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To cite this article: Jan H. Kamphuis & Stephen E. Finn (2019) Therapeutic Assessment in Personality Disorders: Toward the Restoration of Epistemic Trust, *Journal of Personality Assessment*, 101:6, 662-674, DOI: [10.1080/00223891.2018.1476360](https://doi.org/10.1080/00223891.2018.1476360)

To link to this article: <https://doi.org/10.1080/00223891.2018.1476360>



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Published online: 06 Jun 2018.



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Therapeutic Assessment in Personality Disorders: Toward the Restoration of Epistemic Trust

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ABSTRACT

Research evidence suggests Therapeutic Assessment positively affects clients with problems in living, including clients with personality disorders, who are typically quite resistant to change. Importantly, this change takes place quickly, in relatively few sessions. This article draws on a relatively new evolutionary-based theory of epistemic trust (ET) and epistemic hypervigilance (EH) as a lens to plausibly explain the efficacy of TA, and especially its influence on PD clients' alliance and motivation for subsequent psychotherapy (Fonagy, Luyten, & Alison, 2015). ET is the willingness to take in relevant interpersonally transmitted information and it is essential to the immediate success of psychotherapy and its long-term impact. The collaborative, intersubjective framework of TA and many of its specific techniques might be understood as highly relevant to restoring ET in clients, especially those with PD. We close by discussing implications for psychological assessment, psychotherapy, and research.

ARTICLE HISTORY

Received 9 February 2018
Revised 16 April 2018



Therapeutic Assessment (TA) is a semistructured method of collaborative psychological assessment, designed to help clients gain new insights and make positive changes in their lives. Throughout TA, client and assessor work collaboratively. This process starts with formulation of individualized assessment questions that subsequently orient the testing phase, joint discussion of client test responses and behaviors during the extended inquiry of standardized testing, targeted experiential “experiments” in the assessment intervention session, an interactive summary and discussion session, a written synopsis of the process and results provided to the client in accessible language, and finally a follow-up session (see Table 1). Collaborative Assessment (CA), TA’s “close cousin,” uses many of the principles and techniques of TA, but in a less structured way. See Finn, Fischer, and Handler (2012) for distinctions between TA, CA, and similar approaches.

Accumulating empirical evidence suggests that TA and CA can be effective interventions in various settings, and several summaries of the extant research have recently been published (Aschieri, De Saeger, & Durosini, 2015; De Saeger et al., 2014). A meta-analysis on psychological assessment used as an intervention (Poston & Hanson, 2010) showed effect sizes consistent with moderate improvement for process variables (e.g., alliance or satisfaction) and treatment outcome variables (e.g., symptom improvement) combined, and with strong improvement when limited to treatment process variables only. In the following, we present a

selective, more fine-grained analysis of the research on the effectiveness of TA. Next, as the main objective of this article, we use the evolutionarily informed theory of epistemic trust (ET) and epistemic hypervigilance (EH) articulated by Sperber et al. (2010) and elaborated by Fonagy and his colleagues (Fonagy & Alison, 2014; Fonagy, Luyten, & Allison, 2015; Fonagy, Luyten, Allison, & Campbell, 2017a, 2017b) as a lens to consider the effectiveness of TA (Finn, 2007).

Selective empirical observations on the effectiveness of TA

We believe ET theory provides a highly plausible framework for understanding (at least) five intriguing findings that have emerged from extant research on the effectiveness of TA and CA. First, how is it that TA is effective with a wide variety of disorders and client types—without the need to make major modifications in one’s procedures? If one combines controlled group designs with repeated-measure single-subject experiments, TA has shown benefits to clients in residential treatment for substance abuse (Blonigen, Timko, Jacob, & Moos, 2015); college students seeking counseling for depression, anxiety, and interpersonal problems (Finn & Tonsager, 1992); couples in which one member suffers with chronic pain (Miller, Cano, & Wurm, 2013); latency age boys with oppositional defiant disorder (Smith, Handler, & Nash, 2010); outpatient clients with borderline personality

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Table 1. Typical steps in a Therapeutic Assessment and their relationship to epistemic trust/hypervigilance (ET/EH).

Step	Goals/procedures	Relevance to ET/EH
1. Initial session(s)	<ol style="list-style-type: none"> 1. Assessor listens/mirrors/supports client, attempts to avoid eliciting shame, or helps manage shame if it arises 2. Assessor and client coconstruct assessment questions (AQs) 3. Assessor asks about past assessment experiences and addresses any reservations/hurts 4. Assessor invites questions about TA procedures and about himself or herself 	<ol style="list-style-type: none"> 1. By listening and responding in an attuned manner, assessor gives evidence of mentalizing the client and promotes ET 2. AQs elicit curiosity and motivation from client and help build ET 3. Listening to and addressing past hurts lowers EH 4. Normalizing clients' curiosity promotes ET; appropriate transparency lowers EH and builds ET
2. Testing session(s)	<ol style="list-style-type: none"> 1. Assessor selects tests based on client's AQs and explains to client how each test is relevant to client's concerns 2. Assessor uses extended inquiries to scaffold new information from testing that is relevant to client's AQs 3. By using multiple tests across different sessions, assessor slowly builds on previous understandings and gradually introduces Level 2 and 3 information (i.e., information that is incongruous with client's existing working model); assessor and client begin to coconstruct a new narrative that is more coherent, accurate, compassionate, and useful 	<ol style="list-style-type: none"> 1. Clients see their own goals are taken seriously, which promotes ET; tests are viewed as authoritative sources of information, which facilitates ET; assessors acknowledge that clients' input is necessary to understand test results, which lowers EH 2 + 3. AQs serve as a form of ostensive cuing that elicits ET and facilitates clients taking in new information; attuned scaffolding helps prevent clients from being overwhelmed and allows them to incorporate new information at the fastest rate possible; clients and assessors develop new language to describe clients' experiences and dilemmas
3. Assessment intervention session(s)	<ol style="list-style-type: none"> 1. Using test materials, assessor devises "controlled experiments" that help client "discover" Level 2 and 3 information that might otherwise be rejected 2. Assessor tells client that goal of the session is to help address specific AQs 3. As the "experiment" proceeds, assessor enlists client as co-observer and scaffolds new understandings 4. Assessor offers emotional support and helps manage client shame and anxiety as new information is taken in 5. When new solutions are tried and judged to be successful, clients are urged to "try it at home" and to report back at the next session 	<ol style="list-style-type: none"> 1. Case conceptualization underlying choice of procedures requires sophisticated mentalizing of clients by assessor and sets the stage for ET 2. AQs are used as ostensive cues to facilitate ET in the face of potentially overwhelming information 3. New narratives arise from the collaboration of clients and assessors, which lowers EH and promotes ET 4. By assessors sharing responsibility for regulating for clients' affect, EH is lowered and ET grows 5. Exporting solutions to real life helps clients transfer learning and new ways of being to their social world
4. Summary/discussion session(s)	<ol style="list-style-type: none"> 1. Assessor structures discussion of assessment results using client's AQs 2. Assessor references client's experiences and shared understandings from earlier assessment sessions 3. Assessor shows test profiles and references test scores and findings from nomothetic research 4. Client is framed as "expert on him- or herself" and is invited to confirm, modify, or reject test findings 5. Client is asked to give examples of how assessment findings show up in outside life 6. Assessor offers emotional support and helps manage shame and anxiety 7. Instead of making recommendations, assessor offers "possible next steps" and asks client for input and modifications 8. Client is reminded of written feedback, upcoming follow-up session, and possibility of future contacts 	<ol style="list-style-type: none"> 1. AQs serve as ostensive cues that help open the "information superhighway" and facilitate clients' assimilating and accommodating new information 2. EH is lowered by referring to clients' own insights and experiences 3. Tests are seen as authoritative sources, which facilitates ET 4. Clients are seen as final arbiters, which lowers EH 5. Making connections to outside world promotes virtuous cycle 3 (transfer outside the assessment relationship) 6. Assessor helps regulate client's affective reactions, which lowers EH 7. By recognizing client's power to act on new understandings arising from assessment, EH is lowered 8. Clients feel assessor is continuing to hold them in mind, which lowers EH and promotes ET
5. Written summary provided to client	<ol style="list-style-type: none"> 1. Assessor structures written summary of assessment results using client's AQs 2. Assessor writes summary in plain, jargon-free language adapted to client's intellectual, educational, and developmental level 3. Assessor refers to important experiences/understandings from assessment sessions and uses shared language developed by assessor and client 4. Assessor summarizes nomothetic information discussed during the summary/discussion session 5. Assessor refers to confirming examples provided by client, as well as modifications and disagreements 6. Assessor writes summary in professional but also personal and warm tone (as culturally appropriate) 	<ol style="list-style-type: none"> 1. AQs serve as ostensive cues that facilitate ET 2. Language and content of letter gives clients the experience of being mentalized by assessors and helps ET 3. Collaborative communication and invoking shared memories facilitates ET 4. Scientifically grounded tests are seen as authoritative sources and this facilitates ET 5. Referencing clients' input gives evidence that they were heard and that their opinions are held in mind, which facilitates ET 6. The combination of professional and personal tone helps clients feel respected and valued, which facilitates ET; clients can refer back to written summary to remember assessor and assessment findings

