

Assessing Psychotic Spectrum Disorders in Partnership With Patients: Three Culturally Responsive Therapeutic Assessment Cases

Joelle T. Taknint^{1, 2}, Sohenga Depestre^{1, 2}, Nuha Alshabani^{1, 2}, Abigail M. Martin^{1, 2},
Saarika Virkar³, and Johanna Milord²

¹ Department of Psychiatry, Boston University Chobanian and Avedisian School of Medicine

² Department of Psychiatry, Boston Medical Center, Boston, Massachusetts, United States

³ Department of Epidemiology, Boston University School of Public Health

Therapeutic assessment (TA) is noted for its collaborative, patient-centered nature and ability to create therapeutic benefits through the assessment process itself. TA provides diagnostic clarification and improves readiness for, and engagement in mental health and substance use treatment. Psychotic spectrum disorder (PSD) refers to a collection of symptoms involving significant disturbances or marked alterations in thoughts, perceptions, and behaviors significantly impairing functioning. Psychological assessment, often a first step toward PSD treatment is fraught with challenges including historical and ongoing effects of racism on testing, social stigma, internalized stigma, providers' parentalistic approach to care, and beliefs that patients with PSD cannot partake in decisions about their care. Noting the alignment of TA with recovery-oriented therapeutic approaches for psychosis, and the need for patient collaboration in treatment, researchers and clinicians have begun to call attention to the potential value of TA in PSD assessment. We present three cases illustrating the utility of TA as a culturally responsive assessment approach for PSD. Case A discusses misdiagnosis in a multicultural context and an abbreviated TA approach. Case B addresses the roles of the TA relationship and a multicultural lens in assessing and communicating a delusional disorder diagnosis. Case C discusses partnership with the patient's therapist and using a radically collaborative assessment process to make a diagnosis of schizoaffective disorder. We describe common themes across cases—the power of narrative shifts and creating corrective therapeutic experiences through TA. We discuss TA as a culturally responsive approach and the potential value of TA as an antioppressive practice.

Clinical Impact Statement

In this article, we offer the first case studies on using therapeutic assessment for the evaluation of psychotic spectrum disorders.

Keywords: therapeutic assessment, psychotic spectrum disorders, psychosis, culturally responsive, psychological assessment

Therapeutic Assessment

Influenced by humanistic psychology and the innovative collaborative assessment work of Constance Fischer (Fischer, 1978), therapeutic assessment (TA), conceived by Stephen Finn, has become an increasingly prevalent model of psychological assessment over the past 30 years. TA is noted for its patient-centered nature and its unique ability to create therapeutic benefits to patients through the assessment process itself (Aschieri et al., 2016). TA recasts the psychologist and the patient as coinvestigators into the patient's psychological presentation. The assessment is guided by the questions the patient has about themselves, test data are interpreted collaboratively, and conclusions are reached in partnership with the patient. TA is grounded in the foundational values of: *collaboration, respect, humility, compassion, openness, and curiosity* (Smith, 2016), which enables practitioners to use culturally responsive assessment practices.

TA has been well-established as a unique intervention for not only providing diagnostic clarification but additionally improving readiness for, and engagement in mental health and substance use treatment (Aschieri et al., 2016; Blonigen et al., 2015). A recent meta-analysis indicates moderate to large effects of TA on treatment process variables (e.g., alliance, treatment satisfaction, hopefulness) and moderate effects on patient symptomology and patient self-enhancement variables (e.g., self-efficacy, self-esteem; Durosini & Aschieri, 2021). TA has been used across the lifespan, implemented globally (Chudzik, 2020; Pais & Escobedo-Belloc, 2023), and adapted for use in a variety of care settings including in low-resource settings (Guerrero et al., 2011). Further, TA can promote treatment readiness among patients with severe presentations such as personality disorders (De Saeger et al., 2014; Kamphuis & Finn, 2019).

Psychotic Spectrum Disorders

People who report psychotic experiences have described the phenomenon as losing touch with reality, a spiritual event, or a transcendental experience (Cook, 2019; Ebisch et al., 2013; Howell, 1976; Walsh, 1980). According to the *Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5)*, psychosis refers

to a collection of symptoms that involve significant disturbances or marked alterations in thoughts, perceptions, and behaviors (Arciniegas, 2015). While psychosis is commonly associated with primary psychotic disorders (e.g., schizophrenia) people can experience psychosis as a symptom of mental health sequelae (e.g., major depression), medical conditions (e.g., autoimmune disorders) or neurological disorders (e.g., seizure disorders; Brasso et al., 2021; Keshavan & Kaneko, 2013). Recent epidemiological statistics indicate that the lifetime prevalence of an individual meeting diagnostic criteria for a PSD is between 1.5% and 3.5% in the United States (Perälä et al., 2007; van Os et al., 2001). Further, it is estimated that about 7% of the general population has at least one occurrence of a psychotic experience, such as a hallucinatory or delusional experience, and 80% of the general population have subliminal psychotic or psychotic-like experiences, such as logically implausible beliefs or altered subjective experiences, in their lifetime (Linscott & van Os, 2013; McGrath et al., 2015; van Os & Reininghaus, 2016).

