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Information-Gathering and Therapeutic Models of Assessment: Complementary Paradigms

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The authors reviewed the other articles in the special section and commented on the use of psychological assessment to plan treatment. They call this view of assessment the *information-gathering* paradigm, because the goal is to collect data that will aid in communication and decision making about clients. This contrasts with the *therapeutic model* of assessment, in which the major goal is to produce positive change in clients. The authors summarized evidence of the efficacy of assessment as a brief therapy and discussed its possible therapeutic mechanisms. The information-gathering and therapeutic models of assessment are complementary rather than mutually exclusive, and both speak to the utility of assessment. The current crisis in the clinical use of psychological assessment may be due in part to an overemphasis on the information-gathering model.

As several of the authors in this special section have mentioned, the clinical practice of psychological assessment is currently facing major challenges. Increasingly, third-party payors are reluctant to authorize and pay for extensive psychological assessments, claiming that their utility and incremental validity for health service delivery is questionable (Acklin, 1996; Griffith, in press). Such fiduciary considerations have resulted in a notable decrease in the clinical use of psychological testing (Finn & Martin, 1997)[1] and correspondingly, in some university training programs, graduate courses in psychological assessment have been greatly curtailed. It is tempting to blame the decline in status and use of psychological assessment exclusively on the proliferation of managed care organizations (MCOs). However, as Finn and Martin (1997) noted, for some time many practicing psychologists have viewed psychological assessment as less challenging and prestigious than psychotherapy and have had little interest in trying to preserve this traditional area of psychological expertise. We believe that the poor quality of many psychological assessments and certain highly questionable practices, such as the routine administration of large batteries of psychological tests to psychiatric inpatients (Meier, 1994), have contributed to the shaky reputation of psychological assessment among our nonpsychological colleagues. Also, ongoing battles within the psychological community about the validity and utility of psychological assessment procedures, such as those currently being waged around the Rorschach (cf. Dawes, 1994; Meyer, 1997; Nezworski & Wood, 1995; Weiner, 1996; Wood, Nezworski, & Stejskal, 1996), send a confusing message to nonpsychologists about the value of psychological assessment and provide "ammunition" to MCOs and other parties who want to attack psychological assessment for cost-containment and other nonscientific reasons.

Discussion of Other Articles in This Special Section: The Use of Assessment in Treatment Planning

The articles in the present section (Ben-Porath, 1997; Harkness & Lilienfeld, 1997; Haynes, Leisen, & Blaine, 1997; Nelson & Adams, 1997) were assembled to answer some of the criticisms currently being levied against the clinical practice of psychological assessment. For the most part, the articles concern the use of psychological assessment to assess clients before or during other forms of mental health treatment (behavior therapy, prescription of psychoactive medications, treatment for drug and alcohol addiction, neuropsychological rehabilitation, etc.). The authors in this special section have made a substantial contribution by outlining a clear rationale for the use of psychological assessment in treatment planning and identifying areas where research may be most productive.

Although a comprehensive discussion of these articles goes beyond our purpose, we highlight several themes here. For example, Haynes et al. (1997) identify conditions under which pretreatment assessment is likely to have the greatest utility: (a) when there are a variety of treatment approaches to choose from, (b) when there is a body of knowledge linking treatment methods to client characteristics, (c) when clients have complex multiple problems and a therapist needs to prioritize treatment foci, (d) when initial treatment efforts have failed, and (e) when there are few time constraints, and assessment can be done by lesser paid professionals (e.g., by doctoral trainees). Although

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[1] Our discussions with colleagues seem to indicate that forensic assessment and neuropsychological assessment have been less affected by current market trends.

Haynes and his colleagues offer this analysis in regard to behavior therapy, it seems generally relevant and will be extremely useful to researchers wishing to demonstrate the utility of pretreatment assessment.

Nelson and Adams (1997) specify roles in which assessors might usefully contribute to the treatment process of brain-injured clients by: (a) specifying the goals of treatment, (b) educating treatment teams about the neurochemical substrate of the brain, (c) analyzing reasons for treatment noncompliance, (d) measuring the outcomes of treatment, and (e) educating family members about a client's deficits. Again, these roles may apply to treatment in general, not just neuropsychological rehabilitation, and should help in designing research about the treatment utility of assessment.

Both Haynes et al. (1997) and Harkness and Lilienfeld (1997) emphasize the use of psychological assessment to distinguish between "modifiable" and "nonmodifiable" aspects of the client's situation. Treatment plans guided by this distinction are likely to have greater clinical utility. In this regard, we applaud Harkness and Lilienfeld's differentiating *basic tendencies* and *characteristic adaptations* (McCrae & Costa, 1995) and their suggestion that psychotherapy may best address the latter. We also agree with Harkness and Lilienfeld that one useful target of psychotherapy is the human tendency to seek and create trait-relevant environments, even if certain traits themselves are resistant to change. As Haynes et al. (1997) remind us, "unmodifiable causal variables often have modifiable sequelae" (p. 339). We also echo the assertion of Ben-Porath (1997) and Harkness and Lilienfeld (1997) that the assessment of normal-range personality variables could prove useful in planning treatments for various forms of psychopathology.

Last, we comment on Harkness and Lilienfeld's (1997) discussion of the "clinical hermeneutics error" (p. 350)—the phenomenon in which a therapist so adopts the client's perspective that he or she loses track midtreatment of what is *normal* and underestimates the client's degree of pathology. We agree with Harkness and Lilienfeld (1997) and with Butcher (1990) that psychological testing can be extremely useful by providing a normatively derived estimate of the client's standing on various traits, against which the therapist can continually check his or her perspective. In our opinion, however, the clinical hermeneutics error is not in itself a fatal treatment mistake but a frequent and inevitable result of the shifting field of attention required in psychotherapy of all types. In our experience, good psychotherapists alternately "merge" with their clients to empathically adopt their perspective, and then they step back from this merger to take an outside point of view on the client's problems. Clinical missteps may take place in both directions, not just in the direction of too much merger (e.g., a therapist may be so intent in viewing a nonnormative behavior as pathological that he or she fails to recognize its personal or cultural significance for a client and, thus, is unable to plan an effective intervention). This type of error—of not taking the client's perspective enough—also interferes with attempts to change problem behavior because the context of that behavior is not fully understood. We believe psychological tests can be extremely useful in counterbalancing both phenomena. Tests may serve both as *empathy magnifiers*—allowing us to step into our clients' shoes—and as external *handholds*—allowing us to pull ourselves back out of those shoes to an outside perspective. In this sense, psychological tests act like some of our best psychotherapy supervisors; they alternately help us grasp our clients' inner worlds and then retain a grounded nomothetic perspective on the clients' problems.