(continued)

Table 1. (Continued).

Step	Goals/procedures	Relevance to ET/EH
6. Follow-up session(s)	7. Assessor invites client to comment or ask questions about the written summary and to provide written feedback to the assessor	7. Assessors' interest in and openness to clients' opinions and feedback helps them feel respected and valued and increases ET
	8. Assessor reminds client of follow-up session	8. The possibility of further contact with the assessor helps clients feel valued and increases ET
	1. Assessor shows interest in client and mirrors any positive strivings	1. Clients' feeling remembered and seen facilitates ET
	2. Assessor asks client if there are questions about or reactions to the TA	2. Clients and assessors continue to collaboratively work on new narrative; some clients mention information previously rejected now seems accurate and useful; the fruits of increased ET are often visible
	3. Assessor asks for feedback from client about the TA	3. Assessors' openness to clients' opinions and feedback helps them feel respected and valued and increases ET
	4. Assessor formally says goodbye	4. A formal, structured termination helps manage emotional impact of assessment relationship, lowers EH, and facilitates ET

disorder and suicidal ideation (Morey, Lowmaster, & Hopwood, 2010); multiproblem families with emotionally disturbed children (Tharinger et al., 2009); and clients with complex PTSD (Smith & George, 2012; Tarocchi, Aschieri, Fantini, & Smith, 2013); among others. This breadth of impact suggests that metatheoretical change processes are at work, but what are they?

Second, how is it that such a brief intervention can have clinical impact? Most of the studies already cited and almost all of those cited in the aforementioned meta-analysis involved fewer than five client sessions, yet the average impact of assessment as an intervention was close to that found in meta-analyses of much longer interventions. How is this possible?

Third, how is it that TA can affect clients who are notorious for being resistant to change and who generally need long-term, intensive, relationship-based treatments (i.e., those with personality disorders [PDs])? We conducted a Randomized Controlled Trial (RCT) with 74 clients with complex personality pathology awaiting treatment at a tertiary care facility. This study, comparing the effects of TA to those of a highly credible structured motivation pretreatment intervention—and a qualitative follow-up study—together yielded a pattern of results that led us to step back and reflect (De Saeger, Bartak, Eder, & Kamphuis, 2016; De Saeger et al., 2014). In fact, self-report ratings of demoralization and psychological symptoms did not improve immediately following the five-session TA protocol. However, clients undergoing TA expected more success from their treatment, perceived more progress toward treatment, were more satisfied, and felt more alliance to the clinician than did clients in the control condition (with moderate effect sizes ranging from .56–.68). The qualitative analysis of subsequent semistructured interviews in a subset of clients suggested that (often newly experienced) relational aspects of TA were crucial to its impact, with clients describing feeling empowered, feeling validated, and gaining new personal insights. These client reports were echoed by the great enthusiasm of other therapists and staff in the treatment setting. In other words, TA was deemed very meaningful by both clients and staff, despite it not translating directly to short-term symptomatic improvement. It appears that during TA something of value is taking place in PD clients in a

relatively short period of time, and that “something” might be preliminary and perhaps even prerequisite to the type of treatment utility more narrowly defined as symptom improvement (Hayes, Nelson, & Jarrett, 1987).

Fourth, what accounts for TA's positive effects on clients' motivation for treatment and subsequent alliance with treatment professionals? We have already described the results of our own RCT. Various other studies have also documented TA's effect on alliance, engagement, and treatment satisfaction, such as clients being significantly more likely to follow through with recommended psychotherapy following Collaborative Therapeutic Assessment (CTA) as opposed to traditional assessment (Ackerman, Hilsenroth, Baity, & Blagys, 2000), client-assessor alliance during CTA being a significant predictor of client-therapist alliance in subsequent outpatient therapy (Hilsenroth, Peters, & Ackerman, 2004), client-therapist alliance increasing midtherapy following a TA with another clinician (Smith, Eichler, Norman, & Smith, 2014), clients in residential treatment having better alliance with staff and better relationships with other residents if they took part in a CTA first (Blonigen et al., 2015), and inpatients with suicidal ideation showing significant increases in working alliance over the course of a structured intervention that began with CA (Ellis, Green, Allen, Jobes, & Nadorff, 2012).

Last, in multiple studies of TA, it has been noted that the greatest positive effects of the intervention were not found immediately after the TA was completed, but at some interval (e.g., 2–8 weeks) afterward (Aldea, Rice, Gormley, & Rojas, 2010; Finn & Tonsager, 1992; Newman & Greenway, 1997; Smith, Handler, & Nash, 2010). What accounts for this “delayed” effect of TA, whereas most psychotherapies show a decline in their positive effects once treatment is completed?

Clearly, empirical research into the specific therapeutic mechanisms of TA is needed to answer these questions, but such investigations are likely to be most useful when guided by clinical theory. We believe the theory of epistemic trust (ET) provides encompassing and plausible answers to the aforementioned questions about the efficacy of TA, and that it might help us understand, in particular, what makes TA effective in clients with PDs.

