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How Psychological Assessment Taught Me Compassion and Firmness

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In this article, I reflect on 2 specific assessment experiences and how they helped me grow as a person and as a psychologist. I believe that practicing assessment creates opportunities for personal growth in assessors because (a) to truly understand difficult clients, we must find personal versions of their psychological dilemmas in ourselves, which we might otherwise never be called on to face, and (b) to be effective as assessors, we must say difficult things to clients in plain nonjudgmental language, which forces us to develop courage and wisdom.

I began practicing psychological assessment in 1979 as a 23-year-old graduate student. When I look back on myself at that time, I see a bright, energetic, and rather insecure young man who was concerned about people and who covered up his self-doubts and anxieties with an air of self-importance and accomplishment. Many things have happened in the intervening 24 years that have helped me become who I am today—a wiser and somewhat more secure middle-aged man who sometimes covers up his anxieties with an air of self-importance and accomplishment. Among the things that have shaped me the most, I count my work as a practitioner, teacher, and researcher of psychological assessment. My goal in this article is to illuminate several ways that I think practicing assessment has affected me and to reflect on how this happened.

My title focuses on learning compassion and firmness because these are two of the most important ways assessment has changed me. I want to start with a story about learning compassion that happened in 1982 when I was a psychology intern at Hennepin County Medical Center in Minneapolis. As part of my usual duties, I was assigned to do a personality assessment with a male client about my same age who had been admitted recently to the inpatient psychiatry ward following a serious suicide attempt. This client, whom I'll call John, was memorable in that in just a few days, he had managed to alienate a good deal of the highly experienced nursing staff—not to mention the rest of the people being treated on the ward—with his condescending and disdainful demeanor. In the treatment groups, John called the other patients "idiots" and offered penetrating but harsh comments on why they had the problems they did. One day he reduced a well-liked occupational therapist to tears with his biting remarks about her suggested craft project. And John and I got off to a bad start in our first meeting when he made it clear how impossible it was that a psychology trainee like myself could teach him anything about himself that he did not already know. I left that session with a major dose of negative countertransference, and my supervisor, Dr. Ken Hampton, patiently listened to me rant about why I should even "waste my time" on someone who obviously did not want to be helped when there were so many other deserving people needing assessments. I think Dr. Hampton knew this could be an important assessment for me, and he calmly and firmly instructed me to do the best I could with John, explaining that if we could understand John's off-putting behavior better, it would be of considerable help to the other staff.

John's Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1943) profile was extremely guarded and had no significant elevations on any of the clinical scales. In my mind at the time, this just confirmed the futility of my doing any further testing with John. Again, Dr. Hampton insisted I persevere, and I gave John a Rorschach (Exner, 1993). This was quite a different experience. John produced five reflection responses in his average length protocol, confirming my impressions of his narcissism. He also gave a series of extremely depressive percepts, including a number of morbid images such as people with "empty" insides and a poignant final response about a person who had fallen apart into pieces.

Furthermore, John seemed quite undone by the process of the Rorschach, and for the first time, I felt some sympathy for him. When I inquired gently about how he was doing, he turned on me viciously saying I might truly be the biggest fool he had ever met in all his contacts with the mental health

system and that I needn't bother talking to him about the results of the assessment. He then stormed out of the testing room, got a nurse to let him back in the locked ward, and then refused to talk to me when I followed a few minutes later. To my embarrassment, the nurses and other staff observed all this and couldn't hide their knowing grins.

As a 26-year-old psychology intern, I took this all quite personally, and I stormed off myself to my supervisor's office, where I too had a temper tantrum, although it was slightly more intellectualized than John's. Again, Dr. Hampton listened patiently and asked me to show him the MMPI and read him the Rorschach. I've since come to understand a great deal about the types of MMPI–Rorschach discrepancies represented in John's testing (Finn, 1996), but at the time, I needed help resolving the apparent contradictions.

Could I see, asked Dr. Hampton, how John's offensive interpersonal tactics and defensiveness on the MMPI were so strong because of the extreme inner pain and emptiness he was trying to protect? I thought I could, but why wouldn't John just admit to this pain and let us help him when it obviously troubled him enough to make a serious suicide attempt? Dr. Hampton nodded slowly, looked me in the eye, and asked if I could find no empathy for a person who would rather hide his pain and insecurity with an air of competence and self-sufficiency rather than face the shame of admitting that he needed help. I nodded slowly, starting to "get it." Dr. Hampton watched me closely and then explained projective identification to me in simple language. In fact, he said, what I was now experiencing—in terms of rage and embarrassment and the desire to retaliate—was a version of the feelings John struggled with daily. And for this to have happened, it must mean that I was vulnerable to some of the same dynamics as John.

