Therapeutic assessment in patients with personality disorders

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Introduction
Research evidence on the treatment utility of clinical assessment is limited (Hunsley & Mash, 2007) and there appears to be a rather widespread perception among clinicians that assessment often does not provide them with essential information for treatment planning. Some have even advocated a drastic reduction of its use in clinical practice. In striking contrast to this perception is the concluding statement by Poston & Hanson (2010, 2011), based on a meta-analysis of 17 trials on the efficacy of collaborative psychological assessment:

“Taken together, [the findings] suggest that psychological assessment procedures—when combined with personalized, collaborative, and highly involving test feedback—have positive, clinically meaningful effects on treatment, especially regarding treatment processes” (p. 203).

Of note, these findings were compiled from highly diverse settings in very diverse clients. Evidence specifically pertaining to clients with (severe) personality pathology is very scant indeed. Our hunch however, was that the specific clinical needs of this group of patients may match very well with the clinical features of the collaborative/therapeutic assessment model. The present thesis therefore aims to address the noted gap in knowledge. More specifically, we aimed to empirically investigate the utility of the Therapeutic Assessment (TA) model (Finn, 2007) in clients with personality pathology.

**A brief History of Therapeutic Assessment**

Therapeutic Assessment (TA) is an assessment driven therapeutic intervention that encourages clients to develop new representations of themselves and the world. One of its pioneers is Constance Fischer (1970, 1973), who founded her method of assessment on phenomenological psychology and labeled it Individualized/Collaborative
Psychological Assessment. Fischer considered psychological assessment as practiced often to be dehumanizing. She demonstrated that humanistic and intersubjective values and practices could be successfully incorporated into psychological assessment. According to Fischer, clinicians’ primary intention should be to gain a deeper, individualized understanding of their clients through the use of psychological tests. She deemed the nomothetic aspect of test use of lesser importance. Thus, rather than working from the prevailing focus on test scores, Fischer took what she referred to as “a colleague's perspective” on the client’s psychological functioning. Capitalizing on the close interaction between the assessor and the client, she used the testing situation to understand how it might mirror the client’s struggles and solutions attempted in daily life outside of the testing situation. Fischer’s goal was to provide clients with an understanding of why and how they do what they do. The assumption was that the deeper, individualized understanding would yield a direct, positive impact on clients’ daily lives. Fischer’s work remains influential in the work of assessors practicing from a collaborative/therapeutic assessment paradigm today.

Stephen Finn and colleagues (Finn, 1996a, 2003, 2007, 2015; Finn, Fischer, & Handler, 2012; Finn & Kamphuis, 2006; Finn & Martin, 1997; Finn & Tonsager, 1992, 1997) were inspired by the vision and practices of Fischer and extended and formalized her model to develop TA. TA is a 6-step semi-structured approach that builds a safe and secure relationship between the client and the assessor. It consists of: 1) encouraging clients to generate their own assessment questions, 2) using standardized test administration and extended inquiry procedures, 3) developing an assessment intervention session, 4) providing a summary and discussion session, 5) sharing a written summary of the testing feedback to the client, and 6) providing a follow-up session about a month later. For a more detailed description of the procedure see In Our Clients’ Shoes (Finn 2007, and Chapters 2 and 3).

Over the past 20 years TA has influenced the way psychological assessment is conceptualized and practiced. It uses psychological assessment to encourage clients to revise their core narratives about themselves and to experiment with more adaptive behaviors (Del Giudice, Yanovsky, & Finn, 2014). It differs from traditional, information-gathering models that index a client’s symptoms through the use of standardized tests, which are then used to determine a diagnosis and treatment plan. In TA, the
main goal of the assessment is to maximize the potential for therapeutic change in clients. TA is seen as successful when a client feels respected, valued and co-constructs meaningful answers to his/her assessment questions. Presumably, the answers to these individualized questions can produce beneficial changes.

TA uses standardized tests as well as the client-assessor relationship to reveal the meaning of the symptoms in collaboration with the client. Test results are seen as a way to get into the client shoes as a participant/observer in order to help the client with self-discovery and growth (Finn & Tonsager, 1997). Assessors see themselves as experts in psychological theories and testing while clients are enlisted as experts on their own lives (Anderson & Goolishian, 1992). Key aspects of TA are (1) increasing the clients’ curiosity about themselves and the world around them, (2) using psychological tests that are tied to the clients’ goals for the assessment; and (3) providing individualized feedback. Clients are treated as co-assessors whose participation throughout the whole process is essential to its outcome. They are viewed as collaborators who work with assessors to define their assessment goals and to help interpret the assessment results. Clients’ involvement is presumably enhanced by focusing the assessment on the questions that matter to them, and for which their input is deemed essential. The assessment procedure is presented as a joint venture between the assessor and the assessee, in order to create a new, better fitting narrative for the client. Finn has theorized that – by addressing the needs of self-verification, self-enhancement, and self-discovery – TA is able to facilitate immediate positive changes in clients (Finn & Tonsager, 1997). Harkness and Lilienfeld (1997) eloquently characterized one benefit of such individual differences assessment: it helps the client “to grow a Self” (p. 357 original).