Epistemic trust and personality disorders

ET, according to Fonagy and his colleagues, is trust in the authenticity and personal relevance of interpersonally transmitted knowledge (Fonagy & Alison, 2014, p. 372). When ET exists in a certain relationship, an individual is able to take in, accept, and learn certain information from another and begin to integrate it into his or her view of self and the world. ET is extremely important to the survival and adaptation of both the individual and the species, because each human generation must learn and apply an enormous amount of culturally relevant information to function well, adapt to changing circumstances, and continue to advance our culture. On the other hand, epistemic vigilance about the accuracy and usefulness of information offered by another is also highly adaptive because it protects individuals from accepting and using information that is not accurate. As Sperber et al. (2010) explained from an evolutionary perspective, competitors will try to misinform others to gain an advantage, and it is important for individuals to have healthy skepticism (appropriate epistemic vigilance) to not be misled.

Although both epistemic trust and epistemic vigilance can be adaptive (depending on the interpersonal context), Fonagy and colleagues have written extensively about a situation of pervasive distrust they call *epistemic hypervigilance* (EH), which they believe is particularly prominent in PDs. Individuals with PDs cannot flexibly exercise ET and epistemic vigilance as appropriate, with the result that their views of self and the world are highly resistant to change. EH results in an inability to learn from social experience, broad cognitive inflexibility, and severe problems in interpersonal relationships, all hallmarks of PD. In their recent writings, Fonagy et al. (2017a, 2017b) clarified that even epistemic petrification could be viewed as an adaptive solution to childhood maltreatment, although it is tied to communication failures and social dysfunction later in life. Finally, as we return to later, we believe epistemic *hypovigilance* (or naive trust) is also prevalent in PD, and that many clients vacillate between states of epistemic hypovigilance and hypervigilance.

Epistemic trust, attachment, mentalization, and ostensive cuing

How do individuals achieve the flexible integration of ET and epistemic vigilance, which then leads to the greatest level of adaptation and growth? Fonagy and colleagues theorized an important link between ET and attachment, stating, “secure attachment is unlikely to be necessary for generating epistemic trust but it may be sufficient to do so, and, further, it is the most pervasive mechanism in early childhood because it is a highly evolutionarily effective indicator of trustworthiness” (Fonagy & Allison, 2014, p. 374). The underlying reasoning here is that from an evolutionary perspective it is most adaptive to trust and take in information from our secure attachment figures because they are likely to share our genetic heritage, to be invested in our survival, and to refrain from intentionally misleading us. Fonagy and colleagues cited research information (e.g., Corriveau et al., 2009) showing that securely attached infants are more flexible in their ability

to achieve ET and also to rely on their own appraisals when it would be adaptive. Fonagy et al. (2015) also cited Mikulincer (1997), who suggested that adults with insecure attachment are more likely to reject information that challenges their working models of self and the world in part because their sense of self is vulnerable and they are trying to keep themselves from being emotionally overwhelmed. As a result, insecurely attached adults are more likely to adopt stereotypes and show dogmatic thinking.

Fonagy and colleagues focused on two important processes to explain how secure attachment figures promote appropriate ET in children: mentalization and ostensive cuing. *Mentalization* is an aspect of sensitive caregiving in which a parent actively observes and responds to a child’s intentional state (Fonagy, 1998), seeing the child as having his or her own thoughts, desires, wishes, and emotions (i.e., mental states) and responding in ways that match the child’s subjective experience of himself or herself. Fonagy and Allison (2014) cited a large body of research showing that parents’ ability to mentalize their child “increases the chance of secure attachment, enhances his/her resilience to adversity and promotes cognitive, social-cognitive, and emotion-regulating capacity” (p. 373). Parent mentalization is also important in creating ET, and it “triggers the opening of an evolutionarily protected ‘epistemic superhighway’ that signals readiness for knowledge acquisition” (Fonagy et al., 2015, p. 584). This is promoted by the *ostensive cues* secure attachment figures frequently give to their infants, for example by making eye contact, taking turns in emotional communication (e.g., peek-a-boo), and calling the infant by name. Both in childhood and in adulthood, ostensive cues create a readiness to take in information that follows, or as stated by Fonagy et al. (2015), “When the listener is paid special attention to and noticed as an agent, he/she adopts an attitude of epistemic trust and is thus ready to receive personally relevant knowledge” (p. 583). Ostensive cuing (which is evidence of mentalization) signals the recipient that he or she is in the presence of a deferential source who has his or her best interests in mind and that the knowledge that follows the ostensive cuing can be treated as relevant to his or her adaptation and survival.

Epistemic trust and psychotherapy

In earlier writings, Fonagy and others argued that mentalization is a common factor in all successful psychotherapies and that “the potential effectiveness of all treatments depends not so much on their frame but on their ability to increase a patient’s ability to mentalize” (Bateman & Fonagy, 2004, p. 46). Recently, in an attempt to identify what it is about mentalizing that brings about therapeutic change, Fonagy and colleagues focused on ET. Their current point of view is that, “Seeing the world from the patient’s standpoint opens the patient’s mind by establishing epistemic trust in creating a collaboration. The patient becomes able to trust the social world again as a learning environment” (Fonagy et al., 2015, p. 595) and to change “previously rigidly held beliefs” (p. 597). This is especially true for many personality-disordered clients, who are in

what a state of what Fonagy and colleagues called epistemic petrification (pervasive EH).

As argued by Fonagy and colleagues (Fonagy & Allison, 2014; Fonagy et al., 2015; Fonagy et al., 2017a, 2017b), when psychotherapy is effective, three cumulative cycles of learning are triggered that (a) help move clients from EH to ET, (b) yield increased mentalization on the part of the client, and (c) ultimately, restore more broadly the ability to learn from the outside social world (i.e., relationships outside the consultation room). Thus, by reestablishing ET, the personality-disordered individual is able to eventually leave the consulting room and engage in ongoing social learning in his or her world of interpersonal relationships, select more positive environments, and create a virtuous cycle in which appropriate ET and epistemic vigilance create more self-confidence and ability to be close to others (Fonagy et al., 2017b). To us this implies that psychological interventions that specifically address ET are highly desirable.

Distinctive elements of TA that foster ET

In fact, we believe that in principles and procedures, TA is optimally geared to promote an individual's willingness to (re)consider communication conveying new knowledge from someone else as trustworthy, generalizable, and relevant to the self; that is, to lower EH and promote the restoration of ET. Further, we have come to believe that this process of restoring ET and lowering EH might be the general meta-theoretical ingredient that could help account for the remarkable efficacy of TA across settings and disorders. We now elaborate how different aspects of TA are relevant to ET and EH (see Table 1).

The core values, intersubjective stance, and major goals of TA

TA first and foremost shows respect for clients as agentic beings with their own goals, desires, and important perspectives. TA's basic interpersonal position is exemplified in the following orienting statement:

I see myself as a consultant to you to help you better understand what your situation is now. Therefore, I'd like us to figure out what questions you'd like to have answered from the assessment. Then we'll use testing to help answer your questions. Today, I'll also be asking you about yourself so I can understand your assessment questions, and I'll answer any questions you have about me, the testing, or the feedback session that we'll have at the end of the assessment. Okay? (Finn, 1996a, p. 7)

What will be evident from this statement is that in TA the client is heavily involved in the problem definition, and there is less of a power imbalance than is generally the case in regular assessment (or psychotherapy). In fact, the model treats "clients as integral participants in a collaborative process, whose goal is to observe, understand, and rethink their problems in living" (Finn & Tonsager, 2002, p. 12). The philosophical stance is clearly humanistic, recognizing the innate healing potential of clients and emphasizing the

practice of transparency and authenticity. Also, this stance illustrates the core values of TA, which have been articulated as "collaboration, respect, humility, compassion, openness, and curiosity" (Finn, 2009). TA's viewpoint is also intersubjective, with assessors being trained that "all knowledge is perspectival" and that they, too, must be curious and open to learning about themselves and their tests during their interactions with clients. These core principles of TA promote mentalization on the part of both assessors and clients, and as such create an optimal environment for the reestablishment of ET.

