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Implications of Recent Research in Neurobiology for Psychological Assessment

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In this article, I highlight 3 major findings from current research in attachment, neurobiology, psychopathology, and psychotherapy: (a) attachment failures and early trauma are related to many forms of psychopathology, (b) one of the major sequelae of developmental trauma is disorganization of the right hemisphere, and (c) psychological interventions that promote emotional experience, awareness, and expression are more effective than those that rely solely on cognitive restructuring. I then suggest implications of these findings for the practice of psychological assessment: (a) the relationship between client and assessor is more important than has been acknowledged generally, (b) performance-based personality tests are very useful in part because they tap right-hemisphere and subcortical brain functioning and provide information that clients cannot directly report, and (c) when psychological assessments provide clients with powerful emotional experiences, therapeutic change is often the result. I illustrate these points with excerpts from the Therapeutic Assessment of a 27-year-old man with compulsive sexual behavior.



I find this an exciting time to be a clinical psychologist. My enthusiasm is partly because in recent years, a convergence has developed between research and theory in the areas of attach-

ment, infant development, neurobiology, psychopathology, and psychotherapy that is revolutionizing the way we think about and interact with the clients who seek our services. Such writers, researchers, and thinkers as Allan Schore (1997, 2002, 2003a, 2003b, 2003c, 2009, 2010), Daniel Siegel (1999), Daniel Stern (2004), Ed Tronick (1998), Antonio Damasio (1999), Diana Fosha (2000), and Beatrice Beebe (2000) have fostered a climate of interdisciplinary collaboration that is yielding rich rewards for many areas of psychology. My goal in this article is to extend this bounty to the area of psychological assessment, which, as of yet, has not fully participated in this cross-fertilization. In particular, I discuss how my study of attachment, neurobiology, and new developments in psychotherapy has given me new insights into psychological assessment and its potential power as a clinical intervention in my own work in Therapeutic Assessment.

THE CONSENSUS THAT IS EMERGING FROM NEUROPSYCHIATRY

I wish to highlight three widely accepted findings that are emerging from neuropsychiatry and developmental neurobiology.

Attachment Failures and Early Trauma Are Related to Many Forms of Psychopathology

First, it is now generally understood that secure attachment experiences during critical periods of infant development are essential for the development of such important psychological functions as emotion regulation, empathy, behavioral control, moral development, and social relatedness (Cicchetti, 1994; Schore, 1997, 2003c). Conversely, insecure attachment and developmental trauma are implicated in many different forms of psychopathology, including severe personality disorders, addictions, affective disorders, dissociative disorders, and psychosomatic illnesses. Clearly many of these conditions have genetic

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or innate biological components to them. But, it is also now evident that a powerful environmental factor is the extent to which individuals experienced early caretaking characterized by empathic attunement, collaborative communication, and repair of disruptions—the hallmarks of secure attachment relationships (Stern, 2004). Schore (2003a, 2003b) and others have done an impressive job of delineating the specific mechanisms through which early attachment experiences influence critical areas of brain development. Let me now summarize one important aspect of Schore's work.

The Importance of the Right Hemisphere

One of Schore's major points, for which he has assembled an impressive array of evidence, is that the right hemisphere of the brain—because of its dense reciprocal connections to limbic regions and subcortical areas—is dominant for the processing of attachment and affective experiences (Schore, 2002, 2009). In successful mother–infant¹ interactions there is a complex interplay (in sensorily intact mothers and infants) between eye contact, vocalizations, facial expressions, hand gestures, and movements of the arm and head—all coming together to express interpersonal awareness and emotions (Aitken & Trevarthen, 1997). It has been shown that the coordination of such signals occurs primarily outside of the mother's awareness and is governed primarily by the right hemisphere, which excels at interpreting this host of subtle signals. Schore makes the point that such communications occur from “right hemisphere to right hemisphere” (of mother to infant). One implication of this is that insecure attachment experiences and their negative emotional sequelae have their greatest effect on right-hemisphere functioning and therefore are frequently unconscious and not readily accessible through language (Schore, 2009).

