

- Wagner, E. E. (2008). Beyond "objective and "projective": A logical system for classifying psychological tests: Comment on Meyer and Kurtz (2006). *Journal of Personality Assessment*, 90(4), 402–405.
- Wechsler, D. (1997). *WAIS-III administration and scoring manual*. San Antonio, TX: Psychological Corporation.
- Weissman, M., & Bothwell, S. (1976). Self-report version of the Social Adjustment Scale. *Archives of General Psychiatry*, 33, 1111–1115.
- Westen, D. (1990). Toward a revised theory of borderline object relations: Contributions of empirical research. *International Journal of Psycho-Analysis*, 71, 661–693.
- Westen, D. (1991). Clinical assessment of object relations using the TAT. *Journal of Personality Assessment*, 56, 56–74.
- Westen, D. (1995). *Social Cognition and Object Relations Scale: Q-sort for projective stories (SCORS-Q)*. Unpublished manuscript, Cambridge Hospital and Harvard Medical School, Cambridge, MA.
- Westen, D., Klepser, J., Ruffins, S. A., Silverman, M., Lifton, N., & Boekamp, J. (1991). Object relations in childhood and adolescence: The development of a working representation. *Journal of Consulting and Clinical Psychology*, 59, 400–409.
- Westen, D., Lohr, N., Silk, K. R., Gold, L., & Kerber, K. (1990). Object relations and social cognition in borderlines, major depressives, and normals: A Thematic Apperception Test analysis. *Psychological Assessment*, 2, 355–364.
- Westen, D., Ludolph, P., Block, J. B., Wixom, J., & Wiss, C. W. (1990). Developmental history and object relations in psychiatrically disturbed adolescent girls. *American Journal of Psychiatry*, 147, 1061–1068.
- Westen, D., Ludolph, P., Lerner, H., Ruffins, S., & Wiss, C. W. (1990). Object relations in borderline adolescents. *Journal of American Academy of Child and Adolescent Psychiatry*, 29, 338–348.
- Westen, D., Ludolph, P., Silk, K., Kellam, A., Gold, L., & Lohr, N. (1990). Object relations in borderline adolescents and adults: Developmental differences. *Adolescent Psychiatry*, 17, 360–384.
- Whipple, R., & Fowler, J. C. (2011). Affect, relationship schemas, and social cognition: Self-injuring borderline personality disorder inpatients. *Psychoanalytic Psychology*, 28(2), 183–195.
- White, R. W., Sanford, R. N., Murray, H. A., & Bellak, L. (1941). *Morgan-Murray Thematic Apperception Test: Manual of directions* (Mimeograph, HUGFP 97.43.2, Box 5 of 7). Henry A. Murray papers, Harvard University Archives, Cambridge, MA.

CHAPTER 10

Developing the Life Meanings of Psychological Test Data

Collaborative and Therapeutic Approaches

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This chapter follows a different format than the earlier chapters in that it shifts from presenting the major tests through which we gather norm-based information to describing ways in which psychologists can use that data to access clients' actual lives. Traditionally, assessment reports have been test-oriented and technical (presenting test-by-test standing on various constructs and discussing the implications in conceptual terms for other professionals). Nevertheless, our literature has long called for client-oriented rather than test-oriented reports. Similarly, recent versions of the American Psychological Association's Ethical Guidelines and Code of Conduct (APA, 2010) have called on psychologists to present test findings in ways that the client can understand. These calls have been difficult to answer fully because of psychology's historically having identified itself as a natural science. Fortunately, psychology has fully demonstrated its status as a science and is now freer to pursue ways to explore those aspects of being human that do not lend themselves to positivistic philosophy nor to related laboratory methods. Psychology's recent joining with other social science and service disciplines in adopting qualitative research methods is part of our contemporary development, along with adopting the goal of *understanding* in those circumstances when *explaining* is not the most appropriate goal. Over the past two decades, several MMPI manuals (e.g.,

Finn, 1996b; Levak, Marks, & Nelson, 1990; Levak, Siegel, & Nichols, 2011) have included life-world ways to share findings with clients. At least two Rorschach computer interpretation programs, the RIAP (Exner, Weiner, et al., 2005) and the ROR-SCAN (Caracena, 2008) include client reports that present findings in everyday language and in terms of behavior and experience, as do reports for several other major psychological tests. And the new Rorschach Performance Assessment System (Meyer, Viglione, Mihura, Erard, & Erdberg, 2011) has the explicit goal of connecting Rorschach scores and indices to observable day-to-day behavior.

Before this chapter presents ways in which assessors can collaborate directly with clients to explore their actual lives, we want to acknowledge that, of course, often professionals do want a technical report from the assessor to aid their conceptual understandings. Many questions presented to assessors are readily answerable within our traditional categorical/normative approach. For example, "Is IQ high enough for a gifted student placement?" "Is this person psychotic?" and "Is there neurological impairment (and what sort and how severe)?" In addition, test data certainly help psychologists to think conceptually about clients' dynamics and their similarities to persons who carry various diagnoses, whether categorical or dimensional.

Our goal when we choose to individualize an assessment is to understand and describe the client in terms of his or her life world. We collaborate directly with the client in order to explore behaviors and experiences to which our test data and clinical impressions have provided access. The resulting understandings are truly individualized; they describe a particular person's ways of going about his or her life, when those ways do and do not

Quick Reference 10.1: Philosophical Assumptions of Collaborative and Therapeutic Personality Assessment

- For test development and categorical research, a hypothetico-deductive and logical positivistic frame is appropriate.
- For individualizing test findings, a life-world orientation is necessary.
- Test data are samples of the way a person goes about life.
- Collaboration with clients and their involved others provides a bridge into lived world instances and contexts of test data.
- The focus is on *understanding* how clients take up and shape situations rather than on *explaining* causes of behavior.
- Through collaborative exploration, clients experience themselves as having options, as being agents.

work, and what has already been learned about how the client can change course to meet goals and to bypass old hazards. This process in itself is therapeutic, in the sense that the client experiences himself or herself as deeply understood and accepted by another person (the assessor), as capable and as having viable options, and as having a new "story" about himself or herself that is more coherent, useful, and compassionate than the previous story.

Procedurally, psychologists who take a life-world approach to assessment ask the client what questions, beyond those of any referring party, he or she would like to explore via the test data. Some psychologists prefer to interview, gather collateral data, and study all test data before meeting with the client to explore "what in the world" their relevance might be. Some psychologists prefer to explore with the client initially after several tests have been scored and studied, and then again after further tests have been scored and studied. Initial discussions typically throw light on tests to be considered later. Typically, a concluding session with the client summarizes the understandings they've reached, any points on which they have agreed to disagree, and any concrete suggestions they have developed. These discussions differ radically from "feedback" sessions in which a psychologist unilaterally presents what he or she has gathered from the test data.

Some psychologists follow Steve Finn's model of Therapeutic Assessment. After studying all a client's assessment information, Finn arranges guided experiences (often with test material, such as TAT cards which the client has not already encountered) during which the client will come upon, on his or her own, new insights that were suggested to Finn in the test data. Finn calls these sessions "assessment intervention sessions," for which one goal is to provide deep and memorable experiences for client, ones that yield insights way beyond conceptual discussion.

Whatever the logistics, the psychologist shares impressions as such with the client, allowing them to be corrected, affirmed, revised, and expanded. In this process, the assessor learns and uses the client's language, collects life examples of test data, and explores with the client the circumstances under which these examples occurred and the circumstances in which they have not occurred (when-nots). The client often learns that he or she can transform troublesome circumstances into ones that in the past have allowed constructive action. Reports can be written directly to clients as itemized responses to questions raised, with accompanying suggestions. These reports are intended as reminders for the client of material already discussed. Additional reports for professionals usually spell out the data that grounded assessment explorations; these reports are readable by the clients, who often receive their own copy, at that point recognizing their lives in the more technical report.

Although our practices are based in large part on our clinical experiences and theoretical understandings of psychological assessment and human nature, independent studies support these methods. Hence, before illustrating our particular approaches, we will review the current research.

Research on Collaborative Assessment Practices

Interactive vs. "Delivered" Test Interpretations

A fairly large body of research exists—mainly from counseling psychology—that compares different methods of providing assessment feedback to clients (cf. Goodyear, 1990, for a review). Although some controversies remain, many group comparison studies have shown collaborative/interactive discussions to be superior to those approaches where test findings are unilaterally presented by assessors with minimal client involvement (e.g., Rogers, 1954; Hanson, Claiborn, & Kerr, 1977; El-Shaieb, 2005). In short, clients rated interactive sessions as deeper, more satisfying, and more influential than those where feedback was "delivered" by the assessor to the client.

Ordering of Information in Feedback Sessions

One study examined Finn's (1996b) assertion that it is important to "tailor" for each client the order in which assessment results are presented in a summary/discussion session and to gradually present information that is discrepant from clients' self-views at the beginning of the assessment. Schroeder, Hahn, Finn, and Swann (1993) assessed a group of students, all of whom first received test feedback that was congruent with the way they saw themselves. Next, one subgroup was given feedback that was mildly discrepant, while another was given information that was highly discrepant from the way they saw themselves. Those who received congruent feedback followed by mildly discrepant feedback rated their assessment experiences as more positive and more influential, both immediately after feedback and at a two-week follow-up, than did individuals in the second group.

