

Therapeutic Assessment Promotes Treatment Readiness but Does not Affect Symptom Change in Patients With Personality Disorders: Findings From a Randomized Clinical Trial

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The field of clinical personality assessment is lacking in published empirical evidence regarding its treatment and clinical utility. This article reports on a randomized controlled clinical trial ($N = 74$) allocating patients awaiting treatment in a specialized clinic for personality disorders to either 4 sessions of (a) therapeutic assessment (TA) or (b) a structured goal-focused pretreatment intervention (GFPTI). In terms of short-term outcome, TA demonstrated superior ability to raise outcome expectancies and patient perceptions of progress toward treatment (Cohen's $d = 0.65$ and 0.56 , respectively) and yielded higher satisfaction ($d = 0.68$). Moreover, patients reported marginally stronger alliance to the TA clinicians than to GFPTI clinicians ($d = 0.46$), even though therapists perceived the alliance as equally positive in both groups. No differences in symptomatic ratings were observed. Results are discussed with reference to treatment utility in this particular patient group.

Keywords: therapeutic assessment, psychological assessment, personality disorders, pretreatment intervention, clinical utility

Therapeutic assessment (TA) is a semistructured approach to clinical personality assessment developed by Stephen Finn and colleagues (Finn & Tonsager, 1992, 1997). In its humanistic approach to clients, it is related to collaborative assessment, as explicated by Fischer (Fischer, 1972, 1994, 2000), and the therapeutic approach to assessment put forth by Handler (1995). TA procedures are extensively documented (e.g., Finn, 1996, 2007; Finn & Kamphuis, 2006), and its semistructured nature has lent itself particularly well to transfer and empirical testing.

However, although the accumulating empirical evidence for TA is promising in many respects, the existing published studies have certain methodological limitations and have yielded inconsistent findings.

The TA model has been empirically tested with adults and with families with preadolescent children. Numerous case reports vividly describe the workings of these procedures with these populations (e.g., Aschieri, Fantini, & Bertrando, 2012; Finn, Fischer, & Handler, 2012; Finn & Kamphuis, 2006;

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Smith, Wolf, Handler, & Nash, 2009; Tharinger, Finn, Wilkinson, & Schaber, 2007). In regard to adults, two randomized controlled studies testify to the promising effects of the intervention in reducing symptomatic distress and increasing self-esteem in college students on the waitlist for services at university-based counseling centers (Finn & Tonsager, 1992; Newman & Greenway, 1997). Similarly, in a sample of patients in a university-based community clinic, Hilsenroth, Ackerman, and colleagues found that patients receiving TA demonstrated greater engagement and alliance with the assessor and a stronger therapeutic alliance with the therapist in subsequent psychotherapy, compared with psychological assessment as usual (Ackerman, Hilsenroth, Baity, & Blagys, 2000; Hilsenroth, Ackerman, Clemence, & Strassle, 2002; Hilsenroth, Peters, & Ackerman, 2004). It is noteworthy that the therapist and assessor were not the same person, indicating that the techniques practiced by TA providers to foster a therapeutic alliance model transfer to subsequent providers and might aid in treatment readiness and success. One weakness of the Hilsenroth studies is the lack of examination of patient outcomes such as symptomatology and functioning.

Recent studies also have provided promising, yet limited, evidence to suggest that a pretreatment TA has the potential to improve outcomes with specific psychiatric populations. Germane to the current study is a pilot trial of patients with borderline personality disorder who either received TA prior to manual-assisted cognitive therapy (MACT) or MACT alone (Morey, Lowmaster, & Hopwood, 2010). Patients receiving the TA augmentation experienced greater reductions in affective instability and suicidal ideation, compared with patients who only received MACT, but they did not participate in more treatment sessions, as had been hypothesized. Further, the symptomatic improvements noted by the authors were trends and were from a sample of only seven patients who completed the intervention, which severely limits the conclusions that can be drawn from this study. Additionally, among women with eating disorders, participation in TA did not lead to greater symptomatic improvement, but as indexed by a measure of treatment readiness, women in the TA condition were more likely to have sought treatment during a 6-week follow-up period than women in the traditional assessment group (Peters, 2001).

Three recent single-subject experiments have examined the effectiveness of TA with adults with histories of trauma. Aschieri and Smith (2012) used a time-series design to track the effects of a four-session TA on a traumatized young woman with severe relationship difficulties. The authors demonstrated that there was a statistically significant decrease in the woman's symptoms and in her awareness of her affection for others. Similarly, Smith and George (2012) studied a 52-year-old woman recovering from 4 years of intense medical treatment for Stage IV cancer who also had a history of childhood physical and sexual abuse. Statistical analysis of daily measurements showed that participation in TA coincided with symptomatic improvements in multiple domains. These improvements were maintained during 4 months of bi-weekly psychotherapy after the completion of the TA. Finally, Tarocchi, Aschieri, Fantini, and Smith (2013) tracked the TA of a middle-aged woman with complex posttraumatic stress disorder and found that she showed statistically significant symptomatic improvement.

