20

Teaching Therapeutic Assessment in a Required Graduate Course

Stephen E. Finn
Center for Therapeutic Assessment

Therapeutic Assessment (Finn, 1996; Finn & Tonsager, 1997, in press) is an assessment model in which psychological testing forms the center of a brief psychotherapeutic intervention with clients. Resting on humanistic and phenomenological principles articulated by Fischer (1985/1994), Dana and Leech (1974), Pruyser (1979), and others, Therapeutic Assessment attempts to engage clients in a collaborative, exploratory process through which they learn about the factors maintaining their existing life problems and try out possible solutions to these problems. The techniques of Therapeutic Assessment can be applied to a wide variety of assessment questions and client populations. Several controlled research studies have demonstrated that clients receive lasting benefit from psychological testing conducted according to the principles of Therapeutic Assessment (Finn & Tonsager, 1992; Newman & Greenway, 1997).

As a member of the psychology faculty at the University of Texas at Austin from 1984 to 1992, I routinely taught the theory and techniques of Therapeutic Assessment to first-year clinical psychology graduate students in their required course on personality assessment. This course involved a theoretical/factual component as well as a practical/hands-on component. Students read research and theory about the major personality tests, learned the administration and scoring of each test, and conducted a number of practice assessments while being closely supervised. Early on it became clear to me that students in this course were not only learning how to assess clients; they themselves were also undergoing an important assessment—of their knowledge of psychological testing and their suitability to be clinical psychologists. Furthermore, the assessment to which my students were subjected was analogous to the most difficult of clinical assessment situations—in which clients are tested in part against their will, are ambivalent about self-disclosure, and are aware that

assessment results will be used by others to make major decisions affecting their lives.

To be more specific, my observations about students' personality traits, clinical skills, and knowledge of assessment were often weighed heavily by the clinical psychology faculty in deciding whether to retain a student at the end of the first year. Students were well aware of this fact and felt great pressure to do well in my course. This pressure, in turn, had the potential to inhibit greatly students' comments in class and their willingness to take risks while practicing assessment. In effect, the evaluation component of the course tended to set up a transference situation where I was seen as a feared, omnipotent authority rather than as a benevolent, human instructor. I soon realized that I might best address this stressful assessment situation by applying the same principles and techniques to my teaching that I was educating my students to use in their clinical interactions with clients. In this way I would be "practicing what I preached," and students would have the benefit of experiencing Therapeutic Assessment at the same time that they were learning to do it themselves. I describe the course in its final form even though different elements were changed and added over the years.

Principles of Therapeutic Assessment as Applied to the Graduate Course in Personality Assessment

The underlying principles of Therapeutic Assessment in clinical assessment situations are articulated elsewhere (Finn, 1996; Finn & Tonsager, 1997, in press). A modified set of these principles—as applied to a required graduate course in personality assessment—guided my teaching:

1. A required graduate course in personality assessment is an unsettling and personally challenging experience for students. It demands interpersonal and emotional skills and ways of thinking that have not typically been required in other academic courses; also the instructor's ratings of students will be used by others to make major decisions regarding the students' lives. These factors can cause considerable anxiety for students.
2. A graduate course in personality assessment is also an interpersonally challenging situation for an instructor. It involves providing factual information, giving feedback to students about clinically relevant personality characteristics, modeling interactions with clients, and supporting students through their first interactions with clients. This multifaceted role has the potential to generate considerable anxiety in the instructor.
3. When students and instructors are anxious, they are prone to enact highly stereotyped roles in which instructors play all-knowing experts and students act the part of deferential, passive novices. Such roles interfere with active learning on the part of both students and instructors.
4. Students have the right to know, at the beginning of the course, what aspects of their performance will be evaluated, the procedures used to assess their performance, and how the results may affect them when the course is

completed. Providing such information may decrease students' feelings of powerlessness and lower their anxiety.

5. The instructor has the responsibility of clarifying with the students the goals, purpose, and requirements of the course.

6. Students become most engaged in and benefit most from a course when they are treated as collaborators whose ideas and cooperation are essential to the learning process.

