Therapeutic assessment in patients with personality disorders

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Implementing Therapeutic Assessment in a Clinic for Patients with Personality Disorders: Challenges and Opportunities (a Progress Report)\(^1\)

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Summary

Assessment is often said to be an unnecessary luxury. An exception to this assertion may be the Therapeutic Assessment model. As concluded in a recent meta-analysis, diagnosticians who do not educate themselves in this method may miss out on an important opportunity to stimulate positive changes in their clients. Therapeutic Assessment refers to a collaborative, semi-structured approach to individualized clinical assessment. *De Viersprong*, a specialized center for the assessment and treatment of adolescents and adults with (severe) personality disorders, has implemented this method of clinical assessment. The founder and developer of the model, Stephen Finn, trained part of the diagnostic team of *De Viersprong* in Therapeutic Assessment. In addition, this clinic hosted a randomized clinical trial in 2009 to determine the effectiveness of Therapeutic Assessment in individuals with severe personality disorders. It is too early to report definitive research results, but the initial skepticism at the center has since disappeared. The concern that people with (severe) personality disorders do not benefit from this intervention because of their limited introspective psychological capacities appears to be unfounded. Investing in the collaborative relationship appears to be both the central challenge and the key leverage factor in clients with personality pathology.

Keywords: therapeutic assessment, personality disorders, diagnostics, assessment, collaboration
Introduction

Increasing legal, ethical, and financial pressures demand that simply starting psychotherapeutic treatment is no longer possible without a clear plan in which the purpose, the risks, the duration, method, and format of the treatment are specifically described (Harkness, 1997, p. 349). At the same time, psychological assessment is experienced by some as time-consuming and expensive. Furthermore, the controversy regarding the reliability and validity of various psychological tests does not strengthen the position of “assessment psychologists”. Fortunately, the arrival of collaborative and therapeutically oriented assessment has opened up the field of personality assessment. Psychological assessment is not a fully separate endeavor from subsequent psychotherapy, but can offer input to subsequent treatment such that there is a better chance of treatment success (Peters, Handler, & White, 2008).

Psychological assessment as a short-term (therapeutic) intervention has undergone major developments in recent years. It finds its origin, remarkably enough, in the humanist movement of the 1950s and 1960s (Finn & Tonsager, 1997). Humanists considered the testing and labelling of clients dehumanizing, and Fischer (1972) and colleagues found that using a more humanistic approach with clients during psychological assessment seemed to enhance the outcome of psychological assessment. The consequence of this vision is that assessors have broadened their attention from mere measurement to (a) thinking about the client and his or her context, (b) focusing on the relationship between the client and the assessor, and (c) utilizing transference and countertransference to understand clients better.

Based on a humanistic approach, Constance Fischer developed a collaborative assessment (CA) approach, i.e. a model of clinical assessment in which tests are used in an individualized way, in the context of a close collaboration between the assessor and the client. Fischer considered the nomothetic value of the tests of secondary importance. Tests are primarily used ideographically, i.e., to help the client identify his or her conflict areas (Fischer, 2000). The nomothetic approach aims at discovering generally valid laws, while the idiographic approach emphasizes a thorough study of the unique qualities of the individual (De Boeck, 1988). Building on Fischer’s work, Stephen Finn developed Therapeutic Assessment (TA), attaching great importance to the nomothetic interpretation of tests in conjunction with idiographic use of tests. Compared to CA,
TA is more structured and more specifically described, and accordingly lends itself better to empirical research (Kamphuis & Finn, 2006). In 1997, Finn published an article together with Tonsager that compared traditional information gathering assessments with a more therapeutically oriented way of psychological testing. Their analysis showed that both forms of assessment are complementary (Finn & Tonsager, 1997). This article was ground-breaking for the development of TA. The model aims at a fusion between a therapeutic attitude and psychological assessment. As such, it combines the benefits of psychological testing with the power of a short-term therapeutic intervention (Finn, 2007).