The TA model has also been tested with dysfunctional families and preadolescent children with clinically significant emotional and behavioral issues. Using an aggregate group design of 14 families, Tharinger et al. (2009) found significant improvements in family functioning and child symptomatology following participation in TA. Smith, Handler, and Nash (2010) similarly found significant reductions in preadolescent boys' oppositional behaviors and family distress after receiving TA. Using a multiple-baseline time-series design, Smith and colleagues were able to demonstrate that the gains experienced were sustained through a 2-month follow-up period.

Overall, these results suggest that TA can be effective in reducing distress, increasing self-esteem, fostering the therapeutic alliance, and, to a lesser extent, improving indicators of treatment readiness. On the other hand, symptomatic and functional improvement has yet to be definitively demonstrated with adults, and there is a clear need for long-term follow-up studies. In children, emerging evidence suggests that TA was associated with symptomatic improvement (Smith et al., 2010; Tharinger et al., 2009), but these studies suffer from small samples and nonrandomized designs. In the context of the larger body of literature, the findings of these studies of TA are consistent with the findings of a recent meta-analysis (original analysis: Poston & Hanson, 2010; reanalysis: Hanson & Poston, 2011), which showed a significant overall effect (Cohen's $d = 0.40$) favoring the therapeutic effects of psychological assessment with individualized feedback procedures over comparison conditions, such as waitlist controls, assessment as usual, and other evidence-based active intervention. The authors concluded that when tests are used collaboratively and are accompanied by personalized, highly detailed feedback clients and subsequent treatment endeavors appear to benefit greatly.

Most empirical studies of TA in adult populations have been conducted on narrow versions or singular aspects of the method, such as (a) a clinical interview, (b) administration of a single assessment instrument (the Minnesota Multiphasic Personality Inventory-2, or MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), and (c) individualized, collaborative feedback procedures (also referred to as Summary and Discussion sessions; Finn, 1996). Also, as illustrated in several of the published case analyses, the comprehensive TA model includes idiographic use of assessment instruments in so-called *assessment intervention sessions* and typically a multimethod assessment that may include performance-based testing (e.g., the Rorschach). For these and other reasons, the therapeutic effects of TA and related methods have been critically examined. In response to the Poston and Hanson (2010) meta-analysis, Lillienfeld, Garb, and Wood (2011) noted the need for rigorous research aimed at identifying the mechanisms of action in these models as well as to more confidently demonstrate that observed differences in self-esteem and symptomatic distress are not simply a "flash in the pan" phenomenon. Despite their critique, Lillienfeld et al. stated that "psychological assessment as a brief intervention comprises a promising class of techniques that merit additional investigation" (p. 1048), and they provided vital directions for future research.

TA has not yet been empirically tested in patients formally diagnosed with personality disorders (PDs) according to the criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; American Psychiatric Association, 2000). How-

ever, there is good reason to believe that TA may be of treatment utility for this particular patient population. First, it is widely recognized that patients with PDs have pronounced needs for sustained empathy, require special attention in terms of building and maintaining alliance, and tend to be ambivalent about change (Emmelkamp & Kamphuis, 2007). Emphasis on emotional containment, empathic connection and close collaboration, and recognition of dilemmas of change are all key aspects of TA (Kamphuis & Muskens, 2007), both in spirit and in procedure. As an illustration of the latter, a distinguishing feature of TA is that the primary assessment goals are formulated in collaboration with the client. Likewise, feedback is characterized by its question-driven, individualized nature, and the client's participation is essential in tying the nomothetic test data to their unique life's circumstances. Moreover, complex case formulations are the hallmark of patients with PDs, and application of the comprehensive model of TA, with a multimethod assessment approach, may optimize chances of deriving an individualized formulation that would be helpful in answering the patient's often highly contextualized questions (Smith & Finn, in press).

