposed to stimuli outside of their awareness were defined as “psychological automatism” (e.g., inducing a person to—verbally, nonverbally, or both—behave as if she were praying by simply joining her hands). Through hypnosis, Charcot also induced the manifestation of hysterical symptoms in patients, who had no awareness of those symptoms. In this way, he aimed to demonstrate that hypnosis and hysteria could be considered the same clinical phenomenon, differing only in the way they were purposely or spontaneously triggered.

The second method was developed in the first psychology laboratory founded by Wilhelm Wundt in 1879 in Leipzig, Germany. The main focus of Wundt’s studies was the basic sensorimotor responses to elementary stimuli, analyzed through the systematic introspection method. For example, participants in his experiments were exposed to specific stimuli (e.g., a tachistoscopic presentation of a word) with controlled physical features (e.g., controlled presentation time). After the stimulus presentation, the participants were asked to describe which, if any, features of the target stimulus they were able to recall. In this approach, an important benchmark for the quality of the

collected data was how educated and sensitive the participants were in identifying through introspection the individual effects of external stimuli.

The third early methodological contribution to psychology as a science came from Sir Francis Galton. Galton had an eclectic and versatile scientific acumen, which allowed him to make important contributions in various scientific fields, ranging from meteorology (he was the first scientist to map the isobars) to zoology (he developed “Galton’s whistle,” used to train dogs and cats) and genetics (he was the first scientist to evaluate the effects of genetics and the environment on children’s development, by comparing monozygotic and dizygotic twins). In the field of psychology, Galton is particularly known for being the founder of differential psychology and for the efforts he made to collect large samples of subjects to study individual differences. At the International Health Exhibition in London in 1884, he set up a laboratory to test the mental faculties of individuals among the public. Galton used a research method that made it possible to differentiate individuals according to their performance on specific tasks. The measurements of the individuals’ functions and abilities, once statistically aggregated, resembled the familiar shape of the “normal curve” (Danziger, 1990, p. 112).

The features of each research method were strongly related to both the specific research goal(s) and to the contextual elements that framed their development. In fact, in Charcot’s experimental design, the effects of hypnotic suggestion were inextricably related to the role- and gender-based power imbalance characterizing the larger context of the experiment. That is, the experimenter and the subject were typically in a preexisting physician–patient relationship, within a social context where male medical doctors studied the psychopathological conditions of female subjects. Such an asymmetrical relationship did not concern the researchers who relied on hypnosis, which they defined as objective as a “psychic vivisection” (Binet, cited in Carroy, 1991). This was also the first time in history that the term experimental *subject* (*sujet*) appeared in the psychological literature. It is worth noting that until then, in the French language the word *sujet* indicated the corpses used in autopsies and medical examinations (Danziger, 1990, p. 53).

In understanding the context in which Wundt’s method developed, it is important to note that in the later years of the 19th century, the structure of the laboratories in German universities was such that several students could graduate at the same time doing empirical studies under the supervision of the leading scientist. This microsocial structure had a deep impact on the features of the scientific experiments that were carried on in Wundt’s laboratory. The experiments were indeed collaborative enterprises, in which every member of the laboratory took on different roles, being at different points in time both the experimenter and the research subject (Figure 1 depicts Wundt himself serving as an experimental subject). This organization, besides allowing the laboratory to have subjects easily available for the experiments, also served another purpose. It allowed the researcher to work with educated subjects, who were able to reliably report their sensorial response to the stimuli. After the initial enthusiasm, by the beginning of World



Figure 1. Wundt serving as subject during an experiment. Courtesy of the University of Leipzig.

War I this approach lost much of its appeal due to the limitations in terms of what systematic introspection could “scientifically” study and the practical interest of the research topics.

In contrast to Wundt’s approach, practical usefulness and a breadth of possible applications were among the advantages of the so-called Galtonian or anthropometric approach. Such advantages resonated with the dramatic social changes that were happening in Europe and the United States around the end of the 19th century, including the spread of Darwinism in European mainstream culture (Kamin, 1974; Rose, 1979, 1998). In Europe, large cities, such as London, England, were growing under the pressure of industrial development, with large parts of the population relegated to an underprivileged status and poor sanitary and hygienic conditions, and decision makers and public opinion were challenged by questions about what to do with them and what to think of them. In that social framework, the Galtonian approach was used to assess the mental capacities of people living in the slums and to compare them with those of the bourgeoisie and the aristocracy. In this way, scientific proof was accredited to the idea that illnesses and criminal propensity were features of such underprivileged parts of the population, due to a genetic-based degeneracy in their mental abilities. Similarly, in the beginning of the 20th century, the United States was facing the “second wave” of immigrants from “poor genetic stock countries” (i.e., southern Europe). Assessing the genetic deficiency of immigrants through mental testing provided a scientific argument in favor of restrictive immigration policies and social control (i.e., eugenics) for specific classes of immigrants and inhabitants (prisoners, mentally disabled) presumed to spread their genetic flaws by reproducing.