**Research on the Effectiveness of Collaborative / Therapeutic Assessment**

In recent years, over 30 studies on the effectiveness of Collaborative/Therapeutic Assessment (C/TA) have been reported in the literature. The efficacy of TA has been tested in adults, families with (pre-)adolescent, children and in couples. Study designs include case studies, quasi-experimental and pragmatic trials (Ougrin, Ng, & Low, 2008; Smith, Eichler, Norman, & Smith, 2014), randomized trials (early trials include Finn &
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Tonsager, 1992; Newman & Greenway, 1997) and a meta-analysis (Poston & Hanson, 2010, 2011). Overall, the accumulating empirical evidence generally supports the efficacy of TA and new studies continue to appear with some frequency.

The studies on adult studies can be grouped into two broad categories: (a) studies focused on TA as a means to enhance salient psychotherapy process variables, such as the therapeutic alliance and motivation to change and engage in treatment (e.g. Ackerman, et al., 2000; Bloningen, et al., 2015, Hilsenroth, Peters, & Ackerman, 2004; Holm-Demonia, et al., 2008; Lerner, 2005; Ougrin, Ng & Low, 2008) and (b) studies focused on applications of C/TA as an assessment driven short-term intervention seeking direct symptom improvement. Although an exhaustive review of the literature is clearly beyond the scope of the present introduction (but see Aschieri, De Saeger, & Durosini, 2015), we highlight here the important work of Ackerman et al. (2000). They showed that college students who had participated in TA at a university-based clinic had greater compliance with treatment recommendations, compared to assessment-as-usual (i.e., traditional assessment) (effect size = .42), and that therapeutic alliance ratings post-feedback were significantly related to rating of the quality of the experience of the assessment ($r = .71, p < .01$). Also, clients receiving TA were less likely to terminate psychotherapeutic treatment prematurely. These results were subsequently expanded by Hilsenroth et al. (2004), who conducted a follow-up study in the same subjects. It was shown that clients who received TA reported stronger therapeutic alliance in subsequent psychotherapy compared to clients who had received assessment-as-usual (effect size = 1.02).

Primary examples of TA studies seeking more traditional outcome (i.e. improvements in terms of symptoms and/or self-esteem) are provided by the classic study of Finn and Tonsager (1992) and a subsequent replication (Newman & Greenway, 1997). Finn and Tonsager (1992) conducted a randomized controlled trial ($N=60$) in a university counseling center comparing a short version of TA to an equal number of counseling sessions. Their pilot study was conducted in 60 outpatients on the waitlist of the college-counseling center at the University of Texas at Austin. The TA group participants demonstrated considerably less psychological distress and symptoms than the counseling group. Moreover, they reported a significant and large reduction in client-reported symptomatology ($d = .85$) and increases in self-esteem ($d = .45$). Newman
and Greenway (1997) largely replicated these findings in Australia. Most pertinent to patients with personality disorders (PD) is the study conducted by Morey, Lowmaster and Hopwood (2010). This study compared two groups of self-harming borderline PD clients undergoing a Manual Assisted Cognitive Therapy (MACT; Tyrer et al., 2004). Patients were randomly assigned to a MACT-only condition or MACT+TA condition. Whereas no differences were found between conditions in treatment retention over a six-week period, patients in MACT+TA reported significant decreases in affective instability and suicidal ideation. It deserves mention that the sample size utilized in this study was quite low (N = 7). Moreover, numerous case reports (e.g., Aschieri, Fantini, & Bertrando, 2012; Finn, 2003; Finn, Fischer, & Handler, 2012; Finn & Kamphuis, 2006; Finn & Martin, 1997; Fischer & Finn, 2008; Smith, et al., 2009; Tharinger, et al., 2007; Wygant & Flemming, 2008), some of which employed sophisticated time series designs, vividly report on the beneficial effects of TA in highly diverse populations. Of note, some of these cases do not draw on all the steps of the full TA model and are (sometimes referred to as TA ultra-brief cases).

Finally, Poston & Hanson (2010) conducted a meta-analytic study, which included 17 randomized trials, comprising 1,496 adult and adolescent participants to examine the overall effectiveness of individualized assessment feedback and included trials of the TA model and less structured approaches. A significant overall effect for both symptom reduction and therapeutic process outcome variables was observed (d = .423; Poston & Hanson, 2010). These authors came to the following provocative conclusion:

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

**Personality Disorders**

In 1987, the DSM-III (American Psychiatric Association, 1987) introduced a general criterion for personality pathology, as well as explicit, polythetic diagnostic criteria for
(10) distinct personality disorders (PD). The DSM-IV (American Psychiatric Association, 1994) and the current edition DSM-5 (American Psychiatric Association, 2013) followed-up on this effort, using essentially the same types of behavioral criteria. In adults, the prevalence of PD varies from 13.4% in the general population to over 60% in the psychiatric outpatient population (Verheul & van den Brink, 1999). Clients with PD report a poor quality of life, and their disorder carries great societal cost (Soeteman, Verheul, & Busschbach, 2008).