The hallmark symptoms of PSDs include delusions, disorganized thinking, hallucinations, and negative symptoms (Arciniegas, 2015). It follows that PSDs can severely impact a person's ability to think clearly, engage in daily activities, and communicate effectively. In fact, PSDs are often considered some of the most impairing and severe mental disorders due to the chronic nature of acute episodes of psychotic experiences and the subsequent cognitive, social, and global functioning deficits (Arciniegas, 2015). *Cognitive deficits* may include difficulties with memory, attention, problem solving, and executive functioning. *Emotional and social deficits* can include significant distress and social isolation. Individuals may experience intense fear, anxiety, or depression due to their symptoms or the stigma associated with their condition. Negative symptoms, such as diminished emotional expression or social withdrawal, can further hinder interpersonal relationships. These changes in cognitive and emotional functioning can challenge one's identity and lead to a diminished sense of self-worth. Finally, PSDs often co-occur with other mental health conditions, such as mood, anxiety, and substance use disorders. These comorbidities may complicate the clinical picture, increase symptom severity, and contribute to functional impairment.

Challenges to Psychological Assessment for Psychotic Spectrum Disorders

Early intervention, access to appropriate treatment, and a holistic approach that addresses symptoms and functional impairments are crucial for promoting recovery and enhancing the quality of life for individuals with PSDs (Colizzi et al., 2020). Yet, psychological assessment, which may be the first step toward PSD treatment, historically has resulted in patterns of misdiagnosis based on both individual and systemic oppressive beliefs and attitudes about marginalized identities (e.g., racism and sexism; American Psychological Association [APA], 2017; Garb, 2021).

Racism has significant impacts on the assessment of psychotic disorders, creating disparities and barriers to equitable care (Schwartz & Blankenship, 2014). Racial bias in the diagnosis of schizophrenia and psychotic affective disorders is more likely to occur among Black and Hispanic patients compared to the White patients (Garb, 2021). *Misdiagnosis* of PSDs is related to a lack of culturally responsive assessment when culturally normative behavior is misinterpreted as psychopathology (e.g., misidentification or overdiagnosis; Schwartz & Blankenship, 2014). Conversely, psychotic symptoms may also be overlooked or attributed to cultural factors, leading to delayed or inadequate treatment (e.g., underdiagnosis; Adeponle et al., 2012). People of color with a PSD may face additional intersecting effects of racial and mental health discrimination which is subsequently associated with reduced help-seeking behaviors and engagement in psychological assessment. Moreover, people with PSDs experience internalized stigma or self-stigma; a phenomenon that occurs when a person internalizes negative societal beliefs (public stigma) about their mental health diagnosis (Forgione, 2019; Vogel et al., 2007, 2013).

Recovery-oriented treatment for individuals with serious mental illness such as PSDs, promotes the importance of self-determination, access to choices, and an improved sense of autonomy (Zisman-Ilani et al., 2017). *Shared decision-making (SDM)* models, an approach in which patients and providers collaborate to make health care decisions based on patient preference and the best available evidence, have been recommended for use with people with PSDs (Charles et al., 1997). SDM is associated with patient satisfaction and fewer decision conflicts (Haugom et al.,

2022). However, researchers have shown SDM to be inconsistently implemented among patients with PSDs, particularly those who have experienced involuntary treatment (Drivenes et al., 2020) despite patients' positive responses to SDM (Haugom et al., 2022). This is likely due to barriers such as providers' parentalistic approach to care and beliefs that patients with PSD cannot feasibly or thoughtfully partake in SDM (Zisman-Ilani et al., 2017).

Noting the alignment of TA with recovery-oriented therapeutic approaches for psychosis, and the need for collaborative engagement of patients in the treatment of psychotic disorders, researchers and clinicians have begun to call attention to the potential value of TA as a tool for assessing and providing psychotic spectrum disorder (PSD) diagnoses and recommendations for treatment (i.e., Norman & Breitborde, 2014; Rosen, 2021).

TA allows for the development of a therapeutic working relationship and provides opportunities for self-determination, access to choices, and sense of autonomy as patients are actively involved in each step of the assessment process. Such an approach may reduce barriers (e.g., stigma) that prevent the use of SDM. In fact, an essential element of recovery-oriented SDM is to provide patients with information about their health and holistic treatment options (Makoul & Clayman, 2006). Yet, in most cases, patients with PSDs are often only informed of medication options (Shepherd et al., 2014). In TA, the assessment questions are driven by the patient and may thus result in recommendations that more closely align with the patient's view of recovery as well as expanded treatment options (Haugom et al., 2022; Zisman-Ilani et al., 2017).

In this article, we offer the first case studies we are aware of using TA for the evaluation of PSDs. In line with the identified priorities for TA (i.e., Martin, 2019), we center a multicultural approach within each of these assessments. We further present TA as a culturally responsive intervention which aligns with a recovery framework for conducting psychological assessment with patients with suspected PSDs.

Three Case Examples: TA to Assess PSDs

Our three deidentified case examples demonstrate the utility and impact of a TA approach with patients referred for psychological assessment of suspected PSD. Table 1 provides a detailed

Table 1
Use of TA for Assessment of Suspected PSDs (Detailed Case Example Information)

