

Therapeutic Assessment with the MMPI-2 in Managed Health Care

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The Current Crisis in Psychological Assessment

The role of psychological assessment in mental health care has been declining over recent years, especially because managed care systems have been on the rise. This decline is multiply determined, but is based in part on perceptions of assessment among mental health professionals and in part on pressures from managed health care systems. Perhaps the most important reason behind this decline is the faltering interest in assessment by psychologists, those most directly trained in psychological testing. Reasons for this weakened interest include perceptions that assessment requires less skill and provides less personal satisfaction than psychotherapy, beliefs that assessment is dehumanizing of clients, questions about the incremental validity of assessment, and economic pressures.

Many professionals believe that psychological assessment is a distant second to psychotherapy in challenging their talents and skills as a psychologist. They find more fulfillment and prestige in the provision of psychotherapy than in that of assessment. This attitude may be an unfortunate outgrowth of the traditional approach to psychological assessment. Typically, training in psychological assessment emphasizes the use of standard techniques and rigid protocols to collect “sterile” data. Test data are then mechanically pieced together into a report that is—at best—glanced at by others who often read only the summary statements. The resulting

report is then placed in the client's file for some nebulous future reference. As is to be expected with this approach, traditional psychological assessment is often viewed as a semiskilled technical enterprise that is not personally fulfilling for a doctoral-level psychologist. Generally, as soon as one is able, the task of test administration is delegated to lesser-trained mental health professionals, and doctoral-level psychologists then focus on interpretation of data or supervision of those learning assessment, if they continue to do psychological assessment at all (Moreland et al., 1994; Finn & Tonsager, in preparation).

This traditional approach to psychological assessment is unappealing to many psychologists in that it does not require the creative and adaptive application of the knowledge and skills acquired through training and experience. Even when the interpretation of test data does provide a challenge, it is removed from the interpersonal interaction that lured many into the mental health field in the first place. Holt (1968, p. 29) notes that "All in all, diagnostic testing is not an emotionally and motivationally satisfying activity for the full-time endeavors of the kind of person who is likely to be best at it." The clinician is often left to paperwork—that is, the sometimes grueling process of writing a report for those who requested the testing. Perhaps most significantly, the clinician is often left feeling as though she/he had little impact on the client. Although she/he may have carefully collected (or had someone else collect) test data from the client and correctly analyzed the findings, the resulting report is often only understood by fellow professionals, and it is they who are left to use (or not use) the results of the testing for the benefit of the client. Thus, just as traditional assessment is based upon sterile data, the process often tends to feel sterile as well and it holds little allure for the humanistic professional.

The perceptions that psychological assessment requires less skill, generates more paperwork, and provides less stimulation and fulfillment than psychotherapy all contribute to psychologists holding psychological testing in less esteem. This decline in prestige further decreases the appeal of assessment for the competent professional. This generally diminished regard for the work of psychological assessment may contribute to its not being as well compensated on an hour-for-hour basis as other endeavors of the psychologist. This even further diminishes the appeal of assessment for the newly trained clinician. In the increasingly difficult economic environment, a professional can often be better rewarded financially for work other than psychological assessment.

In addition to these personal factors that may cause psychologists to gravitate away from psychological assessment, some professionals believe that psychological assessment is not in the best interest of the client. Many view traditional assessment as dehumanizing those assessed in both purpose and effect. Traditionally, assessment has served a diagnostic function—where a label or judgment is applied that the client often does not understand. Such judgments have been used to deny clients privileges such as custody of a child, employment, or even freedom to walk the streets. Rightly or wrongly, a diagnostic label can follow a person throughout her/his life, regardless of its accuracy. As Korchin and Schuldberg (1981) note, "assessment became identified with . . . labeling and has been criticized as useless, if not harmful."

Some professionals argue that the process of psychological assessment is inherently demeaning, disrespectful, and abusive of clients. Unfortunately, such critics

do not have to look far to find clients who complain of feeling manipulated, invaded, unappreciated, and ignored after an assessment. Such feelings are heightened when assessments are conducted without test procedures being adequately explained to clients or without test results being shared after an assessment is completed. Fortunately, recent legal advances in clients' right to be informed (Brodsky, 1972) and ethical stipulations that clients be given feedback about test results in language they can understand (American Psychological Association, 1992) have worked to diminish the abuse clients have sometimes felt at the hands of psychologists who misuse the traditional approach to assessment.

From a more technical perspective, psychological assessment is subject to questions of incremental validity and utility. First, does it actually provide more accurate information than can be obtained through other, perhaps less costly methods; and second, if it does provide additional data, is that added information useful? More generally, is psychological assessment worth the time and effort it requires? Parsimony is a quality sought by good clinicians and by managed care systems who seek to limit costs. Many professionals believe that after a few psychotherapy sessions a competent clinician will know the information necessary for treatment without resorting to expensive, time-consuming psychological assessment. A recent survey of nine of the largest managed care firms reflected the belief that an interview is sufficient to clarify diagnosis (Griffith, 1995). For these reasons some clinicians reserve assessment for those few clients who are puzzling, even after many psychotherapy sessions, or for those patients who are uncooperative.

So the issue remains, When is psychological assessment warranted as an effort to gain further information? It seems likely that assessment can be a useful data-gathering tool in many situations, but it may not be so efficient as to warrant being a routine standing order on psychiatric units as it has been in the recent past (Meier, 1994). If additional useful information is needed, one should consider carefully the most effective means of data collection in light of the specific circumstances of a case. Although psychological testing may play an important role at times in information gathering, it may not always be the approach of choice when all factors are considered.

Finally, concerns about dehumanizing the patient and questions of incremental validity fuel the debate that psychological assessment is undesirable and an unnecessary expense to those who are paying the bills. Managed care systems see little need for the information provided by extensive assessment. The aforementioned survey of large managed care firms confirmed that reimbursement of psychological assessment is tightly restricted. All nine companies contacted required precertification of testing, and many reported suspicion of any request for testing. Their preferences were against full batteries due to cost and against projective testing due to validity concerns (Griffith, 1995).