According to DSM-5, the diagnoses of a PD must satisfy the following general criteria, in addition to the specific criteria listed under the specific personality disorder under consideration (p. 646-647):

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture. This pattern is manifested in two (or more) of the following areas:
   1) Cognition (i.e., ways of perceiving and interpreting self, other people, and events).
   2) Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response).
   3) Interpersonal functioning.
   4) Impulse control.
B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
E. The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.
F. The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., head trauma).
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**Therapeutic Assessment in Personality Disorders**

Whereas the DSM-5 provides us with explicit defining features of (various) PDs, it does not (aim to) provide a sense of how it is to work with those patients. In clinical practice, patients with PD often present with highly variable (and often puzzling) symptoms and problems, comorbidity, and ambivalence about change. This ambivalence makes sense when one realizes that the rigid behavioral patterns are rooted in early survival strategies that made sense then, but are now hindering their further development. Different therapies refer to these rigidifying structures as dysfunctional scripts, schemata, object relations or otherwise. In sum, the problems patients and therapists of PD are facing tend to be diffuse in the context of highly rigidified dysfunctional representations of self and others (Kamphuis & Muskens, 2007).

As many authors noted, these clinical features map onto different clinical needs (e.g. Kohut, 1972). Most prominently, it has been widely observed that many of these clients are extremely sensitive to sustained empathy, and that they require special attention in terms of building and maintaining a therapeutic alliance. More traditional assessment approaches tend to focus on the problem areas and the dysfunction, which may make the assessee more defensive as it challenges their usual (egosyntonic) method of survival. After all, undergoing an assessment requires a client to embark on a close encounter with a complete stranger who tends to focus on shameful aspects of functioning and dysfunctional blind spots. These patients are often referred because therapy is not proceeding as expected and/or the therapist and client feel that they have reached an impasse. Instead, it may be helpful if the assessor focuses on building an empathic connection, provides emotional containment, and demonstrates close collaboration. Furthermore, it may be helpful when the therapist can help the client in co-constructing his or her underlying dilemma of change. It seems fair to establish that all characteristics that help building a working alliance with PD, are the hallmarks of TA (Finn, 2007; Kamphuis & Finn, 2018). As such, TA can be hypothesized to be of particular utility in this group of patients. Up to now, however, there is no evidence whatsoever to support this notion.
Aims and Outline

The apparent fit between key features of TA and the clinical needs of clients with personality disorders led us to formulate the following research aims:

1. Describe TA as implemented in a clinic for patients with PDs and document its effects in a case-analysis.
2. Investigate the effectiveness of TA in clients with PDs, as well as explore possible determinants of change.

This research project took place in the Netherlands at De Viersprong, a specialized center for the assessment and treatment of adolescents and adults with (severe) PDs.

Part A of this thesis includes two chapters introducing the TA model. Chapter 2 provides a general introduction to the TA model and how it was organized and implemented at De Viersprong. It mainly serves as an orientation to the model, specifically geared toward a clinician audience (as it was published as modified and translated version in de GZ psycholoog; the Mental Health Psychologist). Chapter 3 illustrates the application of the full TA model in the context of a clinical case involving personality pathology.

Part B of this thesis includes two studies on the effectiveness of TA in clients with PDs, and a study examining the utility of a recent nomothetic innovation in personality assessment, the Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2008). Chapter 4 compares the effectiveness of TA to a highly credible alternative pre-treatment Intervention in a Randomized Clinical Trial (RCT) in clients with PDs. Patients were randomized to either the full TA model (comprising 4 face-to-face sessions), or b) to a pre-treatment package we called the Goal-Focused Pre-Treatment Intervention (GFPTI), also comprising 4 face-to-face sessions). GFPTI was based on a widely used motivational model in the Netherlands (the so-called ‘five-sessions’ model; a highly focused, protocol-driven semi-structured default treatment program developed to be executed in the first line echelon).

Chapter 5: To more fully appraise the results obtained in Chapter 4, and in line with the philosophical stance of TA, we solicited the client’s perspective. More specifically, we aimed to better understand what clients deemed memorable and distinctive about TA. The following questions guided our interviews: What aspects of
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TA, if any, do clients report as memorable? What aspects of TA, if any, do clients deem new, different, or distinctive? What aspects of TA, if any, do clients report as negative about TA? Participants were drawn from the pool of the RCT mentioned earlier.

In Chapter 6, as rather a separate endeavor, we evaluated the utility of the most recent generation of the Minnesota Multiphasic Personality Inventory (MMPI), the Minnesota Multiphasic Personality Inventory-2 Restructured form (MMPI-2-RF; Ben-Porath & Tellegen, 2008) in the context of clients with PD. Specifically, we documented MMPI-2-RF profiles of a psychiatric sample with a Cluster C PD diagnosis and report on the utility of these test scores.

Part C: The final part of this thesis summarizes and discusses its main findings and provides a critical appraisal of its strengths and limitations. Special attention is paid to the clinical utility of the TA model in the context of patients with PD.
References


Chapter 1


Chapter 1