The articles gathered in this special section speak to the validity of our assessment instruments and document numerous ways that psychological assessment can identify client characteristics that are useful in treatment planning. Also, Ben-Porath (1997) reminds us that the superiority of formal statistical assessment methods over informal clinical methods is hardly in dispute. Critics of psychological assessment must address the vast literature on this topic if they want to be taken seriously (Grove & Meehl, 1996; Meehl, 1954).

However, we must also conclude, as have others (e.g., Hayes, Nelson, & Jarrett, 1987; Kaplan, Colarelli, Gross, Leventhal, & Siegel, 1970; Korchin & Schuldberg, 1981; McReynolds, 1985), that empirical evidence for the treatment utility of assessment [2] is weaker than many of us might want. Even the comprehensive reviews by Ben-Porath (1997) and Nelson and Adams (1997) seem to have revealed no replicated studies in which pretreatment assignment or individualized treatment plans, based on psychological test scores, yielded significantly better outcomes than treatments conducted without the benefit of psychological assessment. Sadly, the summary statement of Haynes et al. (1997) concerning the use of functional analytic case models appears applicable to pretreatment assessment in general: "The clinical utility . . . is frequently supported by testimony but is infrequently the object of research" (p. 346). Although we do not agree with those who claim that "no news is perforce bad news," it remains for all of us to take seriously the words of Hayes et al. (1987): "Because treatment utility provides the practical basis for a concern with clinical assessment, it seems important to proceed rapidly to its demonstration" (p. 973). Well-designed studies in this area are still greatly needed, as they were 10 years ago.

Models of Pretreatment Assessment Research

In hopes of spurring further empirical research on the clinical utility of assessment, we review several basic designs. (See Table 1.) For a more comprehensive discussion of research strategies relevant to the treatment utility of assessment, see Hayes et al. (1987).

Differential Treatment Outcome

In the first design, clients with similar problems in living (e.g., major depression) are assessed on relevant clinical outcome variables (e.g., levels of anxiety or depression) and on other psychological variables (e.g., locus of control). All clients undergo a certain fixed treatment protocol (e.g., 10 weeks of cognitive-behavior therapy for depression) and are reassessed posttreatment on the baseline variables (anxiety and depression). The basic research question is whether there is an association

[2] We use this phrase, in keeping with Hayes, Nelson, and Jarrett (1987), to refer to "the degree to which assessment is shown to contribute to beneficial treatment outcome" (p. 963).

Table 1
Research Designs Relevant to Pretreatment Assessment

Design type	Steps	Controls	Advantages/disadvantages
Differential treatment outcome studies	1. Pretreatment measurement of dependent variables (outcome) and independent variables (client characteristics) 2. Treatment 3. Posttreatment measurement of outcome variables 4. Correlation of treatment outcome with independent variables (client characteristics)	None	1. Relatively easy to conduct 2. Not directly relevant to the utility of pretreatment assessment
Differential treatment assignment studies	1. Pretreatment measurement of dependent variables (outcome) 2. Psychological assessment of relevant independent variables (client characteristics) 3. Assignment of clients to different treatments based on independent variables 4. Clients treated for fixed period of time. Treatment staff unaware of assessment results. 5. Posttreatment comparisons of outcome by group	1. Random assignment of clients to different treatments 2. Treatment assignment by more readily accessible variables (e.g., demographic or historical information) 3. Treatment assignment by other assessment method than psychological tests (e.g., interviews)	1. More complex study that is difficult to conduct 2. Directly addresses the utility of pretreatment assessment by psychological tests 3. Treatment assignment rules must be kept fairly simple
Simple pretreatment assessment outcome studies	1. Pretreatment measurement of dependent variables (outcome) 2. Random assignment of clients to assessment and control groups 3. One group receives pretreatment psychological assessment 4. Treatment of clients for fixed period of time 5. Posttreatment comparisons of psychotherapy outcome by group	1. No assessment group—receives treatment only 2. Nonspecific control group—does not participate in pretreatment assessment but participates in some other comparable activity that also involves assessor time and attention 3. Clients or therapists are given spurious information from pretreatment assessment	1. Fairly easy to conduct 2. Indirectly assess the clinical utility of pretreatment assessment 3. Control groups involving spurious feedback raise ethical concerns 4. Provide little information about the specific mechanisms through which pretreatment assessment is beneficial

between treatment outcome and the measured psychological variables; for example, do depressed clients with high internal locus of control respond better to cognitive therapy than those clients with high external locus of control? Research on differential treatment outcomes is necessary for compiling knowledge about the relationship of client characteristics and treatment methods; such studies may then form the basis for more complex research designs. However, studies of differential treatment outcome do not speak directly to the utility of pretreatment psychological assessment. Most of the studies cited by Ben-Porath (1997) and by Rouse, Taylor, and Sullivan (1997) are of this type.

Differential Treatment Assignment

In this more complex design, clients are first measured on relevant clinical variables (e.g., anxiety or depression). Then, clients are assessed on other psychological variables (e.g., introversion–extroversion). The results of the assessment are used to assign the clients to certain predetermined treatments; for example, clients high in introversion are assigned to individual psychotherapy, and clients high in extroversion are assigned to group psychotherapy. Such decisions may be based on the results of studies of differential treatment outcomes. Also, at best, treatment staff are not informed of assessment results used to assign clients to treatments. Finally, after a certain fixed period of treatment, clients are remeasured on the clinical outcome variables. This is a design that Hayes et al. (1987) referred to as "obtained differences/two or more treatments" (p. 967).