At the same time, Darwinism started to be applied to explain power differences between nations. European countries were in fierce competition for colonial resources, and the differences in the way they succeeded in this effort were thought to parallel and express the quality of the genetic breed of its mainland inhabitants. In other words, Galtonian studies of mental abilities in different national groups brought strong arguments to account for the legitimacy in particular of northern European colonialism.

This historical outline shows a connection between the social-political context and the development of certain research practices. Also, it illustrates the different positions of the “subjects” in the experiments aimed at generating knowledge about their abilities, traits, and functioning. In this regard, Danziger (1990) stated:

Any of the objects with which psychological science deals are present in nature fully formed ... scientific psychology does not deal with natural objects, it deals with test scores, rating scales, response distributions ... innumerable other items that the investigator does not just find but constructs with great care: whatever guesses are made about the natural world are totally constrained by this world of artifacts. (p. 2)

Stated differently, psychologists shape, carve, and create (like in an artwork) the object of their work through their practices. Beyond highlighting the influence of the experimenters’ practices in creating the features of the subjects, and somewhat in contrast to the natural sciences, psychological knowledge not only rests on the observers’ vantage point (Sullivan, 1953): Psychology deals with a reality that adjusts itself recursively to the methodology selected to study it. In fact, humans are an interactive kind of research subject (Hacking, 1999), who, differently from quarks, rocks, or numbers, actively react and change in accordance with how they are studied. For example, underprivileged women in Salpêtrière Hospital competed for experimenters’ attention by showing the expected hysterical behaviors (Didi-Huberman, 2003). The individuals in the Galtonian evaluations changed their self-representations when they started to think about themselves in terms of their positioning in the normal curve. Wundtian subjects became progressively more educated in the introspection method, changing their self-perception as an effect of the training in using the method itself. The implication for psychological assessment is that the clients’ appraisal of the clinicians’ behaviors resides, besides from their organization principles, schemes, and narratives, on the relational, interpersonal implications of the practices the clinician adopts to “approach” them. As an example of the effect of psychological practices, the concept of shame and its emergence during a psychological assessment is discussed in the following section.

Shame in psychological development

Developmental psychology and sociology have focused on the role of shame in human development and interpersonal relationships (Scheff, 1988; Schore, 1998). Shame has been defined as the first “social emotion” (Scheff, 1988), emerging in children as early as 14 to 16 months old. It is described as a complex physiological-emotional response to a perceived interruption of the relational contact and attunement with caregivers. In fact, a caregiver’s reactions of rejection or disappointment are important clues for children as to which affect states, behaviors, and thoughts are prohibited. Developmentally, shame is the socially acquired response to the caregiver’s rejections, and becomes associated with the expression of dangerous, unacceptable, or prohibited affect states (Schore, 1998). During their development, children inhibit the expression of specific affect states, as they learn that such affects would be a

threat to the relationship with the caregiver. Nathanson (1992) suggested that although shame is a socially acquired state, it quickly becomes internalized by children to prevent experiencing the negative emotions associated with expected rejection and disappointment. Hence, shame represents one of the primary mechanisms of inhibition of emotional expression (Morrison, 1989).

Shame in psychological assessment

Stephen Finn, the developer of Therapeutic Assessment (TA), stressed the importance of addressing clients' shame both within the context of interaction with the assessor and in interpreting the testing results (Finn, 2007, 2011, 2012b). While interacting with clients, assessors need to be aware that interruptions in the verbal and nonverbal connection could be signals that clients' shame is emerging (Dickerson, Gruenewald, & Kemeny, 2004). When the clients cover their face, interrupt eye contact, and suddenly become silent, they are probably approaching a disavowed emotional state—in some cases it could be sadness or longing, in other cases anger—and at the same time, shame surfaces to hinder the emergence of that specific affect state.

Shame can also be inferred through the results of formal testing. It can emerge directly from self-report testing, when clients report feeling unworthy and internally wrong. In other cases, shame can be one of the mechanisms motivating clients to produce a “defensive” profile on a self-report measure, where they present themselves in unrealistically positive terms (Finn, 2007). Shame can also be identified through performance-based tests, when the results suggest the presence of dissociated affect states that the person is not in contact with. In this case, shame often has an active role in maintaining the use of dissociation (Finn, 2012a).

As Finn (2012b) explained, in TA, identifying and addressing shame is considered particularly important due to its nature as a “blocking experience.” In fact, when shame is activated, it undercuts the relational and emotional connection between assessor and client, which forms an important element for therapeutic change to happen. Therefore, shame needs to be addressed as quickly as possible to (a) restore communication, (b) allow dyadic regulation, (c) begin the integration of previously dissociated affect states, and (d) support the drafting of a new and more compassionate self-story.