Oral vs. Written Feedback

To our knowledge, only one study exists that bears directly on the typical practice of collaborative assessors' providing clients with written as well as oral feedback at the end of an assessment. Lance and Krishnamurthy (2003) compared three groups of 21 clients, each assessed with the MMPI-2 and given feedback according to Finn's (1996b) collaborative guidelines. One group received oral feedback, one only written feedback, and the third both written and oral feedback. In general, the combined feedback condition was superior to the others—those clients reported that they learned

more about themselves, felt more positively about the assessor, and were more satisfied with the assessment than did clients in the other two groups.

Collaborative Compared with Noncollaborative Assessment Preceding Psychotherapy

Hilsenroth and his colleagues conducted an important body of research concerning the differential effects of collaborative and noncollaborative psychological assessment just before clients enter psychotherapy (where the assessor subsequently continues the clients' treatment). One of the first studies (Ackerman, Hilsenroth, Baity, & Blagys, 2000) found that clients who received a collaborative assessment were less likely to terminate before their first formal therapy session compared with those who received a traditional, noncollaborative assessment (13% vs. 33%). In fact, later studies (Hilsenroth, Ackerman, Clemence, Strassle, & Handler, 2002; Hilsenroth, Peters, & Ackerman, 2004; Hilsenroth & Cromer, 2007) have clarified that collaborative assessment enhances clients' positive alliance to the clinician and that this alliance is more predictive of clients' alliance to the therapist later in treatment than is the alliance they feel in early therapy sessions. This research underscores the lasting impact that collaborative assessment can have on the client/therapist interaction.

Collaborative Assessment as a Therapeutic Intervention in Itself

Assessment of Adults. Finally, multiple studies now document that collaborative psychological assessment can produce therapeutic benefits for adult clients. The first body of research involves group comparison designs using randomized control interventions. Finn and Tonsager (1992) found that—compared to a wait-list control—clients at a university counseling center who took part in a collaborative MMPI-2 assessment showed reduced symptomatology, higher self-esteem, and greater hope about addressing their problems in the future. Newman and Greenway (1997) independently replicated these findings in a sample of Australian counseling center clients, with very similar results. Allen, Montgomery, Tubman, Frazier, and Escovar (2003) found that students receiving individualized, collaborative feedback about the Millon Index of Personality Styles (Millon, Weiss, Millon, & Davis, 1994) showed increased self-esteem and rapport with the assessor, compared with students in a control group that did not receive feedback.

Aldea, Rice, Gormley, and Rojas (2010) studied the effects of collaborative assessment on a group of students identified through pre-screening as maladaptive perfectionists. Students were randomly assigned to two groups; one ($N = 34$) was given collaborative feedback on the Almost Perfect Scale-Revised (APS-R; Slaney, Rice, Mobley, Trippi, & Ashby, 2001), while the other ($N = 25$) received attention only. Findings revealed that

providing APS-R feedback to maladaptive perfectionists reduced self-reported global symptomatic distress as well as emotional reactivity.

Morey, Lowmaster, and Hopwood (2010) were interested in whether the addition of a pre-treatment collaborative assessment would produce differential effects in 16 patients diagnosed with borderline personality disorder who were treated with Manual Assisted Cognitive Therapy (MACT; Tyrer et al., 2004). A group receiving collaborative assessment prior to MACT showed somewhat greater clinical improvement—specifically a greater decrease in borderline features and in suicidal ideation—than the group receiving MACT alone.

Essig and Kelly (2013) studied the effectiveness of traditional information-gathering assessment versus therapeutic assessment in a group of 23 students seeking help for career indecision at a large university counseling center. All students participated in two-hour assessments using the Strong Interest Inventory (SII; Donnay, Morris, Schaubhut, & Thompson, 2005). Students in the therapeutic assessment condition ($N = 11$) showed evidence of a more positive vocational identity after the intervention than did students in the information-gathering condition ($N = 12$), with a medium to large effect size.

In 2010, Poston and Hanson published a meta-analysis of studies examining the therapeutic benefits of providing clients with individualized feedback following a psychological assessment. Despite the varying quality of the studies Poston and Hanson examined and the different outcome variables and ways that feedback was approached, the resulting effect size was noteworthy (.42). This figure clearly indicates that clients experience benefits from receiving collaborative feedback about their assessments. Poston and Hanson concluded,

Clinicians should . . . seek out continuing-education training related to these models [of collaborative and Therapeutic Assessment]. Those who engage in assessment and testing as usual may miss out, it seems, on a golden opportunity to effect client change and enhance clinically important treatment processes. Similarly, applied training programs in clinical, counseling, and school psychology should incorporate therapeutic models of assessment into their curricula, foundational didactic classes, and practica. (p. 210)

In addition to group, randomized control studies there are also now a number of published single-subject experiments examining the effects of collaborative assessment with adult clients. Aschieri and Smith (2012) examined the effectiveness of a five-session Therapeutic Assessment (TA) for a woman with a history of trauma who was experiencing academic, self-esteem, and interpersonal problems. Time-series analysis revealed

significant improvements in the woman's daily ratings of *anxiety*, *loneliness*, *recognition of love for herself*, *recognition of love for others*, and the degree that she was *hard on herself*.

A second study (Tarocchi, Aschieri, Fantini, & Smith, 2013) involved an adult woman with a history of repeated interpersonal trauma who had sought treatment for complex posttraumatic stress disorder. The results indicated that the client's self-reported loneliness and despair were significantly reduced during a TA. The woman's anxiety also decreased, although the change only approached statistical significance. The effects were maintained over a two-month follow-up period.

Smith and George (2012) evaluated the effects of participating in a TA and later continuing in psychotherapy with the same clinician. The client was a middle-aged woman who was experiencing troublesome anxiety and depressive symptoms following a successful treatment for metastatic cancer. The woman had a significant reduction in her symptoms immediately after she began the TA. The significant improvements the woman experienced during the assessment were maintained during the subsequent four months of biweekly psychotherapy.

Assessment of Children and Adolescents. Multiple studies have also examined whether collaborative psychological assessment can have a positive impact on children, adolescents, and their families. In a study of an eight-session TA intervention, Tharinger et al. (2009) followed 14 latency-aged children as they and one or more of their parents participated in an assessment. Results showed decreased symptomatology in children and their mothers following the Therapeutic Assessment, as well as decreased conflict and increased communication and cohesion within the families, as rated by both the children and the mothers. (There were not enough fathers to examine changes in fathers.) Also, mothers had more positive feelings about their children and fewer negative feelings after the assessment as compared to before.

Newman (2004) looked at the effects of a brief collaborative assessment with teens who scored high on a screening measure of psychological distress. One group ($N = 18$) were interviewed, took the MMPI-A, and received collaborative feedback. A comparison group ($N = 18$) received five sessions of cognitive-behavior therapy for depression. Those receiving MMPI-A feedback showed a significant decrease in depressive symptomatology and an increase in self-esteem following the assessment, as compared to those in the control group.

Finally, there are also a number of single-subject case experiments involving TA with children and their families. A first study examined the effectiveness of TA for a family with a 9-year-old boy referred for disruptive behaviors and anger outbursts (Smith, Wolf, Handler, & Nash, 2009).

Analyses revealed a significant decrease in parent ratings of the intensity of the boy's worst outburst compared to baseline levels from before the TA. The effectiveness of participating in TA appeared to have continued to grow during a relatively brief (40-day) follow-up period, as shown by significant reductions in the intensity of his worst outburst and in the degree of his hateful behavior directed at his mother.

In this next study, Smith, Nicholas, Handler, and Nash (2011) presented the case of a 12-year-old boy whose parents were concerned about his self-esteem and academic achievement. The boy's father was the only parent able to be involved. There were highly significant changes in the boy's problem behaviors during the 60-day follow-up period, as shown by a notable Pearson's r effect size of .708. Furthermore, analyses showed that the family session with the boy and his father was a turning point in the assessment. Although the boy's behavior had been steadily worsening before the family session, afterward it steadily improved. These results suggest that the family intervention session plays a vital role in the change process in child TA, perhaps especially in those families in which there is a large systemic component of the child's difficulties.

Smith, Handler, and Nash (2010) conducted a series of TA interventions with families of preadolescent boys who met diagnostic criteria for oppositional defiant disorder. Analyses revealed that by the end of the study period, which included a pretreatment baseline, the TA, and a two-month follow-up, each of the families reported statistically significant change on a composite measure of *family distress* and *child symptomatology*. However, one family appeared to have improved very early in the TA, a second family experienced change later in the TA, and the third family realized improvements in the two months that followed the completion of the intervention. These findings are in line with the experience of many clinicians practicing collaborative assessment with children—that is, different families seem to benefit most from different parts of the assessment.

Case Illustrations

In the following section of this chapter, Constance T. Fischer provides a variety of examples of discussing tests with clients throughout the assessment. Then Stephen Finn provides a detailed case example illustrating both a planned assessment-intervention session and how the intervention informed a summary/discussion with a client. Complete recordings of our assessments would show that Finn does some discussion with clients along the way and that Fischer often includes interventional exercises along the way. In the following excerpts, the bracketed T scores and Rorschach scores and ratios illustrate how these data can be cited for professional readers; where

explanations are not provided, familiarity with these kinds of data is not necessary to follow the excerpts. We will close the chapter with a section that addresses questions that often arise in our presentations and workshops. In the meantime, please note that there is no “right way” to take up these practices.

