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CLINICAL CASE APPLICATIONS

Therapeutic Assessment of a Man With "ADD"

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In this article I present the first published complete case study of a psychological assessment done by the methods of Therapeutic Assessment. A client–therapist pair had been working together for several years but felt "stuck" in the treatment. The man had been previously diagnosed with attention deficit disorder (ADD) and sought help for disorganization and difficulties in romantic relationships. The therapist asked for diagnostic clarification but gradually revealed a deeper confusion about how to work with the client. Through the collaborative process of the assessment, the client gradually concluded that he did not have ADD, and he and the therapist reached a joint understanding of their next steps in treatment. This case illustrates how collaborative psychological assessment (a) can help clients revise their "stories about themselves and the world" and (b) provides an effective, nonthreatening way for a consultant to intervene in a client–therapist system that has reached an impasse.

Therapeutic Assessment[1] (TA) is a semistructured form of collaborative assessment described in a series of publications by myself and my colleagues (Finn, 1996a, 1996b, 1998; Finn & Martin, 1997; Finn & Tonsager, 1997, 2002). Although many of these works include excerpts from interactions with clients, to date there is no complete published case study of a psychological assessment conducted by the methods of TA. In this article, I remedy this situation in hopes that a detailed, comprehensive example of TA in action will help those psychologists attempting to use this approach on their own. I've chosen this case because it represents a common scenario in my practice whereby I use psychological assessment to consult to a therapist–client pair who are feeling "stuck" in psychotherapy. Also, I believe this particular case illustrates certain strengths of collaborative psychological assessment.

CASE STUDY

Referral

Elizabeth S, a Master's-level therapist who had been in private practice for 4 years, initiated the assessment after hearing about my work from a colleague. She called and explained that she had been working in art therapy for several years with David, a 28-year-old man, primarily focusing on his desire to be more successful at work and in his romantic relationships with women. Both David and Ms. S felt that therapy had helped him but that recently it lacked a clear focus. Ms. S said that sessions often "meandered" and covered many topics. She reported that David had been diagnosed with attention deficit disorder (ADD) when he was a child but that privately she wondered if he had bipolar affective disorder or a dissociative disorder or had been sexually abused. She asked if a psychological assessment could address these issues and give direction to the floundering therapy.

I replied that no test could say for certain whether someone had been abused or had bipolar disorder but that I could investigate these issues as part of an assessment. I also told Ms. S that often a midtherapy psychological assessment can help document progress to date and define new goals. We agreed that she would ask David to call me to discuss the assessment and that I would get back in touch with her if he called. I said I would mail her two information sheets about TA—one for referring professionals and one for adult clients—and asked her to pass on the latter to David when she talked to him about doing the assessment.[2] Last, I asked if she had shared her ques-

[1] I make a distinction between *Therapeutic Assessment* (uppercase) and *therapeutic assessment* (lowercase). The former is the semistructured form of collaborative assessment developed at the Center for Therapeutic Assessment in Austin, Texas and illustrated in this article. The latter is a term now generally used by some to refer to those psychological assessment practices that are beneficial to clients.

[2] Copies of these information sheets are available from Stephen E. Finn.

tions for the assessment with David; she said that she had and would do so again when discussing the referral with him.

David called about a week later saying that Ms. S had given him the information sheet and that he was very interested in pursuing the assessment. I asked about his goals for the assessment, and he told a similar story to Ms. S. He had been in therapy for over 2 years, felt it had helped him get to know himself, but he was still struggling with two major issues: relationships with women and disorganization. He attributed the latter to his ADD, diagnosed when he was a child. He wondered why he had never responded well to Ritalin® or other psychostimulant medications and asked if the assessment could help explore that question. I said I believed it could. We discussed the cost of the assessment and set a time for an initial meeting. I asked David to think about specific questions he wanted the assessment to address; he agreed to do this and said he would bring them to our meeting. I then called and left a message for Ms. S letting her know that David had contacted me and promising to call her after his and my initial meeting.

First Session

When I greeted David in the waiting room the first time, he bounced up quickly from his seat and shook my hand vigorously. I was struck by his youthful appearance and his high energy. We walked back to my office where he threw himself on the couch. He said he was looking forward to the assessment, and he talked quickly and animatedly throughout the first 15 min of the 90-min session. During the meeting, we worked together to develop questions he wished to address in the assessment, and I collected background information relevant to each of his questions:

1. Do I really have ADD and if not, why do I have trouble concentrating and remembering things?
2. Why can't I break up with girlfriends when they're treating me badly? What in me is too weak to do this?
3. Why is it so hard for me to be alone?

Regarding the first question, David explained that he had been diagnosed with ADD at age 10 after his teachers complained that he didn't pay attention in school and or complete homework assignments. He also mentioned being tested at age 14 because of his "complete disorganization" but knew nothing about the results or the person who evaluated him. David now experienced similar organizational difficulties in his work as a computer technician and had been denied promotions because he was not as productive as his coworkers. When I asked for an example of how his ADD showed up, he said he struggled to remember instructions from his supervisors. Typically, after meeting with one of them, he couldn't remember what they had told him. When I first inquired, David could identify no contexts under which his memory and attention problems were better or worse. When I urged him to think more, he concluded that on days when he felt "agitated," he had more troubles paying attention, but he did not know what caused him to feel agitated. David's doubts about the ADD diagnosis—reflected in his first assessment question—stemmed from comments Ms. S had made in therapy and from his own recognition that the medications he took for ADD "rarely did any good." However, if ADD was not responsible for his attentional problems, he did not know what was. He explained that currently he was not taking any psychostimulants; his current psychiatrist had prescribed Luvox®, but he said he often forgot to take it and did not know if it helped.

Regarding his romantic relationships, David explained that he had a series of girlfriends who treated him badly, yet he hung on to the relationships because he "was in love with them" and felt "it was better than being alone." He described a common pattern. Initially he would start dating a woman to whom he was not that attracted thinking, "It's not the greatest thing in the world, but I can leave her if I meet someone better." Then, within several months he would find himself feeling insecure and possessive and would accuse his girlfriend of being unfaithful. Eventually he would discover he was unable to break off the relationship even if the girlfriend were treating him terribly. For example, his most recent girlfriend had been sexual with David's best friend and then told him about it. He forgave her for this; then she went on to have sex with yet another of his friends. Once again, David was willing to continue the relationship, but the girlfriend ended it, saying that she was tired of David's being "so needy."

Although this comment stung, David said he recognized the truth of it—hence his third assessment question ("Why is it so hard for me to be alone?"). He explained that typically he worked hard to find a new romantic relationship as soon as one ended. At the time of the assessment he had not dated for 2 weeks—his longest period since age 18—mainly at the urging of Ms. S. He found this situation near intolerable in that the "pursuit of a woman" distracted him and kept him "out of bad feelings." He said he hated being alone because he always felt "lost and empty." He coped by (a) planning activities that involved others, (b) watching television, and (c) frequently moving to new cities where he would get caught up in the excitement of meeting new people. In fact, recently he had been considering another move. I asked David what he would feel if he didn't do these things. He replied, "chaos, lost, blackness, panic." I remember thinking at this point in the session that he looked like a lost, small boy. Finally, I asked David how he would answer his own assessment question (about being alone) if he had to make his best guess before we did any testing. In reply, he told me about his early history.

