

CHAPTER 14

Integration and Therapeutic Presentation of Multimethod Assessment Results

An Empirically Supported Framework and Case Example

Justin D. Smith and Stephen E. Finn

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Psychological assessment instruments are a means of getting into our client's shoes (Finn, 2007). Each assessment method and each instrument provides a unique lens through which to see and understand different aspects of clients' experiences. Because every assessment tool has its own strengths and weaknesses, multimethod assessment provides a more complete picture of the client. This in turn helps when we discuss the findings of the assessment with the client and with significant people in the client's life. Existing research suggests that clinicians using a single assessment method are likely to develop an incomplete or biased understanding of the client (e.g., Meyer, Riethmiller, Brooks, Benoit, & Handler, 2000). During the feedback process, such limited understanding can lead clients to feel misunderstood, disrespected, and not listened to by the assessor, which decreases the chances that the assessment will produce a therapeutic benefit (Finn & Tonsager, 1997).

In this chapter we present an empirically supported framework for providing feedback to clients from a multimethod assessment. We believe that this method leads to clients' feeling understood and that this in turn maximizes the potential that the assessment will lead to real and important changes in clients' lives. The conceptual foundations of our model are self-verification theory (Swann, Chang-Schneider, & McClarty, 2007) and our understanding of the contributions of different methods of assessment, including the neurobiological, interpersonal, and motivational factors involved during their administration. Our conceptualization and techniques

are illustrated in the Therapeutic Assessment (TA; Finn, 2007) of an adult woman in psychotherapy for obsessive-compulsive disorder (OCD) and a severe eating disorder who was still mourning the traumatic loss of her mother from when she was a teenager.

Rationale for Multimethod Assessment

Let us first define what we mean by a multimethod assessment. Among personality assessors, the term multimethod assessment is often used for assessments that include a broadband self-report personality inventory, such as the Minnesota Multiphasic Personality Inventory (MMPI; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) or the Personality Assessment Inventory (PAI; Morey, 1991), *and* a performance-based instrument, such as the Rorschach (Rorschach, 1921/1942). Other psychologists use the term multimethod assessment more broadly, to include assessments based on formal assessment instruments and a clinical interview, or a clinical interview and direct observation of the client. We believe a clinical interview is a necessary but not sufficient element of a comprehensive multimethod assessment, and later in this chapter we will discuss the usefulness of observational assessment techniques, especially in assessments involving multiple participants (i.e., couples and families). As we will discuss, we believe the term multimethod assessment is most applicable when similar constructs (e.g., depression, self-esteem) are formally measured with different methods that have distinct sources of error (e.g., self-report and observational rating, or self-report and performance-based test).

One challenge of multimethod assessment is a skillful integration of the findings from different methods. Beutler and Berren (1995), Finn (1996), Meyer (1997), and others have focused on different aspects of this issue. Integration is particularly challenging when different modalities produce discrepant findings, and research indicates that this is frequently the case. More than a half a century ago, Campbell and Fiske (1959) presented an empirical approach to understanding the common occurrence of multiple methods resulting in relative independence: the multimethod-multitrait matrix, which assesses convergent and discriminant validity. In research circles, the discordance between different types of tests has commonly been referred to as method bias. Meyer et al. (2001) provided a clear and useful discussion of this issue as it applies to clinical assessment. They highlighted the potential biases of monomethod assessments, argued that the construct validity of nomothetic assessment is enhanced by assessors' using multiple methods and operational definitions (see Cook & Campbell, 1979), and emphasized how the complexity of the constructs psychologists commonly assess in clinical practice contributes to low cross-method correlations. Further, Meyer and colleagues (2001) empirically demonstrated

that different methods of assessment provide unique and distinctive data that are not available from other sources.

One of the formative works in this area comes from McClelland, Koestner, and Weinberger's (1989) review of the association between behavior and self-attributed and implicit motives, derived by self-report and stories written to pictures, respectively. They concluded that the paucity of significant correlations was due to differences in the motives of the subjects inherent to the two different methods. That is, self-report is likely based on more cognitively elaborated constructs, whereas implicit measures tap into a more primitive, affectively driven system. In keeping with this conclusion, Meyer and Kurtz (2006) argued that the common taxonomy of personality tests as being "objective" or "projective" was outdated and misleading. Accordingly, they proposed new terms they felt more accurately depict the nature of the assessment stimulus and the way in which the assessor interprets the results. The term *performance-based* assessment is increasingly being used in the field of personality assessment to replace the former *projective* label. "Objective" tests are now given more descriptive labels, such as self- or parent report. Complementary classification systems have also been offered. For example, Bornstein's (2002) process-based framework relies on the attribution processes involved in responding. Self-report measures involve a self-attribution process in which the subject consciously assesses the extent to which an adjective, statement of behavior, or other descriptive stimulus applies to them. Assessment methods requiring the subject to respond to the attributed nature of an external stimulus (e.g., inkblot, picture) are labeled as stimulus-attribution tests, with the assumption that subjects draw from nonconscious cognitive systems in the production of verbal responses. Schultheiss (2007) proposed classifying tests according to a widely used model of human memory systems, drawing a distinction between declarative (consciously accessible memory systems) and nondeclarative methods (i.e., nonconscious memory systems whose operation is reflected in the subject's performance).

More recently, Finn (2012) drew from research in attachment, infant development, and developmental neurobiology research to conceptualize the ways in which different psychological assessment methods activate specific brain functions and how assessment psychologists can be more effective agents of therapeutic change. As summarized by Finn, the research of Schore (2003, 2009), Siegel (2012), Cicchetti (1994), and others indicates that attachment relationships in infancy influence critical areas of brain development that provide the foundation for important functions, such as emotion regulation, empathy, social relatedness, moral development, and behavioral control. Underdevelopment of these functions during childhood is implicated in the development and maintenance of a host of problems later in life (e.g., Cicchetti & Toth, 1998; Shaw, Gilliom, Ingoldsby, & Nagin, 2003).

Schore has amassed an impressive amount of evidence showing that the right hemisphere of the brain is dominant in the processing of attachment arousal and other affective experiences, especially those involving trauma. The right hemisphere has dense reciprocal connections to the limbic and subcortical areas of the brain, which process affect and subtle interpersonal signals at a subconscious level and are not readily accessible through language (Schore, 2009). Further, Schore (2009), Bromberg (2006), and others have explained how the successful psychological treatment of individuals with early attachment trauma requires that the therapist form a secure auxiliary attachment relationship with the client and nonverbally relate "right hemisphere to right hemisphere," to use Schore's terminology. This nonverbal communication serves to regulate the client's negative affect states, enhance positive affect states, and reorganize the way in which the right hemisphere processes affect (Schore, 2003). A recent meta-analysis by Diener, Hilsenroth, and Weinberger (2007) revealed that the relationship between affect focus, defined as the therapist drawing the client's attention to his or her affect state in the moment, was significantly correlated with treatment outcomes ($r = .30$), highlighting the importance of activating right-brain processes in psychological interventions.