Collaborative, Interventional Assessment Across Sessions (Constance T. Fischer's Approach)

Custody Evaluation: John Russell. Mr. Russell and his wife were referred by our Family Court for a custody evaluation. I interviewed each parent alone first to gather background information, then again after I had scored the MMPI-2 and 16 PF. I interacted separately with the children, then met with each parent for a discussion of what I planned to say in my report. Along the way, I telephoned three persons named by each parent as “collateral” sources (i.e., persons familiar with one or both parents). I also met each parent with his or her current involved other. As is typical of couples who are mandated by the court for custody evaluation, both parents were initially intent on proving that they were wonderful and that the other was unfit. With the parents' permission, I often discuss test patterns in the meeting that includes the involved other. The following excerpt is from a meeting with Mr. Russell and his girlfriend, Grace.

CF: If at any time you'd rather not continue talking about your test profiles while Grace is here with us, just let me know. [Both persons nodded at each other and to me]. Alright, this is your profile from the test with all those true/false items. [I hold out the MMPI-2 profile so all three of us can view it.] Most people score between these two lines, as you did for most of the scales. Now this blip [MMPI-2 scale 4 = 67T], as you see, is much higher compared with your own other scales and with other people. I'll bet it will help us to understand a difference in opinion that you and your wife have. Hang in here with me while we explore that issue of whether you become angry and whether the kids become frightened of you sometimes. [Mr. Russell stiffens; Grace looks interested.] Yes, this scale's [4] height often reflects that a person frequently feels angry, held back, treated unfairly. [Grace glances at Mr. Russell; he cocks his head.] But look at this other scale [L = 61T]. It can get this high in several ways; one way is typical in these custody evaluations, which is that the person is trying to look good—which shows good sense under the circumstances. [We all nod.] But it also can become this high when a person has very strong moral standards, such as yours. When I was reviewing your pattern, this combination reminded me of when you took this test: You filled in each circle with

very dark penciling, through the whole thing. When I checked on you, you complained that the items weren't relevant to parenting and that you had to get back to your office. You were not a happy camper! [I motion for Mr. Russell to hold his protest for a moment.] But you had agreed to take the test, so you did, without leaving out even a single item. At this point I'm inclined to agree with you that you rarely lose your temper, in part because doing so is against your beliefs. But I think that others sometimes can see that you're restraining yourself from acting in an angry way, and that can be frightening to them. I confess that I felt uncomfortable when I checked in on you.

Mr. Russell [glaring]: Did you expect me to hit you or something?

CF: No, definitely not. But at that time I would not have been surprised if you had stormed out without finishing the test, although I now know that you, being you, would not have done that.

Mr. Russell: Of course not. [Grace nods.]

CF: Still, I was a bit confused, not sure what you were going to do or what I should say.

Mr. Russell: But you're the doctor!

CF: Exactly! So you can imagine that your kids, or even Grace, would sometimes . . .

Mr. Russell [looking a bit softer, more vulnerable]: Is this what you [Grace] were trying to tell me last night?

Grace: Yes, honey, exactly. It's what I meant when I said last night that I wish you would say out loud when you're in turmoil [she uses a hand gesture she apparently had used before] and let me know that you'll talk about it later and that it's not about me—or it is.

Later, when I was summarizing with Mr. Russell by himself all that we had covered, we settled for agreeing to disagree about whether he very often was "in turmoil" when he was with the kids. I told him that I would say in my report that I never found a way to describe that circumstance in a manner that he could agree with, but that I still thought that something like inner protest was happening for him when the kids reported being frightened. I said that I would include in my report that I thought he was now more open to observing himself for signs of being "in turmoil" and that I had suggested that he compare any questionable state with the experience he had of sitting in the room in my suite, being most unhappy with the MMPI-2 but gritting his teeth to live up to his agreement to

complete the test. I said that I would suggest that, even though *he* knew he would not be violent in any way, he ask himself at such times whether someone seeing him might sense his tension and be unsure of how he might behave.

Assessment at the Beginning of Therapy: Ralph Tanner. At the end of a psychotherapy intake session in my private practice, I told Mr. Tanner, a 28 year-old data processor, that I was glad he had called me, that his situation was making sense to me, and that I'd like to start our next meeting with an experiment that would help me further understand him and that I thought we probably could develop some ideas for him through the experiment. I explained that I would show him some pictures (TAT) and ask him to make up stories about the pictures.

CF [after administration of three cards]: See if you can tell a story where there are no bad guys.

Mr. Tanner: I didn't say anybody was bad.

CF: No, actually you didn't. What would you say these people had in common in your stories? [I spread out the three cards and pointed to the relevant character in each as I read aloud from my recording of his stories.] "She's wondering what scheme he's up to" (Card 6GF: woman looking over her shoulder at man); "This one is following her sister, who has left the party and is racing to secretly meet this sister's lover" (Card 9GF: young woman behind tree looking at another young woman running); "He has successfully eluded the crooked FBI agent and is surveying out the window" (Card 14: silhouette of man in window).

Mr. Tanner: People do have to be alert to other peoples' motives!

CF: Yes, your alertness has often helped you.

Mr. Tanner: Damned right!

CF [nodding]: On the other hand, if you always assume that people are conniving [Mr. Tanner: "What?"]—scheming—[Mr. Tanner nods] then friendship and teamwork aren't likely to happen. And you're likely to feel "left out" [Mr. Tanner's complaint via a sentence-completion form he filled out at home].

Mr. Tanner: Well, that's life.

CF: Yes, it can happen. But let's continue the experiment. Are you up for it? [Mr. Tanner gestures weakly "I guess so."] Okay, thanks. On the next picture, how about making up a story where nobody is scheming? On this one that might be difficult, but give it a try [Card 17BM: man climbing rope].

Mr. Tanner: This guy *has* to scheme!—he's escaping over a prison wall.

- CF: Okay, that story certainly would call for lots of defensive planning. [Mr. Tanner lightly pounds the desk and says "Damned right."] Continuing the experiment, imagine a whole different scene.
- Mr. Tanner: That's clearly the story! You tell me if you can find a different one.
- CF: Okay, how about he's in a gym class and he finally beat his own time in climbing to the top of the rope?
- Mr. Tanner: All right. He's looking down to see if somebody is trying to grab his foot and keep him from claiming his little victory.
- CF: Geez! What's wrong with a happy story?! See if you can come up with a happy ending. He's just made his fastest time; maybe say how he feels . . .
- Mr. Tanner: Well, proud, I guess.
- CF: Yes! [Mr. Tanner grins a bit triumphantly himself, but then looks as though he's about to add a vigilant observation.] No, don't go there! [Mr. Tanner looks understandably startled; we both laugh.] Please tell me what it's like to stay with this guy's celebration.
- Mr. Tanner: [glancing over to read my expression]: Not safe; uncomfortable; I don't like this. [He looks at me quizzically.]
- CF: As you say, "Damned right." But you bravely tried the experiment, and now we both know that you can imagine positive outcomes, and that you can risk trusting, often with rewards. You just trusted me with the experiment and trusted yourself. [We're quiet for a while.] Would you tell me another example of when you trusted both yourself and the other person?
- Mr. Tanner: I don't know why, but I've been sort of seeing a picture in my head of when Petey—that's my older brother—used to hold my hand when we crossed the street. [I nod somberly; we're quiet.]
- CF: Such a fine memory!

I thanked Mr. Tanner for trusting me enough to for us to go so far. I said that I imagined that in our therapy work we would explore ways he could "try out" situations instead of automatically being "paranoid" [his word]. My clinical notes indicated "paranoid organization, but not profoundly fixed."

Before our next meeting, he completed the PAI. During our psychotherapy meetings, we both sometimes spoke of Mr. Tanner's "peak score" (PAI Par-H = 71T) and "peaking," and both of us sometimes opined that we should see whether there could be "another story."

Quick Reference 10.2: Typical Steps of a Collaborative/Therapeutic Assessment (Multiple Sessions)

- Obtaining background from the client and any referring party on the issue(s) and agreeing on goals of the assessment
- Acquiring test data and collateral information
- Discussing early data with the client, sometimes leading to client insights and sometimes to alternative actions/reflections that the client might pursue on later occasions
- Consulting test manuals, journals, theories, research, and so forth, in conjunction with personal impressions and background information, to revise current understandings
- Meeting with the client (sometimes jointly with an involved other) to collaboratively explore the psychologist's current impressions in life-world terms
 - Starting with what the client already has said, and moving on to areas he or she has not been focally aware of
 - Using the client's language rather than jargon
 - Attending to contexts of test behavior and life behavior
 - Revising understandings in light of the client's input
 - Looking into "when-nots" of problematic behavior to find starting points for clients to shift course
- Arranging a closing intervention calculated to allow the client to come to lived insights on his or her own [this step occurs most in Therapeutic Assessment]
- Summarizing with the client (sometimes accompanied by an involved other) what has been learned and what the client's next steps might be

Self-Referral: Emanuel Baumeister. Twenty-eight-year-old Mr. Baumeister asked if he could be tested for whether he would be likely to profit from psychotherapy. We came to agree that he was vaguely dissatisfied with life but did not want therapy to make him sad or to tell him that something was wrong with him, especially if it was something that could not be fixed. Mr. Baumeister confided that his girlfriend said he should tell me that he is a warm person but that he is not affectionate or expressive. We later agreed that his request that I call him "Manny" was an instance of his warmth.