TA's overarching goal is to understand clients' core narratives and then help "each client to get the feeling of being an 'author' of his or her new story, a story which is more compassionate, useful, emotionally viable, and coherent than the previous one" (Aschieri, Finn, & Bevilacqua, 2010, p. 257). Essential to this endeavor is building a secure alliance. In addition to the emphasis on more broadly used techniques such as emotional attunement, collaborative communication, and repair of disruptions, TA includes a number of specific elements that promote the reduction of EH and the cultivation of ET. In what follows, we review those elements.

Enlisting clients' curiosity by coconstructing assessment questions

We believe there is a central part of every TA that helps build alliance early in the intervention; every TA begins with one or more sessions in which assessors and clients work to coconstruct assessment questions (AQs) that form the basis of the collaborative exploratory process (Finn, 2007). Early on, the clinician asks the client something like this: "So what things would you like to learn about yourself from the assessment?" "Are there some things you have been wondering about yourself that you'd like to understand better?" "What questions do you have about yourself that we can try to answer together?" Clients' AQs are collected in their own words, signaling that the clinician takes their personal agendas seriously. This is an essential point: By not telling the client what is important and what needs changing, but instead, by centering the assessment on his or her personal concerns and agendas, TA builds in a motivation for clients to engage themselves in the process of assessment in an open and honest fashion. It often is, as one client noted, "the first time [the client] was actually involved in defining the nature of the problem."

To illustrate how AQs function, we refer to Finn's (2012) report on the TA of "Ben," a 27-year-old man with prominent borderline features who was in group and individual psychotherapy focused on managing his dangerous sexual behaviors. Ben and Finn developed the following questions for his assessment: "Why do I keep sexually acting out in dangerous ways, even though I know that it's really stupid?" "What am I going to have to do to stop acting out?" "Why do I hate myself?" As Finn (2007) explained, such AQs serve multiple purposes:

1. They give information about the client's current internal working models. For example, Ben revealed his

extremely negative self-image and his confusion and judgment about his sexual behaviors. This is useful knowledge for a clinician who wishes to affect Ben's views of himself and others.

2. AQs also enlist clients' curiosity about themselves as the TA intervention begins, which helps to lower EH and foster mentalization. In this way, Ben's questions can be seen as "open doors" he was pointing Finn toward, as if to say, "Approach me in this way and I will let you in."
3. By accepting the clients' questions as defining the boundaries of the assessment, the clinician also fosters the client's trust, as if to say, "I understand that this is where you are open to input. I will respect your limits and not directly challenge other aspects of your working model."

We now believe the coconstruction of AQs serves as a form of *ostensive cuing*, which helps establish a safe relationship with the client and moves the clinician into the role of a deferential source of information. This happens for several reasons. First, by referencing clients' questions throughout the assessment, TA clinicians establish the relevance of the information they are about to convey. As Sperber et al. (2010) explained, relevance is highly significant to epistemic vigilance because it is inefficient to put energy into comprehending information that is not personally relevant. By tying new information to the client's AQs, the assessor effectively communicates, "You might want to listen closely now, as what I'm about to say is pertinent to your personal goals." Also, by focusing on the client's AQs, the clinician demonstrates his or her goal of helping the client in the way he or she is willing and ready to receive. As summarized by Hilsenroth and Cromer (2007), research supports this assertion in showing that "collaboratively developing individual treatment goals and tasks" greatly helps clinicians foster a positive alliance with clients. This type of strong alliance is essential for circumventing EH in clients (e.g., those with PDs) who tend to be distrustful of treaters' desire to "fix" aspects of them they are not ready to change.¹

Attentiveness to self-verification and disintegration

TA theory gives central importance to two constructs that are highly related to ET: self-verification and disintegration. *Self-verification* (Swann, 1997) is the natural human tendency to take in information that confirms our internal working models and to screen out information that would disconfirm them. Although normal, self-verification is an especially strong motive for individuals with fragile senses of self, as they are prone to emotional overwhelm and *disintegration*² (Kohut, 1984) when confronted with information that contradicts their working model. As mentioned earlier, this stance

typifies the personality-disordered individuals Fonagy and colleagues described as showing epistemic petrification (pervasive EH). Although such individuals are highly challenging for clinicians to work with, TA assessors try to maintain empathy for these clients, remembering Kohut's (1984) insight that disintegration experiences are unbearable affective-cognitive states and that that fragile clients understandably will do anything they can to avoid them.

TA assessors are trained to use a particular strategy to affect the internal working models and personal narratives of individuals showing EH or petrification. As already mentioned, this strategy involves (a) reducing the clients' anxiety by recognizing their power as collaborators, enlisting their curiosity about themselves, and building a secure alliance; (b) presenting the client with a number of experiences (typically using psychological tests) that create opportunities for "bottom-up" learning (described later), and (c) slowly working both to confirm aspects of clients' working models (self-verification) and then gradually expanding those working models, all the while providing emotional support. In TA, this approach is called moving from *Level 1 information* (that matches clients' working models) to *Level 2 information* (that does not fundamentally contradict, but expands clients' working models) to *Level 3 information* (that challenges clients' internal working models; Finn, 1996a, 2007). ET is fostered not only by the TA clinician coming to be a privileged source through ostensive cuing, and by the clinician's using the AQs to signal the personal relevance of the information that will be offered, but also because the clinician sensitively conveys information that is similar enough to the client's evolving views that it does not engender epistemic distrust.

In fact, this strategy is fully consonant with the theory of epistemic vigilance by Sperber et al. (2010). They distinguished between vigilance toward the source of new information and vigilance toward its content. As mentioned earlier, relevance is one content criterion we all use to regulate epistemic vigilance, but research shows that other content characteristics are also important, such as whether the new information is coherent, logical, and whether it fits with existing "background beliefs." If new information is too divergent from existing beliefs, we are likely to reject it, even if it comes from a deferential source (Sperber et al., 2010).

Attentiveness to shame

A related aspect of TA that we believe helps restore ET in clients with PDs is its focus on shame. In an interesting theoretical contribution, Schoenleber and Berenbaum (2011) articulated how shame regulation might be central to the development and maintenance of each of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [DSM-IV]; American Psychiatric Association, 2000). Shame regulation could be primarily preventive, attempting to preclude shame experiences (e.g., in obsessive-compulsive PD, where a person might adopt extreme standards to avoid the shame of exposure of imperfections), or escape-oriented in the face of immediate or imminent shame (e.g., in avoidant PD, where a person might excessively withdraw from interpersonal

¹Of note, TA assessors also reserve time in the initial session(s) to inquire about previous psychological assessment and psychotherapy experience, cognizant that there might be past hurts from these experiences (i.e., disruptions) that might have fostered EH. When clients report such experiences, assessors show empathy for these past hurts, negotiate assessment contracts that will minimize the possibility of similar disruptions occurring again, ask clients to let them know if they feel uncomfortable, and regularly check in with them (Finn, 1996).