Shame as a by-product of psychological assessment

Besides being a product of interpersonal dynamics rooted in clients' early development, shame can also be viewed as a phenomenon that risks being triggered directly by assessment practices. Looking back at the three research methods delineated in the first section of this article, several issues arise about the assumptions that still guide the clinical practice of assessing various aspects of individual functioning today. These assumptions are rooted in the historical development of such a practice and are generally taken for granted by assessors, who underestimate their potential influence on the clients' functioning and on the emergence of shame in the assessment setting. In this section, each method is analyzed as to how assessors can

unwittingly shame clients based on its corresponding values and principles. Scenarios from assessments involving assessors and clients from different cultural backgrounds are used as illustrative examples.

First of all, the power imbalance that can be in place between assessors and clients very much resembles the features of Charcot's model of assessing individual functioning.

Power dynamics can emerge in the assessment context on the basis of gender and social, professional, and educational differences between the assessor and the client. By taking for granted their role of experts, as in Charcot's method, assessors might overlook such differences that are indeed shielding the emergence of the clients' true self. Psychological assessment and TA inherently offer opportunities for the assessors to enact a one-up role. Considering in particular the case of TA, clinicians ask clients to formulate assessment questions that they will then help to answer through the testing (Finn, 2007). The assessor risks becoming the expert who translates test scores into psychologically meaningful processes. During the assessment, clients might experience the assessors as benevolent and secure figures, as a result of the creation of a positive therapeutic relationship. However, this attitude might also grow to the extent that clients feel motivated to adhere submissively to all the therapist's requests to preserve the relationship with such an important person. Clients might begin to fear that asking for a more egalitarian relationship could provoke retaliation, damage, or rejection (Rennie, 1994). In this case, shame generally holds in place the dissociation of the potential anger directed at the assessor and the assessment. The main signal pointing to the presence of power differences biasing the assessment and fueling clients' shame is the assessors' countertransference. This can be detected when assessors begin to see their clients as defective, insufficiently motivated for the assessment, or needing wise guidance. Assessors might start to feel frustrated about the clients' inability to change in predetermined directions, or they might feel a paternalistic need to guide them in their best interest. This kind of countertransference reaction should set off a warning bell for assessors about the presence of power differences that might play out in the assessment process and that are possibly biasing the assessor's clinical judgment. Cecchin (2004) described different types of therapist behaviors emerging when they act on power differences with their clients. The more therapists act on power differences with their clients, the more they are motivated to tell to their clients the “truth” about their lives. This attitude often leads to therapists also playing the role of teachers, educating clients about what they think clients should do, and moralizers, censuring clients for their faults. In this way they stop being therapists.

Such processes might become even more evident when the assessor belongs to the dominant cultural group and the client belongs to a minority group. In these cases, there is often a difference in social status and level of education that can easily become an imbalance in the perceived power within the therapeutic dyad. In this context, shame is easily activated in clients because they feel less culturally competent, less successful within the mainstream social system, and less knowledgeable than the assessor. If such relational and emotional dynamics are not identified and addressed, the risk of clients superficially complying with the assessor's requests, while hiding important

aspects of their psychological functioning, increases. This in turn might produce biased assessment results, early dropout, and the frustrating experience of clients not following the clinicians' recommendations resulting from the assessment.

Moving to Galton's tradition, the common practice of using standardized tests during the evaluation process forces clients to acknowledge the difference between their performance and their representation of the expected normality. A simple example of this phenomenon is socially desirable responding. The appreciation of such a difference, which is the core of differential psychology, is accompanied by shame in clients, when they assume the assessor will reject, judge, or abandon them if they do not reach the standard of normality in the testing. When assessors collect testing protocols that are constricted or guarded, they interpret such data as a consequence of the client's reaction to certain features of specific assessment contexts (i.e., forensic assessments) or as an effect of structural aspects of the client's functioning (Finn, 1996; Lanyon, 2004). Among the many reasons for defensive protocols, one way to interpret these data could be considering "closed," guarded, or constricted protocols as the clients' attempt to avoid the risk of being rejected or judged by the assessor, and thus feeling shame. Perhaps in contrast to some assessment situations, such as those that are forensic or purely diagnostic, the potential for shame to influence test performance is heightened when the client and assessor are engaged in an assessment that is intended to be therapeutic, and significant effort and attention are given to fostering a strong and trusting therapeutic alliance. In this framework, clients' beliefs about how a healthy person should or should not be, and about what assessors will consider as valuable intellectual or personality features, will guide clients' ways of approaching the tests and will affect the test results. Also, assessors' preferences and assumptions about what are healthy features or liabilities in personality functioning might lead them unwillingly to confirm clients' fears, thus eliciting shame in their clients.