During the Rorschach inquiry, I noticed that several times when I expected to score CF (color dominates form—e.g., Card IX: "Oh wow! A flower!" and Card X: "Fireworks. Yes, like on the Fourth of July."), instead I could score only *F* or *m* (form or inanimate movement) in light of the inquiry (Card IX: "Yes, this would be the stem. Here's leaves, and this would be—they're called 'petals,' right?"; Card X: "There's so much going on, moving outward and

down, like stuff falling to earth.") The following exchange occurred immediately after the completion of the Rorschach inquiry:

CF: Manny, I think I just had a glimpse of what Angela sometimes has experienced with you. I would guess that at those times she's attuned to your being emotionally enthused about something but then you've backed away into a relatively factual position, leaving her confused and disappointed.

Manny: How did you get that? Somehow it's true.

CF: I think that an example was "Oh wow! It's a flower!" [I imitated his enthusiasm], followed by just a factual [I imitated his tone] naming of flower parts. Could you please tell me an example with Angela?

Manny: [after some skirting around the issue]: I'm not sure this is an example—

CF: Go ahead.

Manny: —but it seems like last weekend. I called her from work and said let's meet at our favorite Thai restaurant, and I'd bring her favorite pinot grigio. We were both enthusiastic, but when we met there, I kind of turned away from her beginning to hug me. Angela said I just started talking about a computer problem at work.

Our discussion went in predictable directions, exploring other times he had "turned away" from being close to someone, and when he had *not* turned away, and exploring his feeling safer talking about factual matters and work rather than being openly affectionate, especially in public. Then I asked him to tell me about the flower again, this time trying to continue and to share his initial delight. He hesitated, saying he now felt vulnerable, just as he had during the inquiry.

CF: [thinking about no COP, no H but 2 (H), and two responses that verged on FT (no cooperative interaction, only fictional humans, and two responses that verged on including texture), along with my having witnessed moments I took to be of uncertain openness as he looked to me but then pulled back]: Yes, I think you're right on! And being vulnerable has to do with wanting to connect with Angela, and for that matter with me—differently, but then becoming scared that if you leave your familiar world of logic that . . . [Pause.] That what?

Somewhat to my surprise, given an MMPI-2 scale 6 (paranoia) of 61T (but also a scale 2—depression—of 64T) and a minimally answered sentence completion form, Manny waded into a description of his fears and anguish. I asked what he thought I would say about his self-referral question; he

grinned abashedly and said, "You would tell me that just as I found that I could talk with you, I would find that I could talk with a therapist. [Pause.] And I would be relatively safe." I gave him a thumbs-up, and for a couple of moments we both quietly enjoyed the success of our hard work. I offered him the names of several therapists with whom I thought he could work safely and productively. As I saw him to the door, with a smile I challenged him to call Angela and tell her that although he was a bit scared and might be awkward for a moment, that evening he would tell her his insights from our meeting.

Four years later, Manny contacted me for what turned out to be three follow-up sessions to explore a couple of other topics we had touched on. He reported that after participating in a couple of months of therapy himself, he and Angela had attended half a dozen couples therapy sessions and found them very helpful. They had married, and he was much closer to her and more comfortable in social situations generally.

Example of Assessor Being Corrected: Ms. Marie Pasquale

Ms. Pasquale, a middle-aged widow and department store sales clerk, helped me understand how test results reflected aspects of her daily life.

CF: I wonder if sometimes you've overreacted, with consequences you didn't intend? [e.g., Zd = -3.5; FC: CF+ C = 1:2]

Ms. Pasquale: Well, I imagine so, but not as an adult. [Long, quiet pause.] Sometimes other people don't like the consequences I intended.

CF: Oh? Could you think of an example to help me understand?

Ms. Pasquale: Like yesterday, when the college boys in the apartment next to me started to party, I immediately pounded loudly on the wall. I figured they'd mutter nasty things about me, but it worked. "React fast so things don't get out of hand." I'm quite a bit more restrained when it involves a boss, a policeman, or an old person.

CF: Thanks. That helps!

Summary and Suggestions From a Report (Suicidality Evaluation: Mr. Amed)

Summary. Mr. Amed was referred by his physician for assessment of suicidality. I expanded the assessment to consider his judgment, the character of his depression, and his life circumstances. His wife, Mrs. Amed, was a helpful resource via telephone. All sources of data—interview, direct observation, tests (sentence completion, Bender-Gestalt, MMPI-2, Wechsler subtests, Rorschach)—were consistent with the following concluding

impressions. At our closing summary session, the Ameds were in agreement with these impressions and helped refine the suggestions that follow this section of the report.

Mr. Amed's physician's concern about self-harm is well-placed. Mr. Amed at first denied being suicidal in that he had not imagined, let alone planned, such a course. He did not like the term "depressed," but eventually he agreed that such a term fit his self-descriptions of feeling bogged down, no longer being his usual energetic self, and being preoccupied with the possibility that he might lose his restaurant. His wife's unwavering support and assurances paradoxically have played into his sense that he is not the protector he used to be. At our second session, Mr. Amed and I agreed on the term "despondent." As he has become ever more despondent, he has not taken actions that are necessary for rescuing his restaurant.

Terminal self-harm is possible in two ways: (a) Not attending to safety, as when he thoughtlessly stepped in front of a bus last week (and was yanked back to the curb by a bystander); (b) bursting into action, as he used to but now without proper attention to the big picture—for example, perhaps on impulse driving off a cliff.

Suggestions. 1. Mr. Amed has agreed that he will return to his physician to complete medical tests and to discuss medications that might help him sleep and to get back to his usual, more energetic self. I explained that medications can take weeks to be effective, but that just having taken the actions of conferring with his physician and with me most likely would relieve a bit of pressure. We agreed that he is not "mentally ill," but that he is despondent and thereby is at risk for making poor decisions (or for not making any decision).

2. He tentatively agreed to allow his older brother to help him evaluate his business situation and to help him to make some hard decisions. Mrs. Amed pointed out that it is insulting to the older brother to not allow him to help in the same way that Mr. Amed helped his younger brother several years ago. I suggested that Mr. Amed was not demeaned by allowing me (a woman) to consult with him and that, likewise, accepting help from his wife in their case is not demeaning but rather allows her a chance to honor his years of taking responsibility for the entire family.

3. Mr. Amed rejected my suggestion that he contact a psychologist for short-term support as he gets back to his "position of strength." He is considering agreeing to talk with a revered uncle if his wife tells him that she has become worried about his remaining so despondent that his judgment may be questionable.

4. I promised to mail two copies of this report, with the Summary and Suggestions highlighted, to the Ameds, so both of them could review our ideas and agreements whenever they wished.

Quick Reference 10.3: Report Options

- Letter to client summarizing discussions (narrative account or bulleted issues/questions with agreed upon findings and suggestions)
- Written or verbal report to another professional with the above material but including test data of interest to that professional. The client may also receive this report.

The above reports include:

- Everyday language and concrete examples
- Description of discovered contexts of problematic behavior, and the "when-nots" of that behavior
- Itemized concrete suggestions already explored with the client
- Any agreements to disagree
- Any additional suggestions to report-readers (usually already mentioned to the client)

Therapeutic Assessment: Assessment Intervention Sessions and Summary/Discussion Sessions (Stephen Finn's Approach)

Although the following case was hardly typical, involving an involuntarily referred client and a very challenging assessment intervention session, I (Stephen Finn) present it because it illustrates well the combined impact of assessment interventions and summary discussion sessions.

Background. Mr. Peters was referred for a psychological assessment by the executive vice president of his nationally known high-tech corporation, who reported that Mr. Peters was being considered for promotion to a very high-level position. His superiors were impressed and satisfied with almost all aspects of Mr. Peters's work, but they were concerned about one thing. Mr. Peters's supervisees reported that he had a violent temper at times and that he had been emotionally abusive to them recently. Apparently, Mr. Peters had felt embarrassed at a high-level meeting when it became clear that he was unaware of an important piece of information that everyone else in the room knew. His work team said that after the meeting he had confronted them about not giving him the information he needed, insulted them, and threatened to fire them all. Mr. Peters denied these allegations, saying that he had expressed anger on this and other occasions, but that it had been within appropriate bounds and never abusive. The promotions committee was unwilling to recommend Mr. Peters for advancement unless it was determined either that his anger was not a problem or that it was in fact problematic, and that he was aware of this and working to remedy it. I agreed to assess Mr. Peters and answer one question for the executive vice president: "Is Mr. Peters's anger at times abusive, and, if so, is he willing to

acknowledge this and work on it?" The executive vice president agreed that all other results from the assessment would be confidential between Mr. Peters and me.