7. Students become most invested in a course when it addresses, in part, their own personal and professional goals.

8. When a course addresses students' goals and students are treated as collaborators, their anxiety is lower and their motivation is high; thus, their course performance is more likely to reflect accurately their abilities and personal potential.

9. Giving students feedback about their course performance in a collaborative manner can help them understand and address any performance deficits.

10. When instructors discuss course ratings with students in an emotionally supportive manner, students often feel affirmed, less distressed, and more hopeful, even if the feedback is initially difficult for them to hear.

11. A course on personality assessment can have a lasting impact—both personally and professionally—on students' lives.

12. A collaborative approach to teaching personality assessment also creates opportunities for instructors to learn, hone clinical skills, and be challenged by their teaching.

Flow Chart of a Course in Therapeutic Assessment

Table 20.1 represents a flow chart of my course in Therapeutic Assessment.

Step 1: Assessment Questions Are Specified and Gathered. In Therapeutic Assessment, the assessor engages clients as collaborators at the beginning of the assessment by helping them identify personal goals and form questions to be addressed during the assessment (Finn, 1996; Finn & Tonsager, 1997, in press). In involuntary assessments (such as court-ordered assessments, disability evaluations, and personnel-screening evaluations), clients typically are reluctant to frame personal goals for an assessment; they may even feel that posing assessment questions is dangerous in that such information may be used against them. In such situations, assessors can often gain clients' cooperation by first sharing the referring persons' assessment questions with clients, and negotiating beforehand with the referring person for permission to keep the client's own questions confidential (Finn & Tonsager, 1997).

In my graduate course, I followed the protocol for involuntary assessments by reviewing at the first class meeting the questions the clinical psychology faculty members would ask me to answer about each student at the end of the course. These questions were:

1.

TABLE 20.1
Flow Chart of a Course in Therapeutic Assessment

Step 1–Assessment Questions Are Specified and Gathered
Step 2–Course Contract Is Finalized
Step 3–The Assessment Task Is Explained and Conceptualized
Step 4–The Assessment Task Is Demonstrated by the Instructor
Step 5–Students Rate and Give Feedback to the Instructor
Step 6–Students Role-Play Each Assessment Task
Step 7–Students Perform Each Assessment Task With a Client
Step 8–Students Are Given Feedback on Each Task
Step 9–Students Try Out Modifications of Each Task
Step 10–Students Repeat the Assessment Task With Another Client
Step 11–End of Course Feedback Session Is Given to Student
Step 12–Written Report Is Prepared and Student Comments Invited
Step 13–Students Anonymously Give Feedback to the Instructor
Step 14–Report and Student Comments Are Presented to Faculty

Note. Steps 3–10 are repeated through the course for each assessment (e.g., initial interview, Rorschach administration, feedback session).

Does this student have an adequate knowledge of the theory and research related to personality assessment?

2. How well was the student able to conceptualize clinical case material?
3. Has the student adequately mastered the administration and scoring of major personality tests?
4. How well did the student write assessment reports?
5. At what level are this student's basic clinical skills—for example, empathy, active listening, ability to maintain appropriate boundaries?
6. How did the student respond to supervisory feedback?
7. Did the student demonstrate any behavior that raises concern about her or his suitability to be a clinical psychologist?
8. Is this student ready to participate in a clinical practicum ?

I promised students that I would discuss my answers to these questions with each of them at the end of the semester before I gave my report to the clinical psychology faculty. I also stated that I would be very interested in their ideas and reactions to my answers and would incorporate their ideas in my report. I then invited students to pose additional individual questions that might be useful to them, for me to address during and at the end of the semester. I assured them that these questions (and my answers) would not be shared with the clinical training committee without their permission, and that their course evaluation would not be influenced by whether they came up with additional questions, or by the content of these questions. I gave examples of questions students had posed in previous years (e.g., "Why do I find it hard to talk about sexuality with clients?" "Am I too shy to be a good therapist?" "I've been told I

need to be warmer with clients. How can I do this?") Last, I let students know that they could offer these questions at any point during the semester by discussing them with me, or jotting them down and putting them in my mailbox.