**Purpose and nature of TA**

The purpose of assessment according to the TA model is to ensure that the client procures information useful to changing his or her life. The consequence of this vision is that the assessor must make a shift from a test-centered to a client-centered approach. The assessor becomes a participant-observer rather than a purely objective observer. The model stands for ‘working together’. Involving clients as active participants in an assessment makes them feel more involved and feel that their commitment to the process is essential to the success of the testing. Assessment founded on collaboration rather than on expert information gathering, is hypothesized to induce clients to reveal more accurate and reliable information about themselves. Clients will be inclined to invest more in their testing if the results address their own questions and goals, and will react less defensively. Collaboration is not the only essential element. Empathic validation by the assessor is also crucial. TA hypothesizes that people have a fundamental need to be seen, and that there is a positive effect on motivation when clients feel valued and understood. Providing feedback from a collaborative and empathic viewpoint allows the client to have a better understanding of their problems, which by itself can yield therapeutic benefits. A frequently heard response from clients about this model of assessment is that they feel taken seriously and enjoy the fact that their input has an effect on the outcome. TA is therefore not only used to refine the assessment process but also offers opportunities to revive stalled psychotherapeutic treatments.
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TA: Procedural aspects

Figure 1: Flowchart of the course of Therapeutic Assessment

Below we describe the six steps described the TA procedure (see figure 1).

Step 1
After referral, telephone contact is made with the client. The client is invited to think about the questions that he or she would like to be answered. The procedure is discussed, and the first appointment is set, and confirmed in writing. The client is involved in the procedure with the following information:

“This approach to psychological testing may be different from what you have experienced before. I would like to collaborate with you to ensure that the tests provide information about the things that you find important for your life. I will ask you later what you would like to understand or examine about yourself. I am the expert on the tests, but you are the expert on yourself. Your commitment is therefore essential and decisive for what you can gain from these experiences”.

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Box 1: clinical vignette of a patient in Step 1

A 30-year-old woman was referred to us with the question of whether the client was sufficiently motivated for therapy because each therapeutic intervention stalled on a so-called ‘lack of motivation’ and ‘major resistance to change.’ During the telephone conversation, the client reflected that she was not waiting for another ‘humming psychologist’ who would not understand her and would not give her what she needed. Convinced by the empathic attitude of the assessor she was hesitantly willing to meet face-to-face to see if TA might have something to offer her. During this initial contact, she backed the assessor completely in a corner. The assessor had nothing to offer her, she was like everyone else, etc. The client did not wish to continue. It was only when the assessor put words to her need for ‘real’ support that she was able to relax. This intervention helped her feel “seen” and she was able to open herself up to further testing. The client made a shift from a wholesale global rejection of the other to a stance in which she examined how the other might be of any help to her. She quickly came to the following questions for the assessment: 1) How do I restore contact with my feelings and dare to feel again? 2) How can I develop my identity?; 3) Why am I so dependent on the approval of others?; and 4) Why have I never made progress in my treatment?

Step 2

In the first face-to-face meeting (Initial Interview), the focus is on developing the TA assessment questions. The questions from the referring therapist are discussed as well. The purpose of this session is: (a) to involve the client as an active partner in the collaborative relationship; (b) to collect the background information that is essential to understanding the idiographic context of the questions; and (c) to build and deepen the collaborative relationship. The session is successful when, upon leaving the room, the client feels understood and respected, becomes committed and curious, as well as hopeful about the outcomes (i.e., demoralization is overcome). The attitude of the client to this session often tells a lot about the nature of the problem. Some clients prepare this session in detail and leave nothing to chance. For example, upon arrival they have already completed and typed out their list of 30 questions, leaving the assessor with
no room to contribute. Others absolutely do not know what questions they would like to ask and take a very dependent and defenseless stance. Still others see it mainly as a chore/demand and do not see the point of it (e.g., think of the grumpy adolescent who does not want to let others into his or her inner world). The core task of the assessor is to facilitate the client in formulating his/her questions in a useful way. This can consist of reformulating questions that are too broad or too restrictive, or helping to formulate questions that the assessor hypothesizes to be evident in the narrative but that are not yet explicit for the client. It is important for the assessor to remain as close as possible to the client’s choice of words. The main goal is to stimulate the client’s curiosity and to involve him or her as a co-examiner. It is important to gather relevant background information on each question, using techniques such as mirroring, asking follow-up questions, reformulating, meta-processing, etc. For example, the assessor might probe, “When did the problem start?”, “When is the problem not present?”, “If you were to answer the question now, what would you say?”. Examples of client questions may be: “Do I think differently than others?”, “Why do I get overwhelmed so quickly?”, “Why is it so hard for me to be alone?”.