The implications of this research are numerous and will be enumerated in later sections of this chapter. Returning to the issue at hand, we note that neurobiological research suggests that different assessment methods tap into different areas of the brain (Finn, 2012). The verbal and non-emotionally arousing administration of common self-report instruments, such as the MMPI or PAI, appears to activate more left-hemisphere cortical functions, while tests such as the Rorschach and the Adult Attachment Projective Picture System (AAP; George & West, 2012) activate more right-hemisphere and subcortical functioning due to their visual, emotionally arousing stimulus properties and the interpersonal demands of their administration (see also Fowler, Hilsenroth, & Handler, 1996; Meyer, 1997). As a result, performance-based tests activate implicit schemas about self and other, which are reflected in interpersonal patterns between assessee and assessor as well as in specific responses to test stimuli. In some individuals, such as those with a dismissing attachment status, these implicit patterns are quite discrepant from consciously accessible perceptions reported on self-report inventories (e.g., Dozier & Lee, 1995). Thus, performance-based tests can provide a window into right-hemisphere disorganization and subcortical dysregulation in clients with insecure attachment and developmental trauma histories that would not be readily available otherwise.

Functional magnetic resonance imaging (fMRI) and electroencephalography (EEG) studies using Rorschach inkblots as stimuli have consistently revealed subcortical activation when certain percepts related to emotional arousal are reported. Asari et al. (2008) found that individuals with lower form-quality scores had larger amygdalas—a sign of more frequent amygdalic activation—suggesting that emotional activation greatly

influences the extent to which one distorts reality. In a study involving the receipt of negative feedback, Jimura, Konishi, Asari, and Miyashita (2009) found greater activation of the posterior medial prefrontal cortex, an area implicated in the processing of negative emotions, for those individuals with higher C' scores on the Rorschach. Last, human movement responses (M) on the Rorschach have long been considered an index of developmentally advanced cognitive cognition, such as the ability to imagine (movement from a static stimulus) and the capacity for empathy (due to the implied ability to identify a human being in an ambiguous inkblot). Research using EEG found significant mu wave suppression when subjects perceived human movement (i.e., reported a percept with an M determinant) (Giromini, Porcelli, Viglione, Parolin, & Pineda, 2010). These studies not only provide evidence for the validity of long-held interpretations of these Rorschach scores, but also demonstrate the activation of brain areas associated with salient functions for psychological health and well being, as well as assessment and psychotherapy.

The assessment of attachment security offers a prime example of where activation of different neuroanatomical structures may account for disagreement between methods. Attachment security can be assessed through self-report measures, which yield an attachment "style," or performance-based measures (such as the AAP or the Adult Attachment Interview), which result in an attachment "classification" or "status." A meta-analytic review of the empirical overlap of self-reported attachment style and AAI security classifications showed a trivial association ($r = .09$) (Roisman et al., 2007). These results indicate that these two methods assess different aspects of attachment security and that self-reported attachment styles are not analogous to the results obtained from the AAP.

Neurobiology research findings are again useful in understanding the brain processes involved in the assessment of attachment classification. Buchheim and colleagues (2006) administered the AAP in an fMRI environment. In one study of 16 nonpatient adult women, 6 were classified with an organized attachment status (secure, dismissing, or preoccupied) and 5 were unresolved or disorganized, which is particularly associated with past trauma and various forms of psychopathology. (The scans of five women were not analyzed due to excessive head movement; Buchheim et al., 2006.) The fMRI results showed increased limbic system activation, centered mainly in the right amygdala and hippocampus, in the women classified as disorganized compared to those who were organized. These two brain regions are associated with fear and autobiographical memory, respectively. Thus, the AAP might have reactivated "unresolved" traumatic or negative autobiographical memories in the women with disorganized attachment classifications. A second fMRI study found differences in the neural responses to the "alone" versus "dyadic" pictures of the AAP between a group of 11 women diagnosed with borderline personality disorder (BPD) and 17 nonpatient women. The BPD group had significantly

more activation in the anterior midcingulate cortex in response to the alone pictures and more activation of the right superior temporal sulcus and less activation of the right parahippocampal gyrus compared to nonpatients. These activation patterns indicated greater activation of brain areas associated with pain and fear in the BPD group. Further, the BPD group had more traumatic markers in their verbal responses to the alone pictures, an indication of attachment trauma (George & West, 2012). Advances in neurobiology and brain-imaging technology are helping assessment psychologists better understand the processes that are activated when they use different assessment procedures.

Discordance between methods is not limited to comparisons between self-report and performance-based tests. The literature comparing assessment methods, most commonly self-report compared to observation by the clinician or some other informant, often results in small to medium correlations (e.g., Achenbach, McConaughy, & Howell, 1987). A potent example of the clinical implications of multimethod assessment comes from a study examining clients' reports of suicidality and suicidal ideation during a clinical interview and responses to the MMPI-2 (Glassmire, Stolberg, Greene, & Bongar, 2001). The results showed discordance rates between these methods ranging from 9.6% to 19.1%. Glassmire and colleagues concluded that the six suicidality items on the MMPI-2 contributed valuable information above that obtained through verbal self-report.

After the administration of a well-constructed multimethod assessment, the assessor is left with a wealth of actuarial data derived from various sources and assessment methods alongside clinical intuition, observation, and historical information about the client to provide context and ecological validity to the nomothetic results. The ethical principles of the American Psychological Association (American Psychological Association, American Educational Research Association, & National Council on Measurement in Education, 1999) clearly dictate that assessors provide clients with feedback of the results of assessment. So then, the issue at hand is how to best present findings for the benefit of the client.

An Empirically Supported Framework

The importance of a model grounded in empirically derived theory and techniques is evident in the growing evidence base for the therapeutic effectiveness of psychological assessment in general and collaborative and therapeutic models of assessment specifically. In a meta-analysis of 17 studies made up of 1,496 adult and adolescent participants comparing psychological assessment to a comparison condition, Poston and Hanson (2010) found a significant overall effect (Cohen's $d = 0.423$) favoring the therapeutic effectiveness of psychological assessment. They concluded that personalized, collaborative feedback, highly involving the presentation of test

findings, results in clinically meaningful effects. Studies included in this meta-analysis employing the empirically supported framework described in this chapter (e.g., Finn & Tonsager, 1992; Newman & Greenway, 1997) resulted in the largest group differences, particularly in reducing distress and increasing self-esteem.