Managed care is interested in helping those they ensure for the lowest cost possible. They have fixed financial resources based on the rates they charge for coverage. In order to be competitive with other companies, they must offer rates that are attractive to those seeking health insurance. Their hope for profit and economic survival comes from their ability to hold costs down as low as possible while still meeting the obligations to those they cover. Many insurance companies believe

they are doing a service to those they insure by maximizing the mental health benefit squeezed from generally low limits of coverage for mental health services. To administrators of these managed care systems, the basic questions are, Why spend this amount of money for psychological assessment? What will our subscribers receive in return? What is the value of psychological assessment in relation to other ways limited resources might be allocated? Approached from the perspective of traditional assessment, the answers to these questions may make assessment difficult or impossible to justify.

Therapeutic Assessment

Fortunately, the field of psychological assessment is evolving in response to many of the same observations, issues, and concerns that have motivated the evolution of self-psychological, interpersonal, intersubjective, social constructivist, and feminist philosophies and approaches to psychological treatment. Meier (1994) notes that psychological assessment has historically striven to be relevant and to respond to the changing demands made on it and opportunities open to it. Therapeutic Assessment is a new paradigm for psychological assessment that addresses many of the limitations, reservations, and concerns related to traditional assessment (Finn & Tonsager, in preparation). It is collaborative, interpersonal, focused, time-limited, and flexible. It is an approach to assessment that is very interactive and requires the greatest of clinical skills in a challenging role for the clinician. It is unsurpassed in its respectfulness for clients: collaborating with them to address *their* concerns (around which the work revolves), acknowledging them as experts on themselves and recognizing their contributions as essential, and providing to them usable answers to their questions in a therapeutic manner (Finn & Tonsager, in preparation). When practiced correctly, Therapeutic Assessment is of enormous impact and benefit to clients, providing them with a sense of efficacy in co-directing the process, self-worth in being accurately seen and valued, and hope in exploring new ways of addressing difficult problems. Therapeutic Assessment promises to be an economically efficient approach in helping clients grapple with difficulties they are having.

Goals and Principles

The ultimate goal of Therapeutic Assessment is to provide an experience for the client that will allow her/him to take steps toward greater psychological health and a more fulfilling life. This is done (a) by recognizing the client's characteristic ways of being, (b) understanding in a meaningful, idiographic way the problems the client faces, (c) providing a safe environment for the client to explore change, and (d) providing the opportunity for the client to experience new ways of being in a supportive environment (Finn, 1996; Finn & Tonsager, in preparation). The general principles underlying Therapeutic Assessment work to increase the likelihood of reaching the goal of a transforming experience.

Therapeutic Assessment recognizes that assessment is a vulnerable experience for the client. It involves giving personal information of an uncertain significance

to a stranger who will use that information to draw conclusions that will be used to either help or harm the client. Therapeutic Assessment requires that clients be assessed only after they fully understand the kind of information that can be derived from the assessment procedures and how that information will be used after the assessment. In accordance with current ethical standards, Therapeutic Assessment acknowledges that the assessor has the responsibility of clarifying with the client the goals and purpose of the assessment (American Psychological Association, 1992).

Therapeutic Assessment advances the belief that clients become most engaged in an assessment and are most likely to give accurate information when they are treated as collaborators whose ideas and cooperation are essential to the assessment. Additionally, they become most invested in an assessment when the results will be used to address their personal questions and goals. When clients understand the nature of an assessment and voluntarily agree to participate, they are often looking for emotional support and for new information that will help them address life's problems. By giving clients feedback about assessment results in an emotionally supportive manner, the assessor helps clients feel affirmed, less anxious, and more hopeful and to better understand and manage life's problems.

Research on Therapeutic Assessment with the MMPI-2

Research has just begun to investigate the effects of Therapeutic Assessment, but early results suggest that it can have a substantial beneficial impact on clients. The seminal study of Therapeutic Assessment (Finn & Tonsager, 1992) demonstrated that clients from a university counseling center who received feedback about MMPI-2 results showed a significant decrease in psychological distress, an increase in self-esteem, and increased hopefulness. In this study, students in the experimental group ($n = 32$) were interviewed, took the MMPI-2, and received feedback of results in a session with the assessor. Students in the control group ($n = 29$) were interviewed and did not take the MMPI-2, but they were given "therapeutic attention" by the assessor in the final session.

In comparison to the control group, the experimental group showed clinically significant decreases in psychiatric symptomatology. This change in psychic distress continued to grow over the two-week follow-up period of the study. Relative to the control group, the experimental group also showed significantly increased hopefulness about their problems and a significant increase in self-esteem. These effects were also maintained, and even slightly increased, at the end of the two-week follow-up period. In addition, those who received MMPI-2 feedback had an overwhelmingly positive impression of the assessment experience. The effect of test feedback on self-esteem is particularly noteworthy in that psychotherapy outcome studies rarely document any change in self-esteem after psychotherapy. Subsequent research has confirmed the significant therapeutic effects of MMPI-2 assessments done from a collaborative approach (Newman, 1996).

In a related study (Finn & Bunner, 1993), feedback of assessment results had a significant impact on psychiatric inpatients' satisfaction with clinical services. Most of the subjects were hospitalized for affective disorders or substance abuse. Thirty-four patients completed The Assessment Questionnaire-2 (Finn et al., 1995), a

measure of client satisfaction with assessment. Patients who received verbal feedback about their assessment results ($n = 14$) were more satisfied with their assessment experiences than were those who did not receive feedback ($n = 20$). Those who received feedback rated themselves as having learned more about themselves, feeling more understood, and having more positive feelings about the assessor. This study is important in that client satisfaction is an important outcome variable itself, with obvious implications for client's future use of mental health services.

Factors That May Contribute to Therapeutic Effects of MMPI-2 Assessments

How can assessment with the MMPI-2 have such beneficial impact on the client? One can speculate many possible reasons for the therapeutic effects, some of which have been postulated earlier by Finn and Butcher (1991). Receiving self-verifying information about oneself can have an affirming effect (Swann, 1983). Providing words that describe experiences and feelings of which one is only vaguely aware can aid self-understanding and provide a sense of mastery that is empowering to an individual. Merely openly expressing one's concerns can have a cathartic effect, and when those concerns are understood by a person in some position of authority, one would likely feel less isolated and more hopeful about dealing with their problems. The experience of feeling accurately seen and attended to by another person (mirroring) can be a powerful stimulus to growth of the self.