Step 3
In Step 3, specific tests are selected that address the client’s questions. The assessor explains to the client why he or she selected specific tests, the nature of the tests, which questions are addressed by each test, and what is expected of the client in the test. For example, a memory test may be included for someone who is in doubt about losing their memory. In order to more generally understand the client, as well as to identify the possible dilemmas of change with which a client is struggling, at least one broadband self-report questionnaire is used (e.g., the MMPI-2). In addition, at least one performance-based test is used (e.g., the Rorschach Inkblot test, a sentence completion test, or the Thematic Apperception Test [TAT]). In this phase, tests are scored and interpreted according to the guidelines of manuals and standard reference works (e.g. Graham, 1993; Friedman, et al., 2001; Exner, 1995, 2003; Ganellen, 1996; Weiner, 1998).

The tests help the assessor both to get “into the shoes” (Finn, 2007) of the client, as well as to be able to look at the client more objectively. In TA, each testing session is reviewed with the clients and is discussed collaboratively. The client is asked to add
anything that struck him, and to share his experience when taking the test. Here the
client is also invited to take a more objective look at the test results. With the assessor,
the client is engaged in making sense out of the test data. Perhaps the client notices
s/he left some responses out that they would now like to discuss, and/or the client
wants to share his or her perspective on how s/he was affected by the test. It is an
ongoing reciprocal, collaborative process. For example, someone who spontaneously
mentions after the Rorschach test ‘Hey, thank God, finally color; I’m not fond of gray’.
This comment paves the way, after the standard administration of the test, to return
to the client’s question about her self-reported lack of pleasure and vitality. Such an
‘extended inquiry’ offers the possibility to “test the limits”. In other words, the client’s
material is examined more deeply than is usual in a traditional testing situation. The
aim here is to more deeply understand the client as well as to keep the client curious,
to stimulate her, and to optimally address her mentalizing capacity.

Step 4
The fourth step in the model is the Assessment Intervention Session (AIS) (Finn, 1996;
Finn, 2007). The AIS was one of the later additions to the TA model. It was added because
it often happened in the feedback sessions that clients had difficulty integrating all
the new information. After all, if the new information is substantially different from
the narrative of the client, chances are that he or she will be unable to integrate it,
and the findings may be rejected (Finn 1997; Finn, 2007). The objectives of the AIS
are: (a) to further explore the hypotheses derived from the standardized tests which
may be confusing or puzzling to the assessor, or those that the assessor thinks will
be very challenging for the client to integrate without further exploration and in
divo experience, (b) testing alternative solution strategies to dilemmas of change, (c)
allowing the client to personally experience, discover and experiment with more
adaptive behavior. It is particularly important to co-examine findings of which the
assessor suspects that the client needs direct actual experience before the finding
can be considered and integrated. Examples of frequently used interventions include:
variations on the instruction from the TAT (e.g., “I would like your stories [not] to
turn out positive”), variations in the instructions of neuropsychological tests (e.g.,
asking perfectionists, unaware of the impact of their perfectionism, to do something
carelessly or going through the test norms together with clients, thus allowing them
to discover, for themselves, how their results compare to others), an individualized
Sentence Completion Test focusing on a specific question, creative tasks (e.g., collages,
drawings), role playing, or techniques borrowed from different therapeutic models
(e.g., re-scripting). Planning an AIS requires a good understanding of the dilemma of
change that a client is struggling with. Specific dilemmas maybe best accommodated
by a specific theoretical viewpoint. The ability to draw on knowledge of different
techniques and explanatory models helps the assessor connect as closely as possible
with the experience of the client. It gives him the opportunity to offer the client an
alternative or an explanation that resonates with the client. It is important to carefully
observe and monitor the process together with the client.