Schore (2009), Bromberg (2006), and others have eloquently explained how such negative affect states—and accompanying implicit models of self and other—become dissociated, perhaps to show up in dreams or to be enacted in the transference that develops in a long-term psychotherapy. They and other experts also make a convincing case that successful psychotherapies of individuals with significant developmental trauma rest on the capacity of the clinician to form a secure auxiliary attachment relationship with the client and then, in Schore's terms, to nonverbally relate to the client—“right hemisphere to right hemisphere”—and thereby regulate the client's negative affect states and help the client reorganize his or her right hemisphere (Schore, 2003b).

The Importance of Emotion in Psychological Treatment

All of this work has led to a paradigm shift in psychological treatment (Schore, 2009), in which there is more focus than ever before on the real, affect-regulating functions of the therapist–client relationship and on the importance of dealing with emotion in psychotherapy. In fact, a recent important meta-analysis by Diener, Hilsenroth, and Weinberger (2007) examined existing studies of psychodynamic psychotherapy and looked at outcome as a relationship of how much the therapies specifically focused on affect. Affect focus was defined as

the therapist making comments like, “I noticed that your voice changed a bit when we were talking about your relationship, and I wonder what you are feeling right now,” and “To make these feelings more clear, it might help to try and focus in on exactly what you're experiencing right now, at this moment.” The overall correlation of affect focus and outcome across treatments was $r = .30$, and therapist facilitation of affective experience or expression increased the patient success rate from 35% to 65%. This effect was greater than the well-known association between therapist–patient alliance and therapy outcome, which has been estimated at $r = .22$ (Martin, Garske, & Davis, 2000). In short, the results of this meta-analysis suggest that the more therapists facilitate emotional/experience and expression in psychodynamic psychotherapy, the more clients change in positive ways, and that a powerful predictor of therapeutic success is the extent to which therapists facilitate affect (Diener et al., 2007). In my opinion, this finding suggests that purely cognitive approaches that rely heavily on the processing of verbal communication are not enough for many clients, and that successful therapists help their clients access emotions and then use empathic attunement and a host of nonverbal processes to help the clients regulate those negative affect states. A number of newer, relational psychotherapies rely heavily on these principles in working with clients with severe personality disorders and trauma. Among my favorites are those therapeutic approaches developed by Fosha (2000) and McCullough (1997).

APPLICATIONS TO PSYCHOLOGICAL ASSESSMENT

There are numerous implications of these new understandings for the practice of psychological assessment. Let me highlight three.

The Importance of the Assessor–Client Relationship

First, I believe that in traditional psychological assessment we have grossly underestimated the importance of the assessor–client relationship, as if participating in psychological testing was no more complex for a client than taking a blood test. In my own training, my assessment professor talked to us graduate students about the importance of “establishing rapport” with our “examinees,” but there was little in-depth conceptualization of what this meant or how it was to be achieved. I believe this practice is still more the norm than the exception in most graduate training programs. As many of you know, in my own model of Therapeutic Assessment, we begin every assessment with in-depth discussions with clients about the personal questions they wish to explore through the assessment, and very early on we discovered that this technique led to active client participation in our assessments and less guarded test protocols (Finn, 2007). However, it took me some years to realize that my success in framing questions with clients was largely due to my ability to make them feel safe, attended to, and respected in a relatively short period of time. I then came to understand that in some cases, I had to explicitly teach empathic listening, mirroring, and other relational skills to individuals wanting to practice Therapeutic Assessment.