The guiding framework for assessment feedback described in this chapter builds on the work of Finn and colleagues (e.g., Finn, 1996, 2007; Finn & Tonsager, 1992, 1997), which emphasizes clients' motive for self-verification (e.g., Swann et al., 2007). Self-verification theory posits that human beings are inherently motivated to seek confirmation that their views of themselves and their experiences of the world are accurate, or at the very least, shared by others. When people have experiences in which their self-views and preconceptions are challenged or shattered, a very uncomfortable and disorienting feeling can follow, leading the person to experience the world as not real and to feel that he or she is falling apart. Kohut (1977) termed this experience disintegration anxiety. Clients' intrinsic search for self-verification and the related need to defend against disintegration anxiety guides the process of feedback delivery employed a useful heuristic that Finn has termed "levels of information."

Levels of Information

Finn (1996) postulated that test feedback is more powerful and useful for clients when it is ordered according to clients' existing views of themselves. Schroeder, Hahn, Finn, and Swann (1993) found that undergraduates were more positively impacted by receiving feedback about personality traits when they were presented in this manner. As a result, Finn has recommended that, in most cases, information derived from an assessment be presented to clients in increasing "levels." Level 1 (L1) information is congruent with the client's self-view and is generally readily accepted. Level 2 (L2) feedback is mildly discrepant from the client's self-view and often modifies or amplifies clients' usual ways of thinking about themselves. These findings are typically well received when presented as hypotheses for discussion. Clients rarely reject L2 findings because they are unlikely to be a threat to core beliefs or the client's self-esteem. Finn recommended that the majority of the findings in an assessment feedback session should be L2.

Level 3 (L3) findings are those that are highly discrepant from the client's usual way of thinking. This kind of feedback is typically very anxiety provoking for the client and often mobilizes their characteristic coping mechanisms. Assessors need to monitor how overwhelmed the client is becoming as L2 and then L3 information is presented and decide whether to continue presenting a novel way of viewing and understanding the client's situation. The ordering of feedback from L1 to L2 to L3 is one way of titrating clients' emotional arousal by helping them feel understood and supported by the assessor. Finn (2007) recommends discussing assessment

findings with clients by taking “half steps,” as opposed to jumping directly to the next level. We discuss some of the inherent challenges and potential pitfalls of presenting L3 feedback later in this chapter.

As will be discussed later, although any test can produce L1, L2, or L3 information, there appears to be a correlation between assessment method and the level of results that are produced, with performance-based methods yielding more L2 and L3 information than do self-report tests and self-report tests providing more L1 information. For this reason, Finn (1996) strongly recommended that assessors use a combination of self-report and performance-based tests in most assessments.

Preparing Clients to Accept Feedback

In TA, Finn and his colleagues also paid special attention to how to help clients accept L2 and L3 information. The process of preparing clients for feedback begins in the initial interview and continues throughout the assessment, using various techniques. A complete discussion of this topic is beyond the scope of this chapter, but we wish to mention three techniques that are particularly useful. First, asking clients to pose specific questions about themselves and their situations that they wish to have addressed by the assessment greatly facilitates feedback. Finn (2007) found that getting questions early on enlists clients' curiosity and lowers defensiveness, and that clients' are more willing to accept L2 and L3 information later in an assessment if it is relevant to their questions. Second, engaging clients in discussing their actual test responses, experiences, and test behaviors (generally after standardized administration is completed) can help them grasp information that would be threatening if presented in isolation in a post-testing feedback session (Fischer, 1985/1994; Smith & George, 2012). Finn (2007) calls this technique the “extended inquiry” when it is done spontaneously and without planning, and “an assessment intervention” when it is carefully planned with the goal of highlighting potential L3 findings. (See Finn, 2003, 2011, and Smith, Finn, Swain, & Handler, 2010, for examples.)

Third, a somewhat unique set of procedures is applicable to assessments of couples and families: observation and video feedback. In the child and family TA model, Finn (2007) and Tharinger et al. (2012) invite parents to observe their child's testing from a corner in the room through either a one-way mirror or a video link. This arrangement allows parents to hear and see the results of the assessment themselves, which is less threatening than direct feedback from the assessor. For example, the parents might see their child as being oppositional and noncompliant because he or she is a “bad” child. After witnessing the child seeing “a sad kitty” on Card 1 of the Rorschach and telling stories to picture stimuli with dysphoric themes, they might come to understand the child's problem behaviors as an indicator of underlying depressive affect.

A specific intervention technique in use in a variety of family-based interventions is called video feedback, which involves the parent(s) viewing a videotaped interaction between themselves and their child(ren) alongside the clinician, with the aim of improving parenting skills and the quality of familial relationships. Tharinger et al. (2012) assert that observational techniques help parents “step back” and examine the child and family interactions with new eyes. Smith, Dishion, Moore, Shaw, and Wilson (2013) examined the incremental effects of adding a video feedback component to the feedback session of a family-based collaborative assessment intervention for early childhood problem behaviors. Video feedback given to caregivers when their children were age 2 reduced those caregivers’ negative relational schemas (i.e., attributions about the child) at age 3, which in turn led to less caregiver coercive behaviors assessed at age 5. Video feedback involved parents’ viewing segments of previously videotaped family interaction tasks that assessors had selected as examples of desired, positive parenting behaviors. Smith et al. (2013) postulated that observational techniques such as video feedback allow parents to disembed from emotionally laden interactions in which their responses are based on overlearned relational patterns that lead to inaccurate beliefs regarding the intent of the child’s behaviors. From a neurobiology perspective, we might postulate that such procedures shift information processing from limbic regions to the prefrontal cortex. Smith and colleagues (2013), Tharinger et al. (2009, 2012), and Holigrocki, Crain, Bohr, Young, and Bensman (2009) all found that when assessors support parents in observing their children during an assessment, parents can shift their understanding of their children’s problems and the entire family system can change in positive ways.