When David was 7 years old his parents divorced. He had no idea at the time that his parents were having marital problems and was extremely surprised by the separation. Following the breakup, David lived first with his father and saw his

mother 1 day each month. His father was quite depressed during this period, had severe financial problems, dated a lot of women, and smoked marijuana a great deal. Because of these issues, David eventually went to live with his mother, who also was "very confused and sleeping around." When he was 10 years old, David's mother married his stepfather, a "very strict man" who "didn't like children." When he was 11, David began experimenting with marijuana and got in trouble for stealing liquor from his parents. In high school he "calmed down" and was able to graduate both high school and college.

David explained that Ms. S thought all he had gone through as a child made it hard for him to be alone. He said this was possible, but he was not sure what the exact connection was. He did wonder if he was "always expecting girlfriends to break up with him because his parents had gotten a divorce." We also discussed Ms. S's question about whether he had been sexually abused as a child. He said he himself had no inkling of this but that Ms. S had come up with this idea from some drawings he had done during therapy. We agreed to keep his childhood experiences in mind as we explored his questions for the assessment.

At the end of the session I read aloud the questions David and I had developed together. He said he liked them and that he was excited about the assessment. He agreed to help me track down the professional who had tested him at age 14, saying that he would ask his mother for her name. He also signed a release for me to talk with his current psychiatrist and gave me permission to talk more with Ms. S about him and his therapy. Finally, we set up several appointments over the next several weeks for David to come in for testing.

Contacts With Collateral Sources

Prior to my next meeting with David, I worked to gather background information from other health professionals who had worked with him. First, I scheduled an appointment to meet Ms. S at her office. I often do this when consulting with therapists I have not worked with before, finding that it helps the two of us work as collaborators rather than as competitors during the assessment (Finn, 1997). Ms. S served me tea and seemed to appreciate the opportunity to talk about her work with David. It was clear to me that she cared about him a great deal and was concerned about whether she was helping him. She worried that she was "missing something" and confessed that she was not very sophisticated in psychodiagnosis. I asked for more information about her three questions: (a) Does David have bipolar disorder?, (b) Does he have a dissociative disorder?, and (c) Was he sexually abused as a child? She explained that the first question came from talking to David's current psychiatrist, Dr. K, who had mentioned this possibility. Ms. S wondered about the dissociative disorder because David so often had trouble remembering things. I asked if she had ever seen him in a dissociative state or whether he ever reported depersonalization, derealization, amnesia, or evidence of separate identities. Ms. S said that he did not, nor had she witnessed any of these phenomena. Finally, she showed me several drawings David had produced in therapy sessions and explained how the colors and placements of various objects in the drawings fit with art therapy theories about sexual abuse. I listened respectfully and asked if anything else had made her wonder about abuse. Again, she said she was concerned that she was missing something with David and that she was confused why he let girlfriends "abuse" him so. We parted with a good feeling between us, agreeing to stay in contact as the assessment progressed and to meet again when I had completed the testing with David.

Next, I called Dr. K, the psychiatrist who was treating David, and learned that he had seen David only two times. He explained that David had been prescribed a number of psychostimulants over the years by various physicians, with little positive result. Dr. K said David was "hard to get a read on" and that he wondered if the ADD symptoms weren't due more to a bipolar or cyclothymic process. Dr. K had prescribed Luvox, an antidepressant known to decrease anxiety, but David had not been on it long enough at their last meeting to know if it was helping. Dr. K said David was due for a follow-up appointment very soon in which he would assess the success of the Luvox. He asked me to let him know the results of the assessment as soon as I could.

Several days after our initial session, David called to say that his mother had located a copy of the report from his evaluation at age 14. He said it was interesting and that he would drop it by my office. The report described an achievement and language evaluation done by a PhD speech-language pathologist. At the time, David's individual achievement test scores were high in math and reading, both at the level of a high school senior. However, his spelling and written language skills were much weaker, and the report concluded that "David's ability to organize his written work … is quite poor. It is quite likely that many of David's behaviors which are characterized as 'irresponsible' are actually a result of his difficulties in the area of organization."

Standardized Testing Sessions

Second session. When David returned for his next session, I noticed immediately that he seemed calmer. He said it had been good for him to ask his mother about the earlier assessment and that she had expressed guilt about ways her parenting might have affected him. He had not known how to respond and he expressed hope that Ms. S and I could help him think this through. I said I would be glad to help. We looked at the report from the assessment together and agreed that it supported his belief that his problems with organization went way back. I asked if the evaluation had made much difference in the way his teachers responded to him; he remembered getting

some coaching on study skills but said he felt teachers still thought his poor school performance was his "fault."

In TA, the assessor begins standardized testing with those instruments that seem most related—on the basis of face validity—to the client's main concerns. Thus, I asked David to complete a self-rating scale (the Attention Deficit Scales for Adults; Triolo & Murphy, 1996) for adults regarding ADD symptoms. When he finished I quickly scored and plotted the results, and David and I examined them together. His scores indicated that he saw himself as having long-standing problems with attention, concentration, organization, and short-term memory and that these problems caused him distress and affected him negatively in his social and work relationships. I explained to David that although these results were consistent with ADD, they did not prove it. I then showed him a diagram I had copied from a professional article (Forness, Kavale, King, & Kasari, 1994) depicting how attention and concentration problems can have many sources other than ADD. David found this quite interesting, and our discussion provided a good segue to the next part of the session in which I interviewed him about symptoms of bipolar spectrum disorders, asked about his current drug and alcohol use, and had him complete the Dissociative Experiences Scale (Bernstein & Putnam, 1986).

David did describe some discrete periods of hypomanic mood, often lasting several days, when he felt "on top of the world" and that he could "do anything." During such times he would sleep 4 to 5 hours a night, engage in some impulsive buying, and contact old friends around the world. However, none of these behaviors was ever severe enough to cause him social or financial difficulties. Typically, these periods would end with a "crash" after 2 to 3 days, but David said he had never had a prolonged episode of depression because he always "got [himself] out of them" by being busy or hanging around people. As far as he knew, no one in his extended family had highs like he described or had ever been treated for bipolar disorder. He believed his mother had been on and off antidepressants, but he had never discussed this with her. Interestingly, David said he believed his attention and concentration were actually better than usual during his "highs." On this basis I hypothesized that such periods were unlikely to be the major cause of his memory problems.

Regarding drug and alcohol use, David said that at the time of the assessment he drank two to four beers a week but several times a year would "tie one on." He no longer smoked marijuana, in part because his job required periodic drug screens. On the Dissociative Experiences Scale David scored very low, and we discussed the few items he endorsed at all—one indicating occasional memory difficulties and one in which he said he could occasionally do things with ease that were typically difficult for him. When I asked about the latter item, David explained that when he felt on top of the world it was easier for him to approach women at parties. At the end of the session, David and I discussed what we had learned so far that day: He had long-standing problems with attention, concentration, and organization, but those were not due to drug and alcohol use nor to *phasing out* (the words we used for dissociation). He did have some periods of hypomanic mood, had never had a major depression, and at least by his report, the hypomania didn't account for his ADD-like symptoms. At the end of the session, David seemed thoughtful and grateful for my having included him in my thinking. We set up a time for him to complete the Minnesota Multiphasic Personality Inventory–2 (MMPI–2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) under the supervision of my testing assistant then reaffirmed our next appointment together. Following the session, I called Ms. S and left a message on her phone machine describing the session and what I thought David and I had learned.