Currently I would say that my main goal in the initial session with a client is to demonstrate those relational qualities that will promote the client's seeing me as a potential secure auxiliary attachment figure: emotional attunement, collaborative communication, and repair of disruptions. In keeping with Schore's

¹I refer to “mother's” interactions throughout the article while recognizing that the primary caregiver for some infants might be a father, grandparent, aunt, or uncle.

model, I believe much of this interaction occurs on a nonverbal level. As the client talks about problems and difficulties she most likely is ashamed of, she sees me listening intently with a nonjudgmental, open, curious attitude. I share a sense of what I am hearing and invite the client to confirm or modify what I say. My questions reflect my goal of understanding her particular experience and of finding the right words to describe it. If I misstep and one of my questions provokes shame or intense anxiety in the client, I take note of her reaction and either apologize or simply correct my stance, noting a place of sensitivity that will guide my subsequent comments and questions. My experience is that assessment sessions approached in this way leave clients feeling calmer, accepted, less ashamed, curious about themselves, and more hopeful, and that they set the stage for powerful therapeutic changes to occur in the assessment.

The Importance of Performance-Based Personality Tests

A second major topic in assessment that is illuminated by recent research in neuropsychiatry is that of projective, or as they are now increasingly called, performance-based personality tests. An area of intense debate in recent years has been the relatively frequent lack of concordance between measurements of certain constructs via self-report tests, interviews, or observer ratings and estimations of those same constructs via performance-based personality tests like the Rorschach. The fact is that many seemingly well-functioning individuals have Rorschach results that suggest a great deal of psychopathology (Finn, 1996, 2011a). This lack of concordance has led some critics to assert that performance-based personality tests are invalid, overpathologize, and are little better than reading tea leaves (Wood, Nezworski, & Lillienfeld, 2003). I (Finn, 1996, 2011a) and others (Bornstein, 2004; Meyer, 1997) have attempted to explain such discrepancies and discuss how they are useful clinically, and there is an array of research that supports the validity of performance-based personality tests. But the work of Schore (2009) and others now sets the stage for even more useful discussions.

Basically, I propose that tests like the Rorschach (Exner, 2003), Thematic Apperception Test (TAT; Murray, 1943), Adult Attachment Projective Picture System (AAP; George & West, 2012), and others—because of their visual, emotionally arousing stimulus properties and the emotionally arousing aspects of their administration procedures—tap into material that is more reflective of right-hemisphere and subcortical functioning. Other tests like the Minnesota Multiphasic Personality Inventory (MMPI-2; Butcher et al., 2001), Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), and Symptom Checklist-90-R (SCL-90-R; Derogatis & Spitz, 2000) utilize more left-hemisphere cortical functions because of their verbal format and nonemotionally arousing administration. (I don't want to overly simplify—obviously, both types of tests utilize both hemispheres to some degree.) What this means is that the Rorschach and similar tests tap into more implicit (to use Schore's word) schemas about self and other, which in some individuals (e.g., those with dismissing attachment status) are quite discrepant from their explicit, conscious conceptions. Also, because these procedures tap into right-hemisphere functioning more directly, they also allow us to see how people behave when presented with stimuli that can be quite emotionally arousing. Because many of our clients struggle with emotional regulation, performance-based tests give an idea of how they function when they are emotionally aroused. With those clients

whose problems in living are due to insecure attachment or developmental trauma, these tests often provide a window—that is not readily available otherwise—into their right-hemisphere disorganization and subcortical dysregulation.

Research in this area is just beginning, but now there are multiple studies examining how performance-based personality tests are processed in the brain, and their results seem to support my theory. Several studies concerned a relatively new performance-based personality test, the AAP (George & West, 2012). The AAP is a validated measure of adult attachment representation (status) and shows a high degree of concordance with the Adult Attachment Interview (George, Kaplan, & Main, 1984/1985/1996). It consists of seven cards with line drawings, each of which were chosen to arouse the attachment system. As one goes through the set, the cards are generally progressively emotionally arousing, and as I have written about before (Finn, 2011b), many clients have intense emotional reactions when taking the test. Some of the cards show figures that are alone; others show dyads. The stories are rigorously coded, and the codes are used to assign clients to one of the four major attachment status classifications: secure, dismissing, preoccupied, and unresolved.