When assessing culturally diverse clients, such risks are even stronger because the clients' performance is assessed with instruments created in the mainstream culture and compared to normative data collected from the mainstream population. A great deal of literature points out the biases inherent in such comparisons (see, e.g., Dana, 2005; Ramirez, Ford, Stewart, & Teresi, 2005), and some solutions have been found in terms of assessing test validity and collecting normative data on different ethnic groups. However, there is still a need for further research in this area, as assessors are often faced with having to use standardized tests without any available validity research and specific normative data concerning their clients' racial or ethnic group. In such cases, there is a risk of biases that can result in negative evaluation of the clients' functioning, thus fostering clients' shame. Moreover, clients belonging to minority groups might have the expectation, based on previous experiences of racism and prejudice, that they will be misunderstood and rejected, and that their behaviors will be misinterpreted by an assessor from the cultural majority group. Such clients often come to the assessment with a heavy load of shame related to their diversity, and assessment practices based on the comparison with a desired "norm" can very easily trigger it. Being mindful of this risk buffers shame both in the clinical

interviewing (Fantini, Aschieri, & Bertrando, 2013) and in interpreting testing data (He, Dominguez Espinosa, Poortinga, & Van de Vijver, 2014). Indeed, psychologists' code of professional ethics discusses the issue of interpreting test responses based on normative data that are often unrepresentative of nonmajority groups (American Psychological Association, 2002).

Finally, an assessment approach with Wundtian features can also instill shame in clients, particularly in those whose histories involve excessive rigidity. With such clients, the collaborative Wundtian approach increases the risk of instilling shame as a by-product of self-verification (Swann, Stein-Seroussi, & Giesler, 1992). The theory of self-verification posits that humans tend to accommodate their interpretations of their experiences to their self-representation. Self-verification theory accounts for both intrapsychic and relational behaviors. For example, individuals with low self-esteem will be prone to focus selectively on details of their experiences that confirm their negative view of themselves. They will disregard or even forget experiences or events that are in contrast with their negative self-representations. In couples' relationships, individuals have been found to view their partners as more similar to themselves than they actually are (Donato et al., 2015; Iafrate, Bertoni, Donato, & Finkenauer, 2012; Iafrate, Bertoni, Margola, Cigoli, & Acitelli, 2012), which helps confirm their self-view. Self-verification is an important part of an individual's functioning, as it provides a basic sense of coherence and predictability to the individual's environment. Self-verification is intrinsically contrary to the idea of an experimental subject who is able to learn more about himself or herself through self-observation. In fact, because of self-verification, individuals restrain the potential impact of what they experience by disregarding those elements that do not confirm their preexisting narratives.

From a systemic perspective, enlisting clients as collaborators and actively engaging them in the assessment is the outcome of a learning process. Specifically, the egalitarian relationship with the assessor, the active role in interpreting their own testing results, the awareness of the centrality of their own feelings and emotions in every step of the assessment are by-products of a deutero-learning process (Bateson, 1972). Deutero-learning is the process by which clients learn the rules that govern a new interaction by detecting the differences between the relationships they are living and their previous relational experiences. Asking clients for individualized assessment questions assumes they are able to be in touch with their needs, feel it is legitimate to express them to a stranger, and feel entitled to monitor the progress of the work that aims to provide them with the corresponding answers. Many clients are able to deutero-learn that these features are inherent and welcome within the relationship with the assessor (the letter that introduces the assessment is a powerful tip-off in this sense). However, self-verification theory, especially with clients whose existing narratives include low self-worth, shame, and interpersonal passivity, hinders or inhibits this deutero-learning process, as it overshadows the perception of the clinicians' effort to treat clients respectfully, reflecting positively their expertise in their lives. Later in the assessment, assuming that clients are educated experts can lead to shaming them by not being sensitive and attuned to the adaptive function of self-verification

and pushing clients too hard to embrace a more compassionate view of themselves based on what is emerging from the assessment. This becomes evident when, despite the clinicians' efforts, clients keep on giving voice to old uncompassionate narratives about themselves and their problems. In such cases, assessors can unwillingly promote shame in clients by interpreting their behaviors as "resistance" to psychological change, rather than efforts to maintain an organized sense of self and a coherent view of the world.

Assessors and clients might have different views of what is a more compassionate and thus healthier view of themselves and the world, based on their different cultural backgrounds. For example, a Western assessor might see a female client from a traditional culture as too dependent on her family and might identify that dependency as the cause of her lack of assertiveness. Therefore, the assessor might try to motivate the client to become more independent from her family, or at least to see the connection between her problems and her family relationships. However, the client might experience her relationship with her family as appropriate and normal in her cultural context, and thus she might not feel the need to criticize it or change it. These kinds of misunderstandings can produce a therapeutic impasse in which the therapist sees the client as resistant, and the client feels ashamed of not being able to change according to the assessor's expectations.