For these reasons, we decided to conduct a pretreatment randomized controlled trial (RCT) among patients with severe personality pathology awaiting an already assigned course of treatment. To benchmark the efficacy of TA in this group, we opted for a strong protocol-guided comparison condition, based on the widely applied protocol of standard care for first line in the Netherlands (Stoffer, 2005). The so-called *five sessions model* has been tested in various trials and serves as a standard for good quality first-line care in Dutch mental health care (e.g., see van Straten, Tiemens, Hakkaart, Nolen, & Donker, 2006). This protocol was adapted by experienced PD therapists and had a specific session-by-session agenda that emphasized goal setting and motivation for the subsequent treatment; we therefore labeled this package the *goal-focused pretreatment intervention* (GFPTI). We measured a broad set of outcome indicators, including treatment readiness variables such as perception of progress, outcome expectancy for future treatment, therapeutic alliance, and satisfaction with the quality of services rendered. In addition, we were interested in potential (differential) change in demoralization (Tellegen & Ben-Porath, 2008) and short-term symptomatic improvement. We predicted that TA would result in stronger outcome expectations, higher expectancy for future treatment, better treatment focus, and stronger alliance than would GFPTI, as well as higher satisfaction afterward. We also expected somewhat more improvement in demoralization in TA. We expected no group differences in symptomatic improvement, as previous records from the Viersprong clinic (Bartak et al., 2010; 2011) and state-of-the-art trials with similar patients have shown such gains occur much further down the road (e.g., Giesen-Bloo et al., 2006).

In sum, the present study presents a RCT of pretreatment interventions in patients with severe PDs awaiting their assigned treatments. These patients were randomly assigned to either (a) therapeutic assessment (TA), or (b) goal-focused pretreatment intervention (GFPTI). Evidence of treatment utility was expected on outcomes indicating general treatment readiness, motivation, and psychotherapy process variables, rather than on short-term symptomatic relief.

Method

Participants

Participants were a subsample ($n = 74$) of 117 patients on the waiting list of the Viersprong Institute, a tertiary care facility specialized in the assessment and treatment of adolescents and adults with severe and complex personality disorders. The institute offers several evidence-based psychotherapy programs in outpatient, day-treatment, and inpatient formats. Patients were recruited from three inpatient treatment programs, 4-day treatment programs, and outpatient treatment. Inclusion criteria were (a) having personality pathology, as determined during intake, and (b) being at least 18 years old. Exclusion criteria were (a) severe, disabling psychiatric symptoms that would interfere with psychological treatment, including a severe substance use disorder or active psychosis; (b) an estimated IQ of less than 80;¹ or (c) evidence of language difficulties. The study began in September 2010 and inclusion ended in March 2012. Forty-three patients did not start their pretreatments because they were able to start their assigned psychotherapy; accordingly, the final sample consisted of 74 completers (60.8% female; $N = 45$), evenly divided over the two conditions. Patients ranged in age from 20 to 70 years ($M = 39$ years, $SD = 10.13$ years), and all were White. About one in three patients (32%; $N = 24$) was married, 48.6% ($N = 36$) were unemployed, and 43.2% ($N = 35$) had pursued higher education. Table 1 also shows the breakdown per condition; no significant group differences were noted for any of these demographic characteristics, indicating that random assignment to conditions was successful.

Design and Procedures

Study design. The study design is depicted in Figure 1. First, patients were evaluated in the standard intake procedure, which at the Viersprong includes several clinical interviews as well as administration of the Structured Clinical Interview for *DSM IV* Axis I and II disorders (SCID-I: First, Spitzer, Gibbon, & Williams, 1997, translated version by van Groenestijn, Akkerhuis, Kupka, Schneider, & Nolen, 1999; SCID-II: First, Spitzer, Gibbon, Williams, & Benjamin, 1996, translated version by Weertman, Arntz, & Kerkhofs, 1996). Subsequent to the intake, patients were either immediately referred to their assigned treatment or were referred to the waiting list (>90%). Immediately after being referred to the waiting list, patients received a written invitation to participate in the study, which was followed by a phone contact the subsequent week. Informed consent was obtained after a thorough in-person explanation of the study and its procedures. Specifically, it was emphasized to patients that participation was entirely voluntary and that consent (or not) had no consequences for their waiting period or (selection of) subsequent treatment. Upon consent, a computer program randomly assigned patients to either the TA or the GFPTI condition. We obtained institutional review board approval from the Ethics Review Board of Clinical Psychology of the University of Amsterdam (registered under KP-2010).

¹ When clinical impression and/or educational record suggested an IQ lower than 80, formal intelligence testing was conducted.

