8

THERAPEUTIC ASSESSMENT WITH THE MMPI–2

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Therapeutic Assessment is a paradigm in which psychological testing is used as the centerpiece of a brief psychotherapeutic intervention. We find it helpful to differentiate between Therapeutic Assessment (TA, with capital letters) and therapeutic assessment (with lowercase letters). The former is a semistructured form of collaborative assessment developed by Stephen Finn and his colleagues at the Center for Therapeutic Assessment in Austin, Texas; and the latter is a term now generally used by various authors for humanistically based assessment methods that aim to positively impact clients. Although TA typically relies upon a variety of tests and methods to address clients' problems in living, it has been practiced and studied extensively using just the MMPI–2 as a focus for in-depth exploration. In this chapter, after a general discussion of TA, we focus on TA with the MMPI–2.

For those who are interested, Finn (2000, 2002a) and Finn and Tonsager (2002) provide many details about the development of TA. Basically, while Finn was in graduate training, he was exposed to Butcher's (1990c) and others' guidelines for giving psychological test feedback to clients. Finn began to notice that some clients seemed to markedly improve after

receiving detailed information about their test scores (Finn, 2002a), and he began to experiment with ways to strengthen this phenomenon. Heavily influenced by Sullivanian interpersonal principles, Finn first got the idea of having clients pose questions at the beginning of an assessment that he would address later in a test feedback session (Finn, 2000). Then, Finn and his colleagues began to incorporate into TA techniques of *collaborative psychological assessment* developed by Fischer (1994, 2000), Handler (1995), and others. In collaborative psychological assessment, psychologists try to demystify psychological tests for clients and to involve clients in cointerpreting their test results and specifying how they apply to daily life. Collaborative techniques were adopted into TA because they increased the therapeutic efficacy of psychological assessments for clients (Finn & Tonsager, 2002). In recent years, TA has continued to evolve, adopting a more intersubjective, systemic, and phenomenologic perspective (Finn, 1999, 2002b, 2003, 2005).

HOW IS THERAPEUTIC ASSESSMENT DIFFERENT FROM TRADITIONAL ASSESSMENT?

Finn and Tonsager (1997) contrasted TA with traditional, "information-gathering" psychological assessment on a number of variables, while emphasizing that the two models may be practiced simultaneously. Traditionally, the goals of psychological assessment have been accurate classification and description of clients in order to aid in decision making (e.g., educational placement, treatment planning, employee selection). Therapeutic Assessment retains these aims, while also striving for therapeutic change. Hopefully, at the end of a therapeutic assessment, clients have a new, more accurate, and compassionate understanding of themselves and their problems, so that they feel better about themselves and make better life decisions.

The two models differ also in the procedures they employ. In traditional assessment, psychologists work unilaterally or with referring professionals to identify the kinds of information sought through an assessment, determine which tests should be utilized, observe the client during test administration, interpret test scores, and translate the assessment results into concrete recommendations. In TA, clients are viewed as essential collaborators whose input is invited during each step of the assessment process. For example, clients are asked to list personal questions they wish to have addressed by the MMPI–2 and to notice feelings and associations that take place as they respond to the MMPI–2 items. In subsequent meetings, they are shown their MMPI–2 profiles and are asked to comment on the accuracy of typical, nomothetically based interpretive statements. Assessors and

clients then collaborate in extrapolating such information into recommendations and "answers" to the clients' initial questions, and clients may even review and comment upon any written report derived from the assessment.

The role of the assessor is seen differently in the two assessment models. Traditionally, assessors have been taught that they should be "objective observers" and have been cautioned against being too warm or familiar with clients and about mixing therapy and assessment. In TA, assessors are seen as participant–observers in the assessment process; as such, their reactions, associations, and hunches about clients are important clues that help make sense of more structured data. Also, assessors are encouraged to be supportive and personable with clients, since it is believed that a good assessor–client relationship is essential if clients are to risk "trying on" new conceptualizations of themselves and their life situations. Finn (2005) has even argued that collaborative psychological assessment has the potential to heal and influence assessors, as well as clients.

Finally, TA differs from traditional assessment in its overall view of tests and of the assessment process and in what is considered to constitute an "assessment failure." Traditionally, psychologists have viewed psychological assessment as an objective measurement event—akin to getting an EEG or an X-ray—and psychological tests have been seen as scientifically based tools that permit nomothetic comparisons and predictions of clients' behavior outside the assessment setting. An assessment was considered to have failed if inaccurate information was gathered (e.g., because an assessor deviated from standardized administration procedures) or if that information was not interpreted correctly and turned into well-founded recommendations.

In TA, assessors recognize the importance of standardized administration of empirically validated tests. However, psychological assessment is seen as an interpersonal, intersubjective encounter in which the client–assessor relationship inevitably influences the test scores and observations derived from the assessment. Tests are seen as "empathy magnifiers" and as occasions for productive dialogue with clients, which facilitate the assessor's "getting in the client's shoes" and thereby conveying a "new story" to that client and other significant people in his or her life. Even if an assessment collected useful and accurate information about a client, it would be a failure by TA standards if the client felt abused or diminished by the process or outcome of the assessment.

HOW IS THERAPEUTIC ASSESSMENT DIFFERENT FROM OTHER TYPES OF COLLABORATIVE ASSESSMENT?

Therapeutic Assessment shares much in its practice and philosophy with "individualized" psychological assessment as practiced by Fischer

(1994) and with collaborative assessment practices described by Handler (1995), Purves (2002), and others. In fact, Finn, Fischer, Handler, and Purves acknowledge their mutual influence on one another's work, regularly cite one another's papers, and present together at conferences. Therapeutic Assessment differs from these other approaches in following a semistructured series of steps whenever possible. (These steps are described subsequently in regard to using TA with the MMPI–2.) This orderly set of procedures was developed to aid assessors in balancing and simultaneously maximizing therapeutic goals with those of information gathering. Also, the semistructured format of TA helps organize the complex and sometimes overwhelming process of psychological assessment. The orderly sequence of steps facilitates both teaching and learning TA (Finn, 1998) and should make it easier to replicate TA procedures in future research studies.

STEPS IN THERAPEUTIC ASSESSMENT WITH THE MMPI–2

Finn and Martin (1997) and Finn (1996b) provided detailed descriptions of TA with the MMPI–2, along with transcripts of actual sessions. In this section, we summarize the steps in TA with the MMPI–2 (see Figure 8.1) and illustrate each step with an actual case.

Step 1: Initial Session

In the initial session, the client and assessor meet to discuss the goals and context of the MMPI–2 assessment. If the client has been referred for testing by another professional, the assessor reveals (with that person's permission) the questions the referring professional hopes will be addressed by the assessment. Subsequently (or immediately, if the client is self-referred), the assessor and client work together to delineate questions the client has concerning him- or herself or concerning the client's life circumstances, about which the MMPI–2 may be able to provide insights. The assessor collects background information relevant to each of the client's questions, and the assessor and client contract about the practical aspects of the assessment (such as cost, the number and timing of subsequent sessions, and who will receive information about the client's MMPI–2 results). Finally, the assessor addresses any remaining concerns of the client, introduces the MMPI–2, and arranges for the client to complete the test.