In a pioneering study, George and her colleagues in Germany administered the AAP to a group of 16 nonpatient women while they were scanned in an fMRI machine (Bueheim et al., 2005). Five of the women had excessive head movement, so that left 11 women's scans to be analyzed. Afterward, the women's stories were coded and the women were classified into two groups: those with organized attachment status (secure, dismissing, or preoccupied; $n = 6$) and another with unresolved or disorganized attachment status; ($n = 5$). You will remember that unresolved attachment is particularly associated in research with past trauma and with various forms of psychopathology.

Women with unresolved attachment showed significantly more activation in their limbic areas than did women with resolved or organized attachment. This activation was centered mainly in the right amygdala and the hippocampus, which are associated with perception of fear and autobiographical memory, respectively. From the fMRI results, it appeared that the AAP might have reactivated "unresolved" traumatic or negative autobiographical memories among the women with unresolved attachment, especially the last cards of the AAP, which often elicit stories about traumatic situations. In short, the different AAP results reflected significant differences in how these pictures were processed in the brains of the two groups of women.

A second study examined the AAP performance and brain activation of 11 women diagnosed with Borderline Personality Disorder (BPD) compared to 17 mentally healthy female volunteers (Bueheim et al., 2008). Because of their well-known sensitivity to abandonment, it was predicted that the women with BPD would show a greater number of traumatic marker codes in their stories to the alone cards of the AAP, and that those same women would show increased activation of brain regions associated with fear and pain during such times. Both hypotheses were confirmed. The fMRI results indicated that when viewing the alone pictures, women with BPD showed more activation of limbic regions associated with pain and fear, namely the dorsal anterior cingulate cortex, than did the healthy volunteers.

Other fMRI studies have centered on the Rorschach. For example, in one study, individuals with lower form-quality scores on the Rorschach had larger amygdalas—known to be a sign of their amygdalas being activated more often (Asari et al., 2008).

This suggests that emotional activation greatly influences the extent to which one distorts reality. One study looked at Rorschach scores of individuals receiving positive and negative feedback about their performance on a frustrating simple motor prediction test. When listening to negative feedback, those individuals with more achromatic color (C') scores showed more activation of the posterior medial prefrontal cortex ($r = .34$), an area of the brain known to be implicated in the processing of negative emotions (Jimura, Konishi, Asari, & Miyashita, 2009). It seems that individuals with higher C' scores reacted more strongly to the negative feedback than those without much C'. This finding has implications, I believe, for giving feedback to clients with high C' scores about their psychological assessment results.

In summary, I believe that evidence will continue to accrue that performance-based personality tests have a very important place in our psychological assessment batteries, because these tests allow us to access parts of the brain that are difficult to reach with other methods, and because they are extremely useful in measuring different aspects of emotional and interpersonal functioning that are not well captured by other assessment procedures. More than 70 years after Bruno Klopfer began publishing his influential work on the Rorschach (Klopfer & Kelley, 1942), we are closer than ever to being able to explain why the Rorschach and similar tests work and how to interpret their results and use them to inform subsequent treatment.

Therapeutic Benefits of Providing Emotional Experiences to Clients During Psychological Assessment

Last, I would like to propose that just as successful psychotherapies arouse and help clients deal with an array of affect states, the same is true of psychological assessment. That is, if we want to use our psychological assessments to help clients heal and change (as we aspire to in Therapeutic Assessment)—and not just as sources of information about clients' personalities and psychopathology—we need to learn to maximize the emotional impact of our assessments. This means changing our view of the feedback process in psychological assessment from that of a cognitive transmission of information to that of a highly emotional event that has the possibility of profoundly changing clients' views of themselves. We must also expand our view of the psychological assessor from that of an "objective" technician who is good with tests and numbers to that of a highly interpersonally skilled clinician, who takes responsibility for helping clients deal with the potentially emotionally overwhelming information that can come out of an assessment. Last, if we want to maximize the therapeutic impact of our work, I believe we must learn to use emotionally arousing test materials for maximum benefit. To illustrate, let me now discuss a therapeutic assessment I did several years ago that demonstrates well how performance-based personality tests can be used to make potent therapeutic interventions.

CASE EXAMPLE

Referral

Ben² was a 27-year-old gay man referred to me by John—a psychologist—who told me that he had been treating Ben for

²The client's name and identifying information have been changed to protect his identity.