Table 1
 Descriptive Statistics of Demographic and Clinical Characteristics of Completers by Intervention Condition

Variable	Intervention condition						Effect size ^a
	TA (n = 37)			GFPTI (n = 37)			
	M (SD)	%	n	M (SD)	%	n	
Demographics							
Age in years (SD)	38.83 (10.79)			39.29 (9.56)			.01
Women		59.5	22		62.2	23	.03
Unemployed		50.0	18		47.2	17	.03
Educational status							
Low		16.2	6		8.1	3	.18
Middle		48.6	18		40.5	15	
High		35.1	13		51.4	19	
Household							
Living alone		37.8	14		52.8	19	.18
Living with partner		48.6	18		33.3	12	
Living with other		13.5	5		13.9	5	
Clinical descriptors							
Subjective severity		74.7	28		86.1	31	.08
Duration							
Less than 2 years		8.1	3		0	0	.20
Between 2 and 5 years		16.2	6		16.7	6	
More than 5 years		75.7	28		83.3	30	
Previous treatment		91.9	34		97.2	35	.12
Previous inpatient		24.2	8		14.3	5	.12
Medication treatment		60.6	20		48.6	17	.12
Rating of quality of treatment	1.97 (0.86)			2.17 (0.74)			.25

Note. TA = therapeutic assessment; GFPTI = goal-focused pretreatment intervention.

^a Phi or Cohen's *d*; no statistically significant group differences were observed.

Data collection. Data on our dependent variables were collected four times: (a) prior to randomization, (b) immediately postintervention, (c) 6 weeks after the completion of the intervention, and d) 6 weeks after the start of treatment (see Figure 1). To monitor outcomes, we administered self-report instruments to document several pertinent outcome domains, including treatment readiness, demoralization, psychological symptoms, and satisfaction with services rendered. The same measures were included at each time-point, with the exception of the measures specifically evaluating the interventions (e.g., experience of therapeutic alliance, perception of preparation for treatment, and so on), which occurred at the postintervention assessment only.

Measures

Treatment readiness. The Assessment Questionnaire (AQ; Finn, Schroder, & Tonsager, 1994) was originally designed as a self-report instrument to measure several aspects of the client experience of assessment. It was developed through a combination rational, factor-analytic, and item-analytic techniques and has been used in other studies of assessment satisfaction (e.g., Allen, Montgomery, Tubman, Frazier, & Escovar, 2003; Holst, Nyman, & Larsson, 2009). Respondents rank each question on a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Two subscales are more broadly useful and can track clients' evaluative

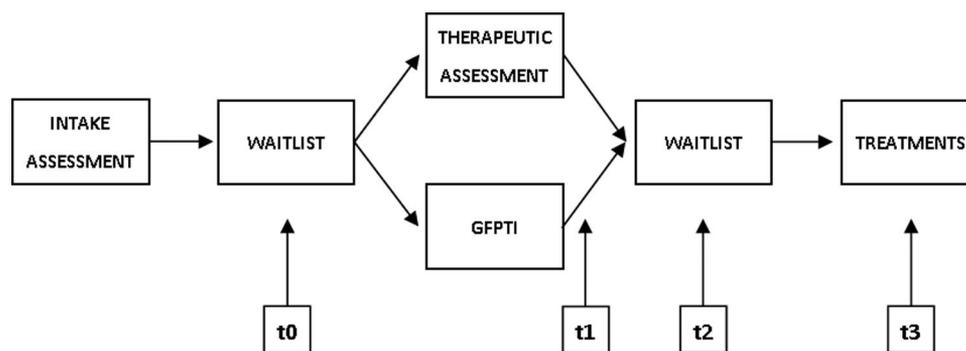


Figure 1. Design of the present study. GFPTI = goal-focused pretreatment intervention; t0 = baseline; t1 = Time 1.

perceptions about the extent to which a psychological intervention (a) produced new self-relevant learning (the New Self-Awareness/Understanding subscale; 13 items) and (b) made the patient feel emotionally accurately understood (the Positive Accurate Mirroring subscale; 12 items). Cronbach's alpha coefficients in the current sample for these subscales were .75 and .78, respectively. We added a one-item visual analogue scale Expectancy for Future Treatment Scale (EFTS; available from first author) for patients to rate their expectancy regarding future treatment ("To what extent do you believe this intervention will benefit your future treatment?"). Scoring is done on a scale from 0 (*I think these sessions will contribute nothing*) to 100 (*I think these sessions will contribute in a major way*). Therapeutic alliance was measured using the Revised Helping Alliance Questionnaire (HAQ-II; Luborsky et al., 1996; Dutch translation by De Weert-van Oene, De Jong, Jorg, & Schrijvers, 1999). The HAQ-II is a widely used 14-item self-report questionnaire. Cronbach's alphas for the 11 multiple-choice items in the present sample were .81 for therapist ratings and .86 for therapist ratings.