Third session. At the beginning of our next session, David talked about his experience of the MMPI–2. He joked about being attracted to my female testing assistant, then described doing the MMPI–2 in one sitting with no breaks, saying he found it remarkably easy to concentrate while he was doing it. I asked what he thought made the difference; he said he felt calmer and more attentive since we began the assessment but could not say why. I told him I had not scored his MMPI–2 yet and wanted to do another test that day that would provide information about his relationship difficulties. He agreed and I then administered the Rorschach, using the standard administration from the Comprehensive System (Exner, 1995).

In TA, one often follows standardized test administration by engaging clients in targeted, collaborative discussions of their experience of a test or of their responses. After the Rorschach, I asked David about the personal meanings of what he had seen on the cards, much as in Harrower's (1956) projective counseling technique. First, I explained that there were several ways to use the Rorschach to understand someone. I would be carefully scoring David's responses and referring to the wide base of available research to compare his responses to those of other people. However, another way was to look at his responses as possible symbols or metaphors of how he experienced himself and the world. I asked if David would be willing to look over the cards again to see if any of his responses struck him as meaningful in that way. As we reviewed the cards, he immediately brought up his first response to Card I ("Maybe two winged creatures holding onto a middle pole. [Inquiry] The middle core is here. These are the two creatures on either side, the legs, arms holding on, wings, heads").[3]

[3]I videotaped all sessions of David's assessment. The following excerpts are transcribed from the tapes. "Steve" is myself, Stephen E. Finn.

David: Sometimes I've felt like this. I see them holding on for dear life. If they let go, they're likely to get blown away or fall.
Steve: And you relate to that type of situation?
David: Yes, that's what I feel if I don't keep busy. Like I'm going to fall into an abyss.
Steve: And what's in the abyss?
David: [Thoughtfully] I don't know. … Terrible feelings, I guess. I don't know any more than that.
Steve: And when you look at these creatures on the card, how do you see them? Are they likely to fall, or will they make it?
David: I think right now they're holding on, but if they let down their guard, they could slip and fall.
Steve: And does that feel like you also?
David: [Long pause] I'm not sure. I mean, I guess I act that way … like I have to hold on hard or something terrible will happen.
Steve: And is that why it's so difficult to be alone?
David: Yes, 'cause that's when the abyss feels closer. I don't want to fall.
Steve: And how about right now? Does it feel the same?
David: [Pause] Again, I'm not sure. But it somehow doesn't seem as scary.
Steve: What doesn't?
David: Letting go. Like I can imagine these creatures loosening up a little and nothing awful happening.
Steve: Any sense why it doesn't seem so scary right now?
David: [Laughs] Perhaps because I'm not alone. You're here too.
Steve: Yes, perhaps that's it.

David and I also discussed two responses that were very similar to each other on Cards III and VII. The latter response was

> It also looks like it could be one of those oil derricks. It reminds me of the other one [on Card III]. You can see where they lit it on fire and it's burning, with the large flame coming out of the top. [Inquiry] It's like the other one. It kind of reminds me of those pictures from Kuwait in the Gulf war. Here is the oil derrick coming out of the ground; the white part is the fire. It's being destroyed.

At first David's only thoughts about these responses concerned the TV news of the Gulf War. "It reminds me of the Kuwait oil situation. I saw it on TV. Some friends of mine were firefighters. We were interested in Red Adair, a specialist who puts these kinds of fires out." I then asked for any symbolic interpretations, which led to the following discussion:

David: I know some times I feel like that—like a fire that's difficult to put out.
Steve: How so?
David: It's those times I told you about, when I feel agitated. It's like there's something hot and dark boiling in me and I don't know what to do about it. It's so out of my control, just like those fires. No one knew how to handle them.
Steve: Except for Red Adair?
David: [Smiling] Yep. Perhaps I'm looking for an expert like that who knows how to handle me and can tell the other people what to do.

As I smiled in return, I imagined David might be hoping I could play that role.

Standardized Test Results

David's basic MMPI–2 profile is presented in Figure 1, the Content Scales are presented in Figure 2, and the Harris–Lingoes subscales are listed in Table 1. As I have come to expect in a collaborative assessment in which the client's goals are being addressed, David produced an unguarded MMPI–2 profile (Lambda = 39*T,* K = 47*T*). The MMPI–2 code type (7"948') suggested severe anxiety (A = 75*T,* ANX = 77*T*) and some cognitive disruption (Scale 8 = 70*T,* Sc3 = 78*T*) that Da-

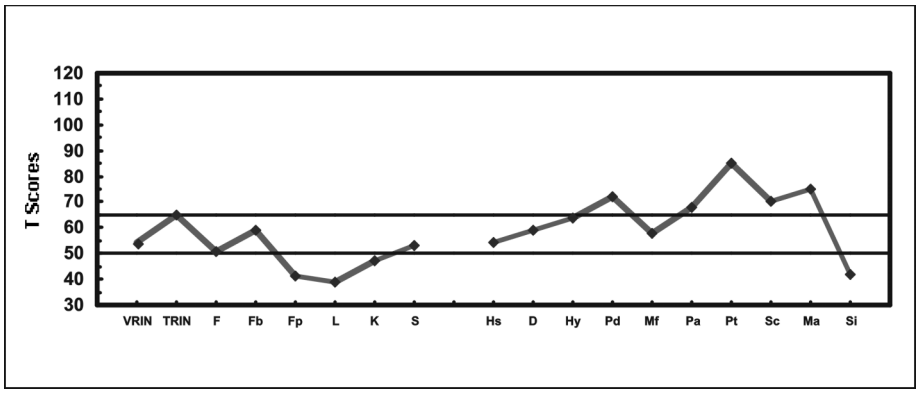

FIGURE 1 David's scores on the MMPI–2 Basic Scales.

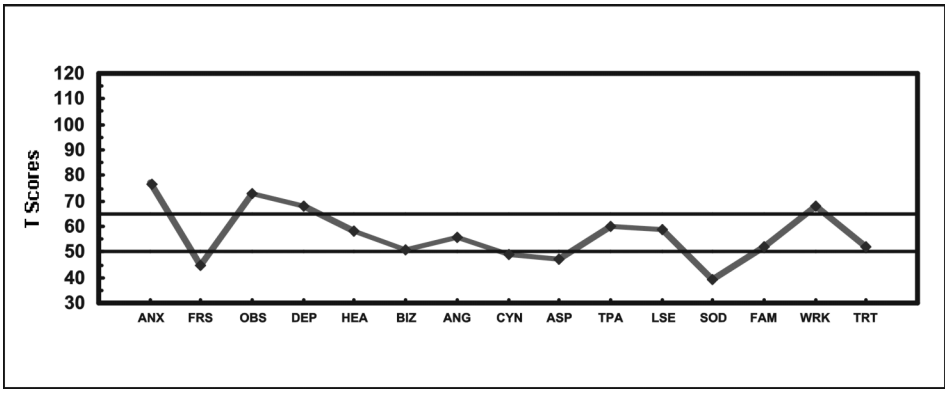

FIGURE 2 David's scores on the MMPI–2 Content Scales.