By centering the assessment around clients' personal concerns and agendas, TA builds in a motivation for clients to respond to the MMPI–2 in an open and honest fashion. Clients' questions are also very important at the end of the assessment, for they provide "open doors" through which the assessor may reveal difficult-to-hear and sometimes unexpected test find-

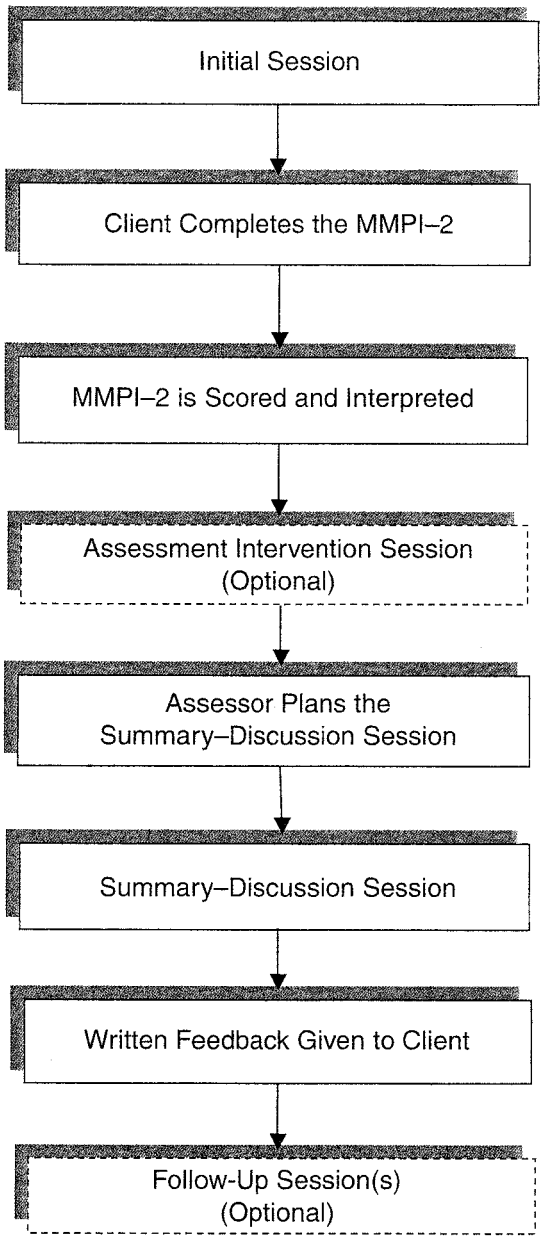

Figure 8.1. Flowchart of a Therapeutic Assessment with the MMPI–2.

ings. As long as an MMPI–2 finding can reasonably be tied to one of the client's assessment questions, the assessor has implicit permission to share the information. Finally, it is believed that helping clients generate questions about their problems engages their curiosity and observing ego; this alone can decrease distress and set the stage for other therapeutic changes to occur.

Case Example

Kamphuis and Nabarro (1999) presented the therapeutic assessment of a traumatized 45-year-old woman, Judith, who had a 20-year history of depression and other psychiatric difficulties. Severe diabetes complicated her psychiatric problems and had resulted in a significant visual impairment, neuropathy, and cardiac disturbances. Over the years, Judith had tried multiple antidepressant medications and various types of intensive psychotherapy. At the time of the assessment, she had just dropped out of a day-treatment program that involved a combination of group therapy and weekly individual therapy. After being told about the procedures of TA, Judith arrived at her first session with Kamphuis (who conducted the assessment) with over 50 handwritten questions she wished to address! As is wise in such instances, Kamphuis worked with Judith to reduce the number of questions to a manageable set, including the following:

> What is wrong with me?
> Am I depressed or is it more my personality disorder?
> When it gets emotional, I am "no longer home." How can I get more control over this, so that I can better stay in touch with my feelings?
> What happens when I "block"?
> Why is treatment not working?
> Am I doing something wrong or is it a misfit?
> Is the treatment worse than the problem?
> Am I good candidate for group therapy or is individual therapy indicated?
> What about physically oriented versus verbal therapies?

The psychiatric resident who was seeing Judith in individual therapy also posed several questions, including the following, which were shared with Judith during the process of the assessment:

> Should the therapy focus on the present or be directed at her past?
> In other words, should we take the here and now or the past as the focus of our sessions?

As this case illustrates, there is another function served by the client's questions for the MMPI–2: they are an assessment tool in themselves and often foreshadow and assist in making sense of the MMPI–2 profile. This is one reason why Finn (1996b) recommended that assessors record clients' exact wording of their questions. Looking at Judith's questions, we can see that she was struggling to understand the reasons for her life struggles, she was worried that she was to blame for not feeling better after all her treatment, and she lacked a coherent understanding of how her treatment plan would address her condition. In her third question, she appeared to ask

about emotional flooding and dissociation and seemed to be searching for an understanding of this phenomenon. In fact, the way she worded the question (i.e., "When *it* gets emotional . . ." rather than "When *I* get emotional . . .") seemed to demonstrate the very dissociative phenomenon she asked about.

Step 2: The Client Completes the MMPI–2

In TA, assessors pay close attention to how the MMPI–2 is introduced to clients and administered. Generally, it is important to begin by explaining that the test is widely used in many different settings and yields information about a range of problems and personality traits. Then the assessor should explain how the MMPI–2 is relevant to the client's questions for the assessment. For example, a client who has asked, "How depressed am I?" may be told that the MMPI–2 has been used in research to measure severity of depression. A client who has asked about recurring problems in intimate relationships may be told that the MMPI–2 yields a great deal of information about personality traits and a person's approach to other people. Again, by referencing the client's personal goals for the assessment and by explaining how the MMPI–2 is relevant, the assessor elicits the client's cooperation and best effort in completing the inventory. Such an action also communicates respect for the client, since the client is "let in" to the assessor's thinking rather than being asked to go along unquestioningly with an undisclosed plan.

Next the assessor shows the client the MMPI–2 booklet and response sheet, reviews the standard instructions, and answers any questions about completing the test. An effort is made to make the administration setting as comfortable for the client as possible. For example, clients are told that they can take short breaks if need be, are offered something to drink, and are encouraged to let the assessor know if they have any questions. Again, such small courtesies communicate the assessor's concern and respect for the client and help create an emotional "holding environment" that is conducive to therapeutic change.

Case Example

With Judith, the standard administration of the MMPI–2 had to be relaxed. She had a visual impairment that prevented her from reading the item booklet or using the (magnified) computerized version of the MMPI–2, and a Dutch-language recording of the items was unavailable. Kamphuis consulted with Judith about other alternatives, and it was agreed that an independent testing assistant would read her the items and subsequently enter her responses. Such an administration procedure is typically frowned upon for fear of distorting a client's test responses. However, Kamphuis believed this was unlikely in Judith's case, given that she had a hand

in choosing this option and the two of them had discussed the possibility of her responses being influenced by the presence of the testing assistant.