Early Assessment Sessions and Preliminary Test Results. Mr. Peters impressed me as suave, intelligent, and dapper; he came to our first meeting impeccably dressed in an expensive suit and easily discussed the reason for the assessment. He said he was aware of the referral question from the executive vice president and that he was sure I would find out this "was all a misunderstanding." After some discussion, in which he denied that his anger was ever abusive, he was willing to acknowledge that even if it wasn't, other people seemed to be unsettled by it at times. He then posed his own main assessment question: "Why are people so frightened of my anger at times?" I was encouraged by this flexibility in his thinking and was left with the impression of a talented, confident man who thought well of himself and did not suffer fools gladly but who was respectful and not overly arrogant (at least with me).

Mr. Peters willingly completed the MMPI-2 after our first meeting, and his basic scale profile was completely within normal limits, except for a slight elevation on K (64T), Scale 5 (64T), and Scale 6 (64T). Examination of the Scale 5 and 6 component subscales revealed that Mr. Peters's slight elevation on Scale 5 was accounted for mainly by Mf2 (Hypersensitivity/Anxiety; 69T, Martin & Finn, 2010) and the elevation on Scale 6 was accounted for mainly by subscale Pa2, Poignancy (72T). These results suggested to me that Mr. Peters was a highly sensitive man but did not wear his feelings on his sleeve and that he might easily take offense or feel humiliated by others. I also wondered whether he struggled with a level of anxiety of which he was unaware.

In our second session, I administered the Rorschach. Mr. Peters clearly found this a difficult and trying experience. He seemed unsettled by his inability to know what a "good" answer was and by the possibility that I might be judging him, frequently commenting that he wondered what I must be thinking of him and his responses. Especially during the clarification phase, he grew rather short with me; several times he demeaned the test, commenting at one point that he didn't know how I was going to draw any conclusions from such a "bunch of foolishness." After the administration, I initiated a discussion of his experience. He admitted to disliking the test, and he softened slightly when I said that many people find it frustrating. But when I wondered aloud whether he might have felt vulnerable to not knowing what his responses revealed, or whether he might have felt "one-down" or "out of control," he denied my interpretations and focused instead on the shortcomings of the test. I even asked him to consider a

deeper meaning of his last Rorschach response—"a mask with holes in it"—but he would have none of this.

When I scored the Rorschach, some of my earlier hunches seemed supported by the data. Mr. Peters appeared to be extremely resourceful, intelligent, and talented ($EA = 27.5$, $DQ+ = 17$), with a certain vulnerability ($Fr = 2$) that matched aspects of Gabbard's (1989) description of the "hypervigilant narcissist." The Rorschach suggested Mr. Peters was using his considerable psychological strengths and a degree of intellectualization ($2AB+Art+Ay = 7$) to manage a great deal of underlying painful emotions, including shame ($V = 3$), depression ($DEPI = 5$), and anxiety ($Sum Y = 5$). Although generally, this accommodation worked well for him ($AdjD = +1$), he seemed vulnerable to occasional lapses in his ability to cope ($D = 0$, $m = 4$, $FC/CF+C = 6/6$). I noted his hypervigilant style (HVI positive, $Cg = 6$) and hypothesized that he wasn't prone to lean on others emotionally when he needed help ($GHR/PHR = 6/5$; $T = 0$; $Isolate/R = .34$). I suspected that Mr. Peters was under considerable stress due to his being considered for promotion and that he might indeed lose emotional control at times when his self-esteem was threatened. However, I was puzzled about how to help Mr. Peters grasp these concepts, given that he had been so dismissive of the Rorschach after our last session. Thus I felt that an assessment intervention was in order.

Assessment Intervention. One of the goals of an assessment intervention is to bring clients' problem behaviors into the assessment room, so that they can be observed, understood, and possibly solved by the assessor and the client working together. Another goal is to help clients discover new things about themselves that the assessor has tentatively gleaned from the standardized testing, so that the client comes to "own" these new insights and thereby assimilate them on a deeper level. I had a hypothesis about how to introduce Mr. Peters to his emotional soft spots, and although I was aware of the risk of overwhelming him, I was also emboldened by the fact that he had considerable psychological strengths and showed a certain flexibility of thought in our first session. I also knew that a great deal was at stake for Mr. Peters in this job promotion, and I wanted to do anything I could (within reason) to help him understand the executive vice president's reservations.

When Mr. Peters arrived for the next session, I told him that we would be doing "a very important test" and that it "could have a lot to do with my report" to the executive vice president. I then proceeded to give him the Block Design subtest of the WAIS-III. I administered in order the first six designs (4–9)—all of which use four blocks. As I expected, he did these effortlessly and quickly, earning full points. I then jumped to the hardest design, which uses nine blocks and has no black guidelines on the design

card, but I gave Mr. Peters only seven blocks. He worked on the problem for about a minute, then said, "It can't be done. It takes more blocks." I then lied, "No, this is the crucial part of this test. See what you can do with the blocks you have." Mr. Peters looked upset, but kept trying for about a minute, then protested again that he needed more blocks. Once again, I said, "Just keep trying," implying that there was a solution. He appeared to grow more and more frustrated, and after a while I pointedly clicked my stopwatch and said, "Well, you didn't get that one." I started clearing the test materials away, and the following dialogue ensued:

- Mr. Peters:* I tell you, that one was impossible to solve.
SF: Are you so sure?
Mr. Peters [angrily]: Damn right I am. If there's a solution, I want you to show it to me!
SF: I can't do that.
Mr. Peters: Why not?
SF: Because you're right, you didn't have all the information you needed [putting two more blocks on the table and looking right at Mr. Peters].
Mr. Peters [turning red in the face]: Why, you fucking sadistic asshole! So was this—this was just about making me feel like an idiot?! You get a hard-on from making other people feel like pieces of shit! Well, I don't have to put up with this [stands up, take his coat, and starts to leave]—you can just take this evaluation and stick it up your ass!
SF: Wait, please. Mr. Peters. You're right that I misled you. And I know that felt humiliating. But really, I didn't do it to be sadistic or cruel. I wanted you to see something. Please sit down. I'm really sorry to put you through this, but I didn't do it for nothing. [He sits back down and looks at me, fuming.] Now just listen to me for a minute. How would you describe your behavior just a moment ago?
Mr. Peters [defensively]: What do you mean?
SF: If you had to describe how you just acted, what would you call it?
Mr. Peters: Justifiably angry!
SF: Of course. And would you say you were abusive?
Mr. Peters: No, of course not! You deserved it!
SF: I know you felt that. But in a business context, wouldn't it be considered inappropriate to call someone a

- "fucking asshole" or tell them to stick something "up their ass," even if you were justifiably angry?
Mr. Peters: I guess so [appearing curious and looking a bit calmer].
SF: You agree? [He nods.] And was this the kind of behavior that your supervisees complained about?
Mr. Peters: I don't actually remember what I said that day. But I know I was just as angry as I was just a minute ago, so it's possible. So—that would be considered abusive?
SF: I think if I were your employee I might say that it was.

We then went on to have a very profitable discussion of anger: what is an appropriate way to express it, how context matters, the vulnerability of employees to a boss's anger, and so forth. This time, Mr. Peters admitted that sometimes he "flipped his lid" and lost control of himself when he was angry. He even agreed that this was likely to happen when he felt "shown up" in front of other people. I took a risk and reminded him again of his last Rorschach response, "a mask with holes in it," and this time he agreed that it might be an apt image of how he feels sometimes. He then spontaneously admitted that doing the assessment with me was scary, because an important decision possibly hinged on what I said, and he didn't yet know what I thought of him.

We ended the session with an exercise from Systems Centered Therapy (Agazarian, 1997) that I have found useful in addressing shame. I asked Mr. Peters to check and see whether he had any fantasies or "mind reads" about what I might be thinking of him after all that had transpired that day. He said he did. I then requested that he ask me a yes/no question that would confirm his mind read. He looked at me directly and asked, "Do you think I'm an ogre?" I said, "No, I do not," and asked him to check inside and see whether he believed my response. He said he did, but that he had another mind read. "Are you going to tell my boss that I'm unsuitable for this promotion?" I said I was not going to say this, because—first of all—this was not the question that I had been asked. I had been asked to determine whether he was aware of any problems with his anger, and I now believed he was. [He nodded.] Second, I said I thought he could work to address his tendency to "flip his lid" at times and that he was likely to improve. Mr. Peters said he believed me. We agreed to meet the following week to summarize the results of the assessment and discuss what his next steps might be.