²Kohut (1984) described disintegration as an experience of great emotional distress, disorientation, and fear that can result when an individual is unable to refute evidence that some central and tightly held belief about the self is wrong.

situations that could yield social evaluation); or aggressive to self or others, to regulate present or past shame experiences (e.g., in borderline PD, where deliberate self-harm is exercised to cope with unbearable shame, at the same time often creating a source of shame). Irrespective of its specific form, shame works as a major “rigidifier” of the client’s experiential and behavioral repertoire. It signals the aspects of self that cannot be addressed, are “off limits,” and hence impermeable for updating on the basis of new evidence.

TA theory recognizes that shame is one of “the least tolerable affects for humans” (Malatesta-Magai, 1991) and TA clinicians are trained to address it in multiple ways (Aschieri, 2016; Finn, 2007). First as mentioned earlier, a central tenet of TA is to provide an atmosphere where clients are treated as competent collaborators, experience a lack of judgment from the clinician, and become curious about themselves. This basic therapeutic stance is identical to that recommended by experts for intervening with shame (e.g., Gilbert, 2011). Also, by allowing clients to delineate their own AQs, TA allows them to avoid topics (at least initially) that would be too shame producing to explore (i.e., shame prevention, as explained by Schoenleber & Berenbaum, 2011). Valid psychological tests can enhance a clinician’s empathy for where shame “landmines” lie, while also providing opportunities for discussing sensitive topics the client might have planned to avoid. If TA clinicians inadvertently elicit shame from their clients, they are trained to make repairs in a way that can actually strengthen the therapeutic alliance (cf. Safran & Muran, 2003). Finally, the overarching goal of TA, of helping clients construct more compassionate narratives about their problems in living, directly addresses shame (i.e., shame repair; Schoenleber & Berenbaum, 2011). When reframed in these terms, shameful “dysfunctional behaviors” that might not be discussed can be transformed into contextualized “problems in living” that can be either addressed or are in need of acceptance.

We strongly believe that shame vulnerability is a major factor that contributes to EH in PD and other clients. In fact, many of the most difficult and alienating aspects of PD (e.g., grandiosity, blaming others, impulsive behaviors) can be conceptualized as defenses against shame (Schoenleber & Berenbaum, 2011). None of us are likely to reduce our epistemic vigilance until we are assured that a communicator will not give us information that would be incredibly painful to hear. By helping clients to avoid and regulate shame, TA clinicians both cultivate ET in their relationships with those clients, and also help move them into a position of lower EH in general.

Use of assessment instruments

Mapping the structure and content of clients’ internal working models

Many a novice psychotherapist is cautioned against making “premature interpretations.” If one wishes to avoid triggering epistemic distrust by presenting Level 3 information to clients, TA might have a distinct advantage. By using standardized psychological tests as a central part of their intervention, TA clinicians have a direct and formalized way of

gaining information about the structure and content of clients’ working models and about aspects of clients’ difficulties that they might not yet be ready to acknowledge.

For example, in the case example mentioned earlier of Ben (Finn, 2012), the young man Finn helped get curious about his dangerous sexual behavior, Finn asked him early in the TA to complete the Minnesota Multiphasic Personality Inventory–2 (MMPI–2; Butcher et al., 2001), a self-report measure of personality and psychopathology that that generally provides the clinician with a mix of Level 1 and Level 2 information. The resulting profile was highly consistent with Ben’s self-presentation in revealing a difficult-to-interrupt pattern of risky and impulsive behavior. However, the MMPI–2 also suggested that the major driving force behind this behavior was that it helped Ben temporarily escape intense shame and other negative affect states of which he was somewhat aware (as shown by his AQ of “Why do I hate myself?”), but the depth and importance of which he failed to comprehend (as shown by his AQ of “Why do I keep sexually acting out in dangerous ways, even though I know that it’s really stupid?”). In addition, as is typical in TA, Finn used several empirically grounded performance-based personality instruments with Ben. Such tests can help reveal aspects of internal working models of which clients are not fully aware (i.e., Level 2 and Level 3 information; Finn, 1996b, 2012). From the Rorschach (Exner, 2003) and Early Memory Procedure (Bruhn, 1990), Finn learned that Ben was prone to falling into intensely painful affective states. These affects appeared to have their origin in severe attachment trauma during childhood related to Ben’s mother being hospitalized repeatedly for depression, Ben’s feeling responsible for her depression, and Ben and his brother being left to manage their fear and loneliness largely on their own. All of this was Level 3 information, as Ben’s working model explicitly involved his having had “good parents” who loved him and had provided him with a “good childhood,” and it was clear that he held onto to this point of view very strongly.

Our point here is that by using assessment instruments, TA clinicians gain a detailed map of clients’ working models, and this allows them to navigate—within a relatively short period of time—the potential “minefield” of therapeutic interactions with personality-disordered and other clients, by understanding what types of interpretations or interactions are likely to enhance ET or reify EH. Finn knew that to help Ben, he could not directly challenge Ben’s positive view of his childhood, and instead needed a way to help him become aware of his shame and the role it played in his sexual acting out.

Tests provide opportunities for top-down as well as bottom-up learning

When used in a collaborative manner, psychological tests also enhance ET by providing opportunities for both top-down as well as bottom-up learning. These two terms refer to complementary methods of knowledge acquisition and transmission (Sun & Zhang, 2004). Top-down learning moves from explicit to implicit knowledge; for example, a clinician says to a

client, “I think you are feeling shame right now because your eyes are downcast, your face is red, and you look like you want to disappear,” and the client accepts the term “shame” as a descriptor for this kind of experience. Bottom-up learning involves going from implicit perceptions to explicit conclusions; for example, the clinician asks the client, “Can you describe what you’re experiencing right now?” and the client replies, “I can’t look at you, my face is hot, and I want to run away or disappear.” The clinician might ask, “Do you have a word for this experience?” and then work with the client’s response, perhaps even asking, “Does the word ‘ashamed’ fit for what you are experiencing?” Although results vary by context and the nature of the knowledge being transmitted, it is generally found that some combination of top-down and bottom-up learning leads to the most efficient and effective learning (Sun & Zhang, 2004). Fonagy and Alison (2014) seemed to acknowledge this in their statement, “It is important that in this process both patient and therapist come to see each other more clearly as intentional agents. It is not sufficient for the therapist to present their ‘mentalizing wisdom’ to the patient if they are not themselves clearly seen as an agentive actor” (p. 377).

We have found that for clients with EH, such as those with personality pathology, an effective strategy is to prioritize bottom-up learning, especially early in a TA, and for the clinician to intentionally avoid positioning himself or herself too much as an “expert.” Then, in the middle stages of the TA, psychological tests are selected that create situations relevant to clients’ problem behaviors and AQs, and the clinician and client work together to draw conclusions. Two core TA techniques are particularly useful here, extended inquiries and assessment intervention sessions (AISs).

In *extended inquiries*, TA clinicians engage clients in discussing their experiences, and responses to a psychological test, with the hope of achieving new understandings (an example will follow later). As documented in many published TA case examples, such tactics can lead even clients with EH to incorporate new views of themselves they might otherwise have found to be threatening or overwhelming (e.g., Finn, 2015; Kamphuis & De Saeger, 2012; Kamphuis, De Saeger, & Mihura, 2018). Because the new information that emerges is based on the client’s own test responses and behaviors, EH is relaxed.