That interpretation was quite a challenge for me at that point in my personal development, and I needed quite a bit of support in supervision and my own therapy to "metabolize" it over time. Dr. Hampton's timing was perfect in that I was able, fairly quickly, to shift my view of John to that of a fellow human being rather than someone who was totally different from me. Also, as I completed the assessment with my supervisor's help, writing the report and eventually giving feedback to John and the staff working with him, I found more compassion not only for John but also for the part of myself that was so like him.

Over the years, I've come to see this experience as representative of one of the most challenging and exciting parts of being an assessor. To really be *empathic* to the clients we assess—and I'm using the word empathy in the Kohutian sense, as the ability to "put ourselves in our clients' shoes"—we are challenged repeatedly to find in ourselves a personal version of the conflicts, dynamics, and feelings troubling the people we assess. And while it's certainly possible to conduct psychological assessments without engaging in such personal exploration, I believe that if you do so, your reports will be wooden, your clients will not really feel moved and understood when you talk about their test results, referring professionals won't feel enlightened, and after a while, you'll feel bored with psychological assessment.

Of course, psychotherapists face a similar challenge, to identify on some level with their clients. If you do a lot of assessment, it's even more challenging for a number of reasons. First, we assessors get asked to comprehend and explain the clients that no one else can understand, often because those clients exhibit qualities that even experienced mental health professionals prefer to deny in themselves. Over my years of doing assessments, I've stretched myself to empathize with how one might commit murder, perpetrate sexual abuse, repeatedly set oneself up to be victimized, engage in all kinds of compulsions, really truly wish to die, and use every known character defense and mind-altering chemical to ward off inner pain. Recently, I was really struggling with an assessment I was doing, so I sought consultation with Dr. Paul Lerner, who also has an article in this special series (Lerner, 2005/this issue), and who helped me see that I didn't really understand my own or other's capacity for sadistically holding other people hostage by being a martyr.

There is another way that doing personality testing challenges us differently than doing nonassessment-based psychotherapy. Our tests are powerful tools that give us access to clients' inner worlds in ways we don't have otherwise (except perhaps through clients' dreams). I have written elsewhere about my view of psychological tests as "empathy magnifiers" (Finn & Tonsager, 1997, 2002). Well, sometimes we see things clearly through magnifying glasses that we might not otherwise choose to see. For example, to go back to my assessment with John, after talking about his Rorschach with Dr. Hampton, I found myself quite haunted by some of the images John reported. This was heightened after my psychotherapist at the time pointed out the similarities to some of my own Rorschach responses, from a protocol administered 2 years earlier just before my first Rorschach course. And it's not just open-response tests that can have these types of effects. I think we can have similar strong emotional reactions just by reading slowly and thoughtfully through the MMPI–2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) critical items endorsed by a highly distressed or disturbed client.

Now, I implied in my title that assessment has taught me firmness as well as compassion, and I want to relate one more, briefer personal story that illustrates this second point. Early in my clinical practice, I became aware of a particular "blind spot" I had by doing an exercise that Alex Caldwell (2003) talked about during his Klopfer award acceptance speech to the Society for Personality Assessment. I used to challenge myself after interviewing clients I was assessing to sketch my best guess of their MMPI profiles before the answer sheets were scored. Over time, I saw a glaring pattern: I consistently failed to predict elevations on Scale 4 or both 4 and 9. And while the hypothesis Dick Rogers (2003) mentioned in his Master Lecture is intriguing—that we'll tend not to see people

as psychopathic unless they surpass our own level of psychopathy—in fact, I'm pretty sure the opposite was true in my case. At that time in my life I had so clamped down on my own "inner psychopath" that I simply kept expecting other people to be as nice as I thought myself to be.

I knew something was off about this and was grateful to have the MMPI to "watch my back." Still, fairly quickly another problem became glaringly apparent. Even when I knew from my assessment materials that clients tended to act out in antisocial ways, I tended to be rather ineffective with them during assessments. I would talk with them about their impulsivity, excitement seeking, and ability to be coldhearted, but I remember feeling at the end of such assessments that I had missed something and that the clients were vaguely disappointed. Similarly, when I saw such clients in therapy, they would tend to leave after four or five sessions. At first, I consoled myself with the maxim that antisocial clients don't respond well in general to mental health interventions. The only problem was, the clients I was seeing weren't hard-core psychopaths at all but simply people who tended to act out as a coping mechanism. Also I was acutely aware that some of my colleagues had much better track records than I did with this type of client.