Therapeutic Assessment and shame as a by-product of assessment procedures

Taking on a top-down expert role, superimposing assessors' values in the relationship by shaming clients about their testing results, and not attuning to clients' needs for self-verification are three risks that are inherent in both traditional assessment and TA. Different from traditional assessment, some specific aspects of TA are designed to buffer these risks. To reduce the risk of enactments similar to those in Charcot's tradition, Finn (2007) stressed the importance of respecting clients as experts on their own lives. If one does so, the pull toward taking on the omniscient role of an all-knowing assessor is constrained by the respect that is given to the clients, and by the view that they are indispensable contributors who help make reliable and useful interpretations of test results by connecting them to their actual life events.

As discussed, the risk of seeing clients as defective when compared to the norms is inherent in the Galtonian tradition. As an example, Meyer and colleagues recently targeted a specific aspect of the standard Rorschach administration, according to the Comprehensive System, that induces shame in clients. In their revision of the Rorschach administration rules, these authors specifically indicated the need to avoid prompting more Rorschach responses in clients by using statements like "Most people see more than one response," to avoid making clients feel ashamed for being different from "most people" (Meyer, Viglione, Mihura, Erard, & Erdberg, 2011, pp. 10–11). This example is particularly noteworthy as it reflects the explicit effort within the scholarly community of modifying standard assessment practices to protect clients from feeling ashamed by such practices. However, more generally and at a less codified level, there are many other instances in which the implicit

comparison of the clients' performances with ideal standards of functioning according to the assessors' personal biases and personal values has a major role in the assessors' actions and choices within the clinical context. Finn (2005, 2014, 2015) emphasized how TA promotes personal growth in clinicians and suggested two paths through which psychological assessment helps assessors themselves to integrate previously split-off affect states. The first consists in using clients' "weaknesses" in testing to explore instances in assessors' lives in which they had similar problems. Finn recommended that assessors try to find their own personal stories and versions of their clients' dilemmas. For example, low IQ scores in a child, despite limiting academic success, can remind assessors of the importance of promoting and developing emotional ways of communicating with their children. Such a reminder is promoted by recalling instances in which assessors felt unable, limited, and cut out from relationships because of their insufficient performance, and comparing them with other times in which they felt understood and accepted unconditionally.

The second path is using "flinch" reactions to specific aspects of clients' functioning, symptoms, or personality, as signals that some aspects of the assessor have been dissociated (Finn, 2015). As Finn (2015) stated:

The more anxiety, anger, resistance, and flinching we encounter when working with a client, probably the more off-balance we are and the more work we have to do in accepting the split-off part of ourselves that they embody. And we can "reverse engineer" our flinching and discover where we need the most help by seeing what it is about others makes us the most anxious. (p. 8)

Assessors can reflect on common features of clients that make them flinch to find information about which dissociated aspects of themselves are highly visible in such clients. Assessors can often increase compassion for these clients and for themselves by realizing the ways in which their self-esteem was protected by not integrating the disavowed aspects of themselves that such clients embody.

Attuning to clients is a multifaceted process that has been described in detail elsewhere (Aschieri, Fantini, & Smith, 2016), and Finn (2007) described the core dynamics that can lead assessors to help clients change while respecting their own pace of change. Educating the desire to help clients by not overlooking their self-verification needs is, according to Finn, the result of a balanced positioning within Karpman's (1968) triangle. According to Karpman, entering into a relationship with traumatized clients, participants embody one out of three prototypical positions: the victim (the person who needs help or that has a problem), the persecutor (the person that creates or that increases the depth of the problem), and the savior (the person who aims at rescuing the victim). The triangle resulting from these positions is dramatic because these positions switch and are generally unstable over time. Finn, and the TA literature at large, have included this concept in several publications as a means to help assessors attune to clients who are couples (Finn, 2007), severely traumatized (Finn, 2014), or violent offenders (Chudzik & Aschieri, 2013). In all these cases, the authors stressed how dramatic it can be for the client and for the outcome of the assessment when assessors, who initially present themselves as saviors, assume different roles. In fact, in

Karpman's terms, when assessors overlook clients' self-verification needs, they are identifying with the savior position. However, failing to acknowledge the clients' dilemma of change, and the adaptive need of maintaining stability in their narratives about themselves and the others, often leads assessors to take the persecutor position with the client, who eventually becomes the perpetrator, leaving the assessor in the victim position. Finn recommended assessors try to maintain a position in the middle of the triangle. Avoiding the extreme versions of the persecutor, the savior, and the victim allows clinicians to attune with clients and provide healthy examples of behaviors based on the core affect states inherent in such positions. A balanced version of the savior position is the ability to help others while maintaining personal boundaries; a balanced version of the persecutor position is the appropriated and modulated expression of anger; and a balanced view of the victim position is the capacity to show one's pain to others and ask for help. By maintaining contact with their own desire to help, their anger, and their fragility, assessors can empathize more fully with all aspects of clients, allowing and giving space within the assessment not only to the part of clients that wants and needs to change, but also to the parts that need to verify their competence and worth in having constructed their preexisting narratives.