Step 2: Course Contract Is Finalized. During the first class meeting I also handed out a detailed syllabus of the course requirements, including information about how each assignment would be graded. For example, as part of the course, students were required to learn the administration of the Rorschach according to the Comprehensive System (Exner, 1993). The course information specified when students would be tested on administration and included a rating sheet I used to grade the observed administration. Last, I answered any questions students had about the course structure and requirements until they and I were satisfied that we had a mutual understanding of the course contract.

The majority of the syllabus was structured to follow the flow of a standard Therapeutic Assessment of a client, that is, initial interview, standardized testing, assessment intervention session, feedback session, and written report (Finn & Tonsager, 1997). For each of these tasks, I would repeat the following steps (3–10) during the course.

Step 3: The Assessment Task Is Explained and Conceptualized. First, I provided readings about each task, and students and I discussed the techniques and underlying principles involved. For example, we thoroughly explored the purpose of the initial interview of a Therapeutic Assessment, the types of problems that can arise, and how to handle these various complications.

Step 4: The Assessment Task Is Demonstrated by the Instructor. Before the course began, I invited colleagues in the community to refer clients to be assessed by myself and the students as part of the course. (It was not difficult to find clients who would agree to such an arrangement in return for a free assessment.) I would select one of these clients to assess myself. Then, I demonstrated each assessment task in front of the class, before the students performed the task on their own. For example, after the students and I had discussed the initial session of a Therapeutic Assessment, I interviewed a volunteer client while students observed during a class meeting. Later, I worked with this same client to demonstrate other parts of the assessment. I videotaped some lengthy tasks, for example, the Rorschach administration, outside of class sessions. I then showed portions of the videotape during class periods and/or asked students to watch the tape on their own before we met. I openly discussed any anxiety I felt about such demonstrations, in order to normalize the students' anxiety about being observed. I also modeled steps I took to deal with my anxiety.

Step 5: Students Rate and Give Feedback to the Instructor. While I demonstrated each assessment task, students rated me on the same form the teaching assistants (TAs) and I would later use to rate them. After I completed each task, I would also rate myself. Then students and I would discuss our observations and ratings of my performance. I would try to model a nondefen-

sive receptivity to their feedback and to be open to learning from the students' observations. This was rarely difficult, as students generally made sensitive, accurate, and insightful comments.

I was repeatedly told by students that my willingness to demonstrate each assessment task was extremely valuable and greatly appreciated. It was also an important way to embody the collaborative principles underlying Therapeutic Assessment. By making myself vulnerable and openly acknowledging my anxiety, mistakes, and learning, I reduced the power imbalance between students and myself and helped to alleviate their anxiety. One can never completely eliminate this power imbalance, nor is it the goal of Therapeutic Assessment to do so. The instructor/assessor is still seen as an expert on assessment, but one who recognizes that no one person has the entire truth about any interpersonal situation and who is willing to learn from the student/client. By demonstrating my work, I also managed to engage the students as coassessors and collaborators in the course and in the observed assessment and thereby increased their excitement and motivation to learn. Last, my actions communicated my respect for students as individuals and as a group, and seemed to empower them to believe that they too could become skilled assessors.

Step 6: Students Role-Play Each Assessment Task. Following the observed demonstration, students would practice each task (e.g., the initial interview) in pairs or small groups—with myself, the TAs, or other students role-playing clients. I tried to encourage students to give each other feedback, based on their subjective experience of playing assessors or clients. By letting students supervise each other, I again tried to resist being viewed as the only expert.

Step 7: Students Perform Each Assessment Task With a Client. Next, students were individually observed while performing each assessment task (initial interview, Rorschach administration, feedback session, etc.) with a volunteer client. The TAs or I would observe these sessions and rate students on the appropriate rating form. Students would rate themselves on the same form after completing the task.