In the *AIS*, TA clinicians use their test-heightened empathy to arrange potential bottom-up learning experiences for clients concerning Level 3 information (which is incompatible with the current working model), often again using psychological tests or test stimuli. For example, Finn hoped to help Ben understand the relationship between his negative feeling states and his compulsive use of sex as a tension-reducing behavior. Finn also wanted a way to begin to shift Ben’s view of himself as having had a “good childhood” because this narrative led Ben to blame himself for the difficulties he had as an adult. So, in a TA session, Finn first asked Ben to rate—on a scale from 1 to 10—“how sexually compulsive” he felt at that time. Ben rated himself at 1. Finn then showed Ben a series of Thematic Apperception Test (TAT) cards and asked him to tell stories that fit the

cards. The first three cards were chosen to be emotionally neutral, so when Finn asked Ben to rate his sexual compulsivity, Ben’s ratings were low. Finn then showed Ben three highly dysphoric cards and to two of them Ben told stories about female figures who were depressed (possibly unconsciously referencing his mother). The third card, TAT 13B, depicts a young boy sitting in a doorway looking dejected, and Ben told this story:

He’s left alone again. There’s no one there for the boy. His parents are gone, his brothers and sisters are off somewhere, and he has no friends. He’s tired of all this and is sitting there waiting for his ... someone to come home. [SF: What is he thinking and feeling?] Awful. Alone. I mean I guess it’s better off to be dead ... (Ben started to cry) since nobody cares and notices.

When Finn asked Ben a few moments later to rate his level of sexual compulsivity, Ben took stock, seemed surprised, and exclaimed that it was at a 10. With Finn’s guidance, Ben then was able to agree that the “sexual acting out is a way to cope with these awful feelings.” Ben also began to spontaneously revise his working model of his childhood, saying about his last TAT story that, “I guess that was me ... that was me when I was growing up. But I don’t like to admit that.” He and Finn were then able to construct a new narrative, in which Ben’s parents were “good people” who “loved him” but who had been overwhelmed with Ben’s mother’s illness and so left Ben alone frequently with painful feelings that were too much for him. Ben’s epistemic vigilance seemed to be relaxed because this new narrative made sense of his own experience in the AIS and he therefore seemed able to incorporate it into his working model.

Tests as “authoritative” outside sources, as well as opportunities for play

As Sperber et al. (2010) explained, one other source characteristic that affects ET is *reputation*, with the implication that all exchanges of information exist in both a personal and a social context: “No act of communication among humans, even if it is only of local relevance to the interlocutors at the time, is ever totally disconnected from the flow of information in the whole social group. Human communication always carries cultural features” (p. 379). This means that inevitably, the extent to which a client believes what a particular clinician says is affected by what the client has heard about that clinician from other clients and staff, what other trusted sources (e.g., peers and family members) believe about the clinician, and by the general reputation in the client’s social group of psychologists, psychotherapists, psychiatrists, or other mental health professionals. The client’s personal experience of the source will still be important for believability, but these contextual variables are nevertheless influential, probably especially early in a communication exchange when a client is deciding whether to even listen to the source.

In TA we are aware that psychological tests are seen as an authoritative source by many clients. This does not mean that PD clients in a state of epistemic petrification will easily revise their working models on the basis of nomothetic test results. Still we have noticed that even the most skeptical clients will listen more intently when we share information

relevant to their AQs from standardized tests and when we back it up talking about research, percentile ranks, and so on. Our sense is that this openness is at least partly related to a cultural reputation of tests being more “objective” or “neutral” than personal (even expert) opinion.

Conversely, the test plane can also make trying on new personally relevant information less consequential. The same dynamic might be conceptualized from a psychoanalytic perspective. Tests, especially in the context of the AIS, can serve as “potential space,” Winnicott’s (1971) term for a sense of an inviting and safe interpersonal field in which one can be spontaneously playful while connected to others. In other words, test stimuli can serve as transitional objects to (more safely) play with, try on, and to infuse with personal meaning, before actually internalizing the emerging insights. In AIS, we deliberately use this “transitional space” (Winnicott, 1971) provided by the consulting room or test environment as a safe haven, and encourage clients to embark on a self-relevant, collaborative mentalizing experiment.

Scaffolding and targeting the zone of proximal development

Those readers with a background in education might see an overlap between TA’s schema of levels of information and the concepts of the zone of proximal development and scaffolding; we believe both are relevant to ET and EH. The *zone of proximal development* (ZPD) is a concept introduced by Vygotsky but developed more fully by others after his death (cf. Zaretskii, 2009). Vygotsky recognized that knowledge acquisition always occurs in a social, interpersonal, and cultural context, and that beyond just assessing what an individual can do alone, it is also useful to know what he or she can do with help, and what is out of reach even with assistance. The ZPD—where supported learning takes place—is the “golden target” in teaching that leads to the most rapid acquisition of knowledge by the learner. *Scaffolding*, a concept developed by Bruner and others (Bruner, 1978; Wood, Bruner, & Ross, 1976) based on Vygotsky’s work, is the process of providing temporary active assistance to help individuals achieve goals that are just beyond their ability. If one can give just enough help, but no more than necessary, a learner will show the fastest rate of knowledge acquisition.

Although Vygotsky applied the ZPD primarily to cognitive skills, and Bruner originally elucidated scaffolding with regard to language learning, both concepts can be broadly applied, are relevant to epistemic trust, and are highly applicable to helping clients update their working models during psychotherapy. In TA, clinicians are trained to deliberately “half-step” (i.e., scaffold) clients toward Level 3 information that is emerging from a psychological assessment, using tests as communication tools, maps of the clients’ working models, and as opportunities for bottom-up learning.

For example, Finn (2007) reported on an extended inquiry of the Rorschach with a middle-aged man, Jeff, done as part of a couples TA. Jeff and his wife, Ann, had sought help because of marital problems related to Ann’s

depression. Jeff found himself increasingly enraged about Ann’s struggles, and one of his main individual AQs was, “How can I deal with the feelings I get when Ann tells me she has slept all day?” Statistical results from Jeff’s psychological testing suggested that he had a dismissing attachment status and tended to avoid negative affects and focus on achievement. Also, Jeff’s Rorschach scores suggested an underlying depression that he kept at bay through a variety of characterological coping mechanisms (minimization, intellectualization, withdrawal, and manic avoidance). When taken together, this information led Finn to hypothesize that Jeff could not be appropriately empathic to Ann’s depression because he was defended against his own; in fact, from a systemic point of view, the couple appeared to be engaged in mutual projective identification where Ann “held” the depression for both, and Jeff “held” the capacity to keep going and disconnect from emotion. Finn’s dilemma was how to explore this hypothesis with Jeff and eventually, with the couple. The following is an excerpt from the extended inquiry of Jeff’s Rorschach. Finn had just finished the standardized administration of the test. Notice the “half-steps” Finn used to help Jeff revise his working model that Ann was depressed, but he was not.

SF: What was that test like for you?

J: OK ... I’m curious how you make anything out of it.

SF: Of course! I’ll be scoring your responses and then we’ll discuss your scores and see if they give us any information about your AQs. But for now, I’m curious—did you notice anything in particular about your test responses?

J: Not really. Did you?

SF: Perhaps, but I’m not sure. Can I read you back some of your responses and get your thoughts?

J: Sure.