Category	Patient A	Patient B	Patient C
Referring provider and their referral questions	Therapist: Referral for diagnostic clarification, questions about if patient meets criteria for bipolar disorder and/or ADHD.	Therapist: case manager: How can we best understand this person's fear of religious persecution? What is happening diagnostically and what is the most appropriate treatment?	Psychiatrist: Referral for diagnostic clarification and assessment of cognitive challenges. Goal to provide patient with a better understanding of symptoms and treatment recommendations.
Formal care team	Outpatient therapist and psychiatrist	Case manager and outpatient therapist	Outpatient therapist and psychiatrist
Natural supports	Identified one friend, family in Singapore	Rabbi and members of religious community	Mother, grandparent, and limited social connection with friends.
Treatment history prior to the TA	<ul style="list-style-type: none"> Brief psychiatric hospitalization (suicide attempt) No previous psychological assessment Outpatient psychotherapy, psychiatrist Past diagnoses: ADHD, bipolar disorder, schizoaffective disorder 	<ul style="list-style-type: none"> Brief psychiatric hospitalization (paranoia) No previous psychological assessment Biweekly outpatient psychotherapy Robust case management Declined psychopharmacological interventions in the past Past diagnoses: generalized anxiety disorder, PTSD 	<ul style="list-style-type: none"> Brief psychiatric hospitalization (psychosis and suicide attempt) One prior psychological assessment as a child (resulting in ADHD diagnosis, no subsequent treatment) Weekly outpatient psychotherapy Monthly medication management for psychopharmacology Past diagnoses: ADHD, schizophrenia, schizoaffective disorder, unspecified psychotic disorder
Patient identities (using <i>Hayes, 2008</i> addressing framework ⁶⁴)	<p>A: Adult (mid 30s)</p> <p>D: No developmental disability</p> <p>D: No acquired disability</p> <p>R: Unknown</p> <p>E: South East Asian</p> <p>S: Middle (access to higher ed), low following move to United States</p> <p>S: Straight</p> <p>I: Nonindigenous person (U.S. context)</p> <p>N: South East Asian, precarious immigration status, non-U.S. citizen, English is not primary language</p> <p>G: Cisman</p>	<p>A: Adult (mid 30s)</p> <p>D: No developmental disability</p> <p>D: No acquired disability</p> <p>R: Jewish, following conversion from Christianity</p> <p>E: Latinx</p> <p>S: Middle-upper (upbringing), low following migration</p> <p>S: Straight</p> <p>I: Nonindigenous (U.S. context)</p> <p>N: Colombian, non-U.S. citizen, English is not primary language</p> <p>G: Ciswoman</p>	<p>A: Adult (late 20s)</p> <p>D: No developmental disability</p> <p>D: No acquired disability</p> <p>R: "Culturally" Catholic,</p> <p>E: White European American</p> <p>S: Middle</p> <p>S: Heterosexual</p> <p>I: Nonindigenous (U.S. context)</p> <p>N: U.S.-born citizen, English is primary language</p> <p>G: Cisman</p>

(table continues)

Table 1 (continued)

Category	Patient A	Patient B	Patient C
Psychologist identities	<p>A: Adult (mid 30s) D: No developmental disability D: No acquired disability R: Agnostic E: Japanese and White/American S: Middle-upper S: Straight I: Nonindigenous person N: U.S. citizen, English as primary language G: Ciswoman</p>	<p>A: Adult (mid 30s) D: no developmental disability D: no acquired disability R: Agnostic E: Multithnic (Amazigh (indigenous North African), Dutch, Scots-Irish, Armenian, and Lebanese S: Middle-upper S: Straight I: Nonindigenous (U.S. context) indigenous (North African context) N: U.S. citizen, English as first and primary language G: Ciswoman</p>	<p>A: Adult (late 20s) D: No developmental disability D: No acquired disability R: Spiritual E: First-generation Black Caribbean American S: Low-middle S: Queer I: Nonindigenous N: U.S.-born citizen, bilingual English and other G: Ciswoman</p>
Patient's Therapeutic Assessment Questions	<ul style="list-style-type: none"> • What is the most accurate diagnosis for me? • What is the best way for me to be in romantic and intimate relationships? • How can I know myself better? 	<ul style="list-style-type: none"> • How can I cope better? • What can I do if something like this (persecution) happens again? • Is there a way to feel safer—Can I learn to better assess danger after trauma? • Can we analyze the fear that I will be forced to do things that I do not want to do? • How do I develop a sense of belonging in my Jewish communities? • How with my trauma can I make new friends in the Jewish community? • Is there a way to begin to safely build connections with other Latinx people? How can I “reduce the allergy” 	<ul style="list-style-type: none"> • Do I really have Schizophrenia? • How can I be sure what I have experienced is psychosis? • One of my biological parents has bipolar disorder, maybe there is a biological connection with me having it too. Are my symptoms more similar to bipolar disorder than a psychotic disorder? • Why do I have a hard time with my memory, is there something more going on that more than just ADHD? • Is it possible that my experience of depression is impacting my thinking and memory abilities?
Assessment tools	<ul style="list-style-type: none"> • Minnesota Multiphasic Personality Inventory–3 (MMPI-3) • Wender Utah Rating Scale for ADHD • Diagnostic Clinical Interview • Developmental History Interview 	<ul style="list-style-type: none"> • Minnesota Multiphasic Personality Inventory–3 (MMPI-3) • Yale Brown Obsessive–Compulsive Scale (YBOCS) • Brief Version of Coping Orientation to Problems Experienced Scale (Brief COPE) • Jewish Religious Coping Scale (JCOPE) • PTSD Checklist for <i>DSM-5</i> (PCL-5) 	<ul style="list-style-type: none"> • Wechsler Adult Intelligence Scale, fourth edition (WAIS-IV) • Behavior Rating Inventory of Executive Function–Adult (BRIEF-A informant and self-report versions) • Wide Range Assessment of Memory and Learning, third edition (WRAML3) • Color Trails Test • NEO Personality Inventory–Revised (NEO-PI-R)