Box 2: clinical vignette of a patient in Step 4

A 24-year-old woman with a background of abandonment and violence, who herself had
recently committed violent crimes, is presented with a number of TAT pictures in the
AIS. The stories show no trace of aggression. In discussing this shared observation, the
client herself suggests that anger may be used in her daily life to keep other feelings at
bay. The anger may be intended to camouflage her sorrow, she suspects. The assessor
asks if she has memories of how important people in her live responded to her sorrow in
her past history. The client tells of humiliations and the related fear of trusting anyone
again. After this discussion, the client is asked to choose another picture story card,
and to opt for a different outcome. The client succeeds in telling a story in which both
sorrow and a desire for comfort are present. The fear of closeness became very tangible
in the assessment room. The client understood through these shared experiences in a
more visceral way why her anger was so prominent and what the function of the anger
was. She gained an empathic understanding of her underlying vulnerability and her
desire for support and soothing.
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Step 5
In the fifth step, the focus is on feedback. The aim is to provide clients with a more accurate, coherent story about themselves or, in clinical terms, to present an empathically formulated, individualized case formulation. This session is explicitly not intended as one-way communication. Clients are continuously asked whether the feedback feels accurate and they are invited to translate and further “anchor” the findings into their daily lives. In this way, clients are repeatedly encouraged to take a more objective, observant view in order to reflect on themselves and be able to translate the findings into their own lives. The aim is to encourage the client to truly participate in the interpretation of the findings.

Finn advises to carefully prepare the organization and delivery of the feedback, and he offers specific recommendations for the sequence and style of the feedback (Finn, 2007). The basic rule is to first give feedback on findings that are closely related to the current self-concept of the client, and then successively present more complex and more discrepant findings. In terms of style and word use, the assessor tries to tailor his style and use of words to the client and to anchor findings in jointly observed (test) experiences that have been gathered during the TA. Despite this careful preparation, there is always the possibility that the client will not accept part of the hypotheses. As might be expected, it is inconceivable in the TA model to try and force these hypotheses on to the client. The assessor does not argue the rejected hypotheses, and they are not included in the final report. After all, the chance of deregulating the (PD) client increases if the client’s own narrative is simply rejected. Until that moment, the client’s own narrative has been a guiding principle or, in other words, his or her way of surviving. The goal of TA is to collaborate in developing a new, alternative, ‘healthier’ narrative that enables them to make positive changes in their lives. If personal change is compared to changing the course of a large boat, it can be said that each adjustment (however minimal) to this course in the present may imply a huge change in the future.

Step 6
Finally, a personal letter is sent to the client describing the process that the assessor and the client have gone through together. The excerpt in Box 3 illustrates the personal tone of the letter, devoid of any jargon.
Box 3: clinical vignette of a patient in Step 6

Question from client: What causes me to have to keep so much distance from myself? How do I deal with my emotions?

We discussed this question extensively during our second meeting. On the basis of several pictures, you told a story which led you to discover that you use anger in order not to have to experience vulnerable feelings. Your childhood was greatly lacking in safety. As a child you experienced a lot of helplessness and powerlessness. You were bullied at school, and it was unsafe at home due to the aggressive behavior of your stepfather. Your mother was unable to stand up for you and you were still too small to protect yourself. You learned that others cannot be trusted and will abuse you. It seems that at a very young age you experienced that allowing yourself to feel fear or sadness makes you look vulnerable. Based on your experience, you expect that the other person may then do you an incredible amount of harm, as was the case in the past. (…)