"sexual addiction" for over a year. I had not worked with John previously, but knew that he had a specialty in treating sexual addiction. When he called, John shared that he was concerned and somewhat frustrated with Ben, because Ben continued to "act out" sexually in risky ways, in spite of regular individual and group therapy and participation in a 12-step program for sexual addiction. John said that Ben had a difficult time identifying specific emotional triggers for his sexual acting out, and that he wondered if Ben might need to go to a residential treatment program for sex addicts. This option was a possibility in that Ben worked as a janitor in a national chain "big box" store and had excellent health insurance that would pay for such a treatment.

Initial Sessions

A few days later, Ben called and scheduled an initial session. When I greeted him in the waiting room, I found a slight, dark-haired young man, with a hang-dog look. He spoke softly and rapidly without making much eye contact, and ripped apart a facial tissue as we talked. Ben said his main questions for the assessment were as follows: "Why do I keep on acting out sexually in dangerous ways, even though I know that it's really stupid?," "What am I going to have to do to stop acting out?," and "Why do I hate myself?" His shame as he gave these questions was palpable, and it took all my skill as a psychologist to create some moments of contact with Ben, in which he could see that I was not judging him. For example, I asked Ben what he liked or found positive about his sexual encounters, which seemed to startle him. I commented on his apparent surprise and Ben said no one had ever asked him that question before. He then made direct eye contact for the first time and said, "When I have sex with a good-looking man, I feel good and attractive myself. And I don't usually feel that way at all." Ben then went on to say that he saw himself as a "120-pound weakling" and that he had never been good at sports. I asked more about his early years and found that Ben's mother was hospitalized for depression several times in his childhood and that Ben's father worked a great deal and was rarely home. However, Ben was very protective of his parents when relating this information, and assured me that his parents loved him a great deal.

Test Results

The first test I gave Ben was the MMPI-2 and his profile was a clearly defined 4-7 code type (see Figure 1). This code type is associated with an alternating cycle of acting out followed by severe shame and self-recrimination. This pattern is generally very difficult to interrupt, and most experts agree that the major underlying dynamic with these individuals is severe shame, and that the acting out behavior gives temporary relief from this (e.g., Graham, 2011). As the reader can see, there were no indications of serious depression on Ben's MMPI-2.

In hopes of exploring Ben's question of why he hated himself, I asked him to fill out the first part of the Early Memory Procedure (Bruhn, 1990), in which clients journal about their earliest memories and then rate them for how positive versus negative, and how clear versus fuzzy they are. In Bruhn's interpretive framework, a person's clearest, most negatively rated memory is believed to be a metaphor for his or her core unresolved issue. In Ben's case, his earliest memory—from age 4—was this:

Mom is in bed, where she has been all day, probably for weeks, and my brother and I are trying to get her up so she will eat something. My father