(table continues)

Table 1 (continued)

Category	Patient A	Patient B	Patient C
No. of testing appointments	4		
Concluding diagnoses (DSM-5)	296.80 (F31.9) unspecified bipolar and related disorder (provisional) R/O: brief psychotic disorder with marked stressor, cannabis-induced psychotic disorder, major depressive disorder with psychotic features in partial remission, narcolepsy	296.33 (F33.2) major depressive disorder, recurrent, severe (active) episode 297.1 (F22) delusional disorder, persecutory type, continuous	295.70 (F25.0) schizoaffective disorder, bipolar type 305.1 (F17.200) tobacco use disorder, moderate 305.00 (F10.20) alcohol use disorder, moderate, in sustained remission 314.01 (F90.9) attention deficit/hyperactivity disorder, unspecified type (retained from records)

(table continues)

Table 1 (continued)

Category	Patient A	Patient B	Patient C
Recommendations	<ul style="list-style-type: none"> • Discuss bipolar diagnosis with providers • Closely monitor symptoms to further assess bipolar disorder • Closely monitor suicidal ideation and self-injurious behaviors • Ask clarifying questions about diagnoses and symptoms and remain cautious of using clinical jargon to describe experiences • Continue psychotherapy and explore healthy strategies for stress management 	<p>Referrals made to state's Department of Mental Health and for psychopharmacological evaluation</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • Address the memories of the traumatic event that started the fear of persecution through <i>Imagery Rescripting</i> • Start building connections with Latinx people who you trust (such as your family or other Latinx Jews) • Keep on using your strong religious coping skills and work on building more active coping skills (work with your therapist on increasing cognitive flexibility, work on taking action and problem-solving skills, and reaching out to others for help). • I can face the fear sometimes • I can heal from the trauma • I can "reduce the allergy" to other Latinx people 	<ul style="list-style-type: none"> • Continue psychotherapy, to process new diagnosis of schizoaffective disorder, bipolar type and concerns regarding your prognosis given primary psychotic disorder diagnosis • Consider joining recovery-oriented therapeutic groups to connect with other young adults diagnosed with a PSD • Discuss harm reduction approaches with providers to support goals of limited to no use of substances
Narrative shifts through TA	<p>Narrative shift characterized by feeling less pathologized. Patient gained insight into the specific criteria for diagnoses and the complex multicultural context in which his experiences may have been misunderstood and pathologized. He voiced a greater appreciation for his intermational and multiracial and multicultural background. Patient additionally felt some relief about not having schizophrenia spectrum disorder diagnosis that did not feel relevant to him.</p>		<ul style="list-style-type: none"> • Improved sense of confidence and com-fortibility with engaging in shared clinical decision making with providers • Improved insight and better understanding of his mood and psychotic symptoms and how they impact his cognition "brain fog" • Improved sense of hope for his future and ability to counter prior stigmatizing beliefs with new understanding of his condition.

Note. TA = therapeutic assessment; PSD = psychotic spectrum disorder; ADHD = attention-deficit/hyperactivity disorder; PTSD = posttraumatic stress disorder; *DSM-5* = *Diagnostic and Statistical Manual of Mental Disorders, fifth edition*.
^a Hays's (2008) ADDRESSING framework addresses complexities in identity through considering the totality of Age, Developmental and acquired Disabilities, Religion, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, Native origin, and Gender.

overview of the referral questions, care team, treatment history and context, cultural identities of the assessing clinician and patient using Hays's (2008) Age, Developmental and acquired Disabilities, Religion, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, Native origin, and Gender (ADDRESSING) framework, and the patient's own TA questions which guided the TA. We also provide in Table 1 a list of the assessment tools used to address these questions and a summary of assessment outcomes (i.e., final diagnoses shared with the patient, recommendations, the patient's own shifts in their self-narrative through the TA).

Case Study A: Misdiagnosis Within a Multicultural Context

In case A, the patient was previously diagnosed with schizoaffective disorder. When the patient first engaged with the psychologist, the patient reported he did not know what the schizoaffective disorder diagnosis meant and what symptoms were associated with the disorder. He recalled simply agreeing with providers that he had the disorder during a past hospital admission because he believed it would get him the best possible mental health treatment at the time. The diagnosis was given despite a complicated and ambiguous diagnostic history. The patient had a vague history of paranoia in the context of significant cannabis misuse, history of attention-deficit/hyperactivity disorder diagnosis, as well as a history of suicidal ideation and self-injurious behavior, specifically, blood-letting. Characteristics of the patient associated with his biracial identity, South Asian culture, immigrant status, and international upbringing may have been pathologized, contributing to a premature schizoaffective disorder diagnosis. For example, during a telehealth visit, the patient's background included decorations reminiscent of 1920s safari travel and he wore linen shirts and smoked out of an old-fashioned wooden pipe. While the patient was fluent in English and well-educated, he spoke with an accent and with sophisticated diction but also misused words. Furthermore, the patient's tendency not to question clinical language, and his use of words like "manic," "psychopath," "psychosis," and "grandiose delusion" to describe himself and his experiences despite not knowing the clinical meaning and significance of the terms, likely also resulted in misdiagnosis.