TABLE 1
David's Scores on the MMPI–2 Harris–Lingoes Subscales

Subscales	*T Score*
Depression	
Subjective Depression (D1)	69
Psychomotor Retardation (D2)	48
Physical Malfunctioning (D3)	43
Mental Dullness (D4)	58
Brooding (D5)	74
Hysteria	
Denial of Social Anxiety (Hy1)	45
Need for Affection (Hy2)	51
Lassitude-Malaise (Hy4)	66
Somatic Complaints (Hy4)	67
Inhibition of Aggression (Hy5)	48
Psychopathic Deviate	
Familial Discord (Pd1)	51
Authority Problems (Pd2)	61
Social Imperturbability (Pd3)	52
Social Alienation (Pd4)	62
Self-Alienation (Pd5)	72
Paranoia	
Persecutory Ideas (Pa1)	52
Poignancy (Pa2)	69
Naivete (Pa3)	60
Schizophrenia	
Social Alienation (Sc1)	59
Emotional Alienation (Sc2)	50
Lack of Ego Mastery, Cognitive (Sc3)	78
Lack of Ego Mastery, Conative (Sc4)	61
Lack of Ego Mastery, Def. Inhib. (Sc5)	51
Hypomania	
Amorality (Ma1)	50
Psychomotor Acceleration (Ma2)	58
Imperturbability (Ma3)	59
Ego Inflation (Ma4)	76

Note. MMPI–2 = Minnesota Multiphasic Personaity Inventory–2.

vid was handling by keeping busy, being very social, and engaging in occasional impulsive, defiant behaviors (Pd2 = 61*T*). The MMPI–2 also suggested that he was a very sensitive man (Pa2 = 69*T;* Mf2 = 69*T*) who was gregarious and probably had lots of superficial friendships but that he would find it difficult to trust people enough to form intimate, lasting relationships. Several scores suggested that under David's autonomous, energetic exterior (Ma4 = 76*T*) he might feel discouraged, insecure, and somewhat depressed (D1 = 69*T,* D5 = 74*T*). I took special notice of the elevation on Scale 9, given Dr. K's concern about bipolar disorder. A "Caldwell-ian" (Caldwell, 2001) interpretation of David's profile suggested that David's anxiety, busyness, and defiance were adaptations to a childhood in which adult caretakers were unpredictable, unreliable, and often critical. By keeping busy, failing to meet responsibilities, and worrying, David would distract himself from feelings of emptiness, grief, and terror (Caldwell, 2001). Caldwell also posited that elevations on Scale 7 (and the anxious worrying they depict) are the result of clients' being traumatized by shocking, unpredictable occurrences. I found this interesting given David's report that he was caught quite off guard by his parents' divorce.

David's Rorschach results are presented in Tables 2 and 3.[4] In contrast to the MMPI–2, the Structural Summary suggested a severe underlying depression (DEPI = 6, S–CON = 9) that most likely was long-standing (CDI = 5) and that was overwhelming David's coping mechanisms at the time of the assessment (Lambda = .13, D = –2). I have previously described this kind of discrepancy between the MMPI–2 and Rorschach, seen so frequently in situations like this in which a client is referred for evaluation by a therapist who is puzzled and concerned about a lack of progress in therapy (Finn, 1996a).

Unlike some clients I have seen requesting evaluation for ADD, David showed no ideational disturbance (WSum6 = 0) on the Rorschach. However, his mediation scores suggested that he viewed the world quite differently from most people (X + % = .47; X – % = .27; Xu% = .27). Most likely, his emotional difficulties were affecting his ability to accurately perceive the world around him. This hypothesis is strengthened if one examines the Sequence of Scores, as there is an interesting interaction of affect regulation and cognitive interference in David's responses. David gave relatively few

[4]I am presenting the fourth edition of the Structural Summary (Exner, 1995), as this is what was available at the time I was working with David.

responses to the last three cards of the Rorschach, suggesting that he was backing away from the emotionally arousing aspects of those cards (Afr = .36). Nevertheless, his perceptual accuracy on Cards VIII to X was significantly less than on the first seven cards (X + % for Cards I through VII = .64; X + % for Cards VIII through X = .00). Also, David's FQ– responses tended to co-occur with S (S – % = .75). All this suggested that although he was most likely a bright man (DQ+ = 8), David's ability to think clearly was compromised when he was emotionally aroused and especially when he was angry. Given this, it was not surprising that one of his main coping mechanisms was to avoid emotions.

Further examination of the interpersonal aspects of the Structural Summary helped explain David's quandary around emotions. In short, it appeared that David had never learned to use others as supports in managing difficult emotions ($T = 0$; COP = 1; Isolate/R = .40; Pure H = 1). Left to his own resources, David had few options other than to avoid and shut down emotions, for when he let himself experience emotion, it more often overcame his ability to structure it cognitively (FC:CF + C = 1:2). Until he could get better at regulating affect, David desperately needed others to help him contain and process strong feelings. I was reminded of David's telling me after the Rorschach that the "abyss" seemed less close because I was there with him.

In summary, although it was still possible that David's attentional problems were due to ADD, a more parsimonious explanation was that anxiety and a severe underlying depression were affecting his ability to attend and concentrate. David may have been depressed for so long—for example, since early childhood—that he failed to recognize that he was depressed. It was also likely that David had developed a kind of perceptual screening to cope with emotionally arousing situations and that this further interfered with his ability to remember and focus on the world around him.

David's fear of being alone and his tendency to stay with uncaring girlfriends seemed related to this same emotional quandary. Staying busy and highly social and always being in a relationship were ways David worked to hold off his underlying painful emotional states. Probably he knew what it was like to be overwhelmed by such feelings and worked hard to avoid such an experience. Unfortunately, the things he did to help himself contributed further to his already shaky self-esteem (3r + (2)/R = .27). In the absence of other evidence, there was no need to invoke repressed sexual trauma to explain David's behavior in relationships; his Rorschach gave ample evidence of why he would let himself be treated badly by girlfriends. Furthermore, although no test can accurately indicate whether a client has been sexually abused, neither David's MMPI–2 profile nor his Rorschach showed patterns associated with past abuse (e.g., Kamphuis, Kugeares, & Finn, 2000.)

Last, regarding the question of a bipolar spectrum disorder, I viewed David's test results as equivocal. He did have an elevation on Scale 9 of the MMPI–2, and his Structural Summary showed some features common to individuals with bipolar disorder (Singer & Brabender, 1993). However, the Rorschach showed no signs of severe bipolar disorder (e.g., WSUM6 = 0). As was clear from my interview with him, David did have some hypomanic periods, but the testing suggested no psychotic process was present at the time that I tested him.

Assessment Intervention Session

In TA, "assessment intervention sessions" are special testing sessions sometimes conducted after standardized testing is completed to explore working hypotheses about clients' problems in living and give them a chance to collaboratively reach new understandings (Finn & Martin, 1997). When David and I met next, I set out to explore my hunch that emotional flooding was largely responsible for his attention problems. I also hypothesized that quite often David was close to painful feelings of grief connected to his childhood experiences. With these thoughts in mind, I prepared four or five alternate number recall tasks, similar to the Digit Span subtest

TABLE 2
The Sequence of Scores for David's Rorschach

Card No.	*Response No.*	*Location and DQ*	*Determinant(s) and Form Quality*	*(2)*	*Content(s)*	*P*	*Z*	*Special Scores*
I	1	W+	Ma+	2	(H), Hh		4.0	
	2	WSo	FMao		Ad		3.5	AG
II	3	WSo	F–		Ad		4.5	
	4	WS+	ma.CF.C'o		Sc, Fi, Na		4.5	
III	5	D+	Mao	2	H, Hh	P	3.0	
	6	DS+	ma.C'F–		Sc,Fi,Na		4.5	
IV	7	Wo	FDo		(H)	P	2.0	
V	8	Wo	FMao		A	P	1.0	
VI	9	W+	FY.FC'o		Art, Ad	P	2.5	
	10	D+	ma.C'Fu		Sc, Fi		4.0	PER, MOR
VII	11	WS+	ma–		Sc, Fi		4.0	
VIII	12	W+	Mau	2	A, Na, Art	P	4.5	COP
	13	Wo	Fu		Art, Sc		4.5	
IX	14	Wv	CFu		(Ad)			AB
X	15	Wo	FC–	2	A	P	5.5	