Step 3: The MMPI–2 Is Scored and Interpreted

In TA, there is great respect for the nomothetically based hypotheses that may be derived from standardized tests; thus, the next step is to score and interpret the MMPI–2 profile as if it is the sole source of information about the client. That is, assessors are asked to first interpret MMPI–2 profiles as if they are blind to the clients' assessment questions and to seek a coherent integration of all the various test scores available for consideration. Finn (1996b) presented one possible outline for integrating such information. Butcher and Williams (1992), Graham (2000), Greene (2000), and Nichols (2001) detail other organizational strategies. After appraising the MMPI–2 independent of a client's questions, assessors then review the profile again, holding the client's questions in mind. At this stage, assessors begin to sketch out tentative answers to a client's questions and to anticipate which of these answers will be most challenging for the client to hear and understand.

Case Example

Judith's basic MMPI–2 profile is presented in Figure 8.2. Exhibit 8.1 shows the main hypotheses derived from the profile, organized as suggested by Finn (1996b). Basically, the profile is the "gull-wing" profile that is typical of women with histories of trauma or dissociation or borderline personality disorder. (Other diagnostic possibilities are indicated in Exhibit 8.1.) It is clear from her responses that Judith feels overwhelmed and highly distressed by serious problems in multiple areas. As we examine the MMPI–2,

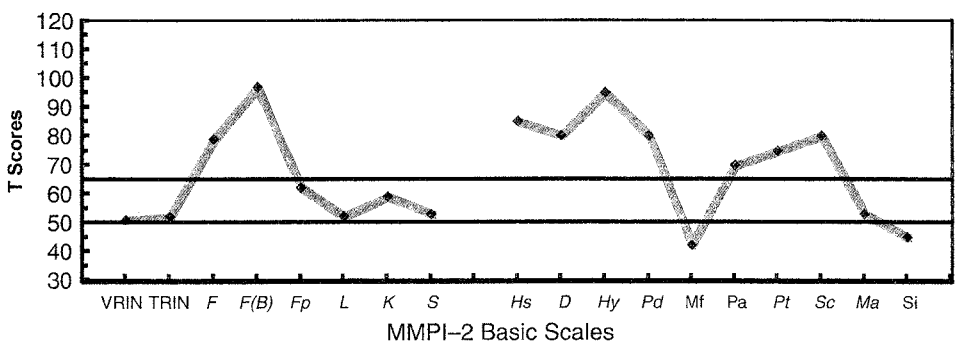

Figure 8.2. Judith's basic MMPI–2 profile. This profile is plotted using the Dutch norms, which are highly similar to the U.S. norms (Derksen, De Mey, Sloore, & Hellenbosch, 1993).

EXHIBIT 8.1
Major Hypotheses Derived From Judith's MMPI–2 Profile

Approach to the Test
She appears to have read and responded carefully to the test items.
She answered openly, and was neither overly self-critical or denying problems.

Amount of Distress and Disturbance
She reported severe emotional distress and severe physical distress.
The profile suggests a severe level of psychological disturbance.

Major Symptoms–Presenting Features
Multiple symptoms and problems, including prominent somatic symptoms, severe depression, anxious worrying, difficulties with emotional control, and lethargy. Some of the somatic symptoms may be unusual, and there is a strong possibility of a thought disorder or of periods of psychosis. Many individuals with this profile have histories of trauma and manifest dissociative symptoms. Many have histories of self-mutilation and multiple suicide attempts. They are easily overwhelmed by their own emotions, especially anger, and may decompensate when emotionally stressed.

Underlying Personality and Relationship Patterns
Similar individuals have extreme low self-esteem (more than the average psychiatric patient) and experience painful self-doubt. They are highly sensitive to criticism and rejection and may perceive rejection where none is present. They tend to be dependent and passive, and they often fail to protect themselves adequately in interpersonal relationships. Many seem wedded to a victim role and feel they have gotten a "raw deal" out of life.

Diagnostic Possibilities
1. Major depression
2. PTSD, dissociative disorder, borderline personality disorder
Rule out: schizoaffective disorder, psychotic depression, and somatization disorder

Treatment Recommendations
Individuals with this profile are known to decompensate in therapies that emphasize emotional uncovering or remembering past traumas; they do best in supportive therapy combined with approaches that teach emotion management skills, such as Dialectical Behavior Therapy.

we can begin to empathize with Judith and understand why she would feel confused and discouraged about her treatment. We can also begin to understand why her treatment staff would find it difficult to know how to best help Judith.

Step 4: Assessment Intervention Session

One of the later developments in TA with the MMPI–2 is the use of a separate assessment intervention session—prior to the summary–discussion session—for assessors to introduce and explore hypotheses with clients that they have derived from the MMPI–2 profile. Assessment intervention sessions were modeled after Fischer's (1994) collaborative techniques for "assessment of process" and were first described in writing as part of TA by

Finn and Martin (1997). Hence, Finn (1996b) makes no mention of assessment intervention sessions, but Finn (2003) gives a detailed account of one, including a partial transcript. Assessment intervention sessions are not necessary or advisable for all clients; therefore, we have listed them in Exhibit 8.1 as an optional step.

Basically, in an assessment intervention session, an assessor uses nonstandardized tests or other techniques—such as psychodrama, role-playing, or art projects—to create vivid experiences for clients that may help them understand their main questions for the assessment. Alternatively, standardized tests may be administered following individualized, nonstandardized instructions, as is illustrated in this chapter. Armed with a set of hypotheses derived from the MMPI–2 about the client's conflicts, defenses, and core issues, the assessor attempts to elicit in the assessment session actual instances of the client's problems in living. If such efforts are successful, the client and assessor may then observe, analyze, and discuss those problems as they occur in the assessment setting and then try to generalize any insights to the client's outside life.

As an example, imagine a client whose main assessment question is "Why do I work so slowly compared to others and how can I go faster?" and whose MMPI–2 profile suggests that he has strong obsessive tendencies (e.g., Scale 7 = 90T and OBS = 75T). The assessor may ask the client to complete a paper and pencil task such as the Bender Gestalt test in an assessment intervention session. If the client showed signs of anxiety, perfectionism, and self-criticality during the Bender Gestalt administration, as would be predicted from his MMPI–2 scores, the assessor could then lead the client in observing and discussing these factors and their relationship to the pace of his work. The assessor could even test out possible therapeutic interventions for anxiety (e.g., deep relaxation, negative thought blocking) to see if any successfully enabled the client to work faster on the Bender. If an intervention helped, the client and assessor could then strategize about applying this strategy outside the assessment room in the actual life situations where the client was bothered by his slowness.

In general, assessment intervention sessions are centered on those psychological issues that could be difficult for the client to grasp from an explanation of the MMPI–2 alone. In our clinical work, many clients describe these sessions as having impacted them greatly.

Case Example

Kamphuis chose to explore one particular set of Judith's questions in an assessment intervention session:

> When it gets emotional, I am "no longer home." How can I get more control over this, so that I can better stay in touch with my feelings?
> What happens when I "block"?

