

The Value of Projective/Performance-based Techniques in Therapeutic Assessment

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Psychological assessment, and projective/performance-based assessment in particular, has seen a decline in recent years, both in training and clinical use. This trend is alarming and raises concerns about the loss of important clinical tools and its effect on the field of psychological assessment as a whole. In this article, we discuss two ways in which this shift affects the practice of psychological assessment: 1) loss of clinically important information accessed only with projective/performance based methods and, 2) loss of an opportunity to connect with clients and help them see aspects of their lives through therapeutic and collaborative use of projective/performance based measures, as practiced in Therapeutic Assessment.

Psychological assessment has been a central aspect of the training and work of psychologists throughout the history of the profession. However, recent evidence shows that since 1995 training in psychological assessment has decreased (Piotrowski, 2015a; Ready and Veague, 2014). While training in general assessment remained relatively stable in the period 2001 to 2011, the nature of that training shifted away from psychological assessment to training in cognitive and achievement measures and symptom rating scales. That shift has been particularly dramatic in projective and performance-based personality tests (Ready and Veague, 2014). Evans and Finn (2016) and Piotrowski (2015b) identify a number of potential reasons for the decline in training in personality assessment over the years.

The question that arises in the midst of this trend is what is gained and what is lost? Potential gains include the fact that self-report measures take little clinician time to administer and score, and they are easy to interpret, requiring little training; whereas, performance-based measures take more time and drain the limited resources available to address client concerns. Thus, with this trend precious resources can be directed toward what is perceived as effective treatment. Self-report tests are now widely and sometimes exclusively used. On the surface this seems like a favorable development.

However, there is substantial evidence that assessors are losing important fundamental underpinnings of effective assessment and even emerging, effective treatment opportunities. Martin (2016) identifies two main ways that projective/performance-based techniques are useful in psychological assessment. The first is providing access to secrets hidden away in the brain and inaccessible through self-report techniques. He argues that assessors are abandoning valuable tools that often are the only way to detect and understand important psychological issues and dysfunctions, such as split-off affect states, including trauma and developmental trauma (Finn, 2007). The second is the opportunity through Therapeutic Assessment to have powerful therapeutic effects with clients through experiential applications of projective/performance-based techniques (Finn & Tonsager, 1997).

Evidence from Neuroimaging Techniques:

Projective/Performance-based measures help identify determinants of dysfunctional behaviors and emotions not detected by self-report assessment. Studies using functional magnetic resonance imaging (fMRI) show parts of the brain that are activated by projective stimuli such as the Rorschach inkblots. These studies help illuminate what areas of the brain are tapped and thus the significance of projective responses. A recent fMRI study by Giromini et al (2017) identified

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the areas of the brain active while viewing the Rorschach cards and searching for responses that are not active while staring at a cross pattern. Results of the study show large portions of the temporal and occipital areas, which are involved in visual perception and processing, particularly complex visual associative tasks; areas in the frontal and parietal lobes associated with attentional processes; and sub-cortical areas related to the limbic system, which are integral to emotion perception and processing. The activations they detected were largely bilateral, involving both right and left brain. These findings are consistent with what would be expected given what is known about the Rorschach task and importantly show involvement of emotions in this seemingly cognitive task.

Asari and his colleagues (2010) have used fMRI to show brain activation when respondents provide a “unique percept” to a Rorschach card (i.e., one not seen by any of the 217 normal controls for the study). These unique responses correspond to form quality that is scored unique or distorted (FQu, FQ-) in the Comprehensive System (Exner, 2003). The primary correlate of unique responses is increased involvement of certain limbic areas influenced by the amygdala, especially the right amygdala. The amygdala is central to emotional experience and emotional memory; thus, its involvement points to the influence of emotional experiences in certain Rorschach responses that have significant interpretive value. These results are consistent with Shore’s contention (2009) that memories and affect states connected with trauma and developmental trauma are primarily stored in the right hemisphere of the brain and associated limbic system. The implication here is that effects of trauma are not easily accessible to the logical left hemisphere and are thus out of awareness. It takes projective stimuli to access important experience and information.

Another important fMRI study by Buchheim et al (2009) involving the Adult Attachment Projective (AAP; George & West, 2012)

supports this contention in dramatic fashion. They compared the amygdala activation of two groups of women while viewing the seven stimulus cards of the AAP, which were designed to increasingly activate the attachment system. The control group was composed of women who were classified as having resolved attachment while the second group was composed of women classified with unresolved attachment (characteristic of developmental trauma). The results showed the average amygdala activation for each group for each of the seven cards. The resolved attachment group showed amygdala activation for each card close to an average amygdala activation level. The unresolved group showed significant under activation to the first two cards, which only mildly activate the attachment system, and a linear trend upward to significant over-activation to cards 5 and 7. These results suggest that those with resolved attachment status are able to modulate their amygdala/emotional response to attachment-activating stimuli while those with unresolved attachment status (i.e., those with significant developmental trauma) have difficulty modulating their emotional response to attachment activating stimuli. The unresolved strategy seems to be to blunt all emotional responsiveness, but when this fails they become over activated and subject to the consequences of emotional dysregulation.

These studies show the importance of assessment instruments that can tap into right brain-limbic processes to collect data that help assessors see what is otherwise invisible and not detectable by self-report measures. The fact that many assessors are abandoning these important projective/performance-based techniques is thus a significant loss.