The experience of connecting in a meaningful way with another person can decrease feelings of alienation and provide a sense of more control in the world through enhanced self-image and feelings of self-efficacy. Feeling respected and valued during the testing situation can be internalized to positively impact self-esteem. It can revive hope and trust and instill confidence that other relationships can be improved. Many people have had little positive experience when in a one-down position so that feeling respected in their vulnerability can have a significant impact on self-esteem and increase hope for relationships.

Finally, the MMPI-2 assessment process can provide a good model for relationships by providing an experience of mutual respect, of being seen for who one is, and of saying good-bye and grieving loss. This model could instill greater confidence in one's ability to manage other relationships in life. Further research is needed to increase our understanding of the therapeutic mechanisms involved in Therapeutic Assessment. Results of such studies could contribute to refinements that further enhance the efficacy and efficiency of psychological assessment.

A Model for Conducting Therapeutic MMPI-2 Assessments

Therapeutic Assessment is flexible in its procedure because it tries to accommodate the questions and needs of clients. However, a general model of MMPI-2 assessment that has proved effective in previous research (Finn & Tonsager, 1992; Newman, 1996) can provide useful guidelines. The following flow chart is a condensation and modification of that described by Finn (1996):

Step 1. Initial interview with client. A 60- to 90-minute interview allows the

client and assessor to build rapport, identify personal questions the client wishes the MMPI-2 to address, review relevant history about the questions, and make a clear contract about the logistics of the assessment, including cost, duration, and timing of the feedback session.

Step 2. Administration of the MMPI-2. The MMPI-2 is administered, scored, and interpreted to gain insight into answers to the client's questions.

Step 3. Assessment intervention session. In this 60-minute session, the assessor uses "softer" tests, such as the Thematic Apperception Tests, to explore findings from the MMPI-2 and engage the client as an observer of her/his behavior *in vivo* (Fischer, 1994). The target behavior is generally one that provides an important insight into an assessment question. For example, a client who has asked, "Why am I so depressed lately?" may produce a 2-4 code type on the MMPI-2, suggesting that her/his depression may be related to feelings of being "trapped." During an assessment intervention, this client may be given cards from the TAT that pull for depressive themes. The client's stories may then be discussed with the MMPI-2 results in mind, with the assessor asking whether characters in the stories have a way out of their predicaments. Parallels may then be explicitly drawn from the story to the client's own situation and to her/his question posed at the beginning of the assessment. Finally, new alternatives can be suggested by the assessor and "tried on" by the client by integrating them into the story. To continue the example, the assessor might suggest that the client needs to be assertive when first noticing twinges of resentment and that this option might prevent a buildup of resentment and help short-circuit the client's depression. The client then retells the TAT story—integrating some aspect of assertiveness—to see how it feels as a potential new way of being. Such a new alternative may provide a small but pivotal step in the client's personal growth and may trigger other therapeutic effects, such as renewed hopefulness.

Step 4. Construct a feedback outline. The assessor uses knowledge of the client and of the feedback process to arrange the answers to the questions asked by the client in such a way as to maximize the impact of the feedback session.

Step 5. Feedback session with client. The assessor communicates the MMPI-2 findings in response to the client's questions and solicits input from the client to refine the findings. MMPI-2 results are presented to the client in such a way that she/he can most likely accept them. Clients may choose to audiotape the feedback session.

Step 6. Written report to client. Following the feedback session, the assessor mails a written report to the client summarizing the assessment results and answers to the client's assessment questions and asks the client for written feedback about the assessment.

Therapeutic Assessment with Managed Care Clients

Educating Managed Care Staff about Therapeutic Assessment

Therapeutic Assessment can be done within a managed care environment, but it typically is necessary to educate staff with whom one has contact about the differ-

ences between this approach and traditional assessment. We have found several ways of doing this, depending on the openness of managed care staff and the number of questions they have about the procedures of Therapeutic Assessment. In increasing order of effort, these are the methods we have found effective for educating managed care staff:

1. *Discuss the principles of Therapeutic Assessment with managed care “gatekeepers.”* Because gatekeepers are responsible for ensuring that members of a managed care plan receive only necessary treatments, it is important that they understand the distinction between a traditional assessment and an assessment conducted according to the principles of Therapeutic Assessment. Often it is possible to discuss these differences when approaching the gatekeeper for preauthorization for the assessment. Relevant points to mention are that the psychological testing is being done as a brief form of psychotherapy, the client will be asked to collaborate in the assessment and will receive feedback about the test results, and the client will receive a short report about the testing. Such information also helps the gatekeeper understand the various charges for which one is seeking preauthorization.

One particular point of information that may be useful to share with gatekeepers involves the policies of the American Psychological Association (1985, 1992) regarding feedback about psychological testing. Both the *Standards for Educational and Psychological Testing* (1985) and the *Revised Ethical Principles for Psychologists* (1992) explicitly state that psychologists are responsible for providing feedback to clients about psychological testing. These policies may be important in explaining to gatekeepers why one is conducting and charging for test feedback sessions, and they provide justification that one is not simply seeking to “pad” the number of hours for which one bills.

2. *Send written information about Therapeutic Assessment.* We have found it very effective to follow up phone conversations with gatekeepers by sending them written information about Therapeutic Assessment. For example, we have a brief information sheet for referring professionals that summarizes the principles and procedures of Therapeutic Assessment (see Table 8.1). Managed care gatekeepers have found this information sheet to be useful in understanding how we conduct our assessments. Often, we will also send a copy of relevant research articles (e.g., Finn & Tonsager, 1992) that document the beneficial effects of Therapeutic Assessment. A short note may be included, asking the gatekeeper to share the enclosed information with other colleagues, thereby maximizing the possibility of reaching other professionals in the managed care organization.

3. *Ask if you may visit and conduct a staffing on Therapeutic Assessment.* Several years ago, we repeatedly faced difficulties getting preauthorizations for assessments from one large managed care organization that contracts with our clinic. At that time, one of us (SEF) asked if it would be possible to visit the organization to discuss Therapeutic Assessment. The offer was enthusiastically accepted and a staffing was held in which Therapeutic Assessment was discussed and gatekeepers got to view videotaped excerpts of actual client–assessor interactions. The response from the managed care staff was overwhelmingly positive and, for quite a while afterwards, not only did we easily receive assessment preauthorizations, we also got a number of referrals from the organization for assessments.