Step 8: Students Are Given Feedback on Each Task. The TAs and I compared our ratings and observations of the students' performance on each task with the students' own ratings. Both strengths and weaknesses were brought up for discussion, and we asked students to respond to our comments, rather than passively accept them as "ultimate truths." We paid special attention to issues students had identified in their individualized assessment questions (posed at the beginning of the course). This approach parallels the feedback process in Therapeutic Assessment, in which clinicians tie assessment findings to clients' individual goals and engage clients in discussing the accuracy and meaning of test findings, rather than acting as if such results represent absolute reality.

Step 9: Students Try Out Modifications of Each Task. In the assessment intervention stage of Therapeutic Assessment, clients and assessors use test

behaviors as analogs of extratest problems in living. Then they search for new solutions to external problems by identifying new ways for the client to approach test materials (Finn & Martin, 1997; Finn & Tonsager, 1997, in press). For example, a client who has posed the question "Why do I have trouble completing my assignments at work?" may copy the Bender-Gestalt figures in an obsessive, painstakingly slow manner. After discussing with the client the similarities between his behavior in the two situations, the assessor might ask the client to draw the figures again, but more rapidly. By trying different ways to speed up the Bender-Gestalt copy, the client and assessor may identify ways that the client can complete more assignments at work.

In the assessment course, after students and I noticed problems in their performance of any assessment task, we would role-play the task again and again, identifying possible solutions and/or blocks to behavior change. For example, a student and I might discover that she failed to do an adequate Rorschach inquiry because she was afraid of annoying the irritable, easily offended client she had been assigned. The student and I would discuss ways to deal with such clients' annoyance, and would try out these strategies together until we were both reasonably confident that she could handle such situations in the future. In class, I would explicitly state my belief that such problems arise for all beginning assessors and that the purpose of the practice assessments was to identify such difficulties and address them before students went on to practicum placements. In rare instances, students and I found that they were unable easily to modify problem behaviors that showed up during their assessments. In such cases, I sometimes suggested to students that they consider psychotherapy.

Step 10: Students Repeat the Assessment Task With Another Client. By the end of the course, students observed me many times, and they, too, were observed many times, as they honed or modified their assessment skills, and repeated each assessment task with another client. Students generally completed two to three full personality assessments as part of the course requirements. Although I had no illusions that this amount of experience would identify and address all potential problems students might encounter, I felt fairly confident that students would have the chance to address most major clinical and characterological issues.

Step 11: End of Course Feedback Session Is Given to Student. When all course requirements were completed, I offered an individual feedback session to each student, which I conducted according to the techniques of Therapeutic Assessment, for example, addressing students' individualized goals, offering positive comments early in the session, beginning with feedback that was likely to fit students' self-concepts, allowing students to challenge my comments (Finn, 1996; Finn & Tonsager, 1997). As with earlier supervisory sessions, I tried to engage each student in a dialogue about my observations and I carefully listened to any disagreements or modifications of my feedback. Before the session ended, I told each student her or his grade and I invited feedback about

the course and/or about me as an instructor. I let students know they would have another opportunity to give me feedback anonymously.

Step 12: Written Report Is Prepared and Student Has Option of Commenting. In Therapeutic Assessment, reports are written in language that clients can understand and are virtually always shared with clients. In addition, clients are given the chance to respond in writing to their reports (Finn & Tonsager, 1997). In my course, I followed this approach with students. Shortly after the feedback session, I prepared my written report about each student for the clinical psychology faculty, including modifications that came out of my discussions with students. I gave students copies of their reports and I invited them to put any reactions or disagreements in writing and give them to me. I promised to present such comments to the clinical psychology faculty at the same time I gave my own report. I believe that my commitment to showing students my reports helped keep my assessments precise and balanced. I avoided impressions and comments that I could not adequately support. Also, as in a clinical assessment, students' comments on my reports were often illustrative of my impressions, and were thereby useful to the other faculty.

Step 13: Students Anonymously Give Feedback to the Instructor. In our clinic, all clients are invited to rate their assessment experiences on a standardized form (the Assessment Questionnaire–2; Finn, Schroeder, & Tonsager, 1995) at the end of an assessment. My department routinely required students to anonymously complete course evaluations at the end of the semester. I always let students know that I paid careful attention to their ratings and comments in designing the course for the following year. I sometimes found that students were more forthcoming in their feedback on the anonymous course ratings than they were when discussing the course with me in their feedback sessions. I see this as an inevitable result of the distrust inherent in involuntary assessment situations.

