Therapeutic assessment in patients with personality disorders

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Citation for published version (APA):
This dissertation reported on a randomized controlled trial (RCT) of Therapeutic Assessment (TA) versus a Goal-Focused Pre-Treatment Intervention (GFPTI) in patients with personality pathology, conducted at De Viersprong, a specialized center for the assessment and treatment of personality disorders in adolescents and adults. We first provided a general description of the TA model as implemented at De Viersprong (Chapter 2), and then illustrated its flow and outcome in the context of a case-analysis (Chapter 3). Next, we reported on the RCT, detailing outcomes in terms of symptomatic functioning, demoralization, and multiple indices of treatment readiness (Chapter 4). As a follow-up, to better understand the working mechanisms of TA, we solicited patients’ qualitative appraisals of what made TA memorable and distinct (Chapter 5). In addition, we reported (Chapter 6) on a novel self-report instrument for the assessment of personality pathology: The MMPI-2-RF (Ben-Porath & Tellegen, 2008).

Main Findings
With respect to the RCT (Chapter 4), these patients, all awaiting treatment \(N = 74\), generally had longstanding psychological complaints, for which they had received multiple treatments, including psychopharmacological treatment for about half of the sample, and inpatient admissions for one in five patients. TA generated higher outcome expectancies and patient perceptions of progress toward treatment (Cohen’s \(d = 0.65\) and 0.56, respectively), and yielded higher patient satisfaction \(d = 0.68\). Moreover, patients reported marginally stronger alliance to the TA clinicians than to GFPTI clinicians \(d = 0.46\), even though therapists perceived the alliance as equally positive in both groups. Contrary to expectation, no group differences in levels of post-treatment psychological symptoms or demoralization were observed.

Our findings were generally in line with the scantily available evidence. Presumably pertinent to TA in PD is the pilot study by Ougrin, Ng and Low (2008) that assessed adherence to subsequent community care in adolescents presenting at the emergency room with serious self-harming behaviors. Those who were offered collaborative assessment were more likely to adhere to the recommendations than those who received assessment as usual. Also, as mentioned in the Introduction, Morey, Lowmaster and Hopwood (2010) reported on 7 (out of 16 intention-to-treat) self-harming patients with borderline PD who completed Manual Assisted Cognitive
Therapy (MACT) with or without TA. Although the low numbers clearly preclude
definite conclusions, the MACT + TA group showed greater reduction in affective
instability and suicidal ideation, but no differences in treatment retention were noted.
Assuming some externalizing personality pathology in their sample of 30 patients
with substance abuse, it is noteworthy to mention that Blonigen Timko, Jacob, and
Moos (2015) observed stronger satisfaction with the assessment when conducted along
TA lines, and these patients also reported higher expectations for and commitment to
their subsequent treatment program.

Puzzled by the discordance between the significant gains in treatment readiness
versus the null findings in terms of symptomatic improvement, we solicited patients’
qualitative appraisals of what made TA memorable and distinct (Chapter 5). Globally
adhering to the guidelines provided by the Consensual Qualitative Research (CQR; Hill,
2012) paradigm, we conducted semi-structured client interviews in a subset of the RCT
participants. Patients reflected on aspects of the relationship, on new personal insights
and better self-understanding, and on gains in self-confidence. Notably, although
80% of patients had a treatment history of greater than 5 years, patients generally
reported novel experiences in TA, mostly pertaining to the different relational frame.
Patients particularly noted that the therapists described the interventions as a joined
venture, with both partners equally responsible for the result. In the words of a female
participant (age 37):

“I was asked more about myself, about my own experiences and ... yes, how I,
myself, really perceive things... in contrast to what I have experienced [in treatment]
before sometimes... that when you give a sketch of your biography you become immediately
labeled in one way or another [...] yes, this time it was really looking at it together, I really
had the feeling we were doing it together”.

In some it appears that the feeling of emerging mastery and hope is of more
importance to our clients. TA gave them a glance of the change Psychotherapy might
provide them.

Self-report Innovations in Personality Assessment of PD: the MMPI-2-RF Model
Self-report assessment remains the dominant method of clinical assessment in both
research and practice. Though not without its limitations (e.g., it requires a minimum of
patient motivation, introspective capacity, and task orientation), from a TA perspective it allows patients another avenue to tell the therapist about their functioning and struggles.

In Chapter 6, we presented a Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2008) investigation of Cluster C personality pathology, as oriented toward the DSM-5 (American Psychiatric Association, 2013). The study generated a hierarchical representation of psychopathology dimensions that provides the clinician with a clinically coherent portrait of Cluster C personality pathology. The profile made conceptual sense, and may be sufficiently specific (i.e. show sufficient discriminant validity) to raise clinical flags. Moreover, the robust elevation on somatic/ cognitive indicators suggested an interesting theoretical hypothesis with respect to the nature of the more internalizing PDs. In sum, these findings were in line with similar work (e.g. Anderson, Sellbom, Kamphuis, Smid, & De Saeger, 2015; Sellbom, Smid, De Saeger, Smit & Kamphuis, 2014; in partly overlapping samples) and provided additional support for the clinical utility of the MMPI-2-RF in assessing patients with personality pathology.

**Selection of Pertinent Outcome Measures in Patients with PD**

As we embarked on this project, we selected change in Demoralization as the primary outcome measure. Contrary to expectation, minimal change was observed both within and between groups. Apparently, TA (or GFPTI) does not suffice to change general unhappiness and life dissatisfaction in patients with PD who are typically suffering from longstanding patterns of dysfunctional feelings, cognitions, relations or behaviors. Demoralization is associated with feelings of hopelessness and pessimism, low self-esteem, insecurity, worry/ rumination, and generalized difficulty in coping with life’s circumstances. In retrospect, it may have been a bit “grandiose” to expect that 4 sessions of TA (or GFPTI) would make a serious dent into the type of problems our patient population faces. As noted, most of our participants had extensive, diffuse and longstanding problems for which they had received multiple treatments. Gains were mostly seen in treatment readiness, i.e. believing that treatment might be effective, that a focus for treatment had been identified, and that it was indeed possible to be understood by a therapist and to acquire self-understanding in a therapeutical context.
But life itself had not changed yet. Alternatively, the lack of change in Demoralization may also point to a measurement issue this measure appears to show more stability than is conceptually is expected.

This beckons the broader question of what should constitute client benefit in definitions of treatment utility of (collaborative/therapeutic) assessment (Hayes et al., 1987). Is it only indexed by short-term symptomatic improvement? When designing the study, we recognized that we were unable to formulate a directed hypothesis with respect to symptomatic complaints (as measured by the BSI). On the one hand, we expected patients to ultimately improve in their functioning, and on the other hand our clinical experience and available outcome data suggested that PD patients often report more symptoms upon successful engagement in therapy, as previously egosyntonic patterns become egodystonic, and old patterns of (dysfunctional) coping are as such recognized and relinquished before new more functional alternatives have been installed. In other words, the time frame of outcome assessment deserves attention. Moreover, short-term symptomatic change or relief