SF: Here are some I noticed: “A bat with holes in its wings (Card I); “A smashed bug” (Card II); “A ripped tuxedo” (Card III), “An upside down bat, hanging by its feet in the dark in a cave” (Card IV). (Pause) Any impressions from those?

J: They all seem gloomy and a bit upsetting.

SF: I thought so, too. Do you think they tell us anything about your situation?

J: Well, if I let myself, I could feel really depressed about the situation at home.

SF: I can imagine. That makes sense. And what do you think if I tell you that each of these responses would get a score for depression in the research-based scoring system for the Rorschach?

J: I’m not really surprised. There’s a lot of depression, but I don’t let myself feel it.

SF: How do you do that?

J: Well in my German family, people don’t get depressed. You just put one foot in front of each other and go to work every day.

SF: Oh, maybe that explains the order of your responses on that last card.

J: How so?

SF: Well your first response, the bat hanging upside down in the dark, gets a score for depression.

J: I can sorta see that. That might be me when I just can’t take it anymore. I go in my man cave downstairs, drink beer, and watch football.

SF: That fits! And do you remember your next response?

J: (Pause) The “Keep on Trucking Guy”? (a reference to the famous Robert Crumb poster)

SF: Yes. (Pauses and looks at Jeff.)

J: That’s what I do! When I’m depressed, I just keep on trucking. And I don’t understand why Ann can’t do that, too.

This led Finn and Jeff to discuss how different people have different coping mechanisms, and that Ann might not be able to push her feelings to the side the way Jeff did. Jeff said he understood this and that he had always appreciated Ann’s emotional sensitivity in contrast to his family’s denial of emotions. Finn asked if Jeff had ever told Ann that he, too, struggled with feelings of depression, and Jeff said he hadn’t, because he didn’t want to “burden” her. Finn wrote, “It’s difficult to describe the wonder and relief that showed on Jeff’s face at that point, as he recognized his own depression, found a framework for his frustration with Ann, saw that he was being unfair to himself by not talking to Ann about his depression, and realized that his own mind had given the key for understanding all this through what he saw on the Rorschach” (Finn, 2007, p. 154). Jeff’s choice to eventually discuss his depressive feelings with Ann in a subsequent couples session was a significant step in the couple’s achieving a better relationship.

To return to ET, we propose that when clinicians successfully engage in the kind of scaffolding illustrated earlier, it has the potential to reduce EH and restore ET. Successful scaffolding requires empathy, sensitive and timely attunement, collaborative communication, and repair of disruptions—the hallmarks of secure attachment—and it is a demonstration of the clinician’s ability to mentalize the client. Although we have described scaffolding up to this point as being led by the clinician, it clearly is an intersubjective process to which both assessor and client contribute. Finn imagined something about Jeff’s inner world that he was able to communicate in a way Jeff could grasp, and Jeff helped elaborate Finn’s notion so that it was more useful and complete.

How TA addresses blind trust

As Sperber et al. (2010) stated, “Vigilance ... is not the opposite of trust; it is the opposite of blind trust” (p. 363). This assertion spurred us to bring up another difficulty we have noticed frequently in our PD clients: blind trust or epistemic hypovigilance. Some clients seem to be much too open to taking in information from others, with sometimes disastrous consequences, yet do not appear to learn from such experiences to develop appropriate ET and epistemic vigilance. Not uncommonly, some clients swing between epistemic hypovigilance, which tends to lead to relational traumas, and then inevitably switch to a stance of EH. Clients with dependent or borderline features come to mind, but we have seen a similar pattern with PD clients with prominent narcissistic, antisocial, avoidant, or even paranoid features. Our hypothesis is that such clients learned early in life to discount important internal cues that regulate ET and vigilance, in part because their primary caregivers were not reliable and trustworthy. Although adaptive when basic survival was at stake, this is highly problematic in adulthood. Such clients appear to quickly sort people into “friends” and

“foes” based on superficial or inconsequential information, and then rigidly maintain such categorizations even when there is ample evidence that they should be modified.

TA has a number of ways that it addresses epistemic “blind trust” and hence also EH. First, again, the basic collaborative frame of TA puts the client in the driver’s seat and helps build self-efficacy, confidence, and “taking one’s own authority.” For example, not uncommonly, clients come for an initial TA session bringing AQs that have been suggested to them by another person (e.g., referring therapist, parent, spouse) and that they might not fully understand. Unless such AQs address the clients’ own areas of concern, this behavior can be evidence of epistemic hypovigilance in action. In such situations, TA clinicians are encouraged to help clients explore their own agendas, which might or might not be related to the concerns others have. Almost always, the AQs suggested by others are abandoned or are greatly modified by the end of the initial session.

In general, during testing sessions, ongoing invitations to clients to describe their experiences, observe their own behavior, check tentative hypotheses against their own lives, and correct or disagree with the assessor serve to help clients pay attention to the cues that guide appropriate ET and epistemic vigilance.

Ensuring transfer to the outside world

Fonagy and his colleagues believe that promoting transfer to the outside world (i.e., change beyond the consulting room) is a cornerstone of effective psychotherapy. In other words, it is crucial that any intervention systematically promotes the third “virtuous cycle” (Fonagy et al., 2017b). We hold that this emphasis is even more crucial in clients with EH, such as those with PD. Generally, PD clients do not show up at the clinic doorstep complaining about their personality pathology. Instead, they contemplate treatment because their interpersonal style has adverse effects on life outcomes (e.g., job functioning, intimate relationships; see also Emmelkamp & Kamphuis, 2007).

We believe TA processes mentioned earlier (e.g., integration of bottom-up and top-down learning, scaffolding, enlisting clients’ curiosity) all promote assimilation and accommodation of new information, and as such, promote transfer of learning. Importantly, TA’s use of collaboration to build clients’ self-efficacy also helps them gain confidence in themselves and take risks after they finish the assessment. In addition, several other procedures integral to TA seem highly relevant to the third virtuous cycle mentioned by Fonagy and colleagues (Fonagy et al., 2017b). First, and perhaps foremost, inviting and coconstructing AQs in the clients’ own words about what it is they want to learn about themselves from the assessment will very likely yield questions that are ecologically valid to (PD) clients. Generally, PD clients will formulate questions that center on recurring problems in their social and relationship functioning (e.g., “Why don’t I work harder?” or, “Why do I cheat on my partner even though I really love him?” or, “How come I am not happy with myself, despite all my accomplishments?”). Consistently exploring these questions as the central frame for the assessment helps keep focus on what it is that matters to

the client “outside.” Moreover, the semistructured AIS and summary and discussion session specifically include steps to check for ecological validity. In the AIS, for example, after inducing a central personality dynamic deemed central to the case conceptualization, the clinician asks the client to (a) name the behavior, and then (b) check it for fit with the problem behaviors outside (Finn, 2007). When new solutions are tried during the session and found to be successful, clients are encouraged to “Try it at home!” and then come back and report what they learned. Likewise, in the summary and discussion session, after each piece of personally relevant feedback, clients are not only asked to check it for accuracy, but also to see if they can provide an example of how the element just discussed shows up in their lives (similar to the interactive style of test interpretation described by Claiborn & Hanson, 1999, in the context of career counseling, and fully consistent with two very early advocates of client participation in test interpretation; Dressel & Matteson, 1950). Also, many clients have told us that the personalized written feedback in TA has been essential in their continuing to remember and try out learnings achieved during the assessment. Finally, in follow-up sessions clients and assessors discuss how insights and suggestions derived from the assessment have helped them or not in their real-life contexts. Such procedural elements systematically foster transfer from the sessions to clients’ wider social world.