In determining the utility of pretreatment assessment, the outcomes of clients in the experimental groups are compared to those of control clients who were assigned to treatment through some other method. In one design, clients in the comparison groups might be assigned to group versus individual therapy randomly; a design demonstrating greater internal validity would use other client characteristics (e.g., clients' stated preference for individual or group therapy) or assessment methods (e.g., interviews) to assign clients to treatments. Both designs directly address the clinical utility of pretreatment assessment, because they pose the question of whether psychological tests (e.g., measures of introversion–extroversion) allow better treatment assignment than do easier, or more accessible, assessment methods. One drawback is that treatment assignment decision rules, by necessity, must be fairly simple; in actual clinical settings, therapists typically have access to much more information on clients as the result of pretreatment assessments, and they may make subtle modifications in therapy throughout treatment as a result of this information.

Simple Pretreatment Assessment Outcome Studies

This type of design uses what Harkness and Lilienfeld (1997) and Hayes et al. (1987) refer to as "the technique of manipulated assessment" (p. 969). This approach more closely approximates actual clinical situations and is fairly simple to implement. Also, pretreatment assessment outcome studies do provide an indirect test of the utility of pretreatment assessment. However, such studies yield little information about the mechanisms through which pretreatment assessment is useful. We know of one published study that falls in this category (Haase & Ivey, 1970); let us describe it to provide an example. Twenty-seven students at a university counseling center were randomly assigned to two groups. One group completed a pretreatment assessment involving the Minnesota Multiphasic Personality Inventory (MMPI); the other group did not. Next, all students received a brief course of counseling. (The mean number sessions for both groups was close to 3.5.) Last, the students and their therapists completed measures of posttherapy adjustment. On both the therapist ratings and the self-ratings, students who underwent pretreatment assessment showed significantly greater adjustment, suggesting that, "pretesting may sensitize the client to counseling, which results in greater . . . client benefits than if no pretesting were performed" (Haase & Ivey, 1970, p. 128).

Clearly, there were several significant shortcomings to Haase and Ivey's (1970) study. First, the clients did not complete pretreatment measures of adjustment, raising some possibility that the posttreatment differences existed before the treatment (in spite of the random assignment.) Also, it is unclear how and why the pretreatment assessment might have been effective. Might clients have benefited from the extra time and attention involved in completing the MMPI? (A better control would have involved the no-assessment group in a parallel activity.) Did therapists have access to the MMPI findings? Were students given feedback about their MMPI results? These questions cannot be answered from the published brief report. However, our main goal is not to criticize this study but to suggest this type of design as a first step in assessing the clinical utility of pretreatment assessment. Such studies could be easily undertaken in many clinical settings where pretreatment assessment is routinely practiced. The use of increasingly sophisticated control groups (e.g., where therapists are not aware of MMPI results but clients are, or where therapists are given spurious information about some clients' test results) could help identify the specific mechanisms through which pretreatment assessment influence subsequent therapy.

A Therapeutic Model of Assessment

Let us now consider a different paradigm of psychological assessment, in which assessment itself is considered to be a potential therapeutic intervention. Although a number of writers have observed that psychological assessment can be therapeutic to clients (e.g., Allen, 1981; Allen, Lewis, Blum, Voorhees, Jernigan, & Peebles, 1986; Baker, 1964; Berg, 1984, 1985; Butcher, 1990; Dorr, 1981; Finn, 1996; Fischer, 1970, 1972; Lewak, Marks, & Nelson, 1990; Moffett, Steinberg, & Rohde, 1996; Mosak & Gushurst, 1972; Verinis & Espindola, 1977), such observations have received relatively surprisingly limited attention from clinicians or researchers. In this article, we refer to this paradigm of psychological assessment as the *therapeutic model,* because its primary goal is interventional. This contrasts with the traditional *information-gathering model,* in which assessment is viewed primarily as a way to collect information that will guide subsequent treatment.[3]

During the past 8 years, we (Finn and Tonsager) have worked independently and collaboratively to develop a comprehensive model of psychological assessment that strives to maximize the interventional aspects of assessment for clients (and their families). We call our approach *therapeutic assessment* to emphasize its transformative goals. Also, although many assessment procedures help clients make positive changes, by therapeutic assessment we refer to a specific theory, set of techniques, and collaborative approach to working with clients that we refined with our colleagues at the Center for Therapeutic Assessment in Austin, TX. Portions of the therapeutic assessment paradigm have been articulated elsewhere (Finn, 1996; Finn, in press; Finn & Martin, 1997; Finn & Tonsager, 1992), and a full account will appear in an upcoming book (Finn & Tonsager, 1997). In the following sections, we present a brief review of the historical context of therapeutic assessment and then contrast the therapeutic model with the traditional information-gathering model of assessment. We then summarize empirical studies that provide evidence of the efficacy of assessment as an intervention and propose an initial theory of the mechanisms underlying such therapeutic change. Finally, we discuss the complementary relation between these two seemingly dissimilar views of assessment and offer suggestions as to further research directions, as well as uses of the therapeutic model in clinical and nonclinical settings.

Historical Context of the Therapeutic Model of Assessment

The practice of therapeutic assessment, using psychological assessment as a short-term intervention, has its roots largely in the humanistic movement of the 1950s and 1960s. This historical context is somewhat surprising, given that a number of humanistically oriented clinicians (e.g., Brown, 1972; Bugental, 1963; May, 1958; Rogers, 1951) voiced strong objections about psychological assessment and considered it to be a dehumanizing, reductionistic, artificial, and judgmental process for clients. However, other psychologists believed that psychological assessment could be a humanistic endeavor and that clients could be helped—not harmed—by their participation, if significant changes were made in how assessments were conducted (e.g., Craddick, 1972; Dana, 1982; Fischer, 1972; Sugerman, 1978).