From Judith's MMPI–2, Kamphuis hypothesized that she was experiencing episodes of emotional flooding, which then led to dissociative lapses and the sense of "no longer being home." He sought a task that could bring such an experience into the room in a controlled way, so that he and Judith could observe and work with her "blocking" and "leaving home." Kamphuis predicted that TAT cards might arouse Judith's emotions, and he chose several cards that typically pull for themes of rejection, loneliness, and abandonment (which the MMPI–2 suggested might be core issues for her). He gave the standard instructions, emphasizing somewhat that Judith should tell emotionally vivid stories, and presented her with Card 13B (a picture of a dejected-looking young boy sitting alone in the doorway of a cabin). The following is from Kamphuis' notes written after the session:

> Judith almost immediately became quite anxious, more so than I had expected. She softly commented that she was not able to do this, and she moved restlessly in her seat in a way I had not seen before. She seemed to try really hard to access her imagination and feelings, but indeed "blocked" and her anxiety gave way to a very flat, absent person, which actually made me quite uncomfortable. It was apparent that the task was too difficult for her, given her degree of emotional overwhelm, and I decided to abort this part of the intervention.

Kamphuis then used a number of techniques commonly employed with individuals who are dissociating to help them get "grounded." He asked Judith to squeeze her fists as hard as she could and to slowly let go of the tension. This was repeated three times. He also asked Judith to stomp her feet forcefully on the floor. Gradually, Judith became more "present" and she and Kamphuis were able to talk about what had happened. Again, from Kamphuis' notes,

> It was hard for her to express what had happened to her when she had tried to respond to the TAT card. She did recognize that it was similar to some of the times she would "sit on the couch, like a Zombie, for hours" after having felt despondent and overwhelmed by emotions. . . . I asked her what else she did [at these times] . . . [S]he indicated that she felt this way often and tended to numb herself with anti-anxiety medication, or hurt herself by scratching her skin, or think about suicide.

Kamphuis then attempted to give Judith a framework for what she had just experienced. Drawing upon his experience with Dialectical Behavior Therapy (Linehan, 1993), Kamphuis drew a diagram for her and introduced the metaphor of an "overflowing bucket," with her being the bucket and the abundance of painful feelings being what was spilling over. He told her,

> When people experience more painful emotions than they can possibly handle, their bucket overflows and they search for an escape, for some means of ending this unbearable state. People choose all kinds of solutions, depending on what they've learned and what works for them. Some choose to use alcohol or drugs, some people hurt themselves,

some engage in risky behaviors, and so on. It sounds like you may choose to numb yourself with medication to get some relief, or to inflict physical pain on yourself to distract yourself from the emotional pain. Or, you flee inward and leave the situation psychologically, so to speak; as you put it, you "block" or are not "home anymore." Does this sound right to you?

When Judith agreed, she and Kamphuis went on to discuss more examples of her dissociating, and they talked about the costs of this method of coping. He then let Judith know that she was not the only one to have these types of difficulties and that many people can learn other, less harmful ways of handling such emotional crises. He shared several ideas of tools other people had found useful, and he asked Judith if she would like to learn how to use such techniques. They ended the session by reviewing their work up to that point and scheduling the time of the summary–discussion session. Judith herself suggested bringing a tape recorder to "be able to listen to it again and share it" with her partner. She asked Kamphuis to be candid and open with her in sharing the assessment results and said that this was the quality she most appreciated in her current psychiatrist.

As is evident from this example, when they are successful, assessment intervention sessions provide a powerful way for assessors to test out ideas they have derived from the MMPI–2 about the client's problems in living. Frequently, such sessions lead to a deeper level of empathy for the client. For example, Kamphuis did not seem to quite grasp Judith's level of fragility and overwhelm from her MMPI–2 but did comprehend it when he saw how she reacted to a single TAT card. Also, assessment intervention sessions provide the opportunity for clients to have someone witness and deconstruct problems that have confused them for years. One senses that Judith felt deeply understood by Kamphuis' naming and calmly explaining her dissociation during the session and that his knowing how to help her get "home again" gave her hope. Her request to bring a tape recorder to the next session seemed positive and possibly indicated that she hoped the assessment would help her partner and others to understand her better too.

Step 5: The Assessor Plans the Summary–Discussion Session

Following the assessment intervention session, the assessor should take time to carefully plan the summary–discussion session with the client. Finn (1996b) gives detailed instructions about this step, but let us review a few major points. First, clients appear to find assessment feedback most useful when it is presented according to how closely it matches their existing ideas about themselves (Schroeder, Hahn, Finn, & Swann, 1993). Early in a summary–discussion session, assessors should relate information that is very close to clients' existing self-conceptions. After this, assessors can pro-

ceed to information that is slightly new and different and, finally, to ideas that are likely to conflict with clients' current understandings of their situations. If one begins with this more difficult material, typically clients will react defensively or with anxiety or will get overwhelmed early in the session. If one never broaches difficult topics, the client may decide the test or tester are incompetent or that the information they revealed on the MMPI–2 is too shameful to discuss.

As discussed in Butcher (1990c), the MMPI–2 Content Scales and Harris–Lingoes scales are extremely useful in judging how clients see their own situations, because the items on these scales have a high degree of face validity. Generally, if clients show an elevation on such content-based scales, they will not find it surprising or threatening when the assessor interprets those scores. Conversely, a client with a score on Scale 2 of 80T may be viewed by others as quite depressed; but, if that client scored 60T on DEP and 59T on D1 (Subjective Depression), the assessor would be ill-advised to begin the summary–discussion session by telling the client that the MMPI–2 suggested a severe clinical depression. The client would likely experience such information as confusing and shocking (unless it had been addressed somehow in the assessment information session), which could make it difficult for the client to take in more information after that point.

A second guideline is that assessors should adapt not only the *content* of the session to the individual client but also the *process and tone* of the session. As Finn (1996b) has noted, this basically requires that assessors use the MMPI–2 as an empathic window into the client's experience and then ask themselves, "If I were this person, what would be the best way to tell me about my MMPI–2?" For example, clients with high *F* scores and multiple elevations on the clinical problem scales are generally overwhelmed, and assessors should plan for shorter summary–discussion sessions, structured around a few major points. Clients with 2–7/7–2 code types tend to be internalizing and quite self-critical, and assessors may want to check at the end of a summary–discussion session if such clients have heard any test interpretations as personal indictments. When giving feedback to clients with 4–9/9–4 code types and other scores indicating psychopathic characteristics, assessors should take care not to be too "sympathetic" in their interpretations. Such individuals lose respect for assessors they see as "bleeding hearts" or "easy touches," so a blunt, matter-of-fact presentation style is probably the best. Finn (1996b) gives many other guidelines for tailoring summary–discussion sessions to individual clients according to their MMPI–2 profiles.

Finally, most clients (except for the psychopathic individuals we have mentioned) seem to appreciate some recognition from the assessor that assessment is a vulnerable experience for clients and that they showed some trust by even agreeing to take the MMPI–2. Such comments fit naturally into discussions of the validity scales in open, unguarded profiles. Or

an assessor may choose to begin or end the summary–discussion session by expressing such appreciations.