Evidence for the efficacy of TA

Meanwhile, considerable research evidence has been gathered in support of the efficacy of TA. Three controlled research projects and a large number of case studies have been published (Finn, 2003, 2007, 2011; Finn & Kamphuis, 2005; Peters, 2008). The most striking findings in these studies were: (a) a reduction in symptomatology and an improvement in self-confidence (Finn & Tonsager, 1992; Montgomery et al., 2003; Newman & Greenway, 1996), (b) an increase in hope (Finn & Tonsager, 1992; Holm-Denoma et al., 2008), (c) the findings were more likely to be accepted if given within the framework of TA (Ackerman, et al., 2000). Finally, (d) an improvement in the working relationship with the subsequent therapist has been observed (Hilsenroth, Peters, & Ackerman, 2004). Following a TA, borderline patients reported a better symptomatic outcome of their treatment with Manual Assisted Cognitive Therapy (MACT; Morey, Lowmaster, & Hopwood, 2010), albeit tested in a very small sample. Little and Smith (2009) found that psychiatric patients could reconcile themselves better with the treatment plan and that their satisfaction with the treatment increased. Finally,
there are several studies where TA appears to be effective in adolescents, children and couples (see for example Finn, 2007; Smith et al., 2009; Tharinger et al., 2007).

As well, a meta-analysis was published in *Psychological Assessment* about the effects of assessment as an intervention in itself (Poston & Hanson, 2010). The analysis of 17 primary studies led to the following conclusion: collaborative assessment yielded a medium effect on symptom improvement, and a major effect on the quality of the working alliance and on the subsequent treatment. The authors’ recommendation was that assessors should seek out training in models of assessment that are collaborative/therapeutic in nature. Those who stick to traditional assessment miss an important opportunity to stimulate positive changes in clients and to take the therapeutic process to a higher level (Poston & Hanson, 2010). To date however, outcome research into TA has generally been limited to people with a ‘mild’ pathology (mainly students or in primary healthcare).

**TA and De Viersprong: extending TA to patients with personality pathology**

People with severe personality pathology are often ambivalent about change and thus inherently also about receiving psychotherapy. In these patients, personal feelings and thoughts are often poorly accessible, and changes in their motivation complicate treatment. A large group of people with personality disorders struggle to build up a collaborative relationship based on experiences in the past, and the drop-out percentage is high (Kamphuis & Muskens, 2007).
The June 2011 version of the DSM-5 describes personality disorders as follows:\textsuperscript{1}

Alternative Model for Personality Disorder according to the DSM-5, section 3.
The essential characteristics of a personality disorder are disturbances in personality functioning (self and interpersonal) and the presence of pathological personality traits.
To diagnose a personality disorder, the following criteria must be met:
A. Significant disruptions in self (identity and self-management) and interpersonal (empathy or intimacy) functioning. B. One or more pathological trait domains or trait facets.
C. The disturbances in personality functioning and the expression of individual personality traits are relatively stable over time and consistent across situations.
D. The disturbances in personality functioning and the expression of individual personality traits cannot be better understood from the development phase or socio-cultural environment of the individual.
E. The disturbances in personality functioning and the expression of individual personality traits cannot be attributed solely to the direct physiological effects of a substance (e.g. abuse of a substance, medication) or a general medical condition (e.g. severe head trauma).

In the revision, it was decided to add a level of personality functioning, because research showed that the level of personality functioning had an important influence on the efficacy and outcome of treatments. The way in which patients perceive and understand themselves as well as others likely has an important influence on the nature of the interaction with their therapists. TA can offer clients with personality disorders a different way of looking at themselves and others. This may improve the working alliance within therapy. Clients with personality disorders have often been stuck in cyclical patterns for years, such that they no longer realize that other patterns of behavior are even possible. Other persons, unfortunately including some therapists,
may describe these patients as difficult, hopeless, conflictual, and turbulent. In short, their problems are (by definition) pervasive, persistent and severe.