Step 14: Report and Student Comments Are Presented to Faculty. Finally, I shared my report about each student—along with any comments she or he had written—with the clinical psychology faculty. My observations were integrated with those of other faculty members to make recommendations about commendation, remediation, or dismissal of students from the department.

CASE EXAMPLE—ELIZABETH

Let me now illustrate the approach I have described with the case of one student, a 23-year-old woman who I name Elizabeth.

First Impressions

In the initial class session, Elizabeth impressed me as a bright, nervous woman. She asked several excellent clarifying questions about the course syllabus, but spoke in a rapid, breathless voice, sometimes stumbling over words. She repeatedly twisted a bead necklace that she wore throughout the class meeting, and several times I had a vision of its breaking and spilling all over the floor. I vaguely remembered meeting Elizabeth 4 months earlier, at the departmental party at the beginning of the first semester, where we chatted about our mutual interest in horseback riding. I also recalled Dr. Smith, the first-semester assessment instructor, telling me that Elizabeth seemed quite "anxious." In keeping with these experiences, I received the following note in my department mailbox the day after the class session:

> Dr. Finn,
>
> I have one additional question for us to consider during the course. Dr. Smith told me that I talk too much with clients and I haven't been able to stop this. I hope you and I can figure out why I do this and how to help me stop.
>
> Elizabeth

I was impressed by Elizabeth's awareness of a problem and her willingness to disclose it to me. I was also encouraged by the "you and I" phrasing in her note, which seemed to indicate her acceptance of the collaborative frame of the course.

Initial Interview

I briefly acknowledged Elizabeth's note at the beginning of the next class session, and she appeared calmer in this and the next several class meetings. She continued to ask excellent questions in class and made insightful comments about the readings I had assigned. I began to see her as a bright and very dedicated student who worked hard and prepared carefully for class sessions. She and I had a short meeting before her first client session, after I interviewed the client I was assessing in class. I took the opportunity to ask Elizabeth more about her "talking too much" with clients. I found out that Dr. Smith's observation reminded her of comments several friends had recently made—that she seemed "wound up." She confessed that this feedback had surprised her at first because she had often been told she was "too quiet" in college. When I asked Elizabeth what she thought about this discrepancy, she said it might be because she "tried too hard" with new things, but then calmed down after a while. I sympathized with the anxiety of doing new things and of overdoing as a result, and we agreed that Elizabeth should "do her best" but not "try too hard" in her first client interview. She also agreed to role-play an initial interview with one of the TA supervisors prior to meeting with her client. At the end of our

meeting Elizabeth also asked me how I felt when the client I had interviewed in class began to cry.

Early Assessment Sessions

Elizabeth's first assessment client was a subdued, apparently chronically depressed young man who sought psychological testing to explore why he had so much trouble keeping friends. As I watched her initial interview I was struck by Elizabeth's calm firm demeanor with the client, and I wondered if Dr. Smith or Elizabeth's friends had misperceived her, or if she had simply corrected her tendency to "talk too much" and "try too hard." After the interview, we both agreed that the session had gone quite well and that Elizabeth had done a good job of both directing the client and letting him talk. I commended her for her poise; she said that she had felt in the interview as she did when riding a "good horse": "comfortable and not at all afraid." We sketched out the next steps in the assessment and scheduled a time for me to watch Elizabeth administer the Rorschach to her client several days hence. She had already watched me administer the Rorschach and had passed a trial administration during which one of the TAs played a client.

Part way into the observed Rorschach session, I noticed a marked change in Elizabeth's comportment, compared to the beginning of the Rorschach or the initial interview. She began to fidget in her seat, several times cut the client off in midsentence with questions, and her speech became rapid and breathy, as I had noted in the first class session. As I watched, I remembered that Elizabeth asked me about my experience of the client I had interviewed, and I developed a hypothesis about her apparent rise in anxiety. The young man Elizabeth was testing had become noticeably distressed on Card V of the Rorschach, after seeing "a bat flying home over a battlefield. His wings are burned and torn. He's been through something terrible and is just trying to make it through—to make it back to his cave." This response was followed by numerous morbid percepts, and the client's general flat affect became more and more depressed until, on Card IX, he began to cry.