Preparing for the Summary/Discussion Session. Prior to my meeting with Mr. Peters, I spent several hours outlining what I planned to explore with him about his test data. I wanted to start my summary with information that would fit his existing "story" about himself, then proceed to

information that might be slightly more challenging, and save for last the information that seemed to conflict most with his previous self-conceptions. (I have written about this strategy and its rationale in other places; see, e.g., Finn, 2007; Finn & Kamphuis, 2006; Finn, 1996b). The following excerpts from my notes show the order I believed would be best:

1. Mr. Peters's strengths: Intelligent, successful, generally good social skills, lots of psychological resources, varied coping mechanisms that allow him to handle a great deal of psychological stress. No serious psychopathology (e.g., Axis I conditions).
2. Information suggested by the MMPI-2: sensitivity, concerned about how others view him, anxiety (?).
3. Information that became evident in the assessment intervention session: Can get flooded by emotion and lose control; his judgment and ability to monitor himself suffer at such times; he hates feeling exposed or shown up; he is feeling stressed by the uncertainty about his promotion. But when he is supported, he can also regroup quickly, look at himself, and use his ability to analyze and problem solve.
4. Possibilities suggested by the Rorschach: Managing some underlying painful feelings of which he is only partially aware—shame? depression? anxiety? These leave him sensitive to humiliation and prone to “flipping his lid” when he is in situations where he feels out of control, exposed, insecure. His strengths are so considerable that he can carry on and do well generally, but he doesn't have a lot of “elbow room” for added stresses.
5. Good social skills overall, but doesn't tend to lean on other people for emotional support, which also means he is more prone to stress and emotional flooding.

Of course, I considered all these points to be tentative hypotheses, and I looked forward to reviewing them with Mr. Peters and getting his input.

Summary/Discussion Session (One Week Later). I checked in with Mr. Peters at the beginning of the session, and he said he was excited and curious about the meeting. I inquired how he had been after the last session, and he said he had felt exhausted the rest of the day, but grateful that I had “pushed” him, because he learned things that would help him succeed in his new position. I commended him for his resilience and his positive attitude and asked whether he could put into words what he had learned. He said, “That when I'm really angry I'm not aware of how I'm acting. I can do things that scare other people, and I've not really seen that before. I want to work on myself so that doesn't happen anymore. I hope we'll talk about how I can change all that.” I said that his comments implied a good new assessment question and that we certainly could address that issue. I proposed

that before we got to that question, it might be helpful for me to give an overview of his test results. He agreed. I reminded him that psychological tests are imperfect, that he was the “expert” on himself, and that he should feel free to agree with, disagree with, or “fine tune” what I had come up with from the testing.

I began, as planned, by talking about Mr. Peters's considerable psychological strengths. He beamed as I summarized the information from the first point in my outline, said it all seemed true, and expressed amazement that the tests could tell all those things about him. I said again that tests could only suggest aspects of his personality and that I was glad that this part of the results seemed accurate. I asked Mr. Peters whether he could give me an example from his life of being able to handle more than other people do. He said that his bosses often gave him the most difficult projects to deal with, because they knew that he could “perform well under stress.” I asked whether this had always been true, and he told of being extremely successful and well liked in high school. His senior year in college, he had been valedictorian, student body president, captain of the track and field team, and a state champion in debate. I remarked how impressed I was and that this seemed to fit with the considerable psychological resources that had shown up on his Rorschach (e.g., EA = 27.5).

I then showed Mr. Peters the basic scales from his MMPI-2, explained how to read the profile, and pointed out that he had no scores in the clinical range, which meant to me that he had no serious mental disorder or emotional difficulties, and that his high scores were more about aspects of his personality than indicative of psychopathology. He smiled and nodded. We then went through his three minor elevations, on scales K, 5, and 6. He smiled again when I interpreted K as suggesting he “didn't wear his feelings on his sleeve” and said he had a reputation among his friends and coworkers of “playing [his] cards close to [his] chest.” We then had the following discussion:

SF: Do you think of yourself as a sensitive person?

Mr. Peters: In what way?

SF: Well, these two scores [pointing to Scales 5 and 6] are typical of people who are very attuned to what other people think about them. They want people to like them, are extremely aware of small things like tone of voice and facial expressions that show what others are feeling, and usually can't just brush it off when people are mad at them or displeased with them.

Mr. Peters: Oh, that's me exactly. My ex-wife used to say that I was too thin-skinned, but I think my ability to read people has helped me at work a lot.

- SF: How?
- Mr. Peters: Well, I can tell what they're thinking even before they say it. I'm not *always* right, but I am a lot of the time. And I can use that information to help smooth feathers, negotiate, and keep everyone happy.
- SF: I bet that's really valuable with your team.
- Mr. Peters: Yep!
- SF: So that must have made it even harder for you after the incident where they said you abused them.
- Mr. Peters: It did. And for once I couldn't figure out how to make them happy.
- SF: And would you say that you easily get your feelings hurt?
- Mr. Peters [considering]: Hmmmm. . . . Again, my ex-wife used to say that I always take things personally. But I'm not sure that's really true.
- SF: Well, let's keep that in mind as we talk about the rest of the testing.

We talked a bit more about the MMPI-2, and then I said I wanted to talk to him more about his Rorschach. I explained that the Rorschach taps "a different level of personality" than the MMPI-2 and shows things that people are sometimes only partly aware of. I then said I thought the Rorschach helped me understand why Mr. Peters had gotten so angry with me and with his staff.

- SF: You see, your Rorschach scores suggest that you may be dealing with some painful feelings deep down, but most of the time you're able to ignore these and keep going.
- Mr. Peters: What kinds of painful feelings?
- SF: Depression, and anxiety, and shame, to start off with. Perhaps a part of you is confident, but another part of you wonders if you deserve all this success. So when something happens where you feel "shown up," you go into a tailspin, and the angry lashing out is a way to get yourself back in balance.
- Mr. Peters: Like, if it's someone else's fault, it doesn't really have to do with me?!
- SF: Exactly! Like, in our case, if I was a cruel sadist, then you didn't have to feel humiliated for falling for my trick. So the anger temporarily gives you back your self-esteem and feeling of being in control.
- Mr. Peters: And what about that time with my assistants?
- SF: I don't know . . . you tell me, but I can guess. Were you blaming yourself deep down for not having asked them for the information you didn't have?

- Mr. Peters: I guess I was. But I didn't see that until right now.
- SF: Okay.
- Mr. Peters: So I guess I'm not as confident as I think I am.
- SF: I think it depends on the situation. The confidence is real, but so are the feelings of shame and anxiety. Could that be true?
- Mr. Peters: Yes. But then what do I do about those feelings when I'm not usually aware of them?

We then went on to talk about the last points in my outline, where I wondered whether Mr. Peters tended to rely on his own resources rather than turn to other people for support. I suggested that he wouldn't be so susceptible to "flipping his lid" if he had better support. He admitted that he tended not to tell others when he was struggling, and he asked me whether I thought he could benefit from psychotherapy. I said I thought therapy could help him learn how to manage his emotions better and practice leaning on someone for support. He asked whether he could call me for therapy after he thought about all this some more. I told him yes, and that if I wasn't able to see him myself, I would be glad to refer him to some excellent colleagues.

Follow-up. Shortly after our summary/discussion session, I telephoned Mr. Peters's boss (the executive vice president) and told him that Mr. Peters and I had agreed that his anger could sometimes be problematic, that he was fully aware of this, and that he was interested in working on this problem. I also wrote a letter to Mr. Peters summarizing our discussions and what we had learned. He called one month later to tell me that he had received the promotion and had just begun seeing a psychotherapist recommended by a friend. I wished him the best of luck, he thanked me profusely for my work with him, and he said he would let me know how he was doing. Several years later, I ran into him at a concert, and he greeted me and told me that he was doing well in his new position. He thanked me again for our work, and I said it had been a pleasure to work with him.

Summary and Clarifications

This chapter has illustrated ways in which test data can provide access to clients' life worlds, thereby allowing psychological assessment to become most useful to all parties—clients, referring sources, and other helpers. Collaborating with clients helps us clinicians refine and individualize our understandings and helps our clients holistically grasp our discoveries. This process is therapeutic, even when that may be a secondary goal. Collaborative, interventional assessment also can be undertaken with therapeutic insight as its goal. Throughout, diagnostic categories, theoretical constructs, and code types are all regarded as *tools* with which to explore a person's life rather than as final *results*. For us, results are findings that the psychologist

can share with other professionals (as with the client) about the ways in which in daily life the person has (and has not) exemplified categories, whether neurological, characterological, psychiatric, or other. In addition, we try to identify already available pathways that may lead the client out of costly or inefficient ways of coping. The client has participated in the development of understandings and suggestions, owns them, and experiences himself or herself as an agent.

These practices, although grounded in our clinical experience and understanding of human beings, are gradually being shown in controlled research to have positive and long-lasting benefits for clients. Collaborative assessment can itself lead to decreased symptomatic distress, greater hope, and greater self-esteem on the part of clients. Also, it can enhance an alliance between therapist and client that impacts subsequent treatment for months. We are excited about the growing body of research that examines collaborative assessment.

As seen in our excerpts, there is no single right way to engage in collaborative assessment. The best way to begin is to expand on the ways you have already found yourself exploring in order to discover “what in the world” test patterns might have to do with the client’s life. Do look for when (and when-not) the client has experienced and acted in particular ways; contextual rather than deductive thinking is most productive. Deep familiarity with several theories of personality development and with ongoing research

Quick Reference 10.4: Suggestions For Trying Out Collaborative Practices

- Take tests yourself and jot down concrete examples, contexts, and when-nots of behavior/experience suggested by your own test patterns.
- Ask a colleague who knows you to provide additional possible examples and when-nots in regard to your test profiles.
- With clients, expand individualized practices in which you already have engaged.
- Gradually try out other practices—amending, expanding, and inventing to fit your own setting.
- Practice asking clients for life examples of your impressions from test patterns.
- Keep a file of life instances of test patterns.
- Ask clients directly for their participation in understanding their test data; ask for any disagreements, refinements, or contrary examples.
- Make use of interactions with clients—share with them assessment-relevant events that have happened during the assessment process.
- If your setting requires a particular format, follow that, but experiment with filling it out with life-world exploration and description.
- Ask for feedback from your report-receivers (clients will already have given you their impressions).

is essential, as is detailed knowledge of the circumstances of the persons you serve (e.g., going through custody evaluation, functioning at a retarded level, living with neurological constraints, being psychotic, being an Iraq war veteran, being an Asian immigrant). Even when considering medical and environmental factors, the point is to make nonreductive use of all these perspectives; make use of them to explore the client’s life world—the ultimate consideration.