*De Viersprong* has invested in the application of TA. Part of the assessment team was trained in the TA method by Stephen Finn and had weekly supervision with a certified TA practitioner (Jan Henk Kamphuis). On going contact with Stephen Finn and others from the Therapeutic Assessment Institute took the form of annual booster sessions, and training programs in the US, and via Skype. In 2009, a Randomized Controlled Clinical Trial (RCT) was started, in which clients on the waiting list for their subsequent treatment were randomly assigned to either TA (first research arm) or the goal focused pre-treatment intervention (GFPTI; *four-session model*) (second research arm). The full TA model was implemented and tested. The control condition was a protocol-driven, semi-structured procedure with a model that proved its effectiveness as a short-term intervention (Stoffer, 2005). The primary hypotheses were:

- The working alliance with both the assessor and the subsequent therapist will be better in the TA condition than in the GFPTI condition;
- The TA group show more improvement in terms of demoralization than the GFPTI condition will.

We originally envisioned four measuring moments: a) a baseline measurement at the start, b) a measurement immediately after the interventions, c) a measurement six weeks after the end of the interventions and d) a final measurement six weeks after the start of treatment². We are not yet ready to report on the research results, but the initial skepticism at *De Viersprong* whether this ‘American model’ would work in the Dutch context evaporated quickly.

Investing in the collaborative relationship has both been a core challenge as well as the key leverage factor with these clients. Clients with personality pathology often have a history of abandonment and rejection, and are often not (anymore) used to being treated with genuine respect. In their experience, mental health care has often been inadequate. We hold that the corrective experience stops the protracted demoralization as one of the most important hallmarks of personality pathology. In

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² The last two assessment moments proved not feasible at De Viersprong because of changes in the patient flow due to reorganization.
contrast, the abstinent and distant attitude typical of traditional assessment approaches rather aggravates the problem that these clients experience in contact with others. Abstinence fits perfectly into the patients’ explanatory model of how others work and will block the curiosity that is necessary for change.

We were not sure that this group of clients would have the requisite introspective capacity to make TA a profitable method. Specifically, we did not deem it likely that clients with personality pathology would be capable of asking the sufficiently ‘rich’ questions on which TA is based. Questions such as “Why do I make myself very big when I am insecure?” “Am I capable of connecting with my feelings?” and “Why do I prefer to hide things than to solve them?” testify to a motivation for change and also to an awareness of a problem. Contrary to these worries in advance, patients appeared to be equally well capable of collaborating with the TA therapist and involving in the TA process as patients with less severe pathology are. In addition, we wondered whether clients, who had been stuck for a long time in many areas of life, could benefit from a short-term intervention. The different interpersonal stance of TA induces and motivates clients to self-observe, which in turn leads to new self-awareness in clients. An often heard comment at the end of a TA course was “so there is still hope”.

Finally, there was a fear that these clients would be disrupted if they experienced the possibility of alternative explanatory models, i.e., the possibility that their own model does not explain all the facts. TA takes place in a relatively short period of time, without clients being in treatment. So far, this fear has proven unfounded. Clients are indeed able to revise their narrative in a short time, without experiencing disintegration. Future research should examine whether they are able to maintain this change.

**Challenges**

The challenges of implementing the TA model in people with severe personality disorders were considerable and diverse. Is it not too ambitious to expect that people with serious problems in different areas of life can benefit from a short-term intervention such as TA? Do the changes that take place within a TA persist? In other words: is the short intervention a match for the daily reality that is often raw and harsh in clients with personality disorders? Moreover, TA is a surprisingly demanding
method, in terms of required expertise but also in terms of the emotional demands on the assessor. The assessor must know and be able to interpret his tests according to the state of the art. In addition, he must be aware of the prevailing therapeutic theories and interventions. Finally, he must be able to enter into a truly intensive collaborative relationship. What is special about people with personality disorders is that they are not satisfied with ‘as if’. A strong team and others who assist the assessor in monitoring the process are essential.
References


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