Table 8.1. Information Sheet for Referring Professionals*What Is Therapeutic Assessment?*

Therapeutic Assessment is an approach developed by Stephen Finn, Constance Fischer, and others. It uses psychological tests and a collaborative assessment method to help clients reconceptualize their lives and move forward in their healing. Research has demonstrated that after a therapeutic assessment, many clients exhibit less distress and have higher self-esteem. In addition, valid and usable test data are collected, which may be used for diagnosis, treatment planning, or documentation of change after treatment.

How Is Therapeutic Assessment Different from Traditional Assessment?

In the Therapeutic Assessment model, psychological testing is seen as a potential intervention and a method of gathering information about a client. We involve clients and referring persons in all stages of the assessment process, as collaborators, co-observers, and co-interpreters of certain test results. We always give verbal feedback to clients about test results and provide a written report when it is desired. At the end of an assessment we solicit written feedback from clients about their experience of the assessment.

When Should I Refer for a Therapeutic Assessment?

We welcome referrals for psychological assessment when you feel this process will be useful to you and your client. Common times for making such a referral are (1) at the beginning of therapy to help in treatment planning, (2) when you and/or your client are puzzled about the client's history or experience, (3) when therapy is "stuck" and you wish an outside event to move it forward, (4) when you feel a client is planning to terminate therapy prematurely, and (5) as part of the termination process to document change and plan for the future. Our collaborative assessment methods are often particularly better than traditional procedures for clients who have strong reservations about being tested. We never proceed with an assessment until we have a client's cooperation.

What Types of Assessment Do You Do?

We accept referrals for outpatient individual assessments, including intellectual testing, learning disability evaluations, personality testing, diagnosis and treatment planning, and neuropsychological screening with clients 4 years of age and above. If we determine that more extensive neuropsychological testing or educational testing is needed, we will make a referral to an allied professional. We also perform innovative evaluations of couples and families, which include the production and analysis of a consensual Rorschach protocol. Except in rare instances we do not accept referrals for forensic evaluations.

What Can I Expect from You, the Assessor?

We will address the questions you and your client pose for the assessment, or let you know beforehand if the assessment is unlikely to provide the information you seek. We will keep in contact with you during the assessment and discuss findings with you before they are shared with the client. We will provide you and your client with a written report, if desired. We will remain in contact with you and/or your client until the assessment results have been fully explored and integrated into your work. We are available to meet with your client months or even years after an assessment to again discuss test results. All assessments done by our clinic staff are closely supervised by our Director, Stephen E. Finn, Ph.D.

What Will You Expect of Me as a Referring Professional?

We ask that you prepare your client for the assessment by discussing the specific questions you would like answered by the assessment and helping the client to form his/her own questions. Early

(continued)

Table 8.1. (continued)

in the assessment, we will contact you to get background information on the client. While the assessment is taking place, your client may need emotional support and/or help describing the experiences of the assessment. If you notice a change in your client's behavior in or outside of therapy during an assessment, please let the assessor know as soon as possible. If possible, we ask that you attend the feedback session where the assessment results will be presented to the client, and we welcome your suggestions before the feedback session about how to best discuss the assessment findings with your client. If we can, we will come to your office for the feedback session, because your client is likely to feel most comfortable in this setting. After the assessment is completed, we will ask you for feedback about our work, so that we may better serve you and other referring professionals in the future.

How Much Does an Assessment Cost?

The fees for a therapeutic assessment vary depending on the complexity of the referral questions and whether a verbal summary or written report is desired. After the initial interview with a client, we quote a fee for the entire assessment, including interviews, testing sessions, test scoring and interpretations, written reports, and feedback sessions. We ask that, if possible, your client pay half this fee at the beginning of the assessment and half at the completion. Typically, we can fairly accurately estimate our fees from talking with you about your client.

How Long Will It Take to Have My Client Assessed?

Because of the high demand for our assessments, we generally have a 3 to 5 week waiting period between the date of a referral and the beginning of an assessment. Once an assessment has begun, we typically provide the feedback session within 4 weeks, except in very complicated assessments. Although we prefer to test clients over 2–3 weeks to allow us to see them in different contexts, we can perform assessments within short periods of time (e.g., 3–5 days) if you so desire.

How Do I Refer My Client?

Please contact Stephen Finn, Ph.D. at (512) 329–5090 to discuss your particular client or if you would like more information about our approach to psychological assessment.

Getting Preauthorization for an MMPI-2 Assessment

Obviously, the procedures a psychologist must follow in seeking preauthorization for a therapeutic MMPI-2 assessment will vary from region to region and according to the specific contract the provider has signed with a managed care organization. Typically in our area, we are allowed to see a client for one hour of initial diagnostic interview (CPT code 90801) before we must seek further approval from a gatekeeper for an MMPI-2 assessment. We use the initial interview, as described earlier, to gather specific goals and questions that the client wishes to have addressed by the assessment. Then, when we approach the gatekeeper, we have the rationale for the assessment in hand. When discussing the client with the gatekeeper, we find it expedient to address the following points:

1. *Presenting issues of the client and initial diagnostic impressions.* For example, a client may seek an assessment due to worrying and difficulties sleeping. We might share with the gatekeeper our impression that the client seemed clinically depressed.
2. *Specific questions to be addressed by the MMPI-2.* For the aforementioned

client these might include such questions as, “Why am I having difficulty sleeping?” “Why am I worrying so much about my business?”

3. *A rationale for the use of the MMPI-2 to address the specific assessment questions.* Some explanation must typically be given for why the MMPI-2 is an appropriate assessment instrument to address the referral questions. For example, in the current example one might explain that the MMPI-2 is a good measure of anxiety and depression, both of which are suspected as underlying the client’s stated difficulties.

4. *Clarification of how to bill the assessment intervention session, the MMPI-2 scoring charges, and the MMPI-2 feedback session.* Different managed care carriers prefer to have us bill the assessment intervention session and feedback session under CPT code 90830 (psychological testing) or as psychotherapy (CPT code 90844). Similarly, some organizations have a specific fee they will cover for the MMPI-2 scoring expenses. Such issues should be openly discussed with the gatekeeper when applying for preauthorization, so that billing can proceed without complications.