Case Example

As befitting Judith's MMPI–2 and the emotionally overwhelmed state it represented, Kamphuis planned to keep Judith's summary–discussion session quite brief, while trying to address her major questions. He composed a brief preliminary summary—framed in self statements—of what he thought Judith had communicated to him and her psychiatrist through the MMPI–2. He ordered these statements by how closely they seemed to match Judith's view of her situation:

I feel overwhelmed and don't know where to begin.
I feel depressed, despondent, and hopeless and experience many physical problems.
I feel worthless.
My bucket is spilling over with intensely painful feelings, and I am scared of what might happen and of losing control.
I feel lonely and like I am getting a raw deal out of life.

Kamphuis then sketched out answers to Judith's assessment questions and to her referring psychiatrist's question, since he would be present at the session. These tentative answers are presented in Exhibit 8.2. He planned to end the session by emphasizing Judith's strengths, judging that these would be most contrary to her existing self-concept. Finally, Kamphuis reminded himself to go slowly and to look for signs that Judith was dissociating during the session, knowing that it would be better to break things off and resume later than go on when Judith was overwhelmed and unable to process information.

Step 6: Summary–Discussion Session

If there has been an assessment intervention session, the assessor typically begins the summary–discussion session by inquiring about the client's reactions to that session and discussing those. Then the assessor reviews the plan for the session with the client—typically, to discuss and answer the client's questions posed at the beginning of the assessment—and invites the client to interrupt, agree, disagree, ask questions, and share any reactions during the session. With many clients, it is useful to show the MMPI–2 profile next, and orient the client to it. (Finn, 1996b, gives a sample script.) Finally, the assessor begins to review the major findings of the profile and how they relate to the client's assessment questions.

Research confirms our clinical experience by showing that the best method for reviewing test findings with clients is an interactive one (Hanson, Claiborn, & Kerr, 1997) rather than a didactic one. (For this reason,

EXHIBIT 8.2
Prepared Tentative Answers to Judith's Assessment Questions

1. *(From the referring therapist) Should the therapy focus on the present or be directed at Judith's past? In other words, should we take the here and now or the past as the focus of our sessions?*
Therapy should focus on the present, as Judith is currently in crisis. To focus on the past would be something like worrying about the foundation of the house while it is on fire. First, therapy should help make life livable again by building some sense of emotional mastery. In the future, as things have stabilized, it may be useful to examine the origins of Judith's emotional pain and to evaluate what parts of it might be processed.

2. *(From Judith) What is wrong with me? Am I depressed or it is more my personality disorder?*
The MMPI–2 is not a diagnostic instrument per se, but it does give information relevant to determining diagnoses. Even when using antidepressants, you score very high on MMPI–2 scales that measure depression. Most likely, therefore, you are experiencing severe depressive symptoms. The MMPI–2 suggests that your depression may express itself in problems with concentration (e.g., not being able to think clearly, feeling unfocused), loss of pleasure and interest in activities and things around you, a deeply sad despondent feeling, lack of energy, and thoughts about death. However, there are more painful feelings than can be accounted for by depression alone. Your scores on the MMPI–2 are consistent with those found among people with borderline personality disorder and/or who have a history of trauma.

3. *When it gets emotional, I am "no longer home." How can I get more control over this, so that I can better stay in touch with my feelings? What happens when I "block"?*
As we learned during our last session, when things happen that bring up intense or conflicting emotions for you, your "bucket flows over" and then you "block" and/or dissociate as a way of protecting yourself from emotional flooding. Although this is a disturbing and scary experience, the ability to do this probably protected you in the past in situations where you were trapped and overwhelmed and had very few other options. Now, however, you do have different choices available. You can start to recognize warning signals that your emotional bucket is close to overflowing and learn ways to help. You can also learn techniques for "grounding" yourself if you do dissociate. If these tools work, you will be left with the feelings you were working to escape and it's important to know what to do then. There are specific therapies designed to help you successfully manage intense feelings, for example, by learning to soothe yourself, distract yourself, or talk to others to get help "holding" the overwhelming feelings.

4. *Why is treatment not working? Am I doing something wrong or is it a misfit? Is the treatment worse than the problem?*
The standard treatment program is probably too intensive, given how much emotional pain you are experiencing, and may have become a stressor in its own right. It did not help matters that the communication between you and your therapist did not work out well. I do not think you did anything wrong that led to the treatment not working. I think framing the question as you did is an example of looking for faults in yourself. I hope you can catch yourself when that happens and stop it. When people experience too much emotional pain, it is impossible to do effective work in therapy or to process emotional issues. Try not to expect too many things at the same time from yourself—doing so adds to your sense of falling short and to feelings of despondency.

continued

EXHIBIT 8.2
(Continued)

5. *Am I a good candidate for group therapy or is individual therapy indicated? What about physically oriented versus verbal therapies?*
You indicated to me that you had significant experiences in physically oriented therapies. I think such therapies might help you anchor yourself in your body and learn to recognize emotions as they occur. They may also help you to develop some sense of control over your emotions. Right now, I think the specifics of the therapy are less essential than that it provide you with a sense of security and stability that helps you develop new coping skills. Therapy should probably follow a hierarchy or sequence from (a) getting you out of crisis to having a livable life; (b) once life is livable, working on processing feelings; and (c) finally working on more growth-oriented issues.

we now call these types of sessions *summary–discussion sessions*, rather than *feedback sessions*, for the latter term implies a unilateral flow of information from assessor to client.) We suggest that assessors share one piece of information, all the while carefully watching clients' demeanor to judge their reactions. If a client agrees with the finding, the assessor asks for an example of how it is borne out in the client's life and then listens carefully to the example to make sure the client is not simply blindly agreeing to the assessor's interpretation. If a client disagrees, one may ask the client to help modify the finding so it fits with the client's experience. If a client totally rejects a hypothesis derived from the MMPI–2, an assessor has several options. Sometimes, it is useful to restate the finding using different language; at other times, one asks the client if any part of what one has said seems correct. At other times, it is better to simply back off and agree that the test could be wrong. As Finn (1996b) has emphasized, one should *never* argue with a client about the validity of an MMPI–2 finding.

As discussed earlier, the assessor tries to present information in order of how well it matches clients' existing self-concepts, all the while looking for signs of overwhelm or defensiveness from the client. If the client is overwhelmed, it is best to stop and come back later to finish reviewing the remainder of the client's questions. If one is able to cover all the pertinent assessment questions, one moves toward ending the session by inviting other questions and reactions from the client. The assessor typically ends the session by thanking the client again for participating, by mentioning that a written summary will follow, and by inviting the client to attend a follow-up session in 4–6 weeks. Finn (1996b) also suggests that assessors share some way with clients that they felt moved or learned something through working with the client.