Elizabeth reacted by becoming more and more directive and by speaking very rapidly, especially during the Inquiry. This seemed to confuse the client, and there was a rather tense ending to the Rorschach administration. After the session, Elizabeth herself was upset, and she commented that she was aware she had "talked too much." When I asked if she knew why, she said she had been anxious because this was her first Rorschach, and she felt she had once again "tried too hard." When I shared my hypothesis that she had gotten more active as her client got more distressed, Elizabeth paused to consider and then quickly agreed that this was so. She said she had been afraid the client was going to "fall apart" and she had no idea "how to put him back together again." This led to a fruitful dialogue, where I noticed that Elizabeth had seemed calmer in the initial interview, where the client was somewhat withdrawn and depressed, but not overtly upset. Elizabeth agreed and spontaneously noted that both of the clients she had tested in the previous semester (under Dr. Smith's supervision)

had been highly emotional and very distressed. We concluded that Elizabeth got uncomfortable when clients showed painful emotions, and she tended to react by talking too much and becoming controlling. I reminded her of her question about how I felt when the client I interviewed began to cry, and we spent some time discussing my reactions and ways to handle such situations.

Assessment Intervention

The next day, Elizabeth and I met to role-play ways to handle distressed clients. I modeled simply acknowledging clients' pain, without trying to fix or control it. Elizabeth confessed that this was a novel idea for her; she tended to feel responsible for others' distress. At first, as I role-played a weeping client she reacted by trying to cheer me up. I drew an analogy to horseback riding, and we discussed how a rider must stay calm and unruffled if a horse is frightened by a sudden noise or event. At this point, Elizabeth seemed to catch on and she successfully handled several other situations that I presented to her. Last, we reviewed how she could have responded to her client when he began to cry during the Rorschach. Later that week, Elizabeth met with her client again to conduct the assessment intervention session for his assessment.

I had asked Elizabeth to begin by asking the client about his experience of the Rorschach administration. Not surprisingly, the client seemed even more subdued and withdrawn at the beginning of the session. However, he was able, with Elizabeth's help, to say that he felt upset after their previous meeting. I was pleased as Elizabeth calmly asked questions about his perception of her. Then, to my surprise, the client spontaneously offered, "You know, what happened with us happens with me and my friends all the time. That's part of the problem I've been having." The client went on to relate how his friends couldn't handle his depression, and how misunderstood he felt when they offered suggestions, told him to "stop moping," or suggested he "just go out and have fun." Elizabeth participated in this discussion beautifully, and was able to incorporate the client's observations later in the TAT testing we had planned. After the session, she and I joyfully discussed the client's learning and her ability to react well to his distress.

Later Assessment Sessions

For Elizabeth's second assessment, we both agreed that she would work with a middle-aged woman who was described by the referring therapist as "prone to fits of hysterical crying." I did not personally supervise this assessment, but the TA reported that Elizabeth handled the initial interview and early testing sessions quite well, even though the client became markedly distressed at several points. Then, during the feedback session, Elizabeth again became rather anxious and strident, and insisted on the rightness of several of her interpretations. Afterward, both she and the TA were puzzled about her behavior, because the client had not been markedly distressed during the feedback, and in fact, had seemed pleased and appreciative of the assessment.

I was concerned when Elizabeth came to see me during my office hours the next day, for she looked disheartened and a bit haggard. Once again, she was rather breathless as she talked about the feedback session with her client, speaking rapidly and stumbling over words. I gently probed about what might have made her anxious during that session, until Elizabeth broke down and began to cry. I remembered my advice to her and stayed calm and inquisitive, as Elizabeth finally disclosed another piece of the puzzle: Her mother had been diagnosed recently with ovarian cancer. In fact, Elizabeth had found out about her mother's illness only the morning before the first assessment class meeting. (No wonder she had been so anxious that day!) The day of the feedback session with her second client, Elizabeth had learned that her mother's cancer was not responding to chemotherapy. Furthermore, it came out that Elizabeth was extremely close to her mother, who was a highly emotional woman who had always looked to Elizabeth to help contain her depressed feelings.