Billing for an MMPI-2 Intervention

Table 8.2 shows a sample bill for an MMPI-2 intervention. In this instance, the assessment intervention session has been billed under CPT code 90830 (psychological testing) and the MMPI-2 feedback session has been billed under CPT code 90844 (psychotherapy). Again, because the procedures of Therapeutic Assessment constitute test-based psychotherapy, the provider has some flexibility in how to list these charges and should consult the gatekeeper when seeking preauthorization.

Occasionally we work with a managed care organization that does not require preauthorization before bills are submitted. In such an instance, an explanation of

Table 8.2 Sample Bill for Therapeutic MMPI-2 Assessment

Bill for Psychological Services				
Client: Ms. S				
Identification No.: 999-99-9999				
Date of Birth: XX-XX-XX				
Diagnosis: 301.9				
Date	Service	Time	CPT	Charge
XX-XX-XX	Initial interview	1 hour	90801	\$100.00
XX-XX-XX	Psych. testing	1 hour	90830	\$90.00
XX-XX-XX	Psych. testing	1 hour	90830	\$90.00
XX-XX-XX	Psychotherapy	1 hour	90844	\$80.00
Total Charges				\$350.00
Stephen E. Finn				
Stephen E. Finn				
Licensed Psychologist				
TX license #2-3064				
Tax ID #—xxx-xx-xxxx				

the bill for an MMPI-2 intervention is often in order, since the procedures of Therapeutic Assessment differ from those of traditional assessment. Table 8.3 shows a sample letter we have drafted for such purposes.

Enlisting Clients as Advocates of Therapeutic Assessment

Infrequently, we run across an insurer that balks at paying for any psychological testing or—more frequently—that wishes to severely limit the number of hours of psychological testing in such a manner that a Therapeutic Assessment cannot realistically be performed. (For example, one company refused to pay for more than one hour of psychological testing for an MMPI-2 assessment.) Obviously, we first attempt to work with such an insurer by providing them with information about Therapeutic Assessment, as detailed above. In the few instances where this strategy has failed, we have found it useful to involve clients in the preassessment process,

Table 8.3 Letter to Insurance Company Regarding Billing for MMPI-2 Intervention

[Date]
[Insurance Company]
[Street Address]
[City], [State] [Zipcode]

Dear colleagues:
This letter accompanies a bill for my client, [Client Name], and will explain some of the charges. [Client Name] recently participated in a brief psychotherapeutic intervention at our clinic. This intervention is called “Therapeutic Assessment” and has been developed by myself and other colleagues at the University of Texas at Austin and the Center for Therapeutic Assessment. The enclosed article by Finn and Tonsager (1992) documents the efficacy of one version of this therapy—using only the MMPI-2—on clients’ distress and self-esteem. [Client Name] participated in a longer version, involving [Total hours] total contact hours and the following psychological test instruments: [Tests Used]. Because this intervention combines both elements of assessment and psychotherapy, the total contact hours have been billed as follows: Diagnostic Interview = [Int Hours] hours, Psychological Testing (and Report) = [Testing Hours] hours, Psychotherapy = [Therapy Hours] hours. This breakdown reflects the hours spent with the client in the various activities.

If you would like further information about Therapeutic Assessment or about the billing on [Client Name], please feel free to contact me at the number above. We look forward to continuing to work with your clients at our clinic.

Sincerely,

Stephen E. Finn
Director and Licensed Psychologist

as advocates of Therapeutic Assessment. A few well-placed phone calls from a client or—even more effective—from the client's employer can do wonders in influencing an insurer to look more favorably on Therapeutic Assessment.

Another important strategy—especially when working with a new carrier—is to ask satisfied clients to call or write a brief letter to their insurance carrier after an assessment expressing their satisfaction with Therapeutic Assessment and detailing how it helped them. We have done this on several occasions and have received feedback that the clients' letters had a positive impact on the insurance carriers to which they were sent.

One indirect way to use client feedback with insurance carriers is to collect information regarding client satisfaction with assessment services and to share this information with gatekeepers when discussing Therapeutic Assessment. We routinely ask clients to fill out a standardized evaluation form, the Assessment Questionnaire-2 (Finn et al., 1995), following a psychological assessment. On several occasions, we have been able to use such data to demonstrate that most of our clients are highly satisfied with their assessment experiences.

Case Example

Referral Ms. S was a 35-year-old woman referred for a personality assessment by her psychotherapist, Dr. B, who felt that she and Ms. S had reached an impasse in their treatment. Ms. S had sought psychotherapy 8 months earlier complaining of being “angry all the time” and concerned about how frequently she yelled at her two young children (ages 6 and 4). While both women felt that they had made progress in understanding the source of Ms. S's anger (i.e., physical abuse in childhood and marital problems), Ms. S felt she had made little progress in controlling her anger. Ms. S was now contemplating terminating psychotherapy due to her frustration with its slow pace; Dr. B hoped the assessment would provide information that would rescue and reorient the stalled treatment.

Initial Contact with Insurer Dr. B had already made contact with Ms. S's insurer to let them know that she had referred Ms. S for an assessment. Thus, when the assessor (SEF) called for preauthorization, he requested and was granted approval to conduct and bill for an initial interview (CPT 90801) with Ms. S.

Initial Interview with Ms. S Ms. S arrived 10 minutes late for the initial interview but claimed to be enthusiastic about the assessment. She confirmed Dr. B's referral and explained that she wanted therapy to help “get rid of her anger,” especially with her husband. She described him as a disabled Vietnam veteran “with PTSD” who abused prescription medications and left all household duties to her. She said that she had worked extensively in therapy on confronting her husband with her anger toward him, but still found herself “stuck” when it came time to talk with him. To date, he had refused to attend sessions with Dr. B. Ms. S also puzzled aloud about her continuing feelings of anger at her parents, explaining that she had “cut them off” six months earlier. She described her mother as a “controlled alcoholic” who drank every day to “get numb.” She said her father was a World War II com-

bat veteran and told of his beating her “until she urinated in her pants” when she was a child. Ms. S had discontinued contact with her parents after her younger sister revealed that she had been sexually abused by her father as a child. Ms. S had expected that her anger toward her parents would subside because she no longer talked with them, but said that she still “dug her nails into her palms” whenever she thought of them.