Case Example

Kamphuis began his session with Judith by reviewing the plan for the session and proposing a division of roles. He would serve as the "test

expert," telling what the MMPI–2 had to say about Judith and her assessment questions. She was the "self expert," whose job it was to see if the results seemed to fit her experience. The psychiatrist, finally, was welcome to give or ask for clarifications or to contribute otherwise. Kamphuis then showed Judith the graph of the basic MMPI–2 profile (magnified so that she was able to see it) and went over the major findings of the MMPI–2 (worded in terms of the self-statements presented earlier). Judith generally agreed with these statements and gave examples of how they applied. Kamphuis noted these additions carefully on his outline for the session. He then reviewed her assessment questions and his tentative answers (see Exhibit 8.2), stopping to ask for Judith's feedback after each one.

Judith stated that she wasn't surprised by the findings, and Kamphuis' impression was that she indeed seemed to take them in stride. The referring psychiatrist chimed in to say that he and Judith had discussed the possibility of her having had traumatic experiences, but that, at present, neither of them were clear on the details of what these might have been. When Kamphuis talked about Judith's being too hard on herself and her believing that she was the sole reason for her treatment impasse, the psychiatrist quickly jumped in to emphasize that point. Judith said that she had not wanted to be a "nag" about her dissatisfactions with treatment; thus, she looked for faults in herself. She agreed, however, that since she had left the treatment program, her day was much less structured and intense, unbearable feelings were pressing, more so than before. She agreed with Kamphuis' formulation that she needed help managing her feelings and that this was the top priority for her work in therapy. She also agreed that her aftercare needed to be focused first on crisis management and that she needed continuity and support most.

When asked for reactions and feedback, Judith said she was most happy that her intense distress had been documented convincingly and clearly. She had not always felt that her emotional pain had been taken seriously and even had questioned herself about whether her urgent desire for help had legitimacy. The psychiatrist said that the assessment was helpful in confirming his impression and in providing a starting point to collaboratively plan Judith's aftercare. Kamphuis closed by talking personally about his experience of Judith's strengths. He had found her to be an intelligent, articulate, and ultimately determined woman, who, once ready, was able to draw lines and stand up for herself. He and Judith joked about how hard it was for her to take compliments, and they said goodbye.

Step 7: Written Feedback Given to Client

In TA, the assessor sends a letter to the client shortly after the summary–discussion session, reviewing the major points from the session and incorporating the client's modifications and examples (noted during

EXHIBIT 8.3
Highlight: Essentials of Therapeutic Assessment With the MMPI–2

- Therapeutic Assessment is a paradigm in which psychological testing is used as the centerpiece of a brief psychotherapeutic intervention.
- Therapeutic Assessment has been used extensively with the MMPI–2 as the main psychological assessment instrument.
- Essential to Therapeutic Assessment is the collaboration between assessor and client throughout the assessment process, most notable in
  (a) The collaborative formulation of assessment questions, which determine the limits of the observational field for the subsequent assessment;
  (b) The active participation of the client as the "expert on self" who helps observe and comment on his or her own test performance;
  (c) The participant–observer stance of the clinician, who shares developing hunches throughout the assessment;
  (d) The interactive summary–discussion section at the end of the assessment procedure;
  (e) The written feedback given to the client in the form of a letter that describes the MMPI–2 results in everyday language.
- There is now replicated evidence that Therapeutic Assessment with the MMPI–2 can result in meaningful therapeutic change. Proposed working mechanisms include (a) self-verification, (b) self-enhancement, and (c) self-efficacy–discovery.
- Therapeutic Assessment is likely most beneficial when clients are voluntary participants, are actively seeking for new understandings of persistent problems in living, and are able to meaningfully collaborate in the assessment.
- Therapeutic Assessment offers the least incremental benefits when the desired final product is a diagnostic labeling or a relative standing on predetermined trait levels or when the assessment is involuntary.

the summary–discussion session). In this way, the client sees his or her own impact on the assessment findings. With the client's permission, a copy of this letter is also sent to the referring professional.

Case Example

We have not included Judith's letter in the chapter, as it greatly resembles the text in Exhibit 8.2. Finn (1996b), Finn and Martin (1997), and Finn (2003) provide examples of letters sent to clients at the end of a MMPI–2 assessment.

Step 8: Follow-Up Session(s)

At the summary–discussion session, clients are invited to return at some later date (typically in 4 to 6 weeks) to talk about their later reactions to the assessment and any new questions they have. In our clinical experience, such meetings serve as "booster sessions" in enhancing the beneficial aspects of TA (see Exhibit 8.3).

Case Example

Because of Kamphuis' transition to a different work place, he and Judith did not meet for a follow-up session. However, Judith's psychiatrist did write him several months after the assessment to provide follow-up information. Here are a few excerpts from that document:

> The first and immediately visible result of the assessment was that [Judith] was relieved that she had been acknowledged in her problems. Moreover, the assessment suggested specific guidelines for continued treatment and made it more understandable why the earlier group therapy had been difficult for her. Like many borderline patients, she had learned to see herself as "difficult and impossible" whereas the assessment made her feel understood and taken seriously.
>
> As her treating psychiatrist, I benefited most from the specificity with which this TA addressed the treatment questions. . . . In addition, the TA provided us with a shared frame of reference that reflected major input from the patient herself. . . . After a prolonged and troubled aftercare period (which included a hospital admission), Judith was included in a multicenter structured treatment program for borderline patients, which she felt optimistic about.

WHAT IS THE EMPIRICAL SUPPORT FOR THERAPEUTIC ASSESSMENT?

To date, four controlled studies have investigated the effects of Therapeutic Assessment while using the MMPI–2 as the principal assessment instrument (Finn & Tonsager, 1992; Lance & Krishnamurthy, 2003; Newman & Greenway, 1997; Peters, 2000). Finn and Tonsager (1992) were the first to put their TA model to the empirical test. Sixty-one students who were scheduled for treatment at the University of Texas Counseling and Mental Health Center were randomly assigned to either supportive nondirective counseling (n = 29) or a TA protocol limited to an initial interview and MMPI–2 test administration and test feedback (n = 32). The two treatments were matched for duration, each spanning three clinical sessions, and the groups showed equivalence at baseline in terms of symptomatic distress and self-esteem. Immediately following the interventions, only students who had received therapeutic feedback reported increased self-esteem. The difference between the two groups was substantial as was evident from the Cohen's effect size d of .38 (medium effect size). No immediate effects were observed for symptomatic distress. At follow-up, however, the TA group reported substantially lower symptomatic distress than the control group (Cohen's d = .36) and the improvement in

self-esteem was maintained (d = .46). No positive changes were observed for the control group.

As a modified replication, Newman and Greenway (1997) conducted a similar study in Australia, improving on the Finn and Tonsager (1992) design by having the control group take the MMPI–2 as well. This addition ruled out that the observed effects in the Finn and Tonsager study were due merely to the administration of the MMPI–2 per se (rather than to the overall TA protocol, including the MMPI–2 feedback). By and large, the authors replicated the results observed by Finn and Tonsager, albeit with somewhat smaller effect sizes. At follow-up, Cohen's d was .14 and .22 for self-esteem and symptomatic distress effects, respectively. Together, these two studies document that a three-to-four-session semistructured assessment protocol *by itself* can produce marked therapeutic changes, something that had never before been demonstrated in a controlled design. It is worth noting that neither of these studies employed the full set of TA procedures described here, that is, incorporating assessment intervention sessions, written feedback, and follow-up sessions.