Integrating Findings of Multimethod Assessment

As discussed earlier, we believe that multimethod assessment is clinically useful because it helps assessors compensate for the limitations of different assessment methods and integrate their strengths. One instance where this integrative approach has been well articulated concerns the convergence or divergence of findings from self-report and performance-based personality methods. Earlier we reviewed the primary neurobiological, interpersonal, cognitive, and motivational factors of these two assessment methods. Now let us spell out the implications of these factors for understanding different assessment findings and discussing them with our clients. Finn (1996) proposed a model for integrating findings from the MMPI-2 and Rorschach; however, this model is generally applicable to combinations of other self-report and performance-based personality tests. Four primary patterns (see Figure 14.1) can be obtained from considering the level of distress or disturbance on the two tests. Distress and disturbance can be looked at generally or as it regards specific problem areas (e.g., thought disorder, anger

		Apparent Degree of Disturbance on Self-Report Instrument	
		High	Low
Apparent Degree of Disturbance on Performance-Based Instrument	High	Cell A	Cell B
	Low	Cell C 1 2	Cell D

FIGURE 14.1. Configurations of self-report and performance-based assessment findings.

control problems.) The two convergent cells (A and D) represent assessment situations where the results of both tests show either high or low levels of disturbance. These results are relatively easy to interpret and subsequently to discuss with clients. Cell A indicates that clients' problems are clearly evident in their day-to-day functioning, they are aware of these problems, and they are willing and able to report them on a self-report inventory. This is a common pattern among voluntarily referred help-seeking clients. Test results falling in Cell D indicate that clients function well in structured and less structured situations, with and without interpersonal interaction, and are rarely found in clinical settings. In both cases of convergent results, the client is unlikely to be surprised by feedback on the assessment findings.

Two cells, B and C, indicate an apparent disagreement between the two types of tests. Cell B indicates low disturbance on self-report and high disturbance on the performance-based test. This finding suggests that the client has psychopathology that emerges in less structured, interpersonal, emotionally arousing situations. However, the client is believed to function relatively well in structured situations where he or she can enlist intellectual resources to manage emotional arousal. Such clients are often unaware of the full extent of their difficulties and are thus unable to report them directly. Giving feedback to such clients is complex because any discussion of their underlying difficulties may not be self-verifying (i.e., may be L3 information). These clients are also prone to becoming overwhelmed, flooded, confused, or defensive when assessors try to discuss their underlying problems.

Situations where there is high disturbance on self-report instruments and low disturbance on performance-based tests are represented by Cell

C. This is the least common constellation in clinical settings and is more frequently found among clients applying for disability or involved in an assessment for forensic or litigation purposes. Cell C can be further divided to account for the client's level of engagement on the performance-based test. In the case of the Rorschach, for example, the complexity of the protocol is evident in the number of responses (*R*), the percentage of Pure Form responses, and the amount of color determinants coded. When engagement is adequate on the Rorschach, the distressed and disturbed self-report findings may represent a "cry for help" from the client or the possibility of deliberate malingering—in situations when the assessment context suggests the client may be motivated to present with high psychiatric disturbance. When there is low engagement and complexity in the client's Rorschach responses, the client may have reacted with withdrawal, constriction, or dissociation in response to the highly arousing interpersonal and emotional demands of the performance-based test administration. In such situations it is generally better to believe and affirm the client's distress and disturbance on the self-report test and to hypothesize that others may not always be able to perceive the client's level of distress. The client will feel deeply misunderstood if the assessor mistakenly asserts that symptoms were intentionally overreported on the self-report measure.

Reaching Appropriate Depth Is Necessary for Lasting Change

Lilienfeld, Garb, and Wood (2011) suggested that the therapeutic benefits of assessment feedback evidenced by Poston and Hanson's (2010) meta-analysis could be explained by a phenomenon called the Barnum effect. The Barnum effect refers to a type of subjective validation in which a person finds personal meaning in a statement that likely applies to many people. Such phrases are often called Barnum statements. An example of a Barnum statement would be, "You have a need for people to like and admire you, and yet tend to be critical of yourself." The decade's old assertion that clients' positive reactions to personality test feedback are due to the Barnum effect is not supported by empirical evidence (e.g., Furnham & Schofield, 1987). Recent research on the Barnum effect is scant, likely because it was largely rejected more than a quarter century ago. Studies that have been conducted provide evidence that speaks against the Barnum effect (e.g., Andersen & Nordvik, 2002; Schroeder et al., 1993). The findings of the Schroeder et al. (1993) study indicate that the greatest therapeutic benefits occur when the majority of feedback is L2. Given that L2 feedback is conceptualized as being slightly discrepant from current self-views, which likely raises some anxiety for the client, this finding suggests that therapeutic outcomes of assessment are somewhat contingent upon eliciting moderate emotional arousal during feedback. These results are consistent with the meta-analytic findings of Diener et al. (2007) indicating that better outcomes were related to clients' in-session emotional exposure. In

assessment, this occurs when feedback is highly individualized and is presented in accordance with our framework.

Advantages of Multimethod Assessment

In terms of the feedback process specifically, multimethod assessment has some distinct advantages over reliance on a single measure or clinical judgment. One of the challenges of our guiding framework is to determine which levels of information test findings are for each client. Fortunately, the different assessment methods of a multimethod assessment provide a scaffold. The convergence of findings from different methods is a key factor in determining the congruence of a finding with the client's self-view. For example, self-report measures reveal the client's general self-view at the time of testing and their self-representation (how they believe others see them). Thus, the majority of the findings from self-report measures are L1 and L2. Self-report item endorsement can be L2 because of the empirical correlates of response constellations: Although clients endorse certain individual items, they might not fully appreciate their meaning when considered in conjunction with other responses. For example, clients might endorse experiencing fatigue, difficulty sleeping, apathy, and dysphoria on a self-report questionnaire, but they may not have considered that they are depressed. With proper preparation and presentation of the findings, this finding could be easily rejected if the assessor leapt to the conclusion that the finding is L1.

Returning to the model in Figure 14.1, we see that the convergence of test results in Cells A and D suggests that clients are likely to accept the findings of the assessment regardless of the source of the findings (i.e., the instrument). In cases where a discrepancy exists between the findings on multiple methods (Cells B and C), the assessor should begin with an acknowledgment of the self-report findings prior to presenting the results of the performance-based test(s). In the case of Cell B, where there is a suggestion of underlying pathology that the client is unaware of, or at least is reluctant to report, the level of disturbance, the assessor must proceed cautiously and adequately prepare the client. This is illustrated in our case example.

Additionally, the inclusion of performance-based assessment methods affords unique, client-specific material. Finn (1996) suggested presenting assessment findings employing the language, imagery, and metaphors used by the client during clinical interviews and performance-based test responses. For example, we might know from her MMPI-2 that a client is severely depressed, but we may choose to discuss it with her using the language of her first response to Card I of the Rorschach: "The testing suggests that lately you are feeling battered and tired from the 'wars' you have been through, and you're wondering if you're going to be able to keep

on going.” Using such client-generated languages, images, and metaphors can help clients feel deeply mirrored and understood, and that someone is helping to “hold” or “regulate” difficult emotional states. This effect can be particularly salient when presenting L3 findings: The client is more likely to accept and integrate L3 findings into their existing self-concepts if they are able to stay interpersonally regulated. The “right-brain to right-brain” communication between the client and assessor serves this function. Metaphor can similarly aid in the client’s understanding and acceptance of abstract or complex psychological processes.