Ms. S posed the following questions for the assessment:

1. Why am I so angry all the time?
2. What can I do to better manage my anger and express it?
3. Is this a good time for me to stop therapy?

Ms. S agreed to complete an MMPI-2 to address these questions, and she contracted to meet with the assessor two more times—once after the MMPI-2 to further explore her questions (i.e., the assessment intervention session) and once after that with Dr. B to go over the assessment results. The assessor also promised Ms. S a brief written report addressing her questions. It was made clear that this plan was contingent upon our clinic’s getting preauthorization for the assessment.

Steve’s initial impressions of Ms. S were that she was an intelligent, capable woman who had made a good adaptation to a difficult past. He was struck by her stated desire to “get rid of her anger,” as if it were an offensive trait that she wished to have removed. Steve noted that Ms. S seemed disappointed with Dr. B in discussing her psychotherapy, and he hypothesized that her desire to stop psychotherapy was an expression of anger, similar to her “cutting off” her parents. The MMPI-2 seemed to be an excellent instrument to explore Ms. S’s questions, because of the great deal of information it provides about the management and expression of anger.

Second Contact with Insurer After the initial interview with Ms. S, Steve called her insurer again to seek preauthorization for the assessment. At this point, because of his earlier contact, Steve simply needed to give his initial impressions of Ms. S, relate their mutually developed assessment questions, and give a rationale for the proposed sessions. The gatekeeper approved three additional service hours beyond the diagnostic interview: two hours of psychological testing (CPT 90830)—to cover the assessment intervention session, the scoring and interpretation of the MMPI-2, and the writing of the brief report—and one hour of psychotherapy (CPT 90844) for the assessment feedback session. (The actual bill for Ms. S’s assessment was presented earlier, in Table 8.3.)

Analysis of MMPI-2 Results Figure 8.1 presents the main graph of Ms. S’s MMPI-2 results. The profile is valid and it appears that Ms. S responded to the items in a consistent manner (TRIN = 10; VRIN = 5). The configuration of L, F, and K suggests that she answered the test items candidly, without any significant attempt to influence her self-presentation. The profile reveals little emotional distress, although there were indications of family problems (FAM = 62T) as reported by her in the interview.

The major difficulties indicated by the profile are—not surprisingly—characterological issues concerning the expression of anger. To quote Butcher and

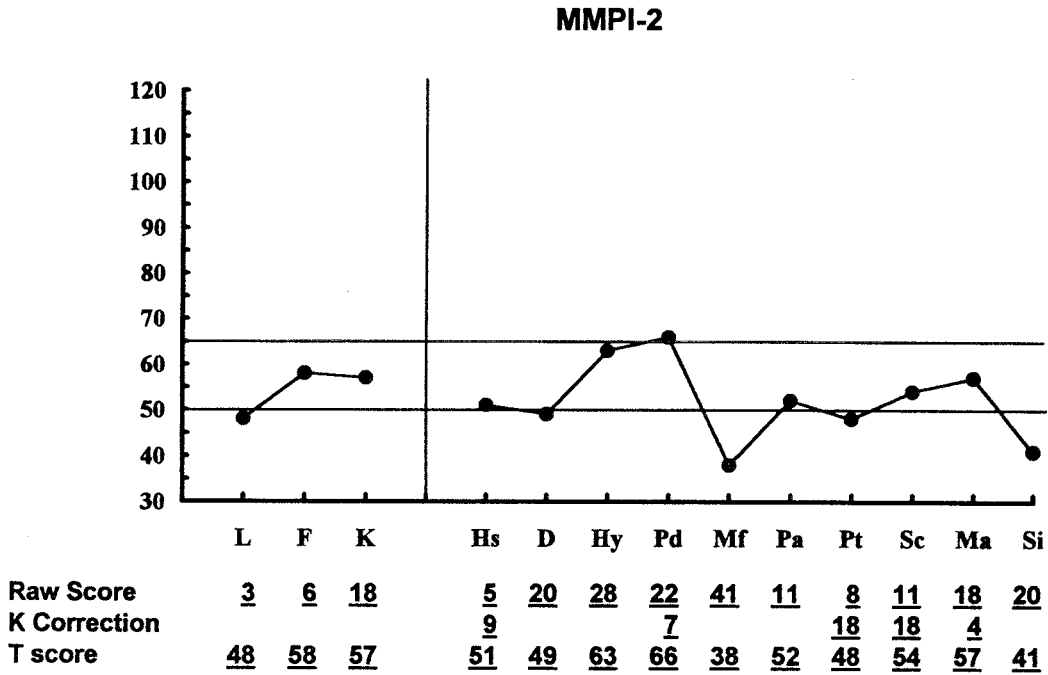


Figure 8.1. Ms. S's basic K-corrected MMPI-2 profile.

Williams (1992, pp. 116–117), people with Ms. S's code type (4–3) typically demonstrate:

“... chronic, intense anger. ... Individuals with this clinical profile may harbor hostile and aggressive impulses but cannot express them appropriately. ... Usually somewhat overcontrolled, they tend to experience occasional brief episodes of assaultive, violent acting-out. They tend to lack insight into the origins and consequences of their aggressive behavior. ... Individuals with this code type show long-term and ingrained feelings of hostility toward family members. They tend to demand attention and approval from others. They are overly sensitive to rejection and are usually hostile when criticized. They may be outwardly conforming but inwardly rebellious.”

From this information it was possible to formulate initial answers to Ms. S's assessment questions: She probably felt angry all the time because she tended to over-control her anger until she “boiled over.” Managing her anger better would require her to be aware of her anger earlier and to express it directly while she could still do so in a controlled fashion. This strategy would likely be especially difficult because of her need for approval and her intense fears of rejection, and she would be most likely to defer to men (low 5). It would seem unwise to end therapy until she made more progress on these issues, and perhaps her current plans to terminate were an indirect way of expressing anger toward Dr. B.