Implications for psychological assessment

In psychological assessment, the more clients are open and willing to disclose and participate actively in the process, the more the assessment results will be complete and accurate in describing the clients' psychological functioning (Finn, 2007). Therefore, clinical dynamics that trigger clients' defensiveness and withdrawal need to be addressed to ensure collection of reliable information. Furthermore, when the assessment goals involve not only information gathering, but also facilitating therapeutic change in clients, as in TA, addressing such dynamics becomes even more important. As explained in detail before, the emergence of shame in the assessment context greatly interferes with clients' openness and involvement in the assessment process. Shame is a blocking experience that prevents the expression of important aspects of the individual psychological functioning and damages the interpersonal rapport and attunement between clients and assessors. Therefore, identifying and counteracting shame becomes of the utmost importance in an approach to clinical assessment that aims to collect accurate information and be transformative for clients.

Approaching the assessment process with the awareness of how and why our practices in and of themselves can instill shame in clients can be helpful to assessors for various reasons. First, knowing that shame can be triggered by our assessment practices provides additional value to the use of testing. Test results, in fact, can be used to infer and define which dissociated states clients fear will cause them rejection and pain, as well as how strong and safe the clinical relationship with the assessor is, and to what extent the latter is perceived as a potential source of shame or of interpersonal support.

Second, when facing challenging and reluctant clients, ruling out the possibility that their defensiveness is protecting them from shame within the relationship with the assessor provides professionals with several options to try out in the sessions to

promote clients' participation in the assessment. Among these are discussing the perception of the assessors' role, power, and sources of authority; discussing what clients might fear their testing could show or admitting to having felt unworthy in some aspect of the self; respecting the clients' pace of change; and talking about the advantages of maintaining "old stories" about themselves.

Also, when shame does emerge in the relationship with the assessor or in the results of psychological testing, assessors are primed to intervene. Consistent with the literature concerning the treatment of shame (Bromberg, 2011), clinicians need to actively convey to the client that dissociated affect states do not pose a threat to the therapeutic relationship, nor will the clinician reject the client if they emerge. Finn (2012b) suggested that during TA, the assessor can employ several techniques to counteract shame; among the more frequently used are reframing/normalizing ("I see you feel shame for ... but given the experience that you had of ... I think it is perfectly normal not to be able to do ..."), actively counteracting shame ("I do not think you are ..."), and using self-disclosure on the part of the assessor as a way of helping the client feel less judged and isolated.

Third, assuming that the outcome of the assessment relies on the quality of the relationship with the assessor (i.e., being aware of the effects of working within a Charcot-like model of clinical assessment) might serve as a reminder that all the information and the "narratives" that the clients bring into the assessment are "just" outcomes of the conditions in which they were created. They are not objectively collected data. As long as assessors maintain a critical and reflexive attitude toward the ways they have contributed to constructing their knowledge about clients, clients might as well parallel the process and gain more awareness about how their own narratives about themselves and the world are relative to the means and conditions in which they were created. That is, they might stop considering such narratives as objective ways of looking at themselves and the world and start considering the role of their experiences and their attachment relationships, in shaping them.

Finally, developing awareness of the assessors' role in eliciting shame in clients helps to challenge the pragmatic definition of responsible behavior in clinical psychology. In this regard, the aspirational section of the American Psychological Association (2002) Code of Ethics, Principle B: Fidelity and Responsibility, states that "Psychologists are aware of their professional and scientific responsibilities to society and to the specific communities in which they work" (p. 3). Bianciardi and Bertrando (2002) suggested that the criteria for responsible action could be thought of either as practical or as logical and epistemological. With regard to practical responsibility, the clinician assumes that reality can be objectively understood and known scientifically. From this perspective, clinicians' choices would be considered responsible if they were based on the use of standardized procedures evaluated according to effectiveness criteria.

If clinicians are more skeptical about the possibility of knowing any psychological truth of clients devoid of their contribution in shaping it, they will instead be likely to endorse logical and epistemological criteria of responsibility. That is, they will try to maintain awareness of their own role in creating and

influencing the observed “objects,” (epistemological responsibility), and they will try to use coherent theories to account for the facts of which they are knowingly authors (logical responsibility). For instance, there is growing attention to certification of the administration and coding and interpretation of performance-based testing. This is an important step in ensuring the role and reliability of assessors from a pragmatic perspective. Clearly, this pragmatic responsibility is prerequisite, but focusing on “being able to do” a procedure correctly can overshadow the real problem, namely, “being able to understand the implications of doing something correctly.” Developing awareness of the assessors’ positioning and possible meanings associated with their clinical decisions completes and enhances the quality of their actions and allows for better care of clients.