Demoralization and psychological symptoms. We selected the Demoralization scale (RCdem; Tellegen et al., 2003) from the MMPI-2 to measure unhappiness, dysphoric mood, a sense of helplessness, inability to cope with one's current circumstances, and general dissatisfaction with one's condition. RCdem consists of 24 true/false questions; Cronbach's alpha in the present sample was .92. Symptom severity was assessed with the Brief Symptom Inventory (BSI; Derogatis, 1975; translated version by de Beurs, 2006). The BSI is a patient report of 53 items covering nine symptom dimensions, but we used only the Global Symptom Index (GSI). Participants rate each item on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*). Ratings characterize the intensity of distress during the past 7 days. Cronbach's alpha in the present sample was .96.

Client satisfaction. The Client Satisfaction Questionnaire (CSQ8; Larsen, Attkisson, Hargreaves, & Nguyen, 1979) was used to assess the patient's perspective on the value of services received. The items for the CSQ8 were selected on the basis of ratings by mental health professionals of a number of items that could be related to client satisfaction and by subsequent factor analyses. The CSQ8 is one dimensional, yielding a homogeneous estimate of general satisfaction with services. Two items (Items 2 and 6) were removed upon initial analyses because these items referred to treatment options not available in the current study and had negative item-total correlations. The adapted six-item version yielded a Cronbach's alpha of .81.

Interventions

Therapeutic assessment (TA). TA refers to a collaborative, semistructured approach to individualized clinical assessment. A distinguishing feature of TA is that the primary assessment goals are formulated in collaboration with the client as questions to be answered by the assessment. Test selection is guided by the client's and referring clinician's questions, while subsequent administration and scoring are conducted according to standardized techniques. Nonstandardized techniques can be used in one or more so-called *assessment intervention sessions* that are designed to elicit and subsequently experiment with key, but inadequately understood, personal dynamics. Individualized feedback is another

key element of the TA procedure and is characterized by its question-driven, patient-centered, and collaborative nature. Individualized feedback implies that the normative test data are translated into the idiographic context of the client's everyday life.

In the present study, the TA model was operationalized in four face-to-face sessions. The first session focused on collecting questions and taking the MMPI-2. The second session focused on taking performance-based tests, including the Rorschach (Exner, 2009). The third session was reserved for the assessment intervention session, and the final session involved discussion of the assessment feedback.

Goal-focused pretreatment intervention (GFPTI). GFPTI is a protocol-driven method, based on a widely used model in the Netherlands, the so-called *five sessions model* (Stoffer, 2005). The manual was adapted for the Viersprong patient population by a licensed clinical psychologist on the GFPTI team. Similar to the TA condition, it included four face-to-face sessions (protocol available from author upon request). Patients received a workbook that included homework assignments and a written explanation of the goal of each session. Throughout the intervention, patients were actively encouraged to think about the most central problem they need to address in pretreatment. Specifically, they were asked to reflect on the question "If your treatment were successful, what problems would it help solve?" These problems then became central in the subsequent face-to-face meetings.

The first session focused on attacking demoralization and promoting hope by providing psycho-education on the dynamics of maladaptive behaviors and their potential for change. The second session was aimed at the main problem on which the treatment will focus. The third session involved examining the dilemma of change (i.e., positive and negative consequences of problem behaviors), and how this was manifested in the participant. The last session focused on achieving a shared re-appraisal of the problems and included goal setting for the remaining period prior to treatment. The manual is available upon request from the first author.

Therapists

All 13 participating therapists had graduate degrees in clinical psychology. Prior to starting the RCT, the therapists were randomly assigned (by means of a lottery) to either the TA or GFPTI conditions. Nine therapists participated in TA, four of whom were licensed and five of whom were in training for licensure.² Four therapists participated in GFPTI, two of whom were licensed. Prior to the study, both TA and GFPTI therapists participated in an intensive, supervised training program that included written handouts and role-plays. In the case of TA, this also involved an intensive workshop by the developer of TA (Finn). During the course of the RCT, both conditions held weekly supervision sessions (at least 1 hr each), to ensure continued treatment fidelity. GFPTI supervision was provided by a licensed and highly experienced clinical psychologist. TA supervision was provided by two of the authors (De Saeger and Kamphuis; both certified TA practitioners) who did not conduct any of the interventions themselves.

² More therapists were trained in TA, because about half of the TA therapist group left for subsequent employment after their internships (i.e., the clinical assessment rotation). The GFPTI therapists were more senior and were members of the permanent staff, well familiar with the protocol.

Of note, in no case were the TA assessor/GFPTI therapist and subsequent therapist the same person. All of the therapists were naive to the hypotheses. The study was conducted as a horse race, with all supervisors believing that their approach would yield superior effectiveness.