TABLE 3
The Structural Summary for David's Rorschach

LOCATION FEATURES			DETERMINANTS BLENDS		SINGLE		CONTENTS		APPROACH Card:		Locations:	
							H	= 1, 0				
Zf	= 14		m.CF.C'		M	= 3	(H)	= 2, 0	I	:	W.WS	
ZSum	= 50.5		m.C'F		FM	= 2	Hd	= 0, 0	II	:	WS.WS	
ZEst	= 45, 5		FY.FC'		m	= 1	(Hd)	= 0, 0	III	:	D.DS	
			m.C'F		C	= 0	Hx	= 0, 0	IV	:	W	
W	= 12				Cn	= 0	A	= 3, 0	V	:	W	
(Wv	= 1)				CF	= 1	(A)	= 0, 0	VI	:	W.D	
D	= 3				FC	= 1	Ad	= 2, 1	VII	:	WS	
Dd	= 0				C'	= 0	(Ad)	= 1, 0	VIII	:	W.W	
S	= 5				C'F	= 0	An	= 0, 0	IX	:	W	
					FC'	= 0	Art	= 2, 1	X	:	W	
DQ					T	= 0	Ay	= 0, 0				
———		(FQ–)			TF	= 0	Bt	= 0, 0	SPECIAL SCORES			
+	= 8	(2)			FT	= 0	Bl	= 0, 0		Lvl–1	Lvl–2	
o	= 6	(2)			V	= 0	Cg	= 0, 0	DV =	0	0	
v/+	= 0	(0)			VF	= 0	Cl	= 0, 0	INC =	0	0	
v	= 1	(0)			V	= 0	Ex	= 0, 0	DR =	0	0	
					Y	= 0	Fd	= 0, 0	FAB =	0	0	
	FORM QUALITY				YF	= 0	Fi	= 0, 4	ALOG =	0		
					FY	= 0	Ge	= 0, 0	CON =	0		
	FQx	Fqf	MQual	SQx	rF	= 0	Hh	= 0, 2	Raw Sum6 =	0		
+	= 1	0	1	0	Fr	= 0	Ls	= 0, 0	Wgtd Sum6 =	0		
o	= 6	0	1	2	FD	= 1	Na	= 0, 3				
u	= 4	1	1	0	F	= 2	Sc	= 4, 1	AB	= 1	CP	= 0
–	= 4	1	0	3			Sx	= 0, 0	AG	= 1	MOR	= 1
No	= 0		0	0	(2)	= 4	Xy	= 0, 0	CFB	= 0	PER	= 1
							Id	= 0, 0	COP	= 1	PSV	= 0

RATIOS, PERCENTAGES, AND DERIVATIONS

R	= 15	L	= 0.15				FC:CF + C	= 1:2	COP	= 1	AG	= 1
							Pure C	= 0	Food	= 0		
EB	= 3:2.5	EA	= 5.5	EBPer		= –	SumC':WSumC	= 4: 5.5	Isolate/R			= .40
eb	= 6:5	es	= 11	D		= –2	Afr	= 0.36	H:(H) + Hd + (Hd)			= 1:2
		Adj es	= 8	Adj D		= 0	S	= 5	(H) + (Hd):(A) + (Ad)			= 2:1
							Blends:R	= 4:15	H + A:Hd + Ad			= 6:4
FM	= 2	SumC'	= 4	SumT		= 0	CP	= 0				
m	= 4	SumV	= 0	SumY		= 1						
						P	= 6	Zf	= 14	3r + (2)/R		= .27
a:p		= 9:0	Sum6	= 0		X + %	= .47	Zd	= +5.0	Fr + rF		= 0
Ma:Mp		= 3:0	Lv2	= 0		F + %	= .00	W:D:Dd	= 12:3:0	FD		= 1
2AB + Art + Ay		= 5	WSum6	= 0		X – %	= .27	W:M	= 12:3	An + Xy		= 0
M–		= 0	Mnone	= 0		S – %	= .75	DQ+	= 8	MOR		= 1
								Xu%	= .27	DQv		= 1
SCZI	= 2	DEPI		= 6	CDI	= 5	S – CON	= 9	HVI	= Yes	OBS	= No

on the Wechsler Adult Intelligence Scale–III (Wechsler, 1997). I also reviewed and selected several Thematic Apperception Test (TAT; Murray, 1943) cards for us to do.

David arrived looking very upset; he confided that he had just had a fight over the phone with his ex-girlfriend and was still very angry. I listened while he vented for a short time then interrupted and said I wanted to use this opportunity to check out some things I thought I understood about his problems with attention and memory. Was that OK? He said it was, so I first asked him to rate how agitated he felt at that moment on a scale ranging from 0 to 10, with 0 being *not agitated at all* and 10 being *the most agitated he'd ever felt.* He rated his agitation at 10. I then administered the first number recall task. David did quite poorly, being able to remember only four digits forward and three digits backward. He agreed this was no surprise, as he had said previously that he could not remember things at times he felt agitated. We then worked to find out what would decrease his agitation. First, we tried simply talking more about the situation with his girlfriend, with me listening carefully and mirroring back what he said. This brought his agitation down to a 7. I then led him in a short relaxation and breathing exercise, after which he rated his agitation as 5. We then did another digit recall task; this time he did better and remembered seven digits forward and five backward. After we finished, we talked:

Steve: Well, what did you notice?
David: I could remember more that time. I wasn't so distracted. How well did I do?
Steve: That was a normal average score.

David: Really? That's good to know.
Steve: And perhaps we've also learned something about what's going on when you're agitated, and what helps to calm you down.
David: You mean like when I feel agitated, I might be angry, and I need to talk and get over it and maybe slow down and breathe?
Steve: That seems like one possibility. Does that fit for you?
David: Yes … [Tentatively]. Although I'm not sure I'm angry all that much.
Steve: I believe you, let's try one other thing.

I then pulled out the TAT cards I had selected and asked David to tell a story to card 3BM (using the standard instructions). His story was as follows:

> This looks like a woman who is so confused that she's dropped to the ground where she was standing and had a mental shut down. She looks very distraught and grief stricken. Before she was getting ready to go somewhere. She was all dressed up. But then she got some news of some kind—a phone call or a letter—horrible news. She dropped everything, fell to the ground, and her mind stopped. [Steve: After?] She came back to reality and the reality of it hit her again. But then she cried for an hour until she fell asleep.

Following the story, David rated his level of agitation at 7 and we did yet another digit recall test. This time he could only remember six digits forward and five backward. We noted this and he took a moment to tell me, "This picture is what happens to me when I get a big shock. My brain has a meltdown." I asked for times when he might have felt like this, and he told of a childhood incident from after his parents divorced. His father and he were going out to dinner and David got angry over something. His father said he could not go because he was mad and then left him. He eventually came back and got David, but David had been near hysterical with fear in the meantime. I then selected another TAT card (13B) and asked David to tell me a story to fit that picture:

> It looks like a little boy who's got more on his mind than a boy his age should have on his mind. … He's thinking hard and emotions are flying around his head. He almost looks adult-like, but he's a child. It looks like maybe his parents are children as well as him. The adults in the family are acting like children and the children are being forced to act like adults without wanting to. He's being forced to be alone. The family doesn't know what's going on. Feelings are washing over him. [Steve: What does he need?] He needs parents that are actually adults and that have wisdom. He needs someone to treat him like he's a child, so he doesn't have to be so self-reliant.