Assessment Intervention Session While discussing the above information with Ms. S would, by itself, most likely have been of therapeutic benefit, Steve decided to conduct an assessment intervention session with Ms. S to further explore her questions. As described earlier, one goal of this session was to create *in vivo* examples of

Ms. S's presenting problems, so that these could be discussed in light of the MMPI-2 results. Steve selected the Thematic Apperception Test (TAT) for the intervention session and began by giving Ms. S the first card (picturing the boy with the violin) along with the standard instructions. Ms. S told the following story:

MS. S: "It's a little boy whose parents make him play the violin. He doesn't really want to practice. He's sitting there looking at it, going 'Why do I have to do this? I've already put in my work today.' He begrudgingly picks it up and begins to practice."

SEF: "What is he feeling?"

MS. S: "Tired."

Below is the dialogue that Steve and Ms. S had following this story:

SEF: "That seems like the kind of situation where a child might feel frustrated. I noticed you said 'tired.'"

MS. S: "You're right, maybe this boy could say 'Listen mom, I don't like the violin,' but he doesn't."

SEF: "And he's tired. Is that at all like you?"

MS. S: "I do a lot of things in my life and I would probably choose to cut back, but that's what I really get a kick out of so I won't . . . When I'm frustrated I really go gung ho and clean house, etc. As Dr. B puts it, I 'stuff it.'"

SEF: "This little boy does too. How about telling the story over again with the little boy being more assertive?"

Ms. S then told the following story to Card I:

"Okay, the beginning's the same. He comes home and his mother tells him to go practice the violin. He sits there and looks at the violin, thinking 'I don't really want to do this. What I really want to do is get on my bike and go play with Billy down the road and go to our fort in the woods.' Finally, he looks at the violin long enough and turns and tells him mom, 'I want to go play.'"

SEF: "What happens then?"

MS. S: "His mom tells him, 'Okay, but you'll have to practice when you get home.'"

SEF: "How does he feel?"

MS. S: "Relieved that he got out of it and he goes and plays with Billy at the fort."

Again, Steve led Ms. S in a discussion:

SEF: "How did it feel to tell that?"

MS. S: "Well, I noticed my nails in my palm again. It's difficult, although it makes so much more sense. For some reason it doesn't set well with me. It's not my style. . . ."

SEF: "You said 'it doesn't set well.' What about it?"

MS. S: "It just feels uncomfortable. I think it's a good thing. It just feels wrong."

SEF: "Can you describe the discomfort?"

MS. S: "I'm not terribly assertive. It's intimidating to go up against people."

Notice how these responses provide rich examples of the difficulties described in the MMPI-2 code book. With Steve's guidance, Ms. S is "discovering" on her own the results of the standardized testing.

The assessment intervention session continued with Steve asking Ms. S to tell an "assertive story" to Card 4 (a picture of a woman with her hand on the arm of a determined looking man):

MS. S: "It appears to be like this 1930s kind of picture. He's a rugged blue-collar working man and she's a stay-at-home housewife. In my mind there's not much assertive about that. The only story that comes to mind is her hanging on to him and saying, 'Don't go—stay with me.'"

... He's gotten up this morning and he's getting ready to go do a fairly dangerous job. His wife has been concerned about it. She tries to grab hold of him and tell him not to go. He basically pushes her aside and goes on to work."

Once again, the ensuing discussion confirmed the results of the MMPI-2:

MS. S: "I just couldn't think of an assertive story."

SEF: "Well it sounds like the man's being assertive."

MS. S: "Oh, I didn't think about that. I thought I had to make the woman assertive."

SEF: "It was easier to picture him assertive?"

MS. S: "Yeah, I don't know why."

SEF: "Is that similar to you—that you have more experience with men being assertive than women?"

MS. S: "It's similar to my growing-up life. . . . My mom was not very verbally assertive . . ."

Here we see the expression of Ms. S's internalized stereotypes of men and women, shown in her low score on Scale 5 of the MMPI-2.

Because of her difficulties telling an assertive story to Card 4, Steve then modeled an assertive story by telling about a woman confronting her husband about an affair. Ms. S enthusiastically claimed to like the story.

MS. S: "That was great. I like the way she did that."

SEF: "What gets in the way of your imagining stories like that?"

MS. S: "I get so angry some of the time that I don't want to say things that are hurtful and I might be sorry for. I know grudges build up in me, then sometimes I blindside my husband over some small thing."

SEF: "So you're afraid of hurting others with your anger?"

MS. S: "And not making sense. It'll sound like the babbling of a crazy woman."

The final insight came when Steve asked Ms. S to tell an "angry or assertive story" to Card 18GF, a picture of a younger woman supporting an older woman on a staircase:

MS. S: "It looks like a woman strangling somebody. The older woman is maybe the mother. She [the younger woman] has never had a very good relationship with her mother and her

mother is ailing. She's been taking care of her for years. The mother's continued to treat her bad even though the daughter's become her caretaker. The mother said one thing too many and she [the daughter] just turned her around and backed her up and put her hand around her neck and said, 'If you don't knock it off I'm going to choke you.' . . ."

This story provided the crucial piece for Steve to make a summary interpretation:

SEF: "How does that feel?"

MS. S: "God awful! I never thought I would make up a story about choking somebody. That wasn't confrontation either."

SEF: "Well what I'm wondering is if you don't stuff your anger for so long, like the boy with the violin, that you build up huge grudges. Then when it all comes tumbling out it's pretty explosive—even violent. Then you might feel foolish and ashamed and start holding it all in again."

MS. S: "I think that's right. I think of my father and I never wanted to do that to somebody else. He could get so out of control. But are you saying that because I won't be angry that I end up acting like him?"

SEF: "Perhaps so. Things might work better if you could give yourself more permission to be angry in small doses. Then you might not explode so much at your children."

Feedback Session As might be expected, the assessment intervention session had well prepared Ms. S for the MMPI-2 feedback. Ms. S's first two questions were easily addressed in the first part of the feedback session. Steve was able to use another well-known characteristic of persons with the 4-3 profile to confront Ms. S about her plans to terminate psychotherapy. The following excerpt is from the last third of the feedback session:

SEF: "There is one other characteristic of people with your test scores that I'd like to discuss. I think it might have to do with your last question."

MS. S: "Okay."