This shift in the practice of psychological assessment required clinicians to broaden their focus of attention beyond the information gleaned from the test measures to include such aspects as the client–assessor relationship, the context of the assessee's difficulties, and the clinicians' own countertransference. The humanistic view also challenged the long-held belief that sharing

[3] Historically, the traditional model of psychological assessment has also been referred to as the psychometric tradition, clinical tradition, or diagnostic psychological testing. See Tallent (1992) and Korchin and Schuldberg (1981) for additional information about this paradigm of assessment.

test feedback would be harmful to clients (e.g., B. Klopfer & Kelley, 1946; W. G. Klopfer, 1954). The decision to share test feedback with clients was also due to recognition of clients' legal rights to access professional records (Brodsky, 1972). More recently, ethical guidelines (American Psychological Association, 1990; Pope, 1992) have also required assessors to share test findings with clients.

As clinicians began sharing test feedback more regularly with clients, they reported a number of ways that clients benefited from the experience. For example, it was noted that sharing test feedback could (a) build a therapeutic alliance at the onset of therapy (e.g., Allen, 1981), (b) set goals for psychotherapy (De La Cour, 1986), and (c) refocus and revitalize a "bogged down" treatment (e.g., Cooper & Witenberg, 1985). In addition, clinicians reported a number of specific client benefits following test feedback sessions, including, (a) an increase in self-esteem, (b) reduced feelings of isolation, (c) increased feelings of hope, (d) decreased symptomatology, (e) greater selfawareness and understanding, and (f) increased motivation to seek mental health services or more actively participate in ongoing therapy (Finn & Butcher, 1991).

Parallel to the increased recognition that assessment feedback could be therapeutic, some clinicians began to write about client changes during assessment, prior to a formal feedback session. Such changes seemed to occur when clients were included as active participants in the assessment process, in discussing the reasons for assessment, observing test results, and interpreting test scores (e.g., Allen, 1981; Appelbaum, 1959; Berg, 1985; Finn, 1994; Fischer, 1985/1994; Harrower, 1956; Harrower, Vorhaus, Roman, & Bauman, 1960; Jaffe, 1988). Gradually, some clinicians began to question whether it was necessary or helpful to make any sharp distinction between assessment and treatment. For example, Allen (1981) stated that assessment was "treatment in microcosm" and asserted that "all the concepts that are employed to understand the therapeutic relationship (e.g., alliance, transference, countertransference) are central to the testing process" (pp. 251–252).

Contrast With the Information-Gathering Model

What does it mean to view psychological assessment as a therapeutic intervention, rather than as a procedure used to gather information to plan and monitor treatment? Let us contrast the two models of assessment. (See Table 2.)

Goals. In the information-gathering model, assessment is seen primarily as a way to facilitate communication between professionals and to help make decisions about clients. By describing clients in terms of already existing categories and dimensions (e.g., *schizophrenic, IQ of 100, 2–7 code type on the MMPI-2*), assessors hope to convey a great deal of information about clients in an efficient manner. Also, such descriptions are the basis for important decisions, such as whether clients are mentally competent or dangerous, whether they should receive one treatment or another, be granted custody of a child, hired for a certain job, or be given publicly funded special education services. Given the inherent uncertainty involved in such weighty decisions, clinicians and researchers have long emphasized the statistical reliability and validity of their assessment instruments; these characteristics allow one to make nomothetic comparisons (i.e., generalizable across persons and situations and used by a number of clinicians) between a particular client and similar clients who have been treated in the past or studied in research.

In contrast, in the therapeutic model, the major goal is for clients to leave their assessments having had new experiences or gained new information about themselves that subsequently helps them make changes in their lives. The assessor's primary task is to be sensitive, attentive, and responsive to clients' needs and to foster opportunities for self-discovery and growth throughout the assessment process. In many ways, the goals of therapeutic assessment parallel the aims of all psychotherapies, because all are committed to helping people confirm, challenge, and change how they act, think, and feel about themselves.

Process. In the information-gathering paradigm, clinicians have generally relied on a three-step process in conducting assessments: (a) data collection; (b) deductive, unilateral interpretation of assessment data; and (c) recommendations. The first step has often been relegated to psychometricians or lower level trainees who have received training in standardized test administration and have been instructed to minimize any social interactions throughout the testing sessions. During the second step, assessors typically make deductive interpretations from the collected test data, observations, and historical information about the client, to develop an understanding of the individual. Such interpretations are unilateral in that clients generally do not participate in constructing them. In the final step, assessors use the test data and interpretations to aid them in their decision making. Typically, throughout the assessment process, there is relatively little information shared by assessors with clients, with the exception of verbal feedback sessions or written reports that can follow this final third step.

Despite using similar assessment instruments, therapeutic assessment proposes a radically different view of the assessment process. In this model, assessors are committed to (a) developing and maintaining empathic connections with clients, (b) working collaboratively with clients to define individualized assessment goals, and (c) sharing and exploring assessment results with clients. Clients are viewed as essential collaborators and are invited and encouraged to actively participate in numerous aspects of their assessments. For example, assessors typically ask clients to comment on the accuracy of possible test interpretations. Such tactics markedly reduce the power imbalance between assessor and client found in the traditional assessment approach, with the goal of helping clients cocreate new understandings of themselves that will resolve problems in living.