One unpublished dissertation has also centered on evaluating the effects of TA-based procedures. Peters (2000) conducted a controlled study on the efficacy of TA among women with eating disorders. She compared TA to information-gathering assessment in a repeated measures design to examine differences in outcome on both general and domain-specific psychopathology. No relative benefits were observed for TA in terms of symptomatology or self-esteem, and neither group evidenced major therapeutic changes. However, on a measure of treatment readiness, women in the therapeutic feedback condition were more likely to seek treatment after the 6-week follow-up measurement. The modest treatment success in this study poses the question as to when (i.e., under what circumstances) TA is more likely to be effective (relative to information-gathering assessment). This question is addressed in the next section, covering therapeutic mechanisms.

Recently, Lance and Krishnamurthy (2003) presented a paper comparing the effectiveness of (a) oral, (b) written, and (c) combined oral and written MMPI–2 test feedback on a multidimensional measure of client satisfaction with assessment (the Assessment Questionnaire—2; Finn, Schroeder, & Tonsager, 1995). The combined feedback approach was superior on overall client satisfaction, and—not surprisingly—was superior to written feedback (only) in terms of the relational experience and superior to oral feedback in terms of new self-insights. Contrary to prediction, oral feedback was less effective than written feedback in terms of sustained new learning and did no better than written feedback in terms of overall satisfaction. This finding underscores the importance of

written documents in providing feedback; clients seem to indicate difficulty maintaining the feedback when it is presented orally only. Unfortunately, no measures of psychopathology and self-esteem were included in this study.

Finally, several case studies have been published in which the MMPI–2 was used in a therapeutic assessment (Finn, 1996b; Finn, 2003; Finn & Martin, 1997; Michel, 2002). These reports may be particularly useful in orienting the practitioner to the type of clinical skills that are involved in doing TA. Detailed descriptions of TA, including numerous verbatim statements, were included in the *Manual for Using the MMPI–2 as a Therapeutic Intervention* (Finn, 1996b) as well as in the Finn and Martin (1997) chapter. Both texts provide the reader with a real sense of how a TA proceeds as well as with some hands-on pointers of the technical and practical aspects of TA. Another source is the recently published elaborate TA case study in the context of an impasse in the treatment of a man with ADD (Finn, 2003). 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. Michel's (2002) two brief case studies showed how TA with the MMPI–2 can be useful with inpatients hospitalized with eating disorders. In her setting, such assessments were useful in confronting clients' denial about deeper psychological issues, assisting hospital staff in treatment planning, and engaging clients and their families in treatment.

WHAT ARE THE MECHANISMS UNDERLYING THERAPEUTIC ASSESSMENT?

As reviewed earlier, there is now replicated evidence that TA can result in meaningful therapeutic change. What mechanisms might account for the observed positive changes? As with other psychotherapies, little research exists on this question. However, it may be useful to review current theories. Finn and Tonsager (1997) speculated, drawing on their extensive clinical experience, that therapeutic change may result from addressing three fundamental human motives, that is, the need for (a) self-verification, (b) self-enhancement, and (c) self-efficacy–self-discovery experiences. *Self-verification* is obtained when the TA brings about a sense of coherence, of confirmation and validation of one's views of self, others, and the world at large. In the context of TA, a client may experience this

self-state when the test feedback underscores how the client's behavior makes sense in light of her or his phenomenal world, for example, the shared understanding of self-destructive behaviors as escape efforts for intolerable feelings. In the case we presented, self-verification seemed evident in Judith's feeling that her problems were taken seriously and were understood by Kamphuis. *Self-enhancement* is experienced to the extent that the TA communicates to the client that he or she is valued, worthwhile, and cared for. Therapeutic Assessment's procedural emphasis on collaboration and the client's key role in providing data and expertise helps foster these experiences. In the case example, Judith's referring psychiatrist mentioned that after the assessment she no longer saw herself as a "difficult patient" but as one who needed a specific kind of treatment. *Self-efficacy* experiences can be derived from the new insights and personal conceptualizations of previously less well-understood problem areas. For example, when current perfectionist attitudes are for the first time tied to early solutions to gain some measure of approval or avoid punishment, an "aha" type experience may be triggered that is quite empowering to the client. In Judith's case, she learned through her assessment about dissociation. Following the assessment, she better understood the cause of such frightening experiences and also learned some techniques to help "ground" herself when she started to dissociate.

As noted however, TA, as other therapies, has not always resulted in far-reaching favorable changes (see, e.g., Peters, 2000). An as yet untested but interesting hypothesis regarding the differential outcomes may be found in Prochaska's transtheoretical model of stages of (psychotherapeutic) change (see, e.g., McConnaughy, DiClemente, Prochaska, & Velicer, 1993; Prochaska et al., 1994). According to this model, clients can be in one of several stages of psychotherapeutic change: precontemplation, contemplation, preparation, action, or maintenance. Particularly relevant to TA may be the distinction between being in the precontemplation stage and being in the contemplation stage. In the precontemplation stage, clients believe it is the environment or other people who need to do the changing. In the contemplation stage, clients are aware of personal problems and are interested in whether these problems can be resolved and whether psychotherapy might be helpful. It seems that in order for TA to result in symptomatic change, clients need some degree of openness and investment in the results of the assessment, a state that is fostered when personal ideas about problem areas are "in flux," no longer perceived as adequate, and in need of revision. A prima facie, voluntary or self-referred assessment seems more likely to satisfy these requirements.

Peters' (2000) (partially negative) findings may be explained along these lines. Her participants were women in an introductory psychology course who took part in the research for course credit; they had been iden-

tified as having eating disorders from a survey given to all students in the class. Obviously, these women were not ostensibly seeking help for their eating problems; and, across conditions, fewer than 15% of the women were classified as treatment seeking. In a sense, Peters' assessments might be viewed as semi-involuntary assessments. (The complicated nature of involuntary assessments is discussed later.) No differences were noted between the two conditions on treatment seeking status at pre- nor at postintervention assessment. Interestingly, however, after the 6-week follow-up period, significantly more participants were motivated to seek treatment following TA as compared to those who completed the regular assessment protocol. While not differentially effective in providing symptomatic relief, TA apparently motivated a higher proportion of women with eating disorders to start contemplating treatment. This suggests that TA may help people move along the dimension of stages of change, wherever they start. If a client is in the precontemplation stage, TA may help the client progress to contemplation. For a client already in the contemplation stage, TA may help the client prepare for or actually take action toward change.

One final observation may speak to the mechanisms governing TA. Across the three controlled studies, a delayed effect of TA was noticeable. In both the Finn and Tonsager (1992) and the Newman and Greenway (1997) studies, symptomatic improvement did not emerge until the follow-up assessment, lagging behind the immediate positive effects in self-esteem and hope. Peters (2000) observed that active treatment-seeking behavior did not emerge until after the follow-up period. It appears that perhaps the TA feedback needs some time to "sink in" for it to have its full impact. This finding is also consistent with the superior client satisfaction associated with the inclusion of a written report in the TA protocol (Lance & Krishnamurthy, 2003). Clients seem to indicate that they need time and repeated opportunity to solidify the new insights about themselves. Again, note that none of these studies used the full TA model, including assessment intervention sessions.