Challenges of Multimethod Assessment Feedback

Having made the case for multimethod assessment, it seems important to also acknowledge that it produces a host of challenges for the assessor. This may be one reason why some assessors use only one method, such as an interview or a self-report measure.

Time and Money

First, it must be acknowledged that multimethod assessment, especially when it includes performance-based instruments, takes more time and is therefore more costly than single-method assessment. Luckily, advances such as computer-assisted coding, and a new, leaner system for interpreting the Rorschach—the Rorschach Performance Assessment System (R-PAS; Meyer, Viglione, Mihura, Erard, & Erdberg, 2011)—have increased the efficiency of such methods. Also, the AAP takes much less time than the previous gold-standard measure for determining attachment status, the AAI. Still it is conceivable that in certain settings, where service demands are high and psychologists are in short supply, multimethod assessment will have to be reserved for clients who are particularly difficult or puzzling.

More Skill Is Required in Giving Feedback

Also, because performance-based measures produce more L3 information, it takes a greater level of skill and sensitivity to give feedback to clients about their results. In fact, we believe that assessors who wish to give feedback to clients through multimethod assessment will greatly benefit from training in psychotherapy in addition to training in psychological assessment. And because information from performance-based and implicit methods is more likely to dysregulate clients, assessors need training in techniques that help prepare clients to incorporate L3 information, such as extended inquiries. As mentioned earlier, assessors will need training in how to determine beforehand what is L1, L2, and L3 information and how to present such findings in a feedback session. Last, training in collaborative assessment

methods seems crucial. The evidence is now clear that collaborative versus “delivered” (i.e., unilateral) feedback has much more impact on clients (Hanson, Claiborn, & Kerr, 1997). And when assessors help clients tie test findings to events and experiences in their daily lives, test feedback becomes more accessible, memorable, and useful (Fischer, 1985/1994).

Demands on the Assessor

Multimethod assessment is more time consuming than is single-method assessment, and Finn (2007) has asserted that it is more emotionally demanding as well. Assessors find themselves thinking about and feeling more about the clients they assess, and emotionally arousing responses to the EMP, Rorschach, and AAP may be difficult to leave at the office door. Many assessors find it challenging that frequently they cannot tell clients everything they have learned from a multimethod assessment; some L3 information would just be too disruptive for the client at the time of the assessment and needs to be “contained” by the assessor. In such situations, it can be very helpful if one can share such information with a referring professional, if there is one, who can “hold it” until the client is ready to hear it later in psychotherapy. For these reasons, Finn (2007) has suggested that therapeutically oriented multimethod assessment is best practiced in the context of a community of colleagues who share similar goals and training.

Case Example

We illustrate our empirically supported approach to feedback with one of the most common assessment configurations in clinical settings—discordant self-report and performance-based results (Cell B)—and describe how the results of a multimethod assessment clarified the etiology of the client’s diagnosis and informed ongoing psychotherapy with the referring psychologist. The first author (JDS) was the assessor in this case, and all first-person pronouns refer to him.

Referral

Karen, a 57-year-old unemployed mother of three young adult daughters, was referred for a psychological assessment in order to help her better understand her diagnosis and clarify the goals and intervention approach of stalled, 2-year-long psychotherapy. Karen was diagnosed with OCD shortly after she began treatment with her current psychologist. Despite what appeared to be an accurate diagnosis, cognitive-behavioral therapy, largely consisting of exposure and cognitive restructuring, had been unable to appreciably reduce Karen’s OCD symptoms. Similarly, she was still unable to maintain employment and was forced to rely on disability,

alimony, and a dwindling trust fund. In our account, we will focus mainly on the verbal feedback provided to Karen regarding one of her assessment questions: "How did my mother's death affect the development of my OCD?"

Background and Early Memories

Karen was the only child of married parents; her father was a scientist and her mother a high school teacher. Karen's report, and her responses on the Early Memory Procedure (EMP; Bruhn, 1992) painted a picture of her mother as critical and harsh, while her father was detached, analytical, and goal-oriented. Karen recalled that her parents were good functional caretakers but that she never felt emotionally supported. She recalled a number of memories during the EMP consistent with this sentiment. The EMP is a test of early autobiographical memories in which the client is asked to recall the five earliest, specific one-time memories or events and describe these events in as much detail as possible. The EMP can be used as an initial assessment procedure to gather and explore information related to early childhood experiences and family history. One of the most salient memories for Karen was from when she was about 4 years old. The family was eating fish and a small bone became stuck in Karen's throat. She wrote, "My father, the engineer, gets out the needle nosed pliers and a flashlight and tries to get the fishbone out by sticking the pliers down my throat." Karen's parents became annoyed because she kept gagging when the pliers went down her throat, and they eventually had to take her to the emergency room to have it removed. She felt blamed for something she couldn't have avoided. She wrote that she wished her parents had acknowledged her helplessness and fear rather than blaming her.

On the sixth memory of the EMP, which is a particularly important or vivid memory from any time in the client's life, Karen immediately chose to write about her mother's death. She reported that the images were really fresh in her mind: arriving home from school to find her father on the front porch and knowing that her mother had died (her father was never home after school), running to him and collapsing on the cement as he met her in the driveway, then crying the rest of the night. In discussing this memory with her later, I learned that Karen's mother had been ill with a very painful type of cancer. When morphine failed to ease her pain, she resorted to a drastic measure: surgery to sever her spinal cord below the shoulders, which did not relieve the pain and resulted in her requiring full-time care. During the day a nurse cared for her in their home. When Karen arrived home from school, she took over her mother's care for the 3-4 hours until her father arrived home from work. Karen was just 12 years old. Among other duties, she administered her mother's pain medication, most often morphine, which required very precise measurement: Too little and her mother would be in intense pain; too much and her mother would die.

Karen reported that she never expressed grief following her mother's death because she felt she needed to be strong for her father because he was "falling apart." Her mother's death was never spoken about, and photographs of her were taken down and hidden not long after her passing. Karen's father drank heavily for about 9 months, during which time Karen's issues with perfectionism and body image intensified. When Karen was 11 years old, prior to her mother's being diagnosed, she recalled her mother telling her that she would need to lose weight to be accepted by her peers. She insisted that Karen weigh no more than 95 pounds (Karen was 5' 2"). As her mother became ill, Karen began restricting and exercising daily. She remembered a time when she was caring for her mother that she went into her room wearing only underwear and a bra. Her mother smiled and remarked that she was beautiful. Karen felt that she had finally achieved the proper weight—she was 90 pounds—and she did whatever was required to maintain that afterward. She struggled with anorexia and binge eating throughout high school, college, and early adulthood, requiring brief hospitalizations more than once during college when her weight became dangerously low. Karen's self-assessment that her mother's death was the catalyst in the development of her OCD appeared plausible.