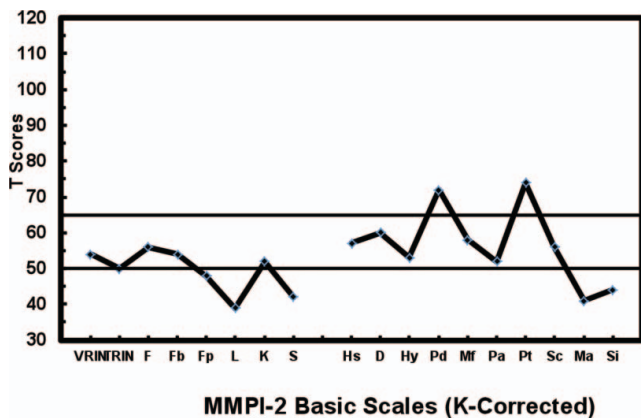


FIGURE 1.—Ben’s MMPI–2 profile. Note. VRIN = Variable Response Inconsistency scale; TRIN = True-Response Inconsistency scale; F = Infrequency; Fb = Back F; Fp = Infrequency Psychopathology; L = Lie; K = Defensiveness; S = Superlative Self-Presentation; Hs = Scale 1, Hypochondriasis; D = Scale 2, Depression; Hy = Scale 3, Hysteria; Pd = Scale 4, Psychopathic Deviate; Mf = Scale 5, Masculinity-Femininity; Pa = Scale 6, Paranoia; Pt = Scale 7, Psychasthenia; Sc = Scale 8, Schizophrenia; Ma = Scale 9, Hypomania; Si = Scale 0, Social Introversion. Excerpted from the *MMPI®–2 (Minnesota Multiphasic Personality Inventory®–2) Manual for Administration, Scoring, and Interpretation, Revised Edition*. Copyright © 2001 by the Regents of the University of Minnesota. All rights reserved. Used by permission of the University of Minnesota Press. “MMPI” and “Minnesota Multiphasic Personality Inventory” are trademarks owned by the Regents of the University of Minnesota (color figure available online).

told us when he left that morning to make sure she got up. We keep trying and trying but she won’t get up. I start crying because I’m afraid my father will be mad at us. I think it was the very next day that the ambulance came and took her to the hospital, where she had shock treatments.

Ben wrote that the strongest feeling in the memory was “feeling like a failure” because he and his brother hadn’t been able to rouse his mother. When we talked about the memory, I asked if he thought there was any connection to his “hating himself” and he said “No.” He said that his mother had apologized a number of times for her depression and that he knew that she loved him.

In contrast to the MMPI–2, on the Rorschach (Exner, 2003), Ben’s Depression Index was 6, suggesting a great deal of underlying painful affect (Table 1). Ben had four Vista responses—suggesting severe shame, a very low Egocentricity index (.12)—confirming how poorly he thought about himself, and his Suicide Constellation score was 9—above the usual cut-off for significant suicidal impulses. Ben also had a large number of White Space (S = 8) and Aggressive Content (AgC = 7) responses, which made me think that he was also dealing with a great deal of underlying anger. His large number of sex responses (Sx = 7) seemed to fit with his sexual acting out and preoccupation.

What I found most interesting, however, was the sequence of scores on Ben’s Rorschach. He had five Morbid responses, spaced throughout the protocol, and I noticed that Ben reported overt sexual percepts immediately after many of the morbid contents or other markers of painful emotion. For example on Card VI, Ben’s responses were “A folded decaying leaf” (to the whole, earning both a Morbid and a Vista score) and then “An erect penis” (a Sex response) to D6. On Card IX, he saw “rotten food,” again to the whole (earning both a MOR and a Food response), followed by “the muscular chest of a man, with erect nipples. He is aroused” (to the D6 area, scored Hd and Sx).

This sequence of scores gave further weight to a hypothesis I had started to develop when I saw the discrepancy between Ben’s MMPI–2 and Rorschach. As I have previously discussed (Finn, 1996, 2011a), this pattern—where the MMPI shows much less distress or disturbance than the Rorschach—is common among individuals who use character defenses to protect themselves from painful split-off affect states. Ben’s Rorschach, as I previously explained, gave a window into Ben’s right-hemisphere disorganization and to the considerable grief, anger, and shame he was keeping at bay. The MMPI–2 gave a picture of the coping mechanisms Ben was using to avoid these painful affect states. The sequence of his Rorschach responses strongly suggested that Ben’s sexual preoccupations intensified whenever he began to get close to his underlying overwhelming negative emotions. No wonder he couldn’t stop his sexual acting out! Finally the Rorschach interpersonal and relational scores helped explain why Ben was unlikely to turn to other people as an alternative way of not being traumatized by his underlying depression.

TABLE 1.—Lower portion of Ben’s Rorschach Comprehensive System Structural Summary.