Results

Clinical Description of Patients

Several indices suggest the severity of mental illness in this sample. First, four patients were completely unable to work because of their psychological problems, and 17.6% received some form of social disability payments. Moreover, 80.2% ($n = 59$) rated themselves as having severe problems (one rating missing). Complaints were typically of long duration, with 79.5% ($n = 59$) of patients reporting severe problems for longer than 5 years. Further illustrating clinical severity, 70 patients (94.5%) had received previous treatment(s), including psychopharmacological treatment for about half of the sample ($n = 40$, 54.4%) and inpatient treatment for about one in five patients ($n = 14$, 19.1%).

Unfortunately, due to temporary staffing problems at the treatment setting, only 54 out of 74 patients (73.0%) were administered the SCID-II. Consistent with their treatment selection, the sample consisted mostly of patients with Cluster C or, to a lesser extent, Cluster B psychopathology. As can be seen, 30 patients (55.5%) received one or more formal *DSM-IV-TR* (American Psychiatric Association, 2000) PD diagnoses; 21 (38.9%) of those met criteria for one or more specific PDs, and an additional nine (16.7%) patients met criteria for PD not otherwise specified (PD NOS; i.e., meeting the general PD criterion and endorsing five or more symptoms). The most frequently diagnosed PD was avoidant PD ($n = 14$, 25.9%), followed by borderline PD ($n = 4$, 7.4%), and obsessive-

compulsive PD ($n = 3$, 5.6%). Comorbid *DSM-IV-TR* Axis-I diagnoses were predominantly in the unipolar affective disorders spectrum; almost half of the patients met criteria for a depressive episode ($n = 25$, 46.3%), and one in six patients met criteria for dysthymia ($n = 9$, 16.7%). Comorbid anxiety disorders were also present, with four patients meeting criteria for social phobia (7.4%), three patients for posttraumatic stress disorder (5.6%), and two patients had either generalized anxiety disorder or obsessive-compulsive disorder (totaling 3.7% each). No psychoses and very few substance use diagnoses were evident (one patient or less per disorder), which is not surprising as patients with these problems were screened out during intake.

Intervention Group Differences on Treatment Readiness and Satisfaction

A one-way analysis of variance (ANOVA) revealed that TA resulted in higher expectancy for treatment outcome than did GFPTI, $F(1, 72) = 7.69, p < .01, d = 0.65$. TA patients also perceived more personal progress from the intervention than did GFPTI patients, $F(1, 72) = 5.47, p < .05, d = 0.56$. Patients in the TA group rated their working alliance as marginally stronger than did GFPTI patients, $F(1, 72) = 3.79, p < .06, d = 0.46$, while the therapists rated the alliance equally strong across conditions, $F(1, 72) = .47, p < .05, d = -0.17$. Trends ($p < .10$) were observed for higher scores on AQ New Awareness and AQ Accurate Positive Mirroring in the TA group compared with GFPTI patients; $F(1, 72) = 3.08$ and 2.89 , corresponding to ds of $.41$ and $.39$, respectively. A large effect size was noted for client satisfaction; with TA patients being significantly more satisfied with the quality of intervention than were GFPTI patients, $F(1, 72) = 5.47, p < .05, d = 0.68$. Of note, both groups were very positive about the quality of interventions (means greater or equal to 2.96, out of a maximum of 4). Results are presented in Table 2.

Table 2

Means and Standard Deviations of Selected Outcome by Treatment Condition

Variable	Intervention condition				$F(1, 72)$	d
	TA ($n = 37$)		GFPTI ($n = 37$)			
	M	SD	M	SD		
Expectancy for Future Treatment Scale	80.03	11.66	70.46	17.44	7.69*	0.65
Revised Helping Alliance Questionnaire (HAq-II)						
Progress	2.54	0.86	2.11	0.66	5.47*	0.56
Patient	25.10	6.83	28.36	7.43	3.79	0.46
Therapist	24.17	5.39	25.19	6.87	0.47	-0.17
Assessment Questionnaire (AQ)						
New Self Awareness subscale	3.57	0.64	3.31	0.62	3.08	0.41
Positive Accurate Mirroring subscale	3.26	0.51	3.06	0.50	2.89	0.39
Total	3.42	0.51	3.19	0.46	4.13*	0.47
Client Satisfaction Questionnaire (CSQ)	19.54	2.56	17.75	2.74	7.72*	0.68
Demoralization scale (RCdem) from MMPI-2						
Pretreatment	16.27	4.54	16.39	5.50		
Posttreatment	15.84	4.54	16.39	5.36	0.50	0.17
Global Symptom Index (GSI)						
Pretreatment	1.29	0.63	1.31	0.60		
Posttreatment	1.26	0.66	1.18	0.63	1.06	0.24

Note. MMPI = Minnesota Multiphasic Personality Inventory-2.