References

- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, *57*, 1060–1073. doi:10.1037/0003-066X.57.12.1060
- Aschieri, F. (2012). Epistemological and ethical challenges in standardized testing and collaborative assessment. *Journal of Humanistic Psychology*, *52*, 350–368. doi:10.1177/0022167811422946
- Aschieri, F., Fantini, F., & Smith, J. D. (2016). Collaborative/Therapeutic Assessment: Procedures to enhance client outcomes. In S. Maltzman (Ed.), *Oxford handbook of treatment processes and outcomes in counseling psychology: A multidisciplinary, biopsychosocial approach* (pp. 241–269). New York, NY: Oxford University Press. doi:10.1093/oxfordhb/9780199739134.013.23
- Bateson, G. (1972). *Steps to an ecology of mind: Collected essays in anthropology, psychiatry, evolution, and epistemology*. New York, NY: Ballantine.
- Bianciardi, M., & Bertrando, P. (2002). Terapia etica: una proposta per l'epoca post-moderna [Ethical therapy: A proposal for post-modern age]. *Terapia Familiare*, *69*, 5–25.
- Bromberg, P. (2011). *The shadow of the tsunami and the growth of the relational mind*. New York, NY: Routledge.
- Carroy, J. (1991). *Hypnose, suggestion et psychologie: L'invention de sujets* [Hypnosis, suggestion and psychology: The invention of subjects]. Paris, France: Presses Universitaires de France.
- Cecchin, G. (2004). Ci relazioniamo dunque siamo: Curiosità e trappole dell'osservatore [We relate therefore we are: Curiosity and the observer's pitfalls]. *Connessioni*, *15*, 57–61.
- Cecchin, G., Lane, G., & Ray, W. A. (1994). *The cybernetics of prejudices in the practice of psychotherapy*. London, UK: Karnac.
- Chudzik, L. (2015, March). *TA with criminal offenders: How to avoid Western cultural blinders*. Paper presented at the annual meeting of the Society for Personality Assessment, Brooklyn, NY.
- Chudzik, L., & Aschieri, F. (2013). Clinical relationships with forensic clients: A three-dimensional model. *Aggression and Violent Behavior*, *18*, 722–731. doi:10.1016/j.avb.2013.07.027
- Cross, W. E. (1971). The Negro-to-Black conversion experiences. *Black World*, *20*, 13–27.
- Dana, R. (2005). *Multicultural assessment: Principles, applications and examples*. Mahwah, NJ: Erlbaum.
- Danziger, K. (1990). *Constructing the subject: Historical origins of psychological research*. Cambridge, UK: Cambridge University Press.
- Dickerson, S. S., Gruenewald, T. L., & Kemeny, M. E. (2004). When the social self is threatened: Shame, physiology, and health. *Journal of Personality*, *72*, 1191–1216. doi:10.1111/j.1467-6494.2004.00295.x
- Didi-Huberman, G. (2003). *Invention of hysteria: Charot and the photographic iconography of the Salpêtrière*. London, UK: MIT Press.
- Donato, S., Parise, M., Iafrate, R., Bertoni, A., Finkenauer, C., & Bodenmann, G. (2015). Dyadic coping responses and partners' perceptions for couple satisfaction: An actor-partner interdependence analysis. *Journal of Social and Personal Relationships*, *32*, 580–600. doi:10.1177/0265407514541071
- Evans, B. F. (2015, March). *Assessing psychological trauma cross-culturally: Integrating personal, interpersonal and societal narratives*. Paper presented at the annual meeting of the Society for Personality Assessment, Brooklyn, NY.
- Fantini, F. (2015, March). *Family traditions, cultural values, assessor's beliefs, and the client in the middle: Therapeutic Assessment of a young Sicilian woman*. Paper presented at the annual meeting of the Society for Personality Assessment, Brooklyn, NY.
- Fantini, F., Aschieri, F., & Bertrando, P. (2013). “Is our daughter crazy or bad?": A case study of Therapeutic Assessment with children. *Contemporary Family Therapy*, *35*, 731–744. doi:10.1007/s10591-013-9265-3
- Finn, S. E. (1996). Assessment feedback integrating MMPI-2 and Rorschach findings. *Journal of Personality Assessment*, *67*, 543–557. doi:10.1207/s15327752jpa6703_10
- Finn, S. E. (2005). How psychological assessment taught me compassion and firmness. *Journal of Personality Assessment*, *84*, 27–30. doi:10.1207/s15327752jpa8401_07
- Finn, S. E. (2007). *In our clients' shoes: Theory and techniques of Therapeutic Assessment*. Mahwah, NJ: Erlbaum.
- Finn, S. E. (2011, March). *What new understandings of shame mean for psychological assessment*. Paper presented at the annual meeting of the Society for Personality Assessment, Boston, MA.
- Finn, S. E. (2012a). Implications of recent research in neurobiology for psychological assessment. *Journal of Personality Assessment*, *94*, 440–449. doi:10.1080/00223891.2012.700665
- Finn, S. E. (2012b, June). *Working with shame in psychotherapy and psychological assessment*. Continuing education workshop sponsored by the European Center for Therapeutic Assessment, Milan, Italy.
- Finn, S. E. (2014, March). *Learning to navigate Karpman's triangle: The healing potential of assessing traumatized clients*. Paper presented at the annual meeting of the Society for Personality Assessment, Arlington, VA.
- Finn, S. E. (2015, March). *The wobbly pot and restrictions in the self: Confronting the possibility of severe disability through Therapeutic Assessment*. Paper presented at the annual meeting of the Society for Personality Assessment, Brooklyn, NY.
- Iafrate, R., Bertoni, A., Donato, S., & Finkenauer, C. (2012). Perceived similarity and understanding in dyadic coping among young and mature couples. *Personal Relationships*, *19*, 401–419. doi:10.1111/j.1475-6811.2011.01369.x
- Iafrate, R., Bertoni, A., Margola, D., Cigoli, V., & Acitelli, L. K. (2012). The link between perceptual congruence and couple relationship satisfaction in dyadic coping. *European Psychologist*, *17*, 73–82. doi:10.1027/1016-9040/a000069
- Hacking, I. (1999). *The social construction of what?*. Cambridge, MA: Harvard University Press.
- He, J., Dominguez Espinosa, A., Poortinga, Y. H., & van de Vijver, F. J. R. (2014). Acquiescent and socially desirable response styles in cross-cultural value surveys. In L. T. B. Jackson, D. Meiring, F. J. R. van de Vijver, E. Idemudia, & W. K. Gabrenya, Jr. (Eds.), *Toward sustainable development through nurturing diversity* (pp. 98–111). Melbourne, FL: International Association for Cross-Cultural Psychology.
- Kamin, L. J. (1974). The science and politics of I.Q. *Social Research*, *41*, 387–425.
- Karpman, S. B. (1968). Fairy tales and script drama analysis. *Transactional Analysis Bulletin*, *7*(26), 39–43.
- Lanyon, R. I. (2004). Favorable self-presentation on psychological inventories: An analysis. *American Journal of Forensic Psychology*, *22*, 53–65.
- Lerner, P. M. (1998). *Psychoanalytic perspectives on the Rorschach*. New York, NY: Routledge.
- Mahoney, M. J., & Granvold, D. K. (2005). Constructivism and psychotherapy. *World Psychiatry*, *4*(2), 74–77.
- Meyer, G. J., Viglione, D. J., Mihura, J. L., Erard, R. E., & Erdberg, P. 2011. *Rorschach Performance Assessment System: Administration, coding, interpretation, and technical manual*. Toledo, OH: Rorschach Performance Assessment System.
- Morrison, A. P. (1989). *Shame: The underside of narcissism*. Hillsdale, NJ: Analytic Press.
- Nathanson, D. L. (1992). *Shame and pride: Affect, sex and the birth of the self*. New York, NY: Norton.