I sympathized with Elizabeth's situation, recommended that she seek support during such a difficult time, and gave her the name of several good psychotherapists in the community. This event demonstrates the fine line that often exists between supervision and therapy. I do not inquire about students' personal issues during supervision unless there is an impasse in their ability to work with clients. Once personal issues are identified, I generally refer students to an outside therapist to explore them further.

Elizabeth calmed down considerably and appeared to leave my office with renewed hope and determination. I was left musing about how I too tend to avoid seeking help when I need it, and I realized that I had never discussed with students the impact that personal emergencies can have on an assessor's ability to be with clients. I resolved to add such a discussion to my course in the future.

In the following weeks, Elizabeth appeared calmer and happier in class sessions. She did an excellent third assessment on a difficult client, and showed no disabling anxiety or controlling behavior during that assessment. Her reports were well crafted and insightful. She also achieved the highest grade in the class on the written final exam.

Feedback Session

My feedback session with Elizabeth, held jointly with the TA supervisor, was smooth and productive. We reviewed Elizabeth's considerable strengths as an assessor and again discussed the difficulties she had shown earlier in the semester. I commended Elizabeth for her ability to improve her clinical skills, and Elizabeth thanked me for my support and responded briefly to my inquiries about her mother's health. She also shared, in an appropriate way, some additional insights she had discovered in therapy about her reactions to others' distress. The TA and I said a few words about our own learning process in this area and we all parted with warm feelings.

Written Report

My written report on Elizabeth's course performance (Table 20.2) was given to the clinical psychology faculty. I shared this report with Elizabeth several days before the faculty met to discuss her performance.

Elizabeth's Comments on the Report

Elizabeth wrote a brief response to my report, which I also shared with the clinical faculty:

> I agree with Dr. Finn's report and feel that I learned a lot about myself and about assessment through his course. Dr. Finn discreetly mentioned "family issues" that were troubling me during the semester. I want to clarify this. My mother was diagnosed with cancer earlier this year and her health is going down hill quickly. This has been quite upsetting for me and my family, but I think that I am handling it as well as can be expected and I have lots of support. I will be spending the summer with my mother and I plan to return to my studies in the fall.

SUMMARY AND CONCLUSIONS

In this chapter I have highlighted the similarities between a required graduate course in personality assessment and the clinical assessment of clients who are involuntarily referred for psychological testing. I have attempted to demonstrate how the same principles underlying clinical Therapeutic Assessment may also be applied to the educational setting. By minimizing any unnecessary power differential between themselves and students, addressing students' personal goals in course evaluations, modeling vulnerability and openness to feedback, and treating students as collaborators in the learning process, instructors of personality assessment may increase the professional and personal impact of their courses on students. Such an approach is challenging to instructors, in that it requires them to be aware of their own anxiety and to minimize defensive reactions to it. However, the rewards of this method are great. Over the years I have had the pleasure of receiving feedback from former students that my course in personality assessment was one of the most important in their graduate training. I am also very aware of how much I have learned about myself, about teaching, and about personality assessment from instructing others in Therapeutic Assessment.

ACKNOWLEDGMENTS

I am grateful to Jim Durkel for his comments on an earlier draft of this chapter and to the many students who instructed me in how to teach psychological assessment.

TABLE 20.2

Written Report Concerning Elizabeth's Course Performance

PSY389L–Theory and Technique of Assessment II–Spring 19XX

Course Evaluation

Student: Elizabeth J. Course Grade: A

TA Supervisor: Mary Jones

Elizabeth impressed me as an intelligent, caring, responsible student who worked very hard on the course assignments and on improving her clinical skills. Both the TA supervisor and I feel Elizabeth has adequately addressed certain difficulties that Dr. Smith noted in her interactions with clients first semester.