Individualized, collaborative assessment can be engaged in with all the populations we assess, with the usual limitations: folks will be more defensive in forensic situations, where our therapeutic interests often have to be sidelined. We have to change gears to mesh with cognitively limited clients. When multiple parties are involved (e.g., in family assessments) it can be difficult to juggle the different competing agendas. Nonpsychologically minded clients require that we shift out of our usual styles, and so on. Cultural context must be taken into account. But always, to one degree or another, assessors can collaborate, individualize, and encourage clients’ sense of agency. If you find yourself in a setting that wants only categorical conclusions, like an IQ score, evidence of neurological impairment, and *DSM 5* diagnoses (although those rarely require testing), then provide what is asked of you. As you come to know the client population and the persons for whom you are answering referral requests, you can begin to individualize your reports, providing value-added understandings.

Yes, third-party payors do reimburse for collaborative assessment. Both of the authors conduct collaborative assessments in private practice. In the past, Steve Finn even received referrals from an HMO that asked him to do Therapeutic Assessment and to bill it as therapy. Most often, we can bill sessions as a combination of assessment and therapy (although it’s always good to check with your contract providers to make sure they don’t consider this unethical). Some self-referrals must be paid for by the individual, as for police academy entrance evaluations. When insurance companies steadfastly refuse to pay, or when insurance is unavailable, many clients are willing to dip into savings, pay over time, or borrow money to purchase a service they anticipate as being individualized and therapeutic.

When psychologists tell us that they are hesitant to intervene or to offer an understanding to a client for fear of being wrong, we reply that it is not wrong to offer an incorrect notion to the client so long as the client understands that your offering is tentative and is meant as a starting point for exploration. Often, an early, mutually agreed upon understanding is disrupted for both parties later in the session, resulting in a reorganization of understandings. Indeed, the process is very much a hermeneutic rather than a deductive one; that is, each clarification leads the assessor, and to some extent the client, to revisit earlier overarching understandings and

to re-examine data to see where they now fit. This process is demanding, but it is not fundamentally different from the dynamic process of impression formation while interviewing a job applicant. We should say, though, that our excerpts here represent the highlights of the collaborative process; just as in all psychological assessment, there are longish periods of data-gathering and of wondering before insightful moments occur.

We think that our life-world orientation is in many ways commonsensical, but because of our discipline's historical strong identification with the hypothetico-deductive and with logical positivist models of natural science, psychology has been slow to differentiate its research model from principles of application and from alternative research methods such as those of qualitative research. However, our times are changing. The public increasingly expects straightforward, down-to-earth communication from its professionals and asks for practical suggestions. Actually, psychologists for many decades have sometimes practiced what we now call collaborative, individualized, and/or therapeutic assessment, albeit not systematically or thoroughly. Many of our colleagues—some for a long while, and some more recently—have practiced and taught variations of this approach. In this volume's first edition, we listed the names of many colleagues in the United States and elsewhere who have mastered and contributed to the practice of collaborative and therapeutic assessment. We are humbled and gratified that at this point in time the number of such psychologists is too numerous for us to attempt a similar list. In addition, there is now a website devoted to collaborative and Therapeutic Assessment (www.therapeuticassessment.com), a case book (Finn, Fischer, & Handler, 2012), and an increasing number of trainings being offered around the world. Clearly, most psychological assessment around the world still adheres to a traditional model. But more and more clients are being exposed to collaborative and Therapeutic Assessment practices.

Below, we present some of our publications, and related works by other authors, that ground, expand on, and further illustrate what we have presented in this chapter.

References and Resources

- Ackerman, S. J., Hilsenroth, M. J., Baity, M. R., & Blagys, M. D. (2000). Interaction of therapeutic process and alliance during psychological assessment. *Journal of Personality Assessment*, 75, 82–109.
- Agazarian, Y. M. (1997). *Systems-centered therapy for groups*. New York: Guilford Press.
- Aldea, M. A., Rice, K. G., Gormley, B., & Rojas, A. (2010). Testing perfectionists about their perfectionism: Effects of providing feedback on emotional reactivity and psychological symptoms. *Behavior Research and Therapy*, 48, 1194–1203.
- Allen, A., Montgomery, M., Tubman, J., Frazier, L., & Escovar, L. (2003). The effects of assessment feedback on rapport-building and self-enhancement processes. *Journal of Mental Health Counseling*, 25, 165–181.
- American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct*. Washington, DC: American Psychological Association.
- Aschieri, F., & Smith, J. D. (2012). The effectiveness of Therapeutic Assessment with an adult client: A single case study using a time-series design. *Journal of Personality Assessment*, 94, 1–11.
- Caracena, P. F. (2008). *ROR-SCAN Rorschach interpretive program*. Edmond, OK: ROR-SCAN.
- Donnay, D. A., Morris, M. L., Schaubhut, N. A., & Thompson, R. C. (2005). *Strong Interest Inventory manual: Research, development, and strategies for interpretation*. Mountain View, CA: CPP.
- El-Shaieb, M. (2005). The MMPI-2 and client feedback: A quantitative investigation and exploratory analysis of feedback models. *Dissertation Abstracts International*, 66, 2303.
- Essig, G. N., & Kelly, K. R. (2013). Comparison of the effectiveness of two assessment feedback models in reducing career indecision. *Journal of Career Assessment*. Advance online publication. doi:10.1177/1069072712475283
- Exner, J. E., Jr., Weiner, I. B., & PAR staff. (2005). *Rorschach Interpretive Assistance Program: Version 5 (RIAP5)*. Lutz, FL: PAR.
- Finn, S. E. (1996a). Assessment feedback integrating MMPI-2 and Rorschach findings. *Journal of Personality Assessment*, 67, 543–557.
- Finn, S. E. (1996b). *Manual for using the MMPI-2 as a therapeutic intervention*. Minneapolis, MN: University of Minnesota Press.
- Finn, S. E. (1998). Teaching Therapeutic Assessment in a required graduate course. In L. Handler & M. Hilsenroth (Eds.), *Teaching and learning personality assessment* (pp. 359–373). Mahwah, NJ: Erlbaum.
- Finn, S. E. (2003). Therapeutic Assessment of a man with "ADD." *Journal of Personality Assessment*, 80, 115–129.
- Finn, S. E. (2005). How psychological assessment taught me compassion and firmness. *Journal of Personality Assessment*, 84, 27–30.
- Finn, S. E. (2007). *In our clients' shoes: Theory and techniques of Therapeutic Assessment*. Mahwah, NJ: Erlbaum.
- Finn, S. E., Fischer, C. T., & Handler, L. (Eds.). (2012). *Collaborative/Therapeutic Assessment: A case book and guide*. Hoboken, NJ: Wiley.
- Finn, S. E., & Kamphuis, J. H. (2006). Therapeutic Assessment with the MMPI-2. In J. N. Butcher (Ed.), *MMPI-2: A practitioner's guide* (pp. 165–191). Washington, DC: American Psychological Association.
- Finn, S. E., & Martin, H. (1997). Therapeutic Assessment with the MMPI-2 in managed health care. In J. N. Butcher (Ed.), *Objective psychological assessment in managed health care: A practitioner's guide* (pp. 131–152). New York: Oxford University Press.
- Finn, S. E., & Tonsager, S. E. (1992). The therapeutic effects of providing MMPI-2 test feedback to college students awaiting psychotherapy. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 4, 278–287.
- Finn, S. E., & Tonsager, M. E. (1997). Information-gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment*, 9, 374–385.
- Finn, S. E., & Tonsager, M. E. (2002). How *Therapeutic Assessment* became humanistic. *The Humanistic Psychologist*, 30, 10–22.
- Fischer, C. T. (1977). Historical relations of psychology as an object-science and subject-science: Toward psychology as a human-science. *Journal of the History of the Behavioral Sciences*, 13, 369–378.
- Fischer, C. T., & Brodsky, S. L. (Eds.). (1978). *Client participation in human services: The Prometheus principle*. New Brunswick, NJ: Transaction.
- Fischer, C. T. (1980). Phenomenology and psychological assessment: Re-presentational description. *Journal of Phenomenological Psychology*, 11, 79–105.
- Fischer, C. T. (1987). Empowering clients by deconstructing psychological reports. *Practice: The Journal of Politics, Economics, Psychology, Sociology, and Culture*, 5, 134–139.
- Fischer, C. T. (1989). A life-centered approach to psychodiagnostics: Attending to the life-world, ambiguity, and possibility. *Person-Centered Review*, 4, 163–170.
- Fischer, C. T. (1994). Rorschach scoring questions as access to dynamics. *Journal of Personality Assessment*, 62, 515–525.
- Fischer, C. T. (1994). *Individualizing psychological assessment*. Mahwah, NJ: Erlbaum. (Originally published 1985).