At that point David began to cry. We talked quietly together as he explained that this picture reminded him of himself as a child. He said that he and Ms. S had talked about this period of his life, but that he never let himself really feel what it was like. We agreed that he had been a tough kid who had tried hard to act like a grownup and that this pattern was hard to break. David slowly calmed, then sat up, turned to me, and changed topics:

David: I don't think I have ADD after all.
Steve: Tell me more.
David: I think this is all about feelings. I can't concentrate when I have too many feelings. My brain melts down and I can't think. And there are so many things I have stored up inside—that I've never gotten to—and it's bad for me. I've been holding all this in for too long and I've got to stop running.
Steve: I think you might be right. And it's like you said last time—you can loosen up a bit and you don't die.
David: You're right. I actually feel good getting into this. This is what I need to do with Elizabeth. Can you tell her?

I told David I would be glad to help and I reminded him that our next meeting was a joint one with Ms. S to review the results of the assessment. I also said I would be talking with her before that meeting and would certainly pass on what we had discovered.

Consultation With Ms. S

Shortly after this session with David, I arranged to meet with Ms. S another time at her office. I had explained that I wanted her thoughts about the results and her help thinking about how to discuss them with David. I began by telling Ms. S that I could see why she had been puzzled about David. His testing suggested he was quite a complicated young man and that it was not easy to figure out the best way to approach his therapy. Immediately Ms. S seemed relieved. I also told her it was clear to me that she and David had formed quite an attachment and that I thought she should be proud of this, as his testing suggested this was not easy for him to do. Again, Ms. S seemed pleased to have me validate her experience.

Then I slowly went through each of the tests, showing Ms. S the results, explaining how I interpreted them, and describing in detail my interactions with David during our sessions. Ms. S was particularly interested in the projective testing, never having seen how it actually worked, and she gave additional associations to David's Rorschach responses based on her therapy with him. Finally, I summarized my tentative answers to some of Ms. S's questions: David did not appear to have a dissociative disorder, might have hypomanic tendencies, and, as she suspected, his attentional problems did not appear to be due to ADD per

se. I was carefully broaching Ms. S's theory about David's having been sexually abused when she broke in:

Ms. S: Oh, I see now that I was way off in that.
Steve: You've changed your mind?
Ms. S: Yes. I think I was just grasping for something to explain David's lack of progress. But you've already explained what was going on, don't you think?

I concurred, and then Ms. S and I discussed ways she and David could work differently in therapy to slowly and gently access more of his underlying painful affect. I explained that while doing this Ms. S would need to teach David how to lean on her more as an emotional support. Without learning this in tandem he could easily become overwhelmed, which would only reinforce the need for him to continue avoiding his feelings. Ms. S asked me specifically how she could support him and asked me to discuss this directly with David in our next session.

Summary and Discussion Session

In TA, we no longer call the sessions at the end of an assessment "feedback sessions," as this name implies a unidirectional flow of information from assessor to client. In fact, when I arrived at Ms. S's office for our meeting with David, he was already there and he quickly took the lead in explaining his new insights about how "old feelings" were causing his "brain to melt down." I filled in how these same feelings made it difficult for him to be alone and kept him stuck in bad relationships. David then told Ms. S that the two of them needed to "get at these feelings" and how good he had felt after crying during the TAT with me. Ms. S said she was committed to doing this kind of work with David and asked me to describe how to make it safe. I then talked with them both about the relationship between affective management and object relations:

Steve: Imagine that when we're born, we have a little container inside to hold emotions. At first this is the size of a thimble. When it gets "full" it overflows, and the baby will feel distressed and cry. … If all goes well, an adult caregiver, usually the mother, then comes and acts like a "saucer" under the infant's "cup." She holds and soothes the baby, "catching the overflow" of emotion. When this happens consistently, the cup grows, say from a thimble size to the espresso-sized cup of a 1-year-old, the coffee cup size of a 2-year-old, etc. If we've had enough good emotional saucers, when we get to be adults we have big "bucket-sized" containers inside that let us hold lots of emotion without being anxious, losing our ability to think clearly, acting out in self-destructive ways, or getting depressed. … Of course, we still need emotional saucers, and will our whole lives. But … we can handle those situations where support isn't immediately available. David, from your testing it looks like you didn't have reliable saucers growing up and were faced with emotions no kid could handle on his own. … Now, your job is to learn to use Elizabeth as a saucer, or you'll just repeat your childhood experience of being flooded by feelings you can't handle and feeling all alone with them.
David: So what does that look like to use someone as a saucer?
Steve: It means staying in contact with them and letting then "hold you" with their eyes and their heart. I bet, if you think about that, you've already had some experiences like that with Elizabeth.
David: [Tentatively] I guess I have. But the whole idea is really pretty strange.

David then asked me directly if I thought the Luvox might help him and I said it might, explaining it was another way to help manage overwhelming emotions. He confessed that actually he had not been forgetting to take it but that it was incompatible with his "tough guy" aspirations to be on an antidepressant. I said this was understandable; growing up he had been treated as if he should be able to handle difficult emotions on his own. This expectation was unreasonable, and he must have developed shame. This was not true, but surely he must have developed shame about wanting or needing help with his feelings. I then mentioned that David might even consider some other medications that could help reduce his agitation and that Dr. K would be the real authority on these. We all agreed that I would call Dr. K to discuss the assessment and that David and Ms. S would follow up with him shortly.

Toward the end of the session, David asked about the advisability of discussing his childhood experiences with his parents. Ms. S and I concurred in suggesting he go slowly with that also. I explained that such interactions might also stir up a lot of emotion for David and that he and Ms. S would want to prepare for that eventuality. In addition I recommended that he think carefully about what he hoped to get out of such discussions.

Shortly after this I left, giving David and Ms. S time to discuss the assessment alone together. They both thanked me and said my work with them had been extremely valuable. I offered to be available to either of them in the future, and David and I talked about the possibility of our having a follow-up session in about a month. I left feeling quite optimistic that the assessment had helped the two of them get "unstuck" in the therapy and that I could be a resource if they ran into further problems.

Written Feedback and Immediate Follow-Up

Approximately 2 weeks after our final session, I sent David a letter summarizing what we had learned in the assessment (see Appendix). I asked Ms. S to review a draft of this letter before I mailed it, and I made several changes based on her suggestions. I also asked David to complete two forms used in our practice for clients to give feedback after an assessment: a questionnaire consisting of a series of open-ended inquiries and the Assessment Questionnaire–2 (AQ–2; Finn, Schroeder, & Tonsager, 1994), a standardized instrument of clients' satisfaction with different aspects of a psychological assessment. I also asked Ms. S to fill out an open-ended questionnaire concerning her impressions of the assessment.