WHEN IS THERAPEUTIC ASSESSMENT MORE AND LESS APPLICABLE?

Little research exists on the question of when TA is most effective; however, a few factors have become obvious through our clinical experience.

Forensic or Other Involuntary Assessment

In forensic or other involuntary assessment situations, clients generally do not present with great curiosity about personal motives or problem

areas. In a sense, such clients are typically in Prochaska's precontemplation stage (Prochaska et al., 1994). In addition, there are typically powerful interests at stake (e.g., parole, child custody, social security) that are of much greater import and urgency to the client than developing personal insight. Such factors may even work *against* clients developing new ways of viewing themselves and the world. Accordingly, all stages of TA may be compromised. First, collaboratively developing assessment questions is overshadowed by the a priori agenda of the referring party. Frequently, clients will even feel that revealing personal concerns would put them at a disadvantage by exposing issues the referring party could use against them. Second, when taking the test, clients may (sometimes, correctly) believe that too much candor about personal shortcomings and problem areas may decrease the chances the assessment will turn out as they wish. Guarded, less informative test protocols may be the result. Finally, when test feedback is provided, it is likely that the client is most invested in hearing findings that are conducive to his or her cause than anything else.

Notwithstanding, the clinician can try to enlist the client by orienting him or her to the nature of the assessment and what its findings will and will not be used for. Explaining that the test may pick up on an overly positive self-presentation may be part of this orientation. In addition, one might say something like,

> The fact is that we will have to look into these (referral agency) questions, as best we can. If you decide to proceed with the testing, you might as well try to get something out of it for yourself. So, are there any questions about yourself you might be curious about; things you are interested in understanding better about yourself?

Sometimes clients will then come up with issues that are relevant to their personal situation. Another technique is to elicit questions by joining with clients about how they feel misunderstood or mistreated by the referring agency. For example, a mother being assessed for termination of parental rights might be helped to ask,

> Why do people think I'm a bad mother, even though I'm not?

Similarly, an adolescent referred by his parents against his will may ask:

> How can I convince my parents that I'm doing OK and they don't need to worry about me?

Such questions are also useful because they allow the assessor to bring in information about the "persecuting" party's point of view, for example, in the first instance,

> The court seems to believe that you've endangered your children by exposing them to your drug use and drug dealing. What would you say about this concern?

As a side note, we believe it is better *not* to proceed with TA, if at all possible, if the client remains opposed to the entire idea of assessment.

Last, when giving feedback in involuntary assessments, we have found it useful to matter-of-factly report our conclusions and findings and the data we used to derive them, while openly acknowledging that clients may have wished for a different outcome. One may then use Fischer's (1994) technique of inviting the client to write a "minority report" expressing his or her opinion of the conclusions. As Purves (2002) has demonstrated, it *is* possible to conduct TA with involuntarily referred clients in very stressful conditions (i.e., mothers being assessed for termination of parental rights) and for most clients to leave the assessment feeling respected and well-treated. As mentioned earlier, it is even possible that such assessments help some clients to move from a precontemplation stage regarding change to a contemplation or even an action stage.

Classification or Selection

When the main goals of the assessment are classification or selection (e.g., administering an IQ test to see if a child reaches the cutoff for inclusion in a gifted–talented program at school), TA has relatively little incremental value over more traditional forms of information-gathering assessment. In other words: When the desired final product is a diagnostic labeling or a relative standing on predetermined trait levels, straightforward administration of assessment instruments is likely just as productive as TA. On the other hand, a collaborative stance always communicates respect to clients and fosters their investment in the assessment enterprise. Also, it is possible that psychological testing will yield somewhat more accurate data when clients are more invested. Still, when no change is sought, and when the assessment is primarily aimed at obtaining a "snapshot" of current functioning or relative standing, without future therapeutic contact, the added costs of TA may not be exceeded by these benefits.

When Clients Are in Crisis

Sometimes clients are referred for assessment when in a high degree of emotional distress. In these instances, it is a judgment call whether TA (or for that matter, any psychological testing) is the best approach. Many clients who are in immediate crisis need containment, practical advice, and reassurance before they can find any curiosity about themselves or meaningfully engage in a process that fosters self-observation. For example, it would be a major empathic break on the part of a psychologist to ask a highly suicidal client to "reflect on puzzles you have in your life that you would like to explore through an assessment." Similarly, someone who has

recently become homeless needs immediate food and housing assistance rather than help "revising existing stories about self and the world"! In such instances, it is best for clients to receive other clinical services first and then proceed with TA when they are calmer and more equipped to tolerate the emotions that are often stirred by this intervention. On the other hand, our experience shows that some clients in long-standing states of crisis and overwhelm benefit greatly from TA and experience it as someone "finally getting to the bottom of things." For example, Finn routinely assesses couples that have spent years feeling dissatisfied with their relationships—sometimes after a great deal of couples therapy—and who present asking, "Is there any hope we can be happy together, and what would it take?" Therapeutic Assessment has proved quite useful in a number of such cases.

Best-Case Scenario

Although a great deal of research is needed to identify the ideal context for TA to produce positive change, we judge it useful at this point for us to put forth our hunches, based on existing studies and years of clinical experience. Therapeutic Assessment seems most likely to yield positive change in the following situations:

1. When clients are voluntary participants in the assessment who believe that the process will be helpful to them in meeting valued goals;
2. When clients have tried other methods of reaching those goals or addressing life problems (e.g., reading self-help books, psychotherapy, following the advice of friends or ministers) and are dissatisfied with the results;
3. When clients are open to the idea that their current ways of viewing themselves and the world are inadequate to explain their life experiences and are searching for new ways of thinking;
4. When clients have not been traumatized previously by experiences with psychological assessment;
5. When clients are cognitively and psychologically able to take part in a process that invites self-observation, curiosity, and introspection (e.g., the client is not acutely suicidal, has food and shelter, and is not in great physical pain);
6. When clients have people who can support them emotionally as they progress through an assessment (e.g., friends, a referring therapist);
7. When major people in clients' lives (e.g., significant others, therapists) are open to new ways of thinking about them and when those individuals are involved in some way in the

assessment (e.g., attending summary–discussion sessions or posing questions to be answered).

CONCLUSION

Therapeutic Assessment is a relatively new brief psychotherapy that uses psychological tests to help clients explore and reach new understandings about their problems in living. The MMPI–2 has been shown in several controlled studies to be an effective centerpiece for Therapeutic Assessment, and detailed instructions and case examples now exist to help clinicians learn the procedures of TA with the MMPI–2. Further research is needed on the mechanisms underlying TA and on the types of clients for whom it is most suited. At this point, TA shows the most promise with clients who voluntarily participate in an assessment in hopes of understanding themselves better and improving their lives.