Conclusions

Theorizing by Fonagy and colleagues (Fonagy & Alison, 2014; Fonagy et al., 2015; Fonagy et al., 2017a, 2017b), as well as writings of Sperber et al. (2010), offer a new, evolutionarily informed theoretical account on the nature of psychopathology and the workings of effective psychotherapy. The central thought guiding the model is that effective interventions specialize in generating epistemic trust in individuals who struggle to relax their epistemic vigilance in more ordinary social situations, and that the restoration of ET is perhaps the most important outcome of psychotherapy. The main objective of this article was to use this model as a lens to consider the effectiveness of TA (Finn, 2007).

Our review of philosophical and procedural characteristics of TA aims to elucidate how TA might bring about restoration of epistemic trust, the prerequisite for clients with personality pathology to consider relating differently to themselves, others, and the world at large. We hold that as a package TA might be particularly effective in dislodging and motivating PD and other clients to try on new thoughts, feelings, and (interpersonal) behaviors in subsequent therapy, and ultimately, in everyday life. Moreover, we believe ET theory is uniquely suited to provide an encompassing explanation for the previously described set of five intriguing findings in the TA/CA literature on its effectiveness.

First, how is it that TA appears to benefit many different types of clients with different problems in living? Although we have given special attention to PD clients in this article, addressing EH and restoring ET is likely to be crucial to helping many clients; therefore, if TA is particularly effective in promoting ET it should show wide utility. Second, how is it

that such a brief intervention can be impactful? By enlisting clients as collaborators, arousing their curiosity and lowering EH, and using personally relevant AQs as ostensive cues, TA assessors become deferential sources who are able to use the “epistemic superhighway” and information from psychological tests to help clients update their working models in a relatively short period of time, and immediately begin trying out new understandings in assessment sessions and in real life. Other forms of therapeutic intervention might need more time both to establish a positive alliance and then to collect and put together an effective case conceptualization that can be used to guide treatment. Third, TA as a brief intervention can exert powerful positive effects on patients with PD because of its sensitive attunement to their (initially) low levels of ET, and through its variety and sequencing of techniques fostering ET. These benefits to treatment readiness could pave the way for ultimate outcomes further on, be it in subsequent treatment or not. Fourth, TA’s particular emphasis on building alliance early in the intervention and maintaining it throughout the intervention by shame regulation and avoiding disintegration experiences is likely to account for its positive effects on clients’ motivation and alliance with subsequent treatment professionals. It appears that many clients leave a TA more or less concluding, “[Some] mental health professionals will respect my competence, hold me in mind, not shame me, judge me, or overwhelm me, and provide emotional support and useful ideas about how to think and act differently in ways that are important to me.” With such an updated working model, clients are more likely to accept referrals for additional treatment and enter those situations with an open attitude. Fifth and finally, ET theory seems uniquely positioned to explain why many of the positive effects of TA continue to grow after clients leave an assessment. If TA truly leads to a lowering of EH and an increase in ET, and to learnings that aid clients in their natural social environments, they should continue to have more success in social interactions and in understanding and addressing any difficulties that arise.

Implications for assessment

To the extent that a goal of assessment is to positively affect clients, many techniques of TA could be particularly effective, including (a) gathering clients’ questions about themselves and their problems at the beginning of an assessment, (b) involving clients as collaborators throughout an assessment, (c) using scaffolding and top-down and bottom-up methods in presenting assessment results with clients, (d) using tests as authoritative sources, or conversely as opportunities for play, and (e) applying the TA concept of levels of information to organize how assessment materials are discussed with clients. All of these features of TA appear to give clients an intense and possibly life-changing experience of being mentalized (seen and held in mind) by the assessor, which greatly affects ET and the ability of clients to return to their worlds with a new capacity for social interaction, ongoing interpersonal learning, and increased flexibility.

Implications for psychotherapy

Therapists are often given general advice to “avoid premature interpretations” and “build alliance” with clients, without being taught how to implement these ideas. We believe that explicitly teaching concepts of scaffolding and top-down versus bottom-up learning to new psychotherapists could greatly help them operationalize what it means to “hold clients in mind.” Also, although many psychotherapists are not trained to use tests, collaborating with other colleagues who do, and who work collaboratively with clients, can provide essential information about places where clients are vulnerable to disintegration experiences and to therapeutic disruptions. There are many points where a CA or TA might be useful in treatment with PD clients, but two that seem particularly obvious are (a) at the beginning of treatment where there is evidence that TA fosters alliance in subsequent psychotherapy (Ackerman et al., 2000), or (b) midtreatment, especially when clients and assessors might feel stuck (Smith et al., 2014). A final area that could be strengthened in psychotherapy training is better awareness of shame: how to recognize it, how to understand it, and how to intervene when it arises. TA’s learnings about shame can be extended to psychotherapy as well as psychological assessment.

Implications for research

We echo the call of the original authors of ET theory for integral testing of the assumptions undergirding the model in clinical contexts and especially as regards PD (Fonagy et al., 2017b). A key challenge will be to derive testable hypotheses, as ET is an encompassing developmental and interpersonal theory based on concepts that are not easy to operationalize. As a research priority, we advocate that a (state) measure of level of ET versus EH be developed, although we presume that a straightforward self-report might not lend itself well to this task. In fact, we surmise that ET theorizing could more readily serve as a heuristic and clinical roadmap than as a framework for experimental testing of its core constructs. Moreover, we conjecture that hypothesis testing might be better done indirectly; that is, by comparing effectiveness of (novel) interventions and strategies that are oriented to or based on this model, versus those that are not (explicitly). In so doing, research designs are recommended that are described in the classic article by Hayes et al. (1987), particularly the manipulated (use of) assessment designs. (One approximation is the study by De Saeger et al., 2014.) For example, one might test the incremental validity of assessment models that pay explicit attention to the cyclical nature of ET (i.e., clients dropping back to lower levels of ET because of negative outside experiences, or therapists misattunement) versus those that do not.

As an example of a novel ET-based intervention, we offer our work (in progress) that we have internally coined “TA_extended.” It concerns an assessment driven intervention for clients with PD who are deemed not (yet) suitable for regular evidence-based treatment programs (often clients with a PD not otherwise specified diagnosis, or with narcissistic features). TA_extended is kicked off by a full TA as

described in this article (cf. virtuous cycle 1, holding the client in mind); followed-up by a 3-month, 5-hr-per-week program combining verbal and nonverbal therapies systematically seeking enhancement of mentalization around the core themes developed in the TA (cf. virtuous cycle 2; increased mentalization). This is followed by a 3-month self-guided period (i.e., no or minimal treatment) in which clients are expected to independently apply the new learnings in their social surroundings (cf. virtuous cycle 3; social transfer); and concludes with two booster sessions reviewing progress and remaining work (which might or might not lead to referral for additional treatment; integration). As one can see, this intervention closely follows the progression of the three virtuous cycles as proposed by Fonagy (Fonagy et al., 2017a, 2017b). We are currently working on a preliminary report describing this intervention in more detail, along with preliminary data and a case analysis.

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