On the AQ–2, David rated himself as highly satisfied with the assessment (Total Satisfaction = 60*T*) relative to a sample of clients who had been evaluated previously at the Center for Therapeutic Assessment.[5] His AQ–2 component scores showed that his high satisfaction was based fairly equally on feeling he had learned new things about himself, felt more secure about who he was after the assessment, liked me and felt liked by me, and had few negative emotions during the assessment sessions. In the open-ended feedback questionnaire, David explained his feelings in his own words (responses are in italics):

> How well did the assessment meet your expectations?
>
> *It was far better. I did this mainly because Elizabeth thought it would be helpful. I had no idea it would help so much.*
>
> What part(s) of the assessment did you find most valuable?
>
> *The whole thing, but especially crying during the stories. I saw how much I've been avoiding my past and how it affects my memory and ability to think.*
>
> What suggestions do you have for improving the way we do assessments?
>
> *Can't think of any.*
>
> What would you tell a friend who was considering getting an assessment from us?
>
> *Do it! Dr. Finn is a really nice man and you'll learn a lot about yourself.*
>
> Please give any other comments.
>
> *I really appreciated the way you included me from the beginning. I didn't realize you would listen so much to my ideas and this helped a lot.*

Interestingly, Ms. S reported similar feelings in some of her written feedback:

> How well did the assessment meet your expectations?
>
> *Far exceeded. I had heard good things about your work but frankly had no idea the assessment would be so useful.*
>
> What part(s) of the assessment did you find most valuable?
>
> *Having the testing validate some of my ideas, while showing others to be red herrings. I now feel much more secure about how to proceed in the treatment.*
>
> What suggestions do you have for improving the way we do assessments?
>
> *None, just publicize more what you do!!*
>
> Please give any other comments.
>
> *Thank you for the respect you showed me during the assessment. I was afraid a psychologist would come in as the "big expert" and look down on me, but you never made me feel that way.*

Long-Term Follow-Ups

Approximately 6 months after the assessment I got a call from Ms. S asking if she could consult with me again about David. I said I would be happy to talk with her and noted the worried tone in her voice. When we met Ms. S reported that right after the assessment her therapy with David had seemed to have new purpose and clarity. The two of them had begun to talk in more detail about David's early experiences in his family and how these related to his adult relationships. As predicted, David had begun to experience strong feelings of sadness and anger, and Ms. S had reminded him to use her as a support. During this time David had increased his therapy sessions to twice a week and was taking the Luvox Dr. K had prescribed. About 4 weeks prior to Ms. S's calling me, however, David had a particularly emotional session with her right before she left on a brief vacation. Then, while Ms. S was away, David had rather impulsively and angrily confronted his mother about his "terrible" childhood, and she had reacted defensively, blaming him for being such a difficult child. By the time Ms. S returned, David was severely depressed, had been drinking heavily, and was furious at her for being away. He talked alternately about quitting therapy and leaving town or about committing suicide. Ms. S had reacted by insisting that David make a suicide contract with her; he refused and they had spent two very difficult sessions in a power struggle about this. Finally, the two of them had agreed that Ms. S would consult with me about what to do.

I sympathized with Ms. S about how scary it was to hear a client talking about suicide and how frustrating it must have been to have David "jump the gun" in talking to his mother about his childhood. I asked Ms. S if she felt guilty at all about taking her vacation, and she confessed that she did. In retrospect she wished she had reminded David in that last session she was leaving so they could have slowed down their work before she went away. We agreed that might have been good and that possibly David's "plunging in" was his way of acting out his various feelings about her going. Last, I asked if Ms. S felt she could be a good saucer for David's feelings of wanting to hurt himself or flee. She seemed startled when I asked this then quickly saw that she had been so intent on preventing his acting out she had not mirrored at all

[5]The standardization sample for the AQ–2 tended to be quite satisfied with their assessments; thus, the *T* scores exhibit a ceiling effect.

his desperation, fury, and fears of being hurt all over again. She told me that at times she was scared by the intensity of some of David's emotions. I said I could see why, given what had showed up on his Rorschach, and I asked if she had enough saucers to hold her while she was busy holding David. Ms. S laughed and mentioned he was not the only one who tried to manage difficulties all alone. I said I related to this and commended her on calling me when she needed help. Two weeks later Ms. S called to say that she and David were out of their power struggle and back on track. In fact, the crisis had led to several breakthroughs: David had acknowledged how much he needed her and how terrified he was of getting abandoned. Also, his mother had called him, contrite, and asked for a joint session with him and his therapist. Ms. S and David were carefully planning how to approach that meeting.

These events all took place over 6 years ago. Ms. S and I have talked briefly during this period, but in preparing this article I got quite curious about what had happened to David. Thus, I called Ms. S to ask for an update. She related that she and David continued to work hard in twice-a-week therapy for about 5 years after the assessment. David periodically experienced bouts of serious depression; however, each time these came up the two of them had worked together to help him manage the feelings. Also, after the crisis I had heard about, David joined a weekly therapy group to get additional support when Ms. S was sick or out of town. Gradually, David's moods stabilized and his romantic relationships improved. In fact, Ms. S told me that about 1 year ago David got married to a lovely woman and relocated because of his wife's job. They had a touching and good termination, with David's being able to feel sad and acknowledge how important the therapy had been to him. Recently Ms. S had a card from him saying that he and his wife were expecting their first child and that if it was a girl, he wanted to call her "Elizabeth." Ms. S and I laughed together and talked about our therapy "children" and "grandchildren."

SUMMARY AND CONCLUSIONS

Admittedly, not every instance of TA has such an unequivocally positive outcome as the one I have presented here. However, I chose this case not only to demonstrate the effectiveness of TA but because it illustrates several important points.

Collaborative Assessment Helps Clients Change Their Life Stories

How can such a relatively brief procedure as a TA help foster such important and long-lasting outcomes for a client? Psychologists know that normally people do not change that easily! As my work with David shows, collaborative assessment techniques are powerful because they focus on helping clients "rewrite" the stories they tell themselves about themselves (which psychologists usually call *identity*) when those stories have become problematic or incomplete in important ways. My purpose with David was to discover his existing stories, use psychological tests as "empathy magnifiers" to come up with new possibilities (Finn & Tonsager, 2002), and then provide David with a set of memorable events (such as my TAT intervention) that would help him revise his self-concept. In this instance, David's old story ("I have ADD") shifted to a new story ("I have too many emotions I've never dealt with that are overwhelming my thinking"), which led to a new set of actions that gradually changed his experience of the world. I also had the advantage in this assessment that a significant figure in David's life (Ms. S) was able to support his new views and ways of being and follow up with him as he integrated his new story into his life.

Compared to other forms of therapeutic intervention, psychological assessment has the advantage of quickly gathering detailed specific information about clients' self-schemas and interpersonal schemas. Furthermore, when TA techniques are applied, clients are enlisted as active participants—in everything from specifying the goals of the assessment, to collecting collateral information, to helping interpret test results. I believe traditional assessment approaches—in which results are either never shared with clients or are shared as a fait accompli at the end of the assessment—do not work as well for changing a client's life story. This is because to all of us as humans our identities are like precious works of art, which we have constructed on the basis of innumerable life experiences and in which we have a great deal of ownership, investment, and pride. Research has demonstrated that in most cases people will distort or discount perceptions and information that challenges their existing self-schemas to verify and maintain those schemas (Swann, 1997).

It is mainly by presenting clients with significant experiences during an assessment, which we as assessors then help to reframe or label in new ways, that we can assist them in authoring new identities. This type of collaboration challenges us as psychologists to contain our hypotheses and insights longer and to give more thought about how to assist our clients in developing new insights. Psychologists may feel less important and more like midwives than parents. However, I am convinced that what is lost in grandiose self-esteem through this process is gained in effectiveness with clients.