Therapeutic Assessment:

The second way projective techniques are useful in psychological assessment is in providing experiences for the client that help the client understand the root of perplexing problematic behavior by connecting the rational, linear functions (often referred to as left brain functions) with the emotional, holistic

functions (often referred to as right brain functions). As one might expect, this experiential understanding is enormously therapeutic.

Background:

Collaborative assessment was formally started by Constance Fischer in the late 1960s (1985/1994). It is grounded in phenomenology and emphasizes collaboration with the client. Working collaboratively solves some of the shortcomings of traditional assessment, including an overemphasis on nomothetic data at the expense of the person. Inspired by the innovators behind collaborative assessment (Fischer, 1985/1994; Handler, 1996; Purves, 2002), Finn developed a semi-structured approach to assessment that he calls Therapeutic Assessment (TA; Finn & Tonsager, 1997; Finn, 2007). It is a paradigm in which psychological testing is used as the centerpiece of a brief psychotherapeutic intervention. The cornerstones of TA are collaboration, curiosity, compassion, humility, openness and respect (Finn, 2009)—essential ingredients for an optimal working relationship (Fischer, 1982). A meta-analysis by Poston and Hanson (2010) confirmed the impressive therapeutic effects this approach to assessment delivers. In fact, these researchers conclude that this approach to assessment should become central to training and practice and that managed care should incorporate it as a short term, effective, evidence-based treatment.

Projective techniques play a central role in TA not only by providing important information as demonstrated by neuroimaging techniques, but also in creating an experiential mechanism that can help the client deeply understand what was previously inaccessible.

Semi-Structure of Therapeutic Assessment:

TA generally follows a six-step process but allows deviations that match the unique needs of each client. General adaptations have been

made for children and families (Tharinger et al, 2011), adolescents (Tharinger et al. 2013), and couples (Finn, 2007). The typical TA starts with an initial session in which the client's questions for the assessment are identified. These questions provide the focus of the assessment, and guide the selection of tests to be administered. The next step is standardized administration of the tests necessary to gain nomothetic data to answer the client's questions. However, idiographic data is not ignored. Finn developed a technique called extended inquiry (EI), which accommodates and mines the unique responses and behaviors of the client to understand their important meaning, and ideally to demonstrate some of that understanding to the client experientially.

When the testing is largely complete and answers to the questions are clarifying, an assessment intervention session (AIS) is planned and executed. This is a critical step Finn devised to help the client see behavior patterns that cause problems in their life and are at the root of answers to their questions. Its purpose is to expand the client's understanding (in both right and left brain) so that they can incorporate previously inaccessible answers in the following feedback session, which is the next session in the typical TA assessment process. In TA this session is called the summary discussion session to connote the collaborative nature of this approach. Answers to questions are discussed following guidelines derived from social psychology research to maximize the effect the results can have. After this final session, a personal letter is written (rather than an impersonal assessment report) outlining the assessment results while incorporating the client's examples, metaphors and images that are meaningful to them and contextualized within the client's life. The last step in the TA process is a follow up session scheduled two or three months after the summary discussion session to allow further discussion of the results, trouble shooting remaining difficulties, and to address any additional questions that have come up

as a result of the client becoming unstuck. For a more complete introduction to TA see Finn & Martin (2013).

The Therapeutic Value of Projective/ Performance-based Techniques:

There are two places in this process in which projective/performance-based measures are instrumental in activating an experience in the client and thus providing important information to the assessor and opening the client to new insights: extended inquiry opportunities (EI) and the assessment intervention session (AIS). Both rely on the power of a stimulus to trigger the kinds of projections that are observed in the fMRI studies mentioned above. The EI happens spontaneously while the AIS is carefully planned to activate an emotional response that is key to the client's questions.

The AIS involves using a testing measure to activate a response in the room that can then be addressed collaboratively in the moment. This is a critical step in the process, and it often relies on a projective technique to do what fMRI studies suggest—to access reactions that are otherwise hidden from the client (and consequently from self-report data) but which fuel problematic behavior. For problems with emotions or relationships, the Thematic Apperception Test (TAT; Murray, 1943) is often employed because the stimulus of certain pictures (thoughtfully selected) invariably trigger projections that reveals underlying patterns of behavior that are not apparent to the client.

The alert assessor, who by this time has become a trusted collaborator, can supportively and gradually focus the client's attention on critical problematic reactions. The client and assessor by now have a body of evidence (both from the testing results and their interactions together) to draw upon in the effort to help the client see and understand a key something she/he has never effectively understood before. Because this is an experiential exploration, the insight is particularly powerful and disruptive of blind

habits. New reactions that are more adaptive than these habits can then be explored with the assessor's help and tried out first in the room (e.g., by telling a different but viable story) and then outside the room in a way the assessor and client devise for the following week. The AIS can be a powerful agent of enduring change. For a case illustrations see Martin (2016).

Summary:

Thus, it seems important aspects of psychological assessment have been lost in the bustle to make psychological interventions quicker, more efficient, and less costly. A major casualty of this trend is that projective/performance-based tests are increasingly not used or even taught in training programs. While this makes psychological assessment less time intensive, it sacrifices at least two vital functions: accessing important information that only projective/performance-based tests can provide and which is often critical to successful treatment, and creating the opportunity for clients see central aspects of their problems in living with new eyes and in potentially life-changing ways.

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