* $p < .05$.

Intervention Group Differences on Demoralization and Symptom Change

A multivariate analysis of variance with preintervention scores as covariates showed no differential effect between treatment groups in change in demoralization and global symptom severity, Wilks' $\lambda = .96$, $F(2, 66) = 1.23$, $p = .30$. Univariate analyses revealed that this finding was consistent across both changes in demoralization (RCdem) and changes in symptom severity, as reported on the GSI (both $F_s < 1.0$, $p = ns$).

Discussion

The present study is the first to test the full model of TA in a patient group with severe personality pathology against a highly credible evidence-based pretreatment motivational intervention. It is also the largest patient sample to date among the published controlled trials. The main findings of the present study can be summarized as follows. At the end of the pretreatment intervention, compared with a protocol-driven motivational pretreatment intervention, patients in the TA condition reported higher outcome expectations for their subsequent treatment, felt more on track in terms of their focus for treatment, and indicated a moderately stronger alliance to the therapist than those who received GFPTI. Overall, TA patients also indicated higher satisfaction with the intervention received. Even when compared with a highly credible control condition, TA exerted medium to large effects in these measures (average effect size: $d = 0.54$; range .40–.68). Across interventions, however, no statistically significant differences in symptom and demoralization improvements were observed.

This study adds to the existing TA outcome literature by extending the model to a severe patient population that tends to hold highly entrenched dysfunctional cognitions, is highly ambivalent about change, and often has limited introspective capacity (Kamphuis & Muskens, 2007). In addition, our study employed the complete TA model, in that patients not only profited from nomothetic test interpretation but also from idiographic use of assessment instruments in the so-called assessment intervention session. Consistent with Peters' (2001) findings among women with eating disorders, the treatment utility of TA relative to a strong pretreatment intervention was not exhibited in immediate symptom reduction. Instead, patients reported having a better sense of what their treatment should be about and expected more of subsequent treatment. Moreover, they reported stronger alliance with their therapists and higher satisfaction with services. In patients with personality disorders, these may be crucial findings, as disappointment and dissatisfaction with previous treatment are the rule rather than the exception in tertiary care for PD in the Netherlands.

Critics might point to the lack of change in psychotherapy outcome measures. However, we believe that both the design and the targeted population of our study argue against overly negative appraisals and, in fact, point to the need for a contextualized evaluation of treatment utility (Hayes, Nelson, & Jarrett, 1987). First, the design of our study precluded benefit from the indirect effects of the intervention. That is, patients had already been allocated to treatment programs prior to the pretreatment interventions. Moreover, no attempts were made to communicate or transfer the findings of either pretreatment intervention to the subsequent therapists. Furthermore, upon completing the pretreatment

intervention, a majority of the patients returned to the waitlist for another several weeks, meaning that subsequent intervention was further delayed. Second, our patient sample consisted of a heterogeneous group of patients referred to a specialized care facility for PDs. About three out of four patients had complaints of more than a 5-year duration, and more than 90% had received previous treatment, which for about half of the patients also included medication. As documented in previous research (Giesen-Bloo et al., 2006), such patients exhibit only mild symptomatic improvement over the course of their first year of treatment. In fact, the GSI change after one full year of treatment in this facility is commensurate with that observed after TA (Bartak, 2010, 2011). These minimal improvements are unlikely the result of ineffective treatment but indicate that straightforward (Axis-I) symptom measures may not be ideal to track patient progress over the course of treatment for severe PD. That said, it is important for future studies to examine whether TA affects clinical outcomes in terms of symptoms or functioning. Such studies ideally should also include a follow-up into treatment, which would allow the assessment of both the direct (i.e., immediately following TA) and indirect effects, factoring in potential effects on subsequent alliance, treatment selection, and treatment planning on the effects of subsequent services.

Our study was not optimally designed to clarify how TA procedures assist clients' engagement in subsequent treatment, but juxtaposing the findings and procedural differences between the two interventions compared in this trial allows us to make some speculative comments. While both pretreatment interventions emphasize motivation and focus, TA follows an individualized and client-driven agenda that is largely guided by the collaboratively formulated assessment questions of the particular patient, whereas GFPTI has a more or less fixed sequence of topics. Perhaps the greater degree of collaboration and control that TA patients experience over the agenda of their intervention, and the respectful interpersonal stance this procedural aspect conveys, contributed to the higher satisfaction, greater expectancy that they would benefit from subsequent treatment, and the greater sense of alliance during the sessions. Especially among patients with PDs, such a sense of personal control in a context of interpersonal respect may be crucial. Of course, these are mere speculations, and other procedural differences (e.g., the use of tests, assessment intervention session, individualized feedback) may be equally or more important in various ways. Future research may help clarify mechanisms of effect. We are currently conducting a qualitative study as a first step to help elucidate the essential ingredients for productive change.