- Phinney, J. (1992). The Multigroup Ethnic Identity Measure: A new scale for use with diverse groups. *Journal of Adolescent Research*, 7, 156–176. doi:10.1177/074355489272003
- Quintana, S. M. (2007). Racial and ethnic identity: Developmental perspectives and research. *Journal of Counselling Psychology*, 54, 259–270. doi:10.1037/0022-0167.54.3.259
- Ramirez, M., Ford, M. E., Stewart, A. L., & Teresi, J. A. (2005). Measurement issues in disparity research. *Health Services Research*, 40, 1640–1657. doi:10.1111/j.1475-6773.2005.00450.x
- Rennie, D. L. (1994). Clients' deference in psychotherapy. *Journal of Counseling Psychology*, 41, 427–437. doi:10.1037/0022-0167.41.4.427
- Rose, N. (1979). The psychological complex: Mental measurement and social administration. *Ideology and Consciousness*, 5, 5–68.
- Rose, N. (1998). *Inventing our selves: Psychology, power, and personhood*. Cambridge, UK: Cambridge University Press.
- Scheff, T. J. (1988). Shame and conformity: The deference-emotion system. *American Review of Sociology*, 53, 395–406. doi:10.2307/2095647
- Schön, D. (1983). *The reflective practitioner: How professionals think in action*. New York, NY: Basic Books.
- Schore, A. N. (1998). Early shame experiences and infant brain development. In P. Gilbert & B. Andrews (Eds.), *Shame, interpersonal behaviour, psychopathology and culture* (pp. 57–77). New York, NY: Oxford University Press.
- Stolorow, R. D., Brandchaft, B., & Atwood, G. E. (1987.) *Psychoanalytic treatment: An intersubjective approach*. Hillsdale, NJ: Analytic Press.
- Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life. *American Psychologist*, 62, 271–286. doi:10.1037/0003-066X.62.4.271
- Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York, NY: Norton.
- Swann, W. B., Jr., Stein-Seroussi, A., & Giesler, B. (1992). Why people self-verify. *Journal of Personality and Social Psychology*, 62, 392–401. doi:10.1037/0022-3514.62.3.392
- Thomas, C. (1971). *Boys no more: A Black psychologist's view of community*. Oxford, UK: Glencoe.