Summary of Assessment Results

Karen's TA consisted of a multimethod assessment of cognitive functioning, personality characteristics, and attachment status. These areas of functioning were assessed because they mapped onto the full list of Karen's assessment questions. Results of the Wechsler Adult Intelligence Scales, 4th Edition (Wechsler, 2008) indicated a Full-Scale IQ of 115, with a significant discrepancy between her Verbal Comprehension (127) and Perceptual Reasoning (98) indices. Her MMPI-2 profile was valid, but suggested that Karen tended to minimize her distress and socially undesirable problems and tried to present herself as "having it all together" ($L = 52$ [T-score], $F = 44$, $K = 74$, $S = 68$). Consistent with this response set, no Clinical Scales were elevated. Scales 3 ($Hy = 61$) and 7 ($Pt = 62$) were the highest, signifying obsessive-compulsive tendencies, anxiety, phobias, irrational fears, and perfectionism and a tendency to manifest psychological symptoms as physical or health complaints ($HEA = 53$; the highest Content Scales score). Karen's strong dependency needs ($Hy_2 = 63$) and overcontrol of anger ($Hy_5 = 62$, $O-H = 63$, $AGGR = 38$) are also notable. Among the Supplementary Scales, only the Repression scale ($R = 86$) was clinically elevated; this score suggested that Karen used repression, denial, and rationalization, was over-controlled, and lacked insight.

The results of the Rorschach, scored using the R-PAS (Meyer et al., 2011), indicated significant psychological impairment. Karen produced a 33-response profile ($R = 124T$; $Pu = 98T$), with evidence of severe perceptual and thinking problems ($EII-3 = 130T$; $TP-Comp = 122T$; $WSumCog$

= 129T; *SevCog* = 138T), morbid thoughts, images, and feelings (*MOR* = 123T), a tendency to misperceive the actions and intentions of others (*M-* = 123T), and a preoccupation with the vulnerability of her body or its functions (*An* = 133T). She also scored very high on a measure that is sometimes associated with past trauma (*CritCont%* = 134T).

Karen's AAP was judged to be Unresolved, indicating that she had significant difficulty regulating affect when her attachment system was aroused and a disorganized defensive pattern. People with this result are unable to consistently reorganize after their attachment system is activated and are prone to experiencing unexpected overwhelming and disorienting affect as a result. There was also evidence in the AAP of failed mourning (i.e., the unresolved loss of an attachment figure), which is the prolonged absence of conscious grieving and a detached psychological state involving deactivation defenses (i.e., the avoidance of emotions and a focus on achievement, rules, and doing things the "right" way). This type of Unresolved attachment status has been found to be related to abandonment by an attachment figure that compromises psychological safety. Consistent with empirical research of failed mourning, Karen experienced physical stress reactions, eating problems, and a compulsive need to care for others at the expense of meeting her own needs (see George & West, 2012). When we discussed her AAP stories after the standard administration (i.e., during the extended inquiry), Karen and I were able to connect her current difficulties with her past experiences in a way that validated her experiences and fostered self-compassion. Karen reported that her attempts to control her life had "ballooned" after her mother died, and she agreed that she avoided painful emotions and tried to be entirely self-reliant so that she would not have to risk another devastating loss.

Planning the Feedback

The results of the standardized testing, most notably the discrepancy between self-report and performance-based assessment methods, suggested that it would be very important to order information about Karen's psychological struggles when giving her feedback, in accordance with self-verification theory. We hypothesized that Karen had developed obsessive-compulsive defenses in response to her traumatic attachment experiences and failed mourning, perhaps in combination with a genetic predisposition toward OCD (her father had an OCD diagnosis). Karen's OCD consisted of contamination fears and behavioral and affective avoidance of perceived threats and emotionally arousing situations. Basically, the testing suggested that she avoided emotions because she easily got overwhelmed and dysregulated by strong feelings. When this happened, her obsessive defenses would kick in as a way to manage her emotions ("If I can just control every aspect of my life, I'll be safer"), but these defenses themselves were painful and distressing. The MMPI-2 indicated that her obsessive-compulsive anxiety,

perfectionism, and health concerns were congruent with her self-view, while failed mourning and the related need for affection were not well integrated. We now present an abbreviated, annotated transcript of the discussion surrounding Karen's primary question about the effect of her mother's death on the development of her OCD. We note the level of information of each finding as well as how the assessor **tired** to help Karen feel understood and valued in order to guard against possible disintegration anxiety when presented with feedback that differed from her current self-views.

Multimethod Assessment Feedback Presentation

ASSESSOR: Before I present assessment results related to this question, what is your best guess as to the answer? [This type of inquiry helps the assessor gauge what new information the client has been able to integrate during the assessment and also helps the assessor determine the level of the findings.]

KAREN: I think it had a lot to do with it. I had control issues around food before that, and I always expected myself to be perfect in school, and I mean perfect—it wasn't enough to get an A, I had to get a perfect score. But after my mother died, my OCD took on a life of its own.

ASSESSOR: Karen, the link you are making seems accurate to me based on the assessment and the experiences you shared with me [validating the client's self-view]. Do you have a sense about why the OCD took on a life of its own? [Using client's words helps the client feel understood.]

KAREN: (*Laughs*). Well, I didn't seem to have much of a choice, did I? My father was falling apart, and I had to keep plugging along for both of us.

ASSESSOR: You were in a really tough situation after your mother passed away. With your father having such a difficult time, someone had to stay strong and make sure the family didn't collapse [L1: Karen feels heard; adding contextual considerations aids in the development of self-compassion.] It seems that you did the best you could at the time to get through a scary situation [introduces the frightening nature of not being cared for by her father following the loss of her primary attachment figure], which was to pull yourself together, focus on school [L1], and try to maintain equilibrium [Karen had used the word *equilibrium* to describe the feeling of being emotionally regulated]. Sometimes the behaviors and thoughts associated with OCD, such as perfectionism in school and focusing on food and your weight, arise out of a need to cope with really intense experiences, emotions, or situations

[L2: introduces OCD as a coping strategy]. Does that seem to fit with your experience?

KAREN: I think so. It was a really terrible time. I didn't know what else to do.

ASSESSOR: It sounds like you were feeling a little helpless and alone [L2: attachment trauma].

KAREN: I was alone. My father was there, but he wasn't himself for a long time after my mother died, especially when he was drinking.

ASSESSOR: I can see why you felt like you had no other options. You did what you had to do to get through [validation]. It's sad that you had to go through that time of your life on your own.

KAREN: (*tearing up*) I just wish someone, anyone, had been there for me to talk with about my mother and how scary it felt to be without her.