SEF: "People with test scores like yours have a strong desire to be taken care of, often because they didn't get much nurturing while growing up—which certainly sounds like it's true for you. Unfortunately, these people were also taught that they should basically take care of themselves. Thus, they usually find it very hard to ask for things from people. This typically leads to a lot of frustration inside that others aren't reading their minds and doing more for them. There's a real Catch-22 going on, of wanting a lot and being frustrated that others aren't picking up on it. Do you think that fits for you?"

MS. S: "Oh yes. I'm always wanting my husband to do more things around the house, but I never ask him to. I just get furious about it."

SEF: "Of course, because you're afraid to say something for fear of being unreasonable like your father."

MS. S: "Exactly."

SEF: "I'm wondering, do you ever get frustrated with Dr. B and wish that she were doing more for you?"

MS. S: (looking tense) "I'm not sure what you mean."

SEF: "I'm thinking that sometimes you might want her to take better care of you—to read your mind—but that she might not pick up on it and that this could be frustrating for you."

MS. S: "Well now that you mention it, I do wish that she would come out more and tell me what I should do with my husband and my children. (She turns to Dr. B.) You're usually so noncommittal."

DR. B: "And does that make you angry?"

MS. S: "It's annoying. Because I feel I need more direction."

SEF: "Good for you. You see right now you're changing your pattern and being assertive. Can you tell Dr. B more about what you want from her?"

MS. S: "Well I've been wondering . . . I mean . . . we've been talking for some time about my husband coming in to our sessions. I have a really hard time asking him. I keep thinking that maybe if you asked him. . . ."

DR. B: "Is that something that you want?"

MS. S: "Well I think he might listen better if you ask."

DR. B: "I think I can do that. Let's talk about it more in our next session."

SEF: (to Ms. S) "Again, I think this is just great what you're doing—saying exactly what you want. I've been wondering . . . Do you think your plans to leave therapy had anything to do with these types of frustrations?"

MS. S: "Well, I guess so. I've been feeling so stuck. . . ."

SEF: "I'm thinking that if you can learn to express your anger and frustrations more, then you'll have other options besides breaking off relationships."

Written Report Following the feedback session, Steve sent a brief written report to Ms. S, shown in Table 8.4. As described earlier, the purpose of this report was to summarize the answers to Ms. S's assessment questions.

Comments from Ms. S As described in Finn (1996), we typically ask clients for written feedback following a Therapeutic Assessment. Ms. S responded to this request by writing a letter to Steve after she received his report. Below is an excerpt:

The assessment was much more helpful than I ever imagined. I still can't believe that the MMPI told so much about me . . . and those story cards were absolutely amazing. . . . I never knew why I was so afraid of being angry. The way we put it together really made sense. . . . I've been thinking a lot about what you said about me not asking Dr. B for what I want and I've decided to stay in therapy for now. She agreed to call my husband and ask him to come in for some couples' sessions and yesterday we had our first one. It was hard but I did manage to tell him some of the things I've been furious about. . . . I didn't act too unreasonable and felt better afterwards. I'm starting to have hope again. . . . Thanks again for all your help.

Table 8.4 Written Report to Ms. S

MMPI-2 Report

Client: Ms. S Age: 35

Referred by: Dr. B Date: XX/XX/XX

1. Why am I so angry all the time?

Your scores on the MMPI-2 suggest that you tend to harbor frustration and resentments for fear of losing control and being unreasonable with your anger (like your father was). Thus, you feel angry all the time because you are holding in your anger. Unfortunately, because you don't express your anger in small doses, it tends to build up and then boil over in explosions—thereby confirming your worst fears and setting you up to try to suppress it all over again. The harder you try to hold in your anger, the angrier you'll feel.

2. What can I do to better manage my anger and express it?

I think the first key is to realize that you can't simply get rid of the part of you that feels anger. If you don't express it early on, it won't go away. Rather, the longer you hold it in, the more likely it is that your anger will pop out in ways that hurt someone or are embarrassing to you. I suggest you make a resolution to say something about your frustrations *as soon as you can* after realizing they are there. You may need to use Dr. B for support in doing this, but it should get easier as you practice and let out some of the old built-up anger. I also suggest you practice by expressing any frustration you have with Dr. B. She is paid to not take your anger personally, even if you do act like your father and get out of hand.

3. Is this a good time for me to stop therapy?

As we explored in the feedback session, I suspect that you've been thinking of stopping therapy because you've wanted more direction and help from Dr. B than you've been getting. If you can't express your frustrations about such things, it's understandable that you would see no option but to end a relationship. Unfortunately, this solution just perpetuates that problems you have with anger.

Instead of stopping therapy, I want to encourage you to keep telling Dr. B what you want from her (as you did in the feedback session) and how frustrating it is not to get what you want. I know that this will be scary, because the MMPI-2 suggests that you weren't allowed to ask for what you wanted as a child. In fact, you will know you are doing a good job at this if you think you are being unreasonably demanding with Dr. B. Again, remember that it is her job to help you sort this all out and that it is safer to practice with her than with your best friends or children.

Ms. S., thank you again for letting me get to know you. Feel free to contact me if you have any questions about this report. Also, enclosed you'll find the form I told you about, for you to give me feedback about the assessment. It will help me if you will fill this out and return it in the enclosed stamped envelope.

Best wishes,

Steve Finn

Stephen E. Finn, Ph.D.

Summary and Conclusions

Many psychologists feel the increased scrutiny of psychological assessment by managed care companies is unwarranted and represents professional harassment. We understand how frustrating it is for busy clinicians to respond to requests for paperwork and demands that they justify their work. Nevertheless, might the requirement of increased accountability be an opportunity for us psychologists to

reexamine our assessment practices and raise our standards of care? Perhaps the increased scrutiny of managed care companies can lead us to better articulate the value of the MMPI-2 and other assessment instruments and to demonstrate through controlled research the benefits that psychological assessment can have on clients.

In this chapter, we have outlined a model of psychological assessment—Therapeutic Assessment—which collaboratively involves clients in framing assessment questions, interpreting test results, and tying test findings to their problems in living. While still in its early stages of development, Therapeutic Assessment with the MMPI-2 has been shown in controlled research to be highly beneficial to clients. Managed care companies have responded very favorably to our approach. At our clinic, we remain committed to training other professionals in Therapeutic Assessment and to researching its powerful effects.

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