1. *Does this student have an adequate knowledge of the theory and research related to personality assessment?*

Yes. Elizabeth obviously prepared each of the course readings with great care and made insightful and useful comments in class discussions. She received the highest grade in the class on the final exam, and her answers demonstrated a sophisticated knowledge of the theory and research regarding personality assessment.

2. *How well was the student able to conceptualize clinical case material?*

Elizabeth showed a good ability in supervision sessions to think psychologically about cases and to integrate theory and case material. She was more able than most first-year students to analyze clients' interactions with her during assessment sessions and to connect these with clients' problems in their outside lives.

3. *Has the student adequately mastered the administration and scoring of major personality tests?*

Yes. Elizabeth is able to adequately administer and score the tests covered in the course. She was precise and careful in her test scoring. However, like almost all students at her level of training, she will need ongoing assistance with the scoring of difficult Rorschach protocols.

4. *How well did the student write assessment reports?*

Elizabeth's reports were finely reasoned and elegantly worded. She always met deadlines for revisions, even when a quick turn-around was needed.

5. *At what level are this student's basic clinical skills–e.g., empathy, active listening, ability to maintain appropriate boundaries?*

At several points early in the semester, Elizabeth's clinical interactions were influenced by her anxiety and her attempts to manage it. At such points, Elizabeth tended to be overactive and controlling with clients–not listening well and imposing too much of her own agenda on sessions. Elizabeth was aware of this tendency from feedback she received last semester and she worked hard to overcome it during this course. I now feel that Elizabeth has adequately addressed the underlying issues contributing to her anxiety, and she now shows good empathy, listening skills, and appropriate flexibility with clients.

6. *How did the student respond to supervisory feedback?*

Elizabeth was receptive to supervisory feedback and was able to use it to improve her skills with clients. She also appropriately reached out for support from her supervisors when she was troubled by family issues that were influencing her course performance.

7. *Did the student demonstrate any behavior that raises concern about her suitability to be a clinical psychologist?*

8. *Is this student ready to participate in a clinical practicum?*

Elizabeth performed in an ethical and responsible way throughout the course. I have no concerns about her taking part in the second-year practicum. I believe that Elizabeth has the abilities, temperament, and dedication necessary to become an excellent clinical psychologist.

Stephen E. Finn

Course Instructor

REFERENCES

Dana, R. H., & Leech, S. (1974). Existential assessment. *Journal of Personality Assessment, 38*, 428–435.

Exner, J. E., Jr. (1993). *The Rorschach: A comprehensive system: Vol. 1. Basic foundations* (3rd ed.). New York: Wiley.

Finn, S. E. (1996). *A manual for using the MMPI–2 as a therapeutic intervention.* Minneapolis: University of Minnesota Press.

Finn, S. E., & Martin, H. (1997). Therapeutic assessment with the MMPI–2 in managed health care. In J. N. Butcher (Ed.), *Objective psychological assessment in managed health care: A practitioner's guide* (pp. 131–152). New York: Oxford University Press.

Finn, S. E., Schroeder, D. G., & Tonsager, M. E. (1995). *The Assessment Questionnaire–2 (AQ–2): A measure of clients' experiences with psychological assessment.* Unpublished manuscript, Center for Therapeutic Assessment.

Finn, S. E., & Tonsager, M. E. (1992). Therapeutic effects of providing MMPI–2 test feedback to college students awaiting therapy. *Psychological Assessment, 4*, 278-287.

Finn, S. E., & Tonsager, M. E. (1997). *Therapeutic Assessment: Using psychological testing to help clients change.* Manuscript in preparation.

Finn, S., & Tonsager, M. (in press). Information gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment.*

Fischer, C. T. (1994). *Individualizing psychological assessment.* Hillsdale, NJ: Lawrence Erlbaum Associates. (Original work published 1985)

Newman, M., & Greenway, P. (1997). Therapeutic effects of providing MMPI–2 test feedback to clients at a university counseling service: A collaborative approach. *Psychological Assessment, 9*, 122–131.

Pruyser, P. W. (1979). *The psychological examination: A guide for clinicians.* New York: International Universities Press.