RATIOS, PERCENTAGES, AND DERIVATIONS											
R	= 26	L	= 0.13	FC:CF+C	= 3/2	COP	= 2	AG	= 0		
EB	= 6:3.5	EA	= 9.5	Pure C	= 0	GHR:PHR			= 1:5		
eb	= 5:9	es	= 14	SumC’:WSumC	= 2:3.5	a:p			= 6:5		
		Adj es	= 11	Afr	= 0.30	Food			= 1		
				S	= 8	SumT			= 0		
FM	= 3	SumC’	= 2	Blends:R	= 5:26	Human Cont			= 5		
m	= 2	SumV	= 4	CP	= 0	PureH			= 1		
						PER			= 0		
						Isol Indx			= 0.23		
a:p	= 6:5	Sum6	= 4	XA%	= 0.77	Zf	= 16	3r+(2)/R	= 0.12		
Ma:Mp	= 4:2	Lv2	= 0	WDA%	= 0.78	W:D:Dd	= 13:5:8	Fr+rF	= 0		
2AB+Art+Ay	= 2	WSum6	= 8	X-%	= 0.23	W:M	= 13:6	SumV	= 4		
MOR	= 5	M-	= 1	S-	= 3	Zd	= +4.0	FD	= 1		
		Mnone	= 0	P	= 6	PSV	= 0	An+Xy	= 1		
				X+%	= 0.50	DQ+	= 6	MOR	= 5		
				Xu%	= .27	DQv	= 2	H:(H)+Hd+(Hd)	= 1:4		
PTI	= 0	DEPI	= 6	CDI	= 4	S-CON	= 9	HVI	= No	OBS	= No

Although he had several Cooperative Movements (COP = 2), other scores suggested Ben did not view other people as helpful emotional supports (Pure H = 1, Isolation Index = .23, GHR:PHR = 1:5). This made sense, given that Ben's parents were probably not able to be steady and attuned emotional supports when he was growing up.

Assessment Intervention Session

Given this tentative understanding of Ben's situation, I then pondered how I could help Ben understand the important role his sexual thoughts and behavior were playing for him, so that he would have less shame and more compassion for himself. I also wanted to help John understand why it was not so easy for Ben to just stop his sexual behavior. I had tried to talk with Ben after the standard administration of the Rorschach about the pattern I noticed in his responses, but he seemed agitated and uncomfortable and said that he needed to leave. (I found out much later that he left the session and immediately went to a place where he met men for anonymous sex.) So I decided to conduct what we in Therapeutic Assessment call an assessment intervention session (Finn, 2007). The purpose of such sessions is to elicit an *in vivo* analog of the client's main problem in living—as reflected in his or her assessment questions—and to engage the client in observing, analyzing, and reaching new understandings. Sometimes, the client and assessor also experiment with interventions that might ameliorate the problem behavior, with hopes that these might be generalized to life outside the assessment sessions.

At our next meeting, I began by telling Ben that we would be exploring his first question, of what led him to act out sexually. He said he was glad. I then asked Ben to rate—on a scale from 0 to 10—how sexually compulsive he felt at that moment in time. He said he was having a good day and was at about a 1 on the scale. I told him I would be checking in with him at various points during the session to see if that rating changed. I then showed Ben a series of cards from the TAT and gave him the standard instructions. I chose my first three cards because I thought they would be emotionally “neutral” for Ben, and it appeared I was right. For example, to a picture of a boat resting on a river bank (Card 12BG) Ben told a story about two brothers who went fishing on a hot summer's day. To a picture of a woman climbing a winding set of stairs (Card 13G), Ben told a story of a person riding an escalator while shopping in a department store. After these neutral cards, I asked Ben for another rating, and he said that he was still feeling at a 1 on the scale of sexual compulsivity. I then gave Ben three cards—3BM (a despondent figure kneeling on the ground), 3GF (a distressed woman standing in a doorway with her hand over her face), and 13B (a boy sitting in a doorway looking dejected) that I believed would elicit his underlying painful affect. His three stories were very dysphoric. The first two stories concerned depressed women, and I suspected they depicted actual incidents involving his mother. This is the story he told to Card 13B:

He's left alone again. There's no one there for the boy. His parents are gone, his brothers and sisters are off somewhere, and he has no friends. He's tired of all this and is sitting there waiting for his . . . someone to come home. [SF: What is he thinking and feeling?] Awful. Alone. I mean I guess it's better off to be dead . . . (Ben started to cry) since nobody cares and notices.