- Fischer, C. T. (1998). The Rorschach and the life-world: Exploratory exercises. In L. Handler & M. Hilsenroth (Eds.), *Teaching and learning personality assessment* (pp. 347–358). Hillsdale, NJ: Erlbaum.
- Fischer, C. T. (1998). Phenomenological, existential, and humanistic foundations for psychology as a human science. In M. Hersen & A. Bellack (Series Eds.) & C. E. Walker (Vol. Ed.), *Comprehensive clinical psychology: Vol. 1: Foundations* (pp. 449–472). London: Elsevier.
- Fischer, C. T. (2000). Collaborative, individualized assessment. *Journal of Personality Assessment*, 74, 2–14.
- Fischer, C. T. (2001). Psychological assessment: From objectification back to the life world. In B. D. Slife, R. N. Williams, & S. H. Barlow (Eds.), *Critical issues in psychotherapy: Translating ideas into practice* (pp. 29–44). Thousand Oaks, CA: Sage.
- Fischer, C. T. (2001). Collaborative exploration as an approach to personality assessment. In K. J. Schneider, J. F. T. Bugenthal, & J. F. Pierson (Eds.), *The handbook of humanistic psychology: Leading edges in theory, research, and practice* (pp. 525–538). Thousand Oaks, CA: Sage.
- Fischer, C. T. (2002). Guest Ed., Humanistic approaches to psychological assessment. *The Humanistic Psychologist*, 30 (1–2, pp. 3–174; 3, pp. 178–236).
- Fischer, C. T. (2006a). Bruno Klopfer, phenomenology, and individualized/collaborative psychological assessment. *Journal of Personality Assessment*, 87, 229–233.
- Fischer, C. T. (2006b). Qualitative psychological research and individualized/collaborative psychological assessment: Implications of their similarities for promoting a life-world orientation. *The Humanistic Psychologist*, 34, 347–356.
- Gabbard, G. O. (1989). Two subtypes of narcissistic personality disorder. *Bulletin of the Menninger Clinic*, 53, 527–532.
- Goodyear, R. K., (1990). Research on the effects of test interpretation: A review. *The Counseling Psychologist*, 18, 240–257.
- Handler, L. (1995). The clinical use of figure drawings. In C. Newmark (Ed.), *Major psychological assessment instruments* (pp. 206–293). Boston: Allyn & Bacon.
- Handler, L. (1997). He says, she says, they say: The consensus Rorschach. In J. R. Meloy, M. W. Acklin, C. B. Gacono, J. F. Murray, & C. A. Peterson (Eds.), *Contemporary Rorschach interpretation* (pp. 499–533). Mahwah, NJ: Erlbaum.
- Handler, L. (1999). The assessment of playfulness: Hermann Rorschach meets D. W. Winnicott. *Journal of Personality Assessment*, 72, 208–217.
- Handler, L. (2006). Therapeutic assessment with children and adolescents. In S. Smith & L. Handler (Eds.), *Clinical assessment of children and adolescents: A practitioner's guide* (pp. 53–72). Mahwah, NJ: Erlbaum.
- Hanson, W. E., Claiborn, C. D., & Kerr, B. (1997). Differential effects of two test-interpretation styles in counseling: A field study. *Journal of Counseling Psychology*, 44, 400–405.
- Hilsenroth, M. J., Ackerman, S. J., Clemence, A. J., Strassle, C. G., & Handler, L. (2002). Effects of structured clinical training on patient and therapist perspectives of alliance early in psychotherapy. *Psychotherapy: Theory/Research/Practice/Training*, 39, 309–323.
- Hilsenroth, M. J., & Cromer, T. D. (2007). Clinician interventions related to alliance during the initial interview and psychological assessment. *Psychotherapy: Theory, Research, Practice, Training*, 44, 205–218.
- Hilsenroth, M. J., Peters, E. J., & Ackerman, S. J. (2004). The development of therapeutic alliance during psychology assessment: Patient and therapist perspectives across treatment. *Journal of Personality Assessment*, 83, 331–344.
- Lance, B. R., & Krishnamurthy, R. (2003, March). *A comparison of the effectiveness of three modes of MMPI-2 test feedback*. Paper presented at the annual meeting of the Society for Personality Assessment, San Francisco, CA.
- Levak, R. W., Marks, P. A., & Nelson, G. E. (1990). *Therapist guide to the MMPI & MMPI-2: Providing feedback and treatment*. Muncie, IN: Accelerated Development.
- Levak, R. W., Siegel, L., & Nichols, D. S. (2011). *Therapeutic feedback with the MMPI-2: A positive psychology approach*. New York: Routledge.
- Martin, E. H., & Finn, S. E. (2010). *Masculinity and femininity in the MMPI-2 and MMPI-A*. Minneapolis, MN: University of Minnesota Press.
- Meyer, G. J., Viglione, D. J., Mihura, J. L., Erard, R. E., & Erdberg, P. (2011). *Rorschach Performance Assessment System: Administration, coding, interpretation, and technical manual*. Toledo, OH: Rorschach Performance Assessment System.
- Millon, T., Weiss, L., Millon, C., & Davis, R. D. (1994). *MIPS: Millon Index of Personality Styles manual*. San Antonio, TX: Psychological Corp.
- Morey, L. C., Lowmaster, S. E., & Hopwood, C. J. (2010). A pilot study of Manual-Assisted Cognitive Therapy with a Therapeutic Assessment augmentation for Borderline Personality Disorder. *Psychiatry Research*, 178, 531–535.
- Newman, M. L. (2004). *Psychological assessment as brief psychotherapy: Therapeutic effects of providing MMPI-A test feedback to adolescents*. Unpublished doctoral dissertation, La Trobe University, Australia.
- Newman, M. L., & Greenway, P. (1997). Therapeutic effects of providing MMPI-2 test feedback to clients at a university counseling service. *Psychological Assessment*, 9, 122–131.
- Poston, J. M., & Hanson, W. M. (2010). Meta-analysis of psychological assessment as a therapeutic intervention. *Psychological Assessment*, 22, 203–212.
- Purves, C. (2002). Collaborative assessment with involuntary populations: Foster children and their mothers. *The Humanistic Psychologist*, 30, 164–174.
- Rogers, L. B. (1954). A comparison of two kinds of test interpretation interview. *Journal of Counseling Psychology*, 1, 224–231.
- Schroeder, D. G., Hahn, E. D., Finn, S. E., & Swann, W. B., Jr. (1993, June). *Personality feedback has more impact when mildly discrepant from self views*. Paper presented at the fifth annual convention of the American Psychological Society, Chicago, IL.
- Slaney, R. B., Rice, K. G., Mobley, M., Trippi, J., & Ashby, J. S. (2001). The Almost Perfect Scale-Revised. *Measurement and Evaluation in Counseling and Development*, 34, 130–145.
- Smith, J. D., & George, C. (2012). Therapeutic Assessment case study: Treatment of a woman diagnosed with metastatic cancer and attachment trauma. *Journal of Personality Assessment*, 94, 331–344.
- Smith, J. D., & Handler, L. (2009). "Why do I get in trouble so much?": A family Therapeutic Assessment case study. *Journal of Personality Assessment*, 91, 197–210.
- Smith, J. D., Handler, L., & Nash, M. R. (2010). Family Therapeutic Assessment for preadolescent boys with oppositional defiant disorder: A replicated single-case time-series design. *Psychological Assessment*, 22, 593–602.
- Smith, J. D., Nicholas, C. R. N., Handler, L., & Nash, M. R. (2011). Examining the clinical effectiveness of a family intervention session in Therapeutic Assessment: A single-case experiment. *Journal of Personality Assessment*, 93, 149–158.
- Smith, J. D., Wolf, N. J., Handler, L., & Nash, M. R. (2009). Testing the effectiveness of family Therapeutic Assessment: A case study using a time-series design. *Journal of Personality Assessment*, 91, 518–536.
- Tarocchi, A., Aschieri, F., Fantini, F., & Smith, J. D. (2013). Therapeutic Assessment of complex trauma: A single-case time-series study. *Clinical Case Studies*, 12(3), 228–245.
- Tharinger, D. J., Finn, S. E., Gentry, L., Hamilton, A., Fowler, J., Matson, M., . . . Walkowiak, J. (2009). Therapeutic Assessment with children: A pilot study of treatment acceptability and outcome. *Journal of Personality Assessment*, 91, 238–244.
- Tharinger, D. J., Finn, S. E., Wilkinson, A. D., & Schaber, P. M. (2007). Therapeutic Assessment with a child as a family intervention: Clinical protocol and a research case study. *Psychology in the Schools*, 44, 293–309.
- Tyrer, P., Tom, B., Byford, S., Schmidt, U., Jones, V., Davidson, K., . . . Catalan, J. (2004). Differential effects of manual assisted cognitive behavior therapy in the treatment of recurrent deliberate self-harm and personality disturbance: The POPMACT study. *Journal of Personality Disorders*, 18, 102–116.