ASSESSOR: Absolutely. Losing your mother left you with intense feelings of loss, sadness, and fear about what your life would be like without her. (*Long pause as Karen cries.*) The test results suggest that you still have a lot of intense feelings inside you that threaten your equilibrium if you were to really feel them [L2: affect avoidance; unresolved mourning]. The testing also suggests that the OCD symptoms we have talked so much about are a way to help keep you safe against these painful and frightening feelings that you worry could overwhelm you if you were to let them out of the box [Karen used the metaphor of storing her emotions in a box with a tight-fitting lid during extended inquiry of the EMP]. I see that you don't want to fall apart like your father did when he was grieving [validation]. It takes a lot of energy to keep all these feelings in that little box [understanding].

The assessor went on to connect Karen's OCD behaviors (e.g., avoiding real things that could hurt her, like pesticides and nuclear radiation) to her desire to protect herself from the underlying feelings that were very difficult to manage if she were to let them out all at once and without assistance. This coping mechanism "filled the gap" for the assistance she had longed for from her father but never received. The assessor helped Karen start the process of grieving over this void in her childhood and also the fact that she now found it difficult to see others as sources of emotional support, even her therapist. In this case, the assessor decided that Karen's minimal insight and strong coping mechanisms rendered presentation of L3 information too threatening. The assessor elected to share the L3 finding (Karen's underlying anger toward her parents, which was evident in each of the tests administered) with her therapist to be addressed after Karen was able to manage her grief. Upon seeing the findings of the assessment, the

therapist reformulated the treatment goals to reflect a conceptualization of OCD behaviors as affect avoidance, particularly grief and longing for support that threatened her self-reliance and put her at risk for being severely injured again.

Conclusions

The use of an empirically supported guiding framework to multimethod assessment feedback increases the potential of positively affecting the client's life and improving subsequent treatment outcomes. The selection of a multimethod assessment battery consisting of self-report and performance-based tests that tap into complementary neurobiological processes, memory systems, and motivational factors is the key to (1) fully understanding clients' dilemmas of change and (2) determining the level of information of key findings. A core aspect of our framework is the recommendation to first present findings that confirm previously held self-views and then gradually move toward more discrepant findings that require alteration of the client's story. Empirical research shows that assessors should provide mostly L1 and L2 findings, and that L2 findings are necessary to achieve therapeutic outcomes (Schroeder et al., 1993). Last, assessors need to practice the interpersonal behaviors that help regulate clients' negative affect states during assessment feedback. This kind of sensitivity is essential for therapeutic outcomes, as the feedback process is inherently anxiety producing under any circumstance and is even more so when findings diverge from clients' existing self-schemas in the way the case example of Karen illustrates.

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REFERENCES

- Achenbach, T. M., McConaughy, S. H., & Howell, C. T. (1987). Child/adolescent behavioral and emotional problems: Implications of cross-informant correlations for situational specificity. *Psychological Bulletin*, 101(2), 213–232.
- American Psychological Association, American Educational Research Association, & National Council on Measurement in Education. (1999). *Standards for educational and psychological testing*. Washington, DC: American Educational Research Association.
- Andersen, P., & Nordvik, H. (2002). Possible Barnum effect in the five factor model: Do respondents accept random NEO Personality Inventory—Revised scores as their actual trait profile? *Psychological Reports*, 90(2), 539–545.

- Asari, T., Konishi, S., Jimura, K., Chkzoe, J., Nakamura, N., & Miyashita, Y. (2008). Amygdalar enlargement associated with unique perception. *Cortex*, 30, 1–6.
- Beutler, L., & Berren, M. (1995). *Integrative assessment of adult personality*. New York: Guilford Press.
- Bornstein, R. F. (2002). A process dissociation approach to objective-projective test score interrelationships. *Journal of Personality Assessment*, 78(1), 47–68.
- Bromberg, P. M. (2006). *Awakening the dreamer: Clinical journeys*. New York: Analytic.
- Bruhn, A. R. (1992). The Early Memories Procedure: A projective test of autobiographical memory, part 1. *Journal of Personality Assessment*, 58(1), 1–15.
- Buchheim, A., Erk, S., George, C., Kächele, H., Ruchow, M., Spitzer, M., et al. (2006). Measuring attachment representation in an fMRI environment: A pilot study. *Psychopathology*, 39(3), 144–152.
- Butcher, J. N., Dahlstrom, W. G., Graham, J. R., Tellegen, A., & Kaemmer, B. (1989). *The Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Manual for administration and scoring*. Minneapolis: University of Minnesota Press.
- Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological Bulletin*, 56, 81–105.
- Cicchetti, D. V. (1994). Integrating developmental risk factors: Perspectives from developmental psychopathology. In C. A. Nelson (Ed.), *Minnesota symposium on child psychology: Vol. 27. Threats to optimal development* (pp. 285–325). Mahwah, NJ: Erlbaum.
- Cicchetti, D. V., & Toth, S. L. (1998). The development of depression in children and adolescents. *American Psychologist*, 53(2), 221–241.
- Cook, T. D., & Campbell, D. T. (Eds.). (1979). *Quasi-experimentation: Design and analysis issues for field settings*. Chicago: Rand-McNally.
- Diener, M. J., Hilsenroth, M. J., & Weinberger, J. (2007). Therapist affect focus and patient outcomes in psychodynamic psychotherapy: A meta-analysis. *American Journal of Psychiatry*, 164, 936–941.
- Dozier, M., & Lee, S. W. (1995). Discrepancies between self- and other-report of psychiatric symptomatology: Effects of dismissing attachment strategies. *Development and Psychopathology*, 7, 217–226.
- Finn, S. E. (1996). Assessment feedback integrating MMPI-2 and Rorschach findings. *Journal of Personality Assessment*, 67(3), 543–557.
- Finn, S. E. (2003). Therapeutic assessment of a man with “ADD” [Case Reports]. *Journal of Personality Assessment*, 80(2), 115–129.
- Finn, S. E. (2007). *In our client's shoes: Theory and techniques of therapeutic assessment*. Mahwah, NJ: Erlbaum.
- Finn, S. E. (2011). Journeys through the valley of death: Multimethod psychological assessment and personality transformation in long-term psychotherapy. *Journal of Personality Assessment*, 93(2), 123–141.
- Finn, S. E. (2012). Implications of recent research in neurobiology for psychological assessment. *Journal of Personality Assessment*, 94(5), 440–449.
- Finn, S. E., & Tonsager, M. E. (1992). Therapeutic effects of providing MMPI-2 test feedback to college students awaiting therapy. *Psychological Assessment*, 4(3), 278–287.
- Finn, S. E., & Tonsager, M. E. (1997). Information-gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment*, 9(4), 374–385.
- Fischer, C. T. (1985/1994). *Individualizing psychological assessment*. Mahwah, NJ: Erlbaum.