I sat quietly with Ben a few moments as he regained his composure. I said, “That one is pretty painful.” He started crying again,

averted his eyes, and said, “I guess that was me . . . that was me when I grew up. But I don't like to admit that.” I asked Ben why he didn't like to admit that, and he explained, “Because . . . I mean . . . I had good parents . . . but they weren't good with kids. But I loved them anyway. I loved them.” I said, “It's painful to think about how bleak it was back then, because then it's hard to think of them as good parents.” Ben reiterated, “They were my parents and I loved them. They did their best. The boy did his best” (pointing to the TAT card).

I sympathized, and then asked Ben to rate how sexually compulsive he was feeling at the moment. He paused and stopped crying, did a quick scan, looked surprised, and said, “A lot! Yeah, a 10! I guess I didn't realize how my feelings . . . I mean as I was telling the story I was thinking of all the ways of acting out and where I was going to go after this session!” He looked agitated, puzzled, and a bit ashamed. I jumped in, “So Ben, it looks to me that the sexual acting out is way to try to cope with these awful feelings.” Ben said, “I guess you're right. I didn't realize how my childhood pushed me to do all these bad things.” I elaborated, “I think there were a lot of feelings of emptiness and loneliness when you were growing up, and it's been hard for you to let yourself know that.” Ben cautiously agreed, but then defended his parents again, “I mean I had a good childhood. My parents did their best. I guess I felt alone, but . . .” I tried to side-step Ben's ambivalence by returning to the less personal TAT card, “Ben, go with me here. When you would think about this little boy, what would he have done with these awful feelings?” Ben laughed nervously and looked away, “I didn't want to tell you this, but . . . the boy would go off to his room to masturbate . . . I didn't know what you were going to think about me . . . of him.” I said I would tell him what I really thought and then waited until Ben made eye contact again. I said, “I think it was a pretty creative way to cope with his terrible feelings.” Ben quickly asked, “It was?” I continued, “I think so. Because it's not like there was somebody else around to talk to, right?” Ben agreed, and from this point in the session he seemed to get lighter and his mood brightened considerably to the point that he started to smile. As I watched him relax and smile, I remember thinking, “He is really beautiful when he looks like this.” We continued to talk about the self-soothing aspects of his sexual behavior, with Ben making more and more connections. Several times I emphasized, “Ben, I think these feelings are too big for you to feel alone. That's why you've had to use other ways to help yourself.” Before Ben left, I expressed concern and asked him what else he could do after the session besides go hunting for sex. He said that he was going to a 12-step meeting and would be seeing John the next day. He also said that he felt less compulsive just from our talking together, and gave himself a rating of 3. I felt very satisfied by something he said toward the end of the session: “I never realized how talking to someone about this could help. I feel so much better.”

Space limitations prevent me from describing the end of Ben's therapeutic assessment in detail.³ I can report that the assessment intervention session and the subsequent feedback session represented a major turning point for Ben (and for John), and 1 year after the assessment Ben was no longer engaging in risky sexual behavior.

³An account of the entire assessment is published in a chapter by Finn and Chudzik (2010).

CONCLUSION

In our current work in Therapeutic Assessment, we are using recent understandings from Schore (2010), Siegel (1999), Stern (2004), Fosha (2000), and others to become even more adept at arranging and making use of these types of emotionally arousing assessment events. This is leading to even more powerful healing experiences for many different types of clients, and I think we will continue learning more about how to conduct assessment-based interventions. Evidence continues to accrue that psychological assessment can be a powerful, brief intervention and that the methods of Therapeutic Assessment maximize such effects (e.g., Poston & Hanson, 2010). I reiterate how excited and privileged I feel to be a clinical psychologist, and particularly, an assessment psychologist, at this juncture in our history. And I wish to express my profound gratitude to my colleagues in the Society of Personality Assessment for their support and encouragement.

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APPENDIX

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