After the patient met with the psychologist twice to complete an interview exploring his developmental and clinical history and to create his TA questions (italicized below), they discovered that he could not proceed with the full TA due to limitations with his insurance. The patient was confused about his diagnosis and why he was having such difficulty in intimate relationships. He was also curious about getting to know himself better as he felt puzzled about his experiences of himself and others in general. He thus asked: *What is the most accurate diagnosis for me? What is the best way for me to be in romantic and intimate relationships?* and *How can I get to know myself better?* To remain aligned with the core TA values of respect and openness the psychologist and the patient collaboratively considered possible solutions to ensure his experience could be both insightful and therapeutic. With the support from her supervisor, the psychologist offered several brief sessions billed as therapy appointments, in lieu of the full assessment. The patient appreciated this solution and the Minnesota Multiphasic Personality Inventory-3 (MMPI-3) and Wender Utah Rating Scale for attention-deficit/hyperactivity disorder were used in a therapeutic manner.

In session, the values of collaboration and openness guided the psychologist to share information about the normative sample of the MMPI-3. This helped the patient to see how he was not adequately represented in the normative sample and how his unique cultural experiences may skew the results of tests and the perceptions of health care providers. Just this small intervention appeared to be a validating experience for him as his unique upbringing often left him feeling isolated and misunderstood throughout his life. TA considers the use of psychological tests as "empathy magnifiers" (Finn & Tonsager, 2002, p. 15), a way to gain perspective from the patient's point of view. Using this concept, the remaining sessions were used to collaboratively explore and discuss the results of the MMPI-3 and Wender Utah Rating Scale as well as share the diagnostic criteria for each of the diagnoses he was considering for himself. As the patient learned more about schizoaffective disorder, it became clearer that it did not accurately describe his symptoms.

Although limited in resources, through a very brief TA, the patient was able to discover answers for his questions; his diagnosis was clarified as unspecified bipolar and related disorder and he

gained insight into challenges with relationships. Further, openly discussing how individuals with marginalized identities face an increased risk of being pathologized by health care providers and standardized measures helped to normalize and validate the patient's multicultural identity. The patient began to understand that more of his difficulties with communication and relationship could be attributable to his marginalized experience of living in the United States with his unique multicultural background, reducing the blame he placed on himself as an individual. Additionally, in this case, shared aspects of identity between the psychologist and patient (i.e., international upbringing, multicultural and biracial identities) were processed in supervision and in the TA. These ultimately contributed to the psychologist's ability to culturally contextualize the assessment data in a nuanced and validating manner.

Case Study B: The Importance of the Assessment Relationship

In Case B, the assessment began with the psychologist and patient both feeling uneasy about working together. After looking up the psychologist, the patient contacted her therapist and case manager to express her concern that the psychologist may be a terrorist and/or antisemitic on the basis of racist biases the patient held about the psychologist's national and ethnic background as a North African person, and assumptions she made about the psychologist's religious intolerance. Thus, the assessment began with a question of whether cultural safety could be cocreated for both parties in the assessment room. For the psychologist, consulting with a colleague, and acknowledging the patient's fear of persecution was at the heart of these hurtful behaviors—the very thing that led her to seek psychological assessment—helped the psychologist to tap into the TA value of compassion, and set the stage for relationship building. The team-based response from the referring case manager and therapist, in which they informed the patient that no discrimination would be tolerated toward patients or staff, helped the psychologist to feel supported in proceeding with the assessment. In approaching the first interaction with the patient with this backdrop, the psychologist leaned on TA's foundational values of *collaboration, respect, humility, compassion, openness, and curiosity* (Smith, 2016),

to try to better understand the patient's fear. These strategies proved useful in allowing both the psychologist and the patient to have a corrective relational experience, feel safe, and further elucidate the context of the patient's TA questions.

The role of the relational process was critical in initially crafting the TA questions (italicized below) for B, who was struggling with persecutory delusions. It was essential that questions were in B's language, that they felt true to her lived reality (e.g., *Is there a way to feel safer?*) and that they simultaneously provided a launching point for framing the investigation with enough openness to shift her narrative and entertain new explanations for what may be maintaining her distress (e.g., *Can I better learn to assess danger after trauma? How can we understand the fear that I will be forced to do things that I don't want to do?*). See Table 1 for all of B's TA questions. Collaboration, openness, and curiosity were central to guiding this first piece of the work.

The TA values of humility and respect drove the decision to honor B's religious identity in the assessment process and to do this within a relational context. For example, as she entered the assessment with fears that the assessor would be antisemitic, it was a corrective emotional experience for B's Jewish identity to be centered in her questions about persecution, how to serve her community, and how to create belonging. As one example of how this was implemented within the assessment context, the psychologist used the Jewish Religious Coping Scale (Rosmarin et al., 2009), to center religious based coping in exploring B's TA questions. This ultimately was helpful in thinking about how other relationships (e.g., with B's rabbi and her faith community) could be included in the treatment recommendations.

Over the course of the assessment, it was the patient's initial fears about the psychologist (influenced by her persecutory delusions) that became so instrumental in creating safe and corrective experiences through the TA relationship. The patient was able to learn through the assessment that the psychologist was not a threat to her and that her religious identity could actually be embraced and indeed celebrated by someone from outside of her faith community as the tremendous resource it was for her in helping manage psychological distress. This in turn provided evidence for the patient that her initial

assumptions were misguided. By discussing this significant shift with the patient at the end of the assessment, the patient was able to acknowledge in real time an instance where assumptions were false and fear of persecution was not substantiated. This process of expanding cognitive flexibility and increasing one's ability to take in and accept new information from an external source as trustworthy and generalizable is directly in line with the current theoretical work proposing that one of the underlying mechanisms that makes TA work is through the restoration of epistemic trust (Kamphuis & Finn, 2019).