- Fowler, J. C., Hilsenroth, M. J., & Handler, L. (1996). Two methods of early memories data collection: An empirical comparison of the projective yield. *Assessment*, 3(1), 63-71.
- Furnham, A., & Schofield, S. (1987). Accepting personality test feedback: A review of the Barnum effect. *Current Psychological Research and Reviews*, 6(2), 162-178.
- George, C., & West, M. L. (2012). *The Adult Attachment Projective Picture System: Attachment theory and assessment in adults*. New York: Guilford Press.
- Giromini, L., Porcelli, P., Viglione, D. J., Parolin, L., & Pineda, J. A. (2010). The feeling of movement: EEG evidence for mirroring activity during the observations of static, ambiguous stimuli in the Rorschach cards. *Biological Psychology*, 85(2), 233-241.
- Glassmire, D. M., Stolberg, R. A., Greene, R. L., & Bongar, B. (2001). The utility of MMPI-2 suicide items for assessing suicidal potential: Development of a suicidal potential scale. *Assessment*, 8(3), 281-290.
- 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.
- Holigrocki, R., Crain, C., Bohr, Y., Young, K., & Bensman, H. (2009). Interventional use of the Parent-Child Interaction Assessment-II Enactments: Modifying an abused mother's attributions to her son. *Journal of Personality Assessment*, 91(5), 397-408.
- Jimura, K., Konishi, S., Asari, T., & Miyashita, Y. (2009). Involvement of the medial prefrontal cortex in emotion during feedback presentation. *NeuroReport*, 20, 886-890.
- Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.
- Lilienfeld, S. O., Garb, H. N., & Wood, J. M. (2011). Unresolved questions concerning the effectiveness of psychological assessment as a therapeutic intervention: Comment on Poston and Hanson (2010). *Psychological Assessment*, 23(4), 1047-1055.
- McClelland, D. C., Koestner, R., & Weinberger, J. (1989). How do self-attributed and implicit motives differ? *Psychological Review*, 96(4), 690-702.
- Meyer, G. J. (1997). On the integration of personality assessment methods: The Rorschach and the MMPI. *Journal of Personality Assessment*, 68(2), 297-330.
- Meyer, G. J., Finn, S. E., Eyde, L. D., Kay, G. G., Moreland, K. L., Dies, R. R., et al. (2001). Psychological testing and psychological assessment: A review of evidence and issues. *American Psychologist*, 56(2), 128-165.
- Meyer, G. J., & Kurtz, J. E. (2006). Advancing personality assessment terminology: Time to retire "objective" and "projective" as personality test descriptors. *Journal of Personality Assessment*, 87(3), 223-225.
- Meyer, G. J., Riethmiller, R. J., Brooks, R. D., Benoit, W. A., & Handler, L. (2000). A replication of Rorschach and MMPI-2 convergent validity. *Journal of Personality Assessment*, 74(2), 175-215.
- Meyer, G. J., Viglione, D. J., Mihura, J., Erard, R. E., & Erdberg, P. (2011). *Rorschach Performance Assessment System: Administration, coding, interpretation, and technical manual*. Toledo, OH: Rorschach Assessment System.
- Morey, L. C. (1991). *Personality Assessment Inventory professional manual*. Odessa, FL: Psychological Assessment Resources.
- Newman, M. L., & Greenway, P. (1997). Therapeutic effects of providing MMPI-2 test feedback to clients at a university counseling service: A collaborative approach. *Psychological Assessment*, 9(2), 122-131.

- Poston, J. M., & Hanson, W. E. (2010). Meta-analysis of psychological assessment as a therapeutic intervention. *Psychological Assessment*, 22(2), 203–212.
- Roisman, G. I., Holland, A., Fortuna, K., Fraley, R. C., Clausell, E., & Clarke, A. (2007). The Adult Attachment Interview and self-reports of attachment style: An empirical rapprochement. *Journal of Personality and Social Psychology*, 92(4), 678–697.
- Rorschach, H. (1921/1942). *Psychodiagnostics* (5th ed.). Berne, Switzerland: Verlag Hans Huber. (Original work published 1921)
- Schore, A. N. (2003). *Affect regulation and repair of the self*. New York: Norton.
- Schore, A. N. (2009). Right brain affect regulation: An essential mechanism of development, trauma, dissociation, and psychotherapy. In D. Fosha, M. Solomon & D. Siegel (Eds.), *The healing power of emotions: Integrating relationships, body, and mind: A dialogue among scientists and clinicians* (pp. 112–144). New York: Norton.
- Schroeder, D. G., Hahn, E. D., Finn, S. E., & Swann, W. B. J. (1993). *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.
- Schultheiss, O. C. (2007). A memory-systems approach to the classification of personality tests: Comment on Meyer and Kurtz (2006). *Journal of Personality Assessment*, 89(2), 197–201.
- Shaw, D. S., Gilliom, M., Ingoldsby, E. M., & Nagin, D. S. (2003). Trajectories leading to school-age conduct problems. *Developmental Psychology*, 39(2), 189–200.
- Siegel, D. (2012). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). New York: Guilford Press.
- Smith, J. D., Dishion, T. J., Moore, K. J., Shaw, D. S., & Wilson, M. N. (2013). Video feedback in the Family Check-Up: Indirect effects on observed parent-child coercive interactions. *Journal of Clinical Child and Adolescent Psychology*, 42(3), 405–417.
- Smith, J. D., Finn, S. E., Swain, N. F., & Handler, L. (2010). Therapeutic assessment in pediatric and primary care psychology: A case presentation of the model's application. *Families, Systems, and Health*, 28(4), 369–386.
- 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(4), 331–344.
- Swann, Jr., W. B., Chang-Schneider, C., & McClarty, K. (2007). Do people's self-views matter? Self-concept and self-esteem in everyday life. *American Psychologist*, 62(2), 84–94.
- Tharinger, D. J., Finn, S. E., Arora, P., Judd-Glossy, L., Ihorn, S. M., & Wan, J. T. (2012). Therapeutic assessment with children: Intervening with parents "behind the mirror." *Journal of Personality Assessment*, 94(2), 111–123.
- Tharinger, D. J., Finn, S. E., Gentry, L., Hamilton, A. M., Fowler, J. L., Matson, M., et al. (2009). Therapeutic assessment with children: A pilot study of treatment acceptability and outcome. *Journal of Personality Assessment*, 91(3), 238–244.
- Wechsler, D. (2008). *Wechsler Adult Intelligence Scale, 4th edition (WAIS-IV)*. New York: Psychological Corporation.