Collaborative Psychological Assessment Is a Powerful, Nonthreatening Way to Consult to Colleagues

This case also illustrates the potential utility of psychological assessment in consulting to treating professionals. Others have recognized that assessment is useful in this way, espe-

cially in clarifying diagnostic uncertainties about a client (e.g., Allen, 1981). However, with the exception of Fischer (1985/1994), few people have noted how often diagnostic referral questions actually reflect more complex treatment quandaries based on the relationship between client and treating clinician. In my experience this is no less true with highly experienced treaters than with therapists like Ms. S who are early in their careers. When this fact is fully appreciated, a different view of assessment as consultation emerges: It is a systemic intervention affecting a client, therapist, and their relationship. Thus, assessors must be highly skilled in managing complex systems to avoid splitting or becoming triangulated in an unhealthy way with the therapist–client pair.

In TA such pitfalls are avoided by treating both client and referring therapist as essential collaborators in the assessment. As already noted, clients are enlisted as coparticipant observers throughout the assessment. This case also demonstrates how the same end is achieved with referring professionals. I involved Ms. S in each step of the assessment: explaining the purpose of the assessment to David, supporting him as the assessment unfolded, interpreting his test responses, discussing the assessment results with him, and constructing the written summary at the end of the assessment. At each stage I endeavored to take neither a one up nor a one down stance toward Ms. S, to respect her vulnerability in seeking my assistance, and to openly join her in acknowledging the difficulties of becoming intimately involved with clients like David. As sometimes happens, this led to her feeling free to consult me again when she and David reached another crisis later in their treatment relationship. I suspect that if more assessors approached referring professionals in this collaborative manner, there would soon be even more call for assessment as consultation to client–therapist pairs in difficulty.

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APPENDIX
Excerpts From Feedback Letter to David

Dear David:

As promised, I'm writing to summarize the information we went over in your assessment feedback session with Elizabeth Smith on June 27, 19XX. My hope is that you and Elizabeth will then have a written document to refer to as you proceed in your therapy.

I'll structure this letter by addressing the questions we came up with for the assessment. Before doing this, however, let me say again how much I respect the way you put yourself into the assessment, David. I am well aware that psychological testing is a vulnerable and difficult thing for anyone to do, and I know from your test results that it is not always easy for you to trust others. I saw the real effort you made to let me see who you are, David, even when that was a bit uncomfortable. I appreciate the courage and trust you showed. Also, thank you again for allowing me to videotape our sessions to use in training other psychologists.

Now to your questions:

Why can't I break up with girlfriends when they're treating me badly? What in me is too weak to do this?

Why is it so hard for me to be alone?

David, your personality test results showed that you are trying to manage a lot of overwhelming emotions, which have been around for a long time. Underneath your energetic and optimistic exterior, you are struggling with a great deal of depression and sadness, anger (especially at authority figures), feelings of worthlessness, and a sense of powerlessness. Although you are an extremely intelligent guy with a lot of varied coping mechanisms, this inner pain has currently exceeded your ability to manage it, with the result that you are experiencing severe anxiety and periodic bouts of depression. As you told me, at times it feels that if you let down your guard, you will fall into an abyss. When you reach this type of situation you always have the option of making a large geographic move—as you have in the past—which distracts you and provides you new and exciting people to interact with. Another past option has been to become immersed in a romantic relationship where you can lose yourself and gain some temporary relief from your inner pain.

In short, it is your unresolved inner pain that makes it difficult for you to be alone and which sets you up for getting caught in bad relationships. Until you can explore and resolve some of the depression and anger you are carrying, it will be difficult for you to 1) choose good partners for romantic relationships, 2) set appropriate limits so you don't get abused by your partners, 3) feel secure that others are telling you the truth, and 4) stop from re-creating relationships where you get emotionally abandoned.

As I mentioned in our last session, your longing to be connected to someone is a good sign—and shows that you haven't totally given up on other people. However, until you have resolved more of the issues from your past, it may be wisest to avoid getting involved romantically and to use therapy and non-romantic friends for your social and emotional support.

Do I really have ADD and if not, why do I have trouble concentrating and remembering things?

As we discussed in our last session, this is a difficult question which we cannot answer with total certainty at this time. It is clear that you are distractible and highly active, David, and you have many of the symptoms of Attention Deficit Disorder. However, as you yourself decided in our next-to-last session, it is quite possible that your attentional problems are caused mainly by your anxiety and depression and by your attempts to cope by staying highly active, "up," and distracted from your negative moods.

I am fairly certain from the testing and from the stories you told that the events of your childhood had a detrimental impact on you. Your parents' divorce and their inability to help you process your anger and sadness about their separation probably left you with a lot of confusing and overwhelming feelings. One of the stories you told to the picture cards seems a good description of what you probably experienced at the time:

> It's a little boy who's got more on his mind than a boy his age should have on his mind. He's thinking hard about a turn of events. It looks like he's not looking at anything. He's thinking hard—with lots of emotions flying around in his head. He almost looks adult-like, but he's a child. It looks maybe like his parents are children as well as him. The adults in the family are acting like children, and the children are being forced to act like adults without wanting to. He's being forced to be alone. The family doesn't know what going on. Feelings are washing over him. He needs parents that are actually adults … that have wisdom. He needs someone to treat him like he's a child, so he doesn't have to be so self-reliant. (TAT 13B)

If this story is an accurate description of a period in your childhood, David, it helps to explain a lot of the problems you are having now. The divorce and separation were probably quite traumatic for you, in part because you didn't have adequate "saucers" to help hold and process the painful emotions you were experiencing. Thus, you had to "cut off" whole parts of your emotional experience and develop ways to manage on your own. Those protected emotions still exist, as you said, "in deep storage," and you add to them still because you continue to manage difficult feelings by avoiding them if you can.

For now, I recommend that you seek treatment for your anxiety, depression, and anger—with psychotherapy and medication—and see if this makes an impact on your attentional problems. If you make significant progress in addressing these underlying issues and still find yourself highly distractible, further testing could help identify other neurologically based causes to your attentional problems.

David, these are the recommendations we discussed in the last session:

1. Think seriously about your impulse to leave town, as it may represent an old way of coping with your anxiety and depression. I know you are unhappy with your current job, but a move will only temporarily postpone the inner pain you are feeling. It might be best to stay put and work hard in therapy to resolve your emotional issues.
2. Keep resisting the urge to get into a romantic relationship, and learn to rely on Elizabeth and on friends more. I know that you don't really know how to do this, as you don't have much experience letting others support you. But keep asking Elizabeth what it would look like to use her as a "saucer."
3. It might be wise to increase your individual sessions with Elizabeth right now, or to add other supports (such as a therapy group). In either case, your work in therapy right now is to access your inner pain—little by little—while getting support from others so it doesn't overwhelm you. As we discussed, you may find yourself distrusting whether Elizabeth (or others) can handle your emotions; if so, such feelings also should be discussed. By alternately exploring your distrust and your inner pain, you should find yourself less anxious and depressed and more able to tolerate aloneness.
4. Your idea of discussing your childhood with your parents is a good one. But take time to work with Elizabeth about how to handle the feelings that could result and to clarify your goals for such discussions.
5. Work with Dr. K to find an antidepressant that works for you. The Luvox may or may not be a good drug for you; he and you may also want to discuss adding a mood stabilizer (such as Depakote) to help with your overactivity and agitation.

Thank you again, David, for letting me get to know you. I admire your many strengths and was impressed by how well you manage some very difficult emotions. If you have any questions or comments about this letter—or if you would like to schedule the follow-up session we discussed—feel free to contact me.

One last request: Would you be willing to complete the enclosed forms about your experience of the assessment and return them to me? Your feedback will help me work in the future with people in situations similar to yours.

Best wishes,
Steve Finn

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