In this case, it was a client and an assessment workshop that helped me make the personal shift required. I was assessing a young woman named Mary who had gotten into some legal trouble for threatening a man at a party with a knife because he refused to have sex with her when the bash was done. At one point, I was talking with Mary about her MMPI (a 4-9-2-7 profile for those of you who are interested) and she looked at me and said, "I wish you wouldn't be so damn nice all the time!" When I looked confused she said, "You always try not to hurt people's feelings. But sometimes it's not good. It would work better if you'd just call a spade a spade!" This impressed me, in part because I had just attended an MMPI workshop with Alex Caldwell where he had discussed his hypothesis about Scale 4 elevations being related to a combination of overly harsh and overly permissive parenting in childhood. I suddenly realized that I was repeating history by acting like an overprotective parent and failing to provide what self-psychologists call an "adversarial transference" experience (Wolf, 1998) for these individuals where they could bump up against a firm, savvy, and yet benevolent authority figure. Years later, Carl Gacono explained to me that antisocial clients can't idealize us if they feel that they can outsmart us and get away with things in the therapy/assessment relationship.

True to form, Mary appeared for our assessment feedback session with a beer in her hand and a glint in her eye that seemed to say, "So what are you going to do about this?" I calmly pointed at the small kitchen off the waiting room and said firmly, "You can put that in the refrigerator and pick it up when we're done." We then went over the assessment results together, which I had worked hard to put into no-nonsense, direct, blunt language. Mary listened respectfully, asked a few questions, and said at the end, "You really got me!" I remember feeling that tremendous excitement of having risen to an occasion and knowing that I would never be quite the same afterwards.

As it turned out, I ended up working in psychotherapy with Mary after the assessment, and years later, she told me how relieved she had been when I made her put up her beer, since in her words, "Mom always let me play in the middle of the highway." The lesson I learned from Mary helped me not only in that assessment but in almost every assessment I've done since then. For I've come to see that our job is not only to find compassion for our clients and to understand the psychological dilemmas underlying their problems in living but also to talk with clients about these issues in clear, forceful language. For many clients, an assessment may be the first time that someone respected them enough to bring up such topics, and our doing so conveys a certain faith in the part of them that wants to grow and change. We do no one any good by constructing excessively sympathetic apologias for clients' psychological "shortcuts." As Mary said, most times it's best just to "call a spade a spade." Our reluctance to do this is, I believe, is in fact due to a common empathic error: We project our own shame on clients and assume they will be devastated if we speak frankly about the less savory aspects of their personalities. In fact, some part of them is longing to get such things out in the open and to better understand why they behave in self-destructive or cruel ways and how to begin to make changes.

In conclusion, I believe that the work of an assessor is not for the faint of heart. To do our jobs well, we must continuously confront our inner shadows and courageously say things to people that no one has said before. This work takes energy, lots of support from others, and an ability to appreciate and even be amused by life's individualized, "remedial classroom"—by which I mean our tendency to create and encounter the same life lessons over and over until we master them sufficiently to move on to the next. Perhaps because—rather than in spite of—these very challenges, I count myself lucky to be a psychological assessor.

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REFERENCES

Butcher, J. N., Dahlstrom, W. G., Graham, J. R., Tellegen, A., & Kaemmer, B. (1989). *MMPI–2: Minnesota Multiphasic Personality Inventory–2: Manual for administration and scoring.* Minneapolis: University of Minnesota Press.

Caldwell, A. (2003, March). *A love affair with an instrument.* Paper presented at the annual meeting of the Society for Personality Assessment, San Francisco.

Exner, J. E., Jr. (1993). *The Rorschach: A Comprehensive System: Vol. 1. Basic foundations* (3rd. ed.). New York: Wiley.

Finn, S. E. (1996). Assessment feedback integrating MMPI–2 and Rorschach findings. *Journal of Personality Assessment, 67,* 543–557.

Finn, S. E., & Tonsager, M. E. (1997). Information-gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment, 9,* 374–385.

Finn, S. E., & Tonsager, M. E. (2002). How *therapeutic assessment* became humanistic. *The Humanistic Psychologist, 30,* 10–22.

Hathaway, S. R., & McKinley, J. C. (1943). *The Minnesota Multiphasic Personality Inventory.* Minneapolis: University of Minnesota Press.

Lerner, P. M. (2005/this issue). On developing a clinical sense of self. *Journal of Personality Assessment, 84,* 19–22.

Rogers, D. (2003, March). *Standardizing* DSM–IV *diagnoses: The clinical applications of structured interviews.* Paper presented at the annual meeting of the Society for Personality Assessment, San Francisco.

Wolf, E. (1998). *Treating the self: Elements of clinical self psychology.* New York: Guilford.

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