Case Study C: Consent, Open Communication, and Therapist Collaboration

In case C, the psychologist and patient engaged in an extensive assessment process that highlighted the importance of ongoing informed consent, providing space for corrective experiences, and transparency when communicating difficult news. In this case, we illustrate how the TA framework lends itself to effectively aiding in the process of communicating challenging diagnoses to patients, such as a PSD. At the time of referral, C was diagnosed and receiving treatment for an unspecified PSD.

As the psychologist and patient began building rapport and identifying his assessment questions (Table 1), it became clear that the patient was both excited to learn “what was actually going on” with regard to his complex constellation of mental health symptoms and at the same time very worried about this evaluation confirming his “worst fear”—having a PSD. C disclosed that he was previously diagnosed with schizophrenia while admitted on an inpatient psychiatric unit following a significant suicide attempt. He described being “labeled” with schizophrenia with limited meaningful interactions with the diagnosing clinician. He expressed frustration with not understanding why he received this diagnosis and why he was prescribed an antipsychotic medication when he felt he was not experiencing psychosis (“no hallucinations”) nor overt functional impairment most commonly associated with PSDs. C shared that he had become wary of receiving any PSD diagnosis given his prior negative interactions with mental health providers. He experienced his inpatient admission as neither transparent

with diagnostic practice nor considerate of his perspective.

As C developed his assessment questions, he began to simultaneously explore these frustrations in his individual therapy sessions, enabling him to begin thinking about and processing new information in therapy between TA sessions. With C's consent, a collaborative dialogue between C's therapist, and TA psychologist took place intermittently from the first TA appointment until the feedback session. The psychologist and therapist were also members of the same multidisciplinary team and had opportunity to regularly consult.

For the psychologist to successfully work with C and provide the opportunity for a corrective experience, there needed to be, first and foremost, mutual trust. The psychologist pursued a therapeutic alliance rooted in a sincere invitation of partnership with the patient. She also knew that it was important to validate C's feelings of frustrations with the mental health care system given his prior negative experiences. Additionally, the psychologist discussed openly the differences between her civilian and C's military background. Through this discussion the psychologist determined, it was important to repeatedly emphasize the value of C sharing his thoughts and ongoing feedback during the assessment process. They talked about C's experience with hierarchical working relationships as C shared that he was not used to having his opinions seriously considered when working with doctors or others with more authority than him. It is likely that C's unexpected experience with the psychologist allowed him to take in difficult clinical information that was previously deemed incongruent with his self-perception.

Overall, there was a commitment from both the psychologist and patient to collaborate by sharing their developing hypotheses and thoughts about next steps (e.g., what to evaluate next or how to use the previous assessment data). The patient was invited onto the “observation deck” (Finn, 2020) and stepped into the role of an expert and active coinvestigator. This likely empowered the patient to inform the psychologist that he often wondered if he had prior manic episodes, especially since he had a biological parent with a bipolar disorder. This increase in self-curiosity in turn allowed the patient to explore areas he had not previously broached in therapy (i.e., his childhood experience as an adoptee, survivor of traumatic experiences, and details of his service

in the military). There was a cyclical process where C's revelations during testing allowed for additional openness in therapy, which in return created more reflective conversations as a coinvestigator during his testing process. Without the patient's invited curiosity and insight informing this assessment, and the invitation for the patient to give ongoing feedback, it is possible that the psychologist could have missed diagnostically relevant information that ultimately helped reconceptualize C's mood dysregulation. Furthermore, it is likely that through co-investigating, the patient was able to trust the assessing psychologist when learning about the different types of PSDs and core symptoms including disorganized thinking, reality testing impairment, and associated cognitive decline (all of which the patient experienced during and outside of major mood episodes).

Given C's initial fears and concerns that his "life would be over" if he had a PSD, the psychologist was hesitant to communicate the final assessment results. The psychologist was additionally worried about the effects of confirmation bias affecting her conceptualization. To address the tendency of perpetuating diagnostic momentum, the psychologist sought out appropriate consultation to ensure that the patient's prior diagnosis of a PSD was not clouding her clinical decision-making process and that she was being culturally responsive (Satya-Murti & Lockhart, 2015). The psychologist utilized individual and group testing supervision to explore and receive feedback regarding her concerns of perpetuating diagnostic momentum. In doing so, the psychologist was encouraged to be transparent with the patient which prompted a genuine reflection between them about their multicultural identities and cultural experiences (Table 1). The psychologist and C specifically discussed how their respective civilian and military backgrounds were likely influencing the assessment process. To be appropriately responsive to the patient's experience in the military, it was important to acknowledge the power differential between the psychologist and the patient. It was further necessary to emphasize the patient's right to question any of the procedures or offered diagnostic impressions given his past experiences with feeling limited to no sense of agency or voice when interacting with people in power (e.g., commanding officers or medical providers). Additionally, to ensure that C was not overwhelmed by the process of exploring

a PSD diagnosis, the psychologist collaborated with his outpatient therapist and shared updated diagnostic considerations throughout the assessment and particularly prior to the final discussion session with C. This allowed C and his therapist to review C's understanding of his psychosis related symptoms, for C to articulate specific evidence from his lifespan for each symptom, and to integrate testing feedback, he was not initially comfortable with into the larger context of his mental health journey.