A strength of the present study is the comparison of TA to a credible, semistructured pretreatment package. In fact, the control intervention was driven by a detailed session-by-session protocol aimed at the identification of goals for treatment. This program is widely employed in the Netherlands and serves as a first-line standard. Accordingly, one might think of this study as a comparative effectiveness study. In terms of the expected differences observed in comparative effectiveness studies of two bona fide interventions, a meta-analysis of studies for depression and anxiety in adults found that evidence-supported protocols being compared to other active psychotherapeutic interventions achieve an average effect size of .33 (Cohen's d), which was not statistically significant from zero (Wampold et al., 2011). Our effects were minimal

for symptom ratings but generally of moderate effect for most of the variables that can be grouped as treatment readiness variables.

From a clinical point of view, it was particularly gratifying that it was feasible to train a team of relatively junior clinicians to successfully implement the complete model of TA. All but two of the clinicians had their clinical license for less than 5 years, and about half were still in training to become licensed. The essential prerequisite appears to be initial investment in learning the assessment instruments, and, as for the GFPTI, to follow up with intensive supervision. Future studies may implement and test a model where TA is integrated with subsequent treatment, and test the incremental benefit of the indirect effects of assessment. This would involve the TA informing treatment planning and treatment selection, both of which were determined a priori in the setting we conducted our trial. In addition, variations on dismantling designs may elucidate the incremental contributions of TA, the direct and indirect effects of TA, and/or inclusion of the assessment interventions session, or the performance-based instrument administration, which require additional time and more advanced training.

This study is not without its limitations. Probably the most pressing issue is that of therapist effects as an alternative explanation for our group-level differences. That is, the favorable effects might be due to generally superior (trained, motivated, experienced) therapists in one condition than in the other. We note that this concern is not particular to our study, as many classic comparative effectiveness studies (e.g., Elkin et al., 1989; more recently Giesen-Bloo et al., 2006) have opted for similar designs, presumably to prevent one intervention from “spilling” into the other and to have specifically trained motivated teams to “race” each other. We took a number of precautions that make this alternative hypothesis less plausible. First, both interventions were conducted by therapists who were extensively trained and experienced in their respective protocols, and informal observation suggested that therapists in both groups were strongly motivated to outperform the competing group. Moreover, none of the study authors served as therapists for either intervention, and at no point during the course of the study was any feedback on effectiveness shared with the therapists. Finally, similar to the approach used by Wampold and Brown (2005), we conducted post hoc nested ANOVAs in which outcome measures were specified as a function of both the intervention (fixed effect) and the participating therapists (random effect). Across outcome measures, none of the therapist variance terms were significant, indicating the absence of consistently superior (or inferior) outcome for any of the participating therapists. Taken together, we believe it is unlikely that the reported group differences were due to therapist effects rather than the interventions per se, but do acknowledge that future studies that have more statistical power or use different designs (i.e., with all therapists delivering both treatments) might provide more stringent tests of this empirical question, as well as focus more on the operant mechanisms of change. Future studies should also speak to the relatively weak procedures for assessing treatment adherence. The present study did include (a) guidance by two detailed session-by-session written-out protocols for each intervention, (b) intensive supervision by specifically trained, motivated, and experienced licensed clinical psychologists, and (c) review of audio-visual recordings of sessions during supervision times. However, no formal ratings of adherence were conducted.

This study makes a contribution toward alleviating the remarkable scarcity of research on the extent to which clinical assessment improves treatment outcome (see also Hunsley & Mash, 2007, for a review) by comparing an evidence-based assessment model to a more general motivational pretreatment package. Treatment utility is often defined as improving treatment outcome, typically in terms of *short-term* symptomatic improvement. By this measure, TA did not outperform the four sessions of a motivational pretreatment. From the more inclusive view of treatment utility however (advocated by a diversity of psychotherapy researchers, e.g., Lerner, 2005, and McWilliams, 2005), TA demonstrated stronger ability to prepare, motivate, and inspire the patient for the tasks of therapy, and to provide focus and goals for therapy. From a patient’s perspective, and particularly in the context of patients with treatment-resistant personality pathology, such effects seem to be of major value.

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