View of tests. In the information-gathering model, psychological instruments are methods which provide the assessor with standardized samples of clients' behaviors. Thus, tests permit nomothetic comparisons and predictions of clients' behaviors outside the assessment setting. A test is highly valued if it can be shown to demonstrate adequate reliability, stability, and validity, and in particular, predictive utility. Although the therapeutic model of assessment considers the statistical properties of psychological tests to be important, it also views tests as opportunities for dialogue between assessors and clients about clients' characteristic ways of responding to usual problem situations and tools for enhancing assessors' empathy about clients' subjective experiences. As a result, test scores are often analyzed from an idiographic as well as nomothetic perspective; in this

Table 2
Information-Gathering and Therapeutic Models of Assessment

Aspect	Information-gathering model	Therapeutic model
Goals of assessment	1. Describe clients accurately in terms of existing dimensions and categories 2. Help make decisions about clients 3. Facilitate communication between professionals	1. Clients learn a new way of thinking and feeling about self and others 2. Help clients explore these new understandings and apply them to their problems in living
Assessment process	1. Data collection 2. Deductive, unilateral interpretation of test data 3. Recommendations	1. Develop empathic connections with clients 2. Work collaboratively with clients to define individualized assessment goals 3. Share and explore information with clients throughout the entire assessment
View of tests	Standardized samples of clients' behavior that permit nomothetic comparisons and predictions of clients' behavior outside of the assessment setting	1. Opportunities for dialogue with clients about characteristic ways of responding to usual problem situations 2. Tools for empathy that allow assessors access to clients' subjective experience
Focus of attention	1. Test scores 2. The decision(s) to be made after the assessment is done	1. Process occurring between clients and assessors 2. Clients' subjective experience 3. Assessors' subjective experience
Role of assessor	1. Objective observer 2. Semiskilled technician who is "better with numbers than people"	1. Participant–observer 2. Highly skilled professional who is knowledgeable about tests, personality, and psychopathology, and highly interpersonally skilled
Assessment failure	1. Biased or otherwise inaccurate information is collected 2. Wrong decision is made after the assessment	1. Clients do not feel respected, understood, and listened to by assessor 2. Clients do not acquire new understandings or are not changed by the assessment 3. Clients feel abused and less capable after assessment

sense, therapeutic assessment is a return to the psychological assessment approaches of Allport (1929) and Murray (1938).

Focus of attention. In the information-gathering model, the focus of the assessment is on the test scores and the decision or decisions to be made after the assessment is done. Generally, in this model, assessors pay little or no attention to their own feelings or thoughts that arise while working with a particular client or to clients' subjective experiences of completing a test. Data gathering is important only to the extent that it occurs in a standardized fashion that permits nomothetic comparison. Some attention is paid to a positive rapport between assessor and client, but, again, this is mainly valued because it facilitates the collection of valid and reliable data. A metaphor that seems to capture the assessment process in this model is of a scientist examining a sample through the lens of a microscope.

Because the goals of a therapeutic assessment are largely interventional, the "lens" an assessor looks through is much broader and includes both the outcome variables and the process occurring between the client and assessor. In this model, rather than focusing primarily on what happens after the assessment, the assessor's attention is turned to the assessment sessions themselves. The three major areas of interest for the assessor are (a) the client's subjective experience of the assessment, (b) the assessor's own subjective experience, and (c) the dynamic interplay between the client and the assessor. In these ways, the assessor's focus closely parallels that of a psychotherapist working from either an interpersonal, humanistic, self-psychological, or intersubjective perspective. This broadened view of the assessment process allows for a deeper understanding of the client and helps to facilitate the development of an empathic connection between the client and the assessor.

Role of assessor. In therapeutic assessment, assessors are recognized as participant–observers who play an active, influential role in shaping the assessment process, along with their clients. The assessor's own personality, appearance, past experiences, and theoretical framework are all seen as potent factors that facilitate (or hinder) the entire assessment process. Such factors influence how clients and assessors relate to one another, what information is shared, how the assessment data are understood or contextualized by the assessor, and whether or not clients experience significant learning or change during their assessments. In this model, the assessor is required to be a skilled and sensitive facilitator of change, who is knowledgeable about tests, personality, and psychopathology and who has a high degree of interpersonal skill.

In contrast, assessors working within the information-gathering model are generally considered objective observers who have relatively little influence on the data collected. In their interactions with clients, such assessors are asked to assume a detached, structured, and predictable stance. Their interactions with clients are often limited to asking questions and recording responses, which tends to place clients in a more submissive and passive role. Also, in this model there is a tendency (among psychologists and nonpsychologists alike) to see assessors as little more than semiskilled technicians. This has led to a stereotype that psychologists who make a career of psychological assessment tend to be "better with numbers than people" and that they typically do not have the interpersonal skills to be successful as psychotherapists.

Definition of assessment failure. In the information-gathering model, assessors consider an assessment to be a failure if either (a) the information gathered from the client is unreliable

or invalid (perhaps because of a lack of objectivity on the assessor's part), (b) a wrong decision is made about the client as a result of the assessment (because of faulty data, misinterpretation of test results, or incorrect recommendations), or (c) the interpretations and recommendations from an assessment are not actually utilized by clients or by the persons responsible for their care. This last situation often leaves assessors who are working within this model feeling that their work is not sufficiently appreciated.

In the therapeutic model, the extent to which an assessment succeeds depends on whether clients' goals and needs were met by the assessor and the assessment process. From this perspective, there are a number of ways that an assessment could be a failure, even if accurate information was collected and appropriate decisions were made by the assessor: (a) *Relational failure:* the client did not feel respected, engaged, appreciated, and understood by the assessor; (b) *Interventional failure:* the client did not learn or experience new ways of being as a result of the assessment; or (c) *Intrapsychic failure:* the client felt less capable, demoralized, and even abused after the assessment. Interestingly, in therapeutic assessment we would not necessarily consider our work in vain if the results of an assessment were not used by outside professionals to make decisions or to shape their interactions with clients. If a client felt deeply touched and changed by an assessment and was able to maintain that change over time, we would consider the assessment to have been well worth our time and effort.

Empirical Evidence for the Therapeutic Model of Assessment

Because relatively little attention has been given to the potential therapeutic value of psychological assessment, it is not surprising that few controlled empirical studies have been conducted. In the first published study (Finn & Tonsager, 1992), we examined the effects on clients at a university counseling center of their participation in a brief psychological assessment. Thirty-two clients took part in an initial interview, completed the Minnesota Multiphasic Personality Inventory–2 (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), and received a 1-hr feedback session conducted according to a collaborative method developed by Finn (1996). Twenty-nine clients in a control group were interviewed and received an equal amount of *therapeutic attention* (i.e., supportive nondirective psychotherapy) in place of test feedback. Compared with the control group, clients who participated in the MMPI-2 assessment reported a significant decline in symptomatic distress and a significant increase in self-esteem, both immediately following their feedback session and at a 2-week follow-up. Clients also felt more hopeful about their problems after the brief assessment.