His therapist reported the patient being more open-minded about feedback after these conversations, and notably, by the time the assessor and patient met for the final feedback session, the patient had already begun accepting that he may have a psychotic disorder. During the feedback session, C spoke about his experience processing what he had learned about himself throughout the TA evaluation with his individual therapist. C shared that he was able to trust that the diagnosis of schizoaffective disorder, bipolar type, "fits and makes sense," because he was included and felt as though he was "along for the ride." He articulated his understanding of mood dysregulation, the spectrum of PSD presentations, and how he had learned how to identify when he is experiencing thought disorganization or "brain fog," as he calls it. C shared that during the TA process he was initially ambivalent about engaging in therapy, because he was wary about receiving any treatment for a diagnosis he did not believe he had (unspecified psychotic disorder). He went from being somewhat reluctant to sharing personal details in therapy and openly exploring his depressive symptoms. The TA contributed to C's gradual progress in therapy, allowing him to meaningfully engage in conversations about stigma, hope, and shared clinical decision making for overall mental health care with his therapist.

Discussion

Narrative Shifts in TA

Across these cases with diverse outcomes (i.e., both removing and making new PSD diagnoses), all patients experienced powerful positive shifts in their self-narrative (see Table 1). When new PSD diagnoses were made (Cases B and C), both patients spoke about increased hopefulness and confidence that they could work toward recovery

goals. In Case C, the patient shifted massively in his perspective on prognosis over the course of the TA. This happened through developing a more coherent story about how this diagnosis developed overtime in the context of biological and social vulnerabilities, and through working collaboratively with the psychologist to situate his own experiences more clearly within the range of PSD presentations.

In Case B, the narrative shift took the form of the patient feeling that she could “face the fear sometimes” and work toward making meaningful social connections within her community due to increased insight that her persecutory delusions were at times the thing that was making her feel unsafe. Coconceptualizing these delusions as a form of trauma in and of themselves empowered the patient, who initially identified strongly with a posttraumatic stress disorder diagnosis. This further enabled the delusional thought content to enter the realm of what could be addressed in her treatment. Additionally, for this patient, she experienced the diagnostic clarification and particularly the coconstructed narrative of how things got to this point as “soul cleansing.”

In Case A, situating the patient’s trajectory of symptoms within a clear assessment of the multicultural context gave life to a new narrative in which he felt less pathologized and more empowered with information about mental health symptoms and diagnoses. Additionally, the patient left the TA with a deeper appreciation for his international upbringing, and biracial and multicultural background. In this way, the very factors that had been pathologized resulting in a PSD misdiagnosis initially, were able to be honored by the patient and the assessing psychologist at the conclusion of the TA. These changes are in line with meta-analytical findings that TA improves patient “self-enhancement” (i.e., self-understanding, self-esteem, and self-confidence; Durosini & Aschieri, 2021), and importantly, are in keeping with the expected outcomes (i.e., self-reflectivity, subjective recovery) of some recovery-oriented interventions for PSDs (Inchausti et al., 2023).

TA’s Collaborative and Inclusive Nature Facilitates Corrective Experiences

TA is a bidirectional process, or *dance*, between the psychologist and patient that invites active collaboration and ongoing communication

at every stage. The invitation to come up to what Finn (2020) calls the “observation deck,” particularly for people with PSDs (who are often excluded from SDM), facilitates opportunities for corrective experiences (e.g., addressing ways in which cultural differences may contribute to misdiagnosing, Case A; working through persecutory delusions, Case B; and addressing hopelessness in relation to mental health stigma, Case C). Given the importance of SDM and recovery-oriented assessment and treatment for PSDs, TA offers a unique approach that dynamically engages patients in identifying their goals while also supporting them with working through clinically impairing symptoms (e.g., reality testing impairment in Case B) and processing challenging information (e.g., diagnosis of schizoaffective disorder, bipolar type Case C).

TA Can Promote Culturally Responsive Care

Cases A, B, and C also highlight how the foundational values of TA (i.e., *collaboration, respect, humility, compassion, openness, and curiosity*; Smith, 2016), support psychologists in providing culturally informed and responsive care. This is of particular importance given the growing acknowledgement of systemic discriminatory practices within mental health care, its detrimental impact on overall health outcomes, and the need to develop and provide culturally relevant and responsive care (APA, 2017, 2021a, 2021b; Substance Abuse & Mental Health Services Administration, 2014). In 2017, APA offered multicultural guidelines that cautioned clinicians about the significant risks associated with diagnosing individuals whose sociocultural experiences are different or unfamiliar to themselves. Those risks include clinicians’ misunderstanding or misinterpreting patient experiences, which can then lead to misdiagnosis (Cases A and C) and subsequent inappropriate or traumatic treatment, further discrimination within research and clinical settings, and overall poorer health outcomes and health disparities (Pierce et al., 1977; Sue et al., 2007). As a result, patients may experience barriers to treatment and services that could improve their quality of life. Alternatively, patients may receive unnecessary treatments with potentially harmful long-term consequences, from misdiagnosis. Such practices are associated with lower self-esteem, feelings of hopelessness, or a feeling of being reduced to a stigmatized

diagnostic label such as “schizophrenic” (Evans-Lacko et al., 2012; Link et al., 1989; Ritsher & Phelan, 2004).