Newman and Greenway (1997) recently extended and replicated the study by Finn and Tonsager (1992) in a sample of clients at an Australian university counseling service. Newman and Greenway used a design very similar to that of Finn and Tonsager (1992), but both their control group ($N = 30$) and their assessment group ($N = 30$) completed the MMPI-2. As in the earlier study, clients participating in the brief assessment showed an increase in self-esteem and a decrease in symptomatology, which persisted over a 2-week follow-up. Although the effect sizes were somewhat less than those demonstrated in the Finn and Tonsager (1992) study, the changes shown by the assessment clients were still clinically (as well as statistically) significant. Also, because of the improved design, it is clear that the benefits to assessment clients were due to their receiving test feedback, not to their having completed the MMPI-2.

Several other studies have attempted to identify the elements of psychological assessment which promote therapeutic change. Finn and Bunner (1993) studied the effects of test feedback on psychiatric inpatients' satisfaction with assessments they completed while in the hospital. Those patients who received test feedback were substantially more satisfied with their assessments than those patients who did not. In fact, among patients receiving no test feedback, 40% were somewhat or very dissatisfied with their assessments, as opposed to 0% of the patients receiving feedback. This study supports Newman and Greenway's (1997) conclusion that test feedback is essential to clients' receiving positive benefit from a psychological assessment.

Schroeder, Hahn, Finn, and Swann (1993) examined Finn's (1996) assertion that test feedback is more beneficial if ordered according to assessees' preconceptions about their test results. In this study, university students were first asked to estimate their standing—relative to other students—on four traits measured by Tellegen's (in press) Multidimensional Personality Questionnaire (MPQ). Then, students' actual scores on the relevant MPQ scales (Well-Being, Social Potency, Social Closeness, and Absorption) were determined. This allowed the computation of a difference score between students' expected trait levels and their actual test scores. Such difference scores were used to guide the test feedback given to students. First, all students received feedback on a *congruent* trait (for which their actual scores closely matched their self conceptions). Next, students were randomly assigned to receive feedback on a second trait that was *congruent, mildly discrepant,* or *highly discrepant* from their self-concepts. Results indicated that, relative to the other two groups, those students who received mildly discrepant feedback on the second trait felt more positively about and were more impacted by the assessment, both immediately following the feedback session and after a 2-week follow-up. These results supported Finn's (1996) assertion that assessors achieve the greatest therapeutic effect by ordering clients' test feedback according to their existing self-concepts; clients should first be given feedback that closely matches their own preconceptions and then be presented with information that is progressively more discrepant from their self-concepts.

Finally, in evaluating the evidence for the therapeutic aspects of assessment, we draw attention to the numerous clinical reports of clients' benefiting therapeutically from psychological assessment (e.g., Blatt, 1975; Clair & Prendergast, 1994; Dorr, 1981; Fischer, 1985/1994; Fulmer, Cohen, & Monaco, 1985; Moffett, Steinberg, & Rohde, 1996; Waiswol, 1995). Although these case reports are not based on controlled research, they too represent a kind of empirical evidence. To illustrate, we highlight one such report by Corsini (1984), concerning his time as the psychologist at a state prison.

One day a prisoner who was about to be released came to thank Corsini for having helped him so much while he was

incarcerated. Corsini was confused in that he did not remember the man and only had a record of having tested him briefly two years earlier. When Corsini inquired what he had done that had so impacted the man, the prisoner replied, "You told me I had a high IQ." Corsini asked more questions and learned that the man

> . . . had always thought of himself as "stupid" and "crazy"—terms that had been applied to him many times—by his family, his teachers, and his friends. In school, he had always gotten poor grades which confirmed his belief of his mental subnormality. . . . but when I said "You have a high IQ" he had an "aha!" experience which explained *everything*. In a flash, he understood why he could solve crossword puzzles better than any of his friends. He now knew why he read Sinclair Lewis rather than Edgar Rice Burroughs. Why he preferred to play chess rather than checkers. Why he liked symphonies rather than jazz. With great and sudden intensity he realized . . . that he was really normal and bright and not crazy and stupid. . . . In short I had performed psychotherapy in a completely innocent and informal way. . . . And to balance the score, I have had two long-term clients—seeing each for over 10 years, and in neither case did I do much for them. (p. 4)

This account may seem extraordinary to some readers, but it certainly fits our clinical experience of the potential impact of psychological assessment. Although such case examples do not prove that psychological assessment is therapeutic for all clients, they do show that at least certain clients have greatly benefited from assessment. Further study of the effects and therapeutic actions of psychological assessment would greatly improve our understanding of such instances.

Therapeutic Mechanisms of Psychological Assessment: An Initial Theory

At this point, we offer our current thoughts about why psychological assessment is potentially therapeutic, that is, what specific mechanisms underlie therapeutic change. However, two caveats must first be offered. Such mechanisms may not operate in all psychological assessments; rather, they may be most applicable to the collaborative approach to psychological assessment used by us (Finn, 1996; Finn & Tonsager, 1997) and by others (Fischer, 1985/1994; Handler, 1996; Purves, 1997). Also, many portions of this theory remain to be empirically tested; at this point it is derived largely from our extensive clinical experience.

We believe that several basic human motives are potentially addressed by psychological assessment (and also by other successful psychotherapies). Table 3 presents a formulation of these motives and their relationship to other theories of psychotherapeutic change.

Self-verification. First, we believe that clients who voluntarily participate in a psychological assessment are often looking for confirmation that the way they view themselves and the world around them is accurate, or at the very least, shared by others. We call this motive *self-verification,* and we believe it is especially acute when clients have had experiences that challenge their usual schemas about self or the world. For example, a spouse or friend may have recently given a client feedback that is highly discrepant from the client's usual ways of thinking about self; for example, a man who believes he is very generous may have been told by several people he trusts that he is extremely selfish. It was Kohut's (1977) insight that such occurrences can generate *disintegration anxiety;* an uncomfortable, disorienting feeling that the world is not real and that one is falling apart.[4] In our collaborative approach to assessment, disintegration anxiety is often evident in the questions clients pose at the beginning of an assessment; for example, "Am I really selfish or is my wife wrong?" As mentioned earlier, we address this anxiety, and the underlying need for self-verification, by beginning an assessment feedback session with information that is consistent with clients' existing self-concepts, thereby reassuring them that psychological testing reaffirms much of the way they already think about themselves. We then attempt to integrate new information with the clients' existing self-schemas, resolving apparent contradictions and allowing clients to regain a coherent sense of self.

Self-enhancement. A second human motive is the desire to be loved and praised by others and to think well of ourselves. This need, which we refer to as *self-enhancement,* has been emphasized by clinicians in the object-relations school of psychotherapy (e.g., Fairbairn, 1952; Winnicott, 1957, 1975); it, too, is often poignantly clear in applied psychological assessment. A large number of the clients we assess have decidedly negative self-concepts; again, these are often reflected in the questions clients pose at the beginning of an assessment; for example, "Why am I so lazy?" or "Why am I such a loser in my close relationships?" In giving assessment feedback, often we can use clients' test scores to positively reframe their negative conclusions about themselves. For example, a client who believes he is "lazy" because he typically accomplishes very little may be told that the MMPI-2 suggests he is clinically depressed. We may further explain that depression often affects people's energy level and that depression is the most likely cause of the client's difficulties completing basic daily tasks. Such interpretations offer clients more positive ways of viewing behavior that they formerly interpreted negatively and may be in part responsible for the increases in self-esteem found in clients following collaborative assessments (Finn & Tonsager, 1992; Newman & Greenway, 1997).

Another way that self-enhancement is served in our collaborative psychological assessments is through the respect and positive regard that we show toward clients. By treating clients as experts on themselves and engaging them as collaborators in each stage of the assessment, we demonstrate that we view them as valuable, capable individuals. Clients often comment at the end of the assessment that they initially came fearing humiliation and exposure of their shortcomings but instead feel affirmed and less ashamed of themselves. As may be true for many psychotherapies, a positive relationship with the clinician–assessor appears to be instrumental in achieving such a result.

Self-efficacy/self-discovery. Writers in the school of ego psychology (e.g., Freud, 1936; Hartmann, 1958; Hartmann, Kris, & Lowenstein, 1946) first drew attention to the human need for exploration, mastery, and control. More recently, this

[4] The need for self-verification is discussed not only in Kohut's self psychology (Kohut, 1971, 1977) but also in the theory of intersubjectivity developed by Stolorow and Atwood (1984). Social psychologist William Swann has also developed an extensive theory about the human drive for self-verification (e.g., Swann, 1983; 1990).

Table 3
Three Client Motives Operating in Psychological Assessment

Motive name	Striving represented	Relevant clinical theory
Self-verification	1. To have our self-concept and our reality affirmed in relationship 2. To maintain a stable and coherent sense of self	Self psychology (and intersubjectivity)
Self-enhancement	1. To be loved, praised, and cherished by important others 2. To think well of ourselves	Object relations
Self-efficacy/self-discovery	1. To grow and strive creatively 2. To learn more about ourselves 3. To develop more mastery over the world	Ego psychology, self-efficacy theory

human motive has been a cornerstone of Bandura's (1994) theory of *self-efficacy.* A good psychological assessment addresses such needs by providing clients with new information about themselves and more efficient ways of organizing information and life experiences they have already had. This was evident in the excerpt by Corsini (1984), quoted above. By providing his client with new information ("You have a high IQ"), Corsini allowed the man to integrate and make sense of a number of seemingly disparate occurrences, from what music he liked to why he excelled at crossword puzzles. This generated an exciting "aha" experience for the client and appeared to increase his sense of self-efficacy as well as his self-knowledge. We refer to this type of intervention as *naming* clients' experiences for them, and we have found that it furthers clients ability to communicate about their experiences (e.g., "I'm not just lazy, I'm depressed."), to see connections with other people (e.g., "Several friends I know have been depressed too."), to generate new solutions to problems (e.g., "If I take antidepressant medication, maybe I'll get more things done."), and to make more accurate predictions about the future (e.g., "If I get over my depression, I probably will be able to finish my college degree."). All of these factors address the human need for mastery and control over the environment.

Again, a collaborative approach enhances the sense of efficacy and self-discovery that can be derived from an assessment in that clients, with the aid of the assessor, find their own new words for and new understandings of problems in living. Rather than simply "handing" the client a more elegant and efficient self-schema, a collaborative assessor seeks to provide a set of test-based experiences, which form the basis for the client's developing a new self-schema (Finn, 1996; Finn & Tonsager, 1997). By enlisting clients as active participators in generating and testing hypotheses about their problems, collaborative assessment has the potential to increase a client's sense of control, relative to more traditional assessment procedures.

Summary. We believe that psychological assessment—especially when conducted in a collaborative fashion—is a powerful brief intervention, because it potentially addresses all three of these basic motives in a unique way. For example, any experienced therapist knows the difficulty of altering the self-esteem of clients with low self-esteem. Because positive comments given to such clients conflict with their existing self-concepts, they tend to disregard all praise and encouragement rather than experience the anxiety of revising their self-esteem (McNulty & Swann, 1991). In therapeutic assessment, we deal with this dilemma by asking clients with low self-esteem to pose questions about themselves at the beginning of the assessment. This engages their curiosity and gives them a sense of self-efficacy. We then look for opportunities during the assessment for them to observe and rate their own performance against an objective standard, satisfying their motive toward self-discovery. (For example, a client who remembers all nine figures from the Bender Gestalt is asked to look up her memory score in a table of norms to discover how well she performed.) In a feedback session with such a client, we would begin by discussing shortcomings in her personality of which she was already aware, thereby giving her an experience of self-verification. We would then move on to present more discrepant information (e.g., her excellent visual memory) while treating her as an essential collaborator whose opinions we value. In these ways, she would be more likely to assimilate and integrate positive attitudes about herself during the assessment.