Within the cases discussed, we see examples of TA prompting the psychologist to actively consider the role of sociocultural factors not only in the conceptualization of clinical symptoms (Cases A and B) but also in consideration of the relational dynamics impacting the delivery and receipt of diagnostic impressions (Case C). More specifically, in Case A, the psychologist discovered that specific aspects of the patient’s identity (his multicultural background, immigrant status, and biracial identity) had not been appropriately considered in previous evaluations. This resulted in an initial misdiagnosis of a PSD. By working with the patient to contextualize assessment data within his cultural context, and by clearly communicating and making a critical and conservative interpretation of test data without a normative sample representative of the patient, the psychologist was able to both validate the patient’s experiences and arrive at a more accurate and culturally responsive diagnosis. In Case B, the psychologist centered the patient’s religious identity. Through respect, curiosity, and cultural humility, the psychologist and patient worked together to create assessment questions (see Table 1) about how the patient could connect with her Jewish community in the context of fear (driven by persecutory delusions). Incorporating religious coping and ethnic identity measures in the assessment tools (see Table 1) was an essential step in ensuring the patient’s Latinx and Jewish identities, which were central to her assessment questions, were explored and understood through the assessment process. In Case C, it was imperative that the civilian psychologist learn about the patient’s military background and discuss openly how this impacted the power dynamics in the TA relationship. Inquiring about and collaborating with patients on bringing these salient social identities and cultural factors into the center of the assessment process was critical in creating culturally responsive assessments.

Aligning on Findings

The process of TA can be of particular value in creating greater alignment with patients on assessment findings. For example, Finn uses *levels of information* as a guidepost for the delivery of feedback. Within TA, assessors may

begin with discussing what Finn terms, *Level 1* information with patients (information consistent with the patient’s own self view), then move to *Level 2* information (expands the patient’s view and conceptualization of what is going on without directly contradicting it), then incorporate *Level 3* information (information that challenges the patient’s existing internal working models; Finn, 2020). We have found this staged approach grounded in the TA relationship, the coinvestigation of the patient’s assessment questions, and the collaborative interpretation of test results throughout the assessment process, particularly useful when working with patients with PSD. Cultivating agreement and a shared understanding on Level 1 findings creates openings to share and discuss information at Levels 2 and 3 more transparently. This can ultimately facilitate the sharing of PSD diagnoses in meaningful and therapeutic ways, an area of significant need given the frequency with which patients with PSDs are not directly informed of a PSD diagnosis (Amsalem et al., 2018).

The value of mutual *respect* in the context of a strong TA relationship is particularly important when there is some disagreement on assessment outcomes, as it can support the psychologist and patient to maintain a stance of *openness and curiosity*, reflect further on one another’s perspectives and make shifts in the time following a feedback session. For these reasons, we find it particularly useful for patients with PSDs to offer a one-time follow-up appointment to further consolidate the new information learned through the assessment and ensure connection to services, in line with the steps of the TA process (Finn, 2020). Much change can occur during this interlude. For example, with patient B, it was only at the follow-up appointment after the feedback session that she began to consider the potential benefit of the recommended psychopharmacological evaluation.

Applications to Other Contexts: Maintaining the Spirit of TA

The cases we presented included abbreviated (Case A), comprehensive (Case B), and very robust (Case C) forms of psychological assessment, all grounded in a TA framework. Case A in particular shows the utility of using a TA framework in brief diagnostic evaluation, even

in the context of limited time and resources. Meaningful narrative shifts still occurred in Case A despite these barriers. This suggests the potential of a TA approach for work with patients with suspected PSDs for effective use in time-limited and resource constrained settings. This is in line with prior research that has found value in using single session TA in triage diagnostic settings (e.g., emergency or crisis contexts; Brown & Morey, 2016), and the effectiveness of TA when delivered in brief format and using just one psychological test (i.e., collection of assessment questions, administration of MMPI-2, delivery of feedback; Finn & Tonsager, 1992; Newman & Greenway, 1997), similar to the procedure used in Case A.

TA as an Antioppressive Approach to Assessment

For people who have felt alienated and or harmed by the mental health care system, TA provides a platform for their voice to be heard and validated, and for their perspectives to be a focal part of the assessment process (e.g., validation of cultural experiences and identities, Case A; inclusion of culture-specific and relevant assessment tools, Case B; and an invitation to curiously question prior diagnostic procedures, Case C). The *dance* of TA is one that establishes a safe and open space for patients to have corrective and validating experiences and encourages them to continue actively participating in their mental health care. The principles and benefits of TA suggest that this model of assessment can additionally function as an antioppressive approach to care. Antioppressive practice (AOP) in mental health care is an approach that actively works to identify and rectify power imbalances and systemic injustices that contribute to mental health disparities and discrimination (Corneau & Stergiopoulos, 2012). AOP aims to provide equitable and inclusive care to all people, regardless of their background or identity, while challenging and seeking to dismantle oppressive structures and behaviors in various systems. Further examination of how TA can promote social justice, equity, and empower people, including those with serious mental illness, who have experienced systemic oppression is recommended for the future study.

Conclusion

The presented case studies underscore the benefits and transformative potential of TA in the assessment of PSDs. These cases offer examples of how TA's collaborative and inclusive approach aligns with the call for culturally responsive assessment and intervention and the application of TA techniques as a form of AOP. Moreover, the cases highlight how TA's framework is suited to engaging in multicultural assessment practice—through centering patients' social identities and world views in the construction of assessment questions, selection of assessment tools, and interpretation of assessment data. TA is a natural fit with recovery-oriented approaches for the treatment of PSDs and can be leveraged by clinicians in diagnostic settings to center patient voices and challenge systemic injustice within mental health care.

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