Complementarity of Therapeutic and Information-Gathering Models

Although in a previous section we contrasted the information-gathering and therapeutic models of assessment, we believe that the two models are not mutually exclusive but that they complement and enhance each other. At this point, let us highlight the interdependence of the two models.

First, as may be obvious, many assessments simultaneously address informational and therapeutic goals; that is, clients may receive therapeutic benefit from an assessment that also helps to guide subsequent psychotherapy. By making minor changes in the assessment process, assessors can enhance the therapeutic effects of an assessment without compromising in any way the valid and reliable test information that is collected. For example, in therapeutic assessment, following the initial session in which clients and assessors work together to develop questions to be addressed by an assessment, assessors next administer the standardized tests needed to answer the clients' (and referring professionals') questions. Nonstandardized techniques are used later in *assessment intervention sessions* (Finn & Martin, 1997), which occur only after the standardized data are collected and with the goal of helping clients discover, on their own, the findings of the standardized testing.

Also, we agree with Fischer (1985/1994) that there are times when nomothetic descriptions of clients are all that is required from an assessment (e.g., in some forensic situations, for job placement, or in disability determinations). In such situations, where clients are often being involuntarily assessed, it seems

both unnecessary and unwise to attempt to achieve therapeutic goals; an individualized assessment approach is likely to be inefficient, costly, and ultimately frustrating for a client. However, in our experience with such assessment situations, some of the techniques of therapeutic assessment can still be applied (e.g., the ordering of test feedback according to its congruence with clients' self-concepts) and these techniques help facilitate goodwill between assessors and clients and keep clients from feeling ill-treated in otherwise difficult assessment situations.

Next, we strongly believe that for an assessment to be beneficial to a client, it must be based on sound data, accurate test interpretations, and a thorough knowledge of the research and psychometric principles underlying a test. Standardized tests that are reliable and valid help assessors develop empathy for a client's situation; they also provide nomothetic standards against which to gauge a client's performance. In our experience, some of the information clients find most valuable from an assessment is about how they compare to others, just as Corsini's (1984) prisoner was excited to learn about his IQ. Normative data can help clients "find their place in the world," thereby relieving anxiety and satisfying the motive for self-discovery. This is what makes psychological assessment so powerful in contrast to enterprises such as astrology and palm reading.

Last, we agree with a number of writers that the nomothetic and idiographic approaches to psychology need not be in conflict, but rather enhance each other (Cronbach, 1975; Tellegen, 1981). As expressed by Allport (1937):

> Psychology in the main has been striving to make itself a completely nomothetic discipline. . . . A psychology of individuality would be essentially idiographic. . . . It is more helpful to regard the two methods as overlapping and as contributing to one other. . . . A complete study of the individual will embrace both approaches. (p. 22)

Conclusion: Current State of Psychological Assessment and Future Directions

The applied practice of clinical psychological assessment is currently facing a major crisis. Less assessment is being practiced, fewer students are being trained in assessment, and a major area that once defined the identity of psychologists appears not to be highly valued by many practioners. Most writers who have commented on this crisis have related it to increasing restrictions on assessors by third-party payors. We agree that such pressures are an important part of the current context; however, many psychologists appear to value assessment less than psychotherapy. Also, convincing research about the utility of psychological assessment in planning treatments and enhancing outcomes remains to be published. Whereas such utility was widely assumed in the past, sophisticated and well-designed studies are now greatly needed.

We submit that an additional reason for the current crisis in clinical assessment is the overemphasis, until now, on the information-gathering function of assessment. If assessment is only a way to gather data to plan treatment, it seems doomed as increasingly sophisticated biological tests and information-collection methods (e.g., computers) are developed. Also, the information-gathering model of assessment views assessors as semiskilled technicians, a role which is not as challenging or exciting to most people as that of therapist.

If our conclusions are correct, one way to address the current decline in assessment would be for psychology, as a discipline, to devote more attention to a therapeutic model of assessment. Although the interventional value of assessment has been noted in passing by many clinicians and emphasized by a select few, such a perspective has been largely overlooked by researchers and academicians. Currently, we and several of our colleagues are attempting to articulate a comprehensive model of assessment as a brief intervention. This approach relies uniquely on the training and skills of psychologists to integrate nomothetic and idiographic data, generate and test hypotheses, and interact with clients. Therapeutic assessment requires a high degree of clinical skill as well as an excellent grounding in the science of psychological assessment. It marks a significant paradigm shift in clinical psychology, one that may be needed if clinical assessment is to survive as anything more than an esoteric curiosity.

We suggest that in the near future, more resources be devoted to studying the use of assessment as a therapeutic intervention. To date, we have concentrated on developing and pilot testing the clinical procedures underlying the use of psychological assessment as a brief therapy. This work has spawned rich hypotheses about the therapeutic mechanisms operating in psychological assessment and their relationships to other forms of psychotherapy. More clinical innovations may certainly be developed in the future. Also, our understanding of the therapeutic mechanisms underlying psychological assessment is likely to become increasingly sophisticated. However, at this point in time further research seems the top priority.

To date, controlled studies have demonstrated that in randomized trials, collaborative assessment is better than nonspecific supportive psychotherapy in ameliorating self-reported client symptomatology and self-esteem; this has been shown with U.S. and Australian university student clients. Future research should focus on explorations of external validity (e.g., generalizability to different types of clients, clinical problems, and assessors) as well as further tests of internal validity (e.g., comparisons of psychological assessment with other therapies or identification of specific treatment elements).

To bring such research to fruition, we as psychologists will be challenged to heal rifts between researchers and clinicians, experimentalists and individual-difference psychologists, assessors and psychotherapists, and between our heads and our hearts. We believe that a great deal is at stake and invite all who are interested to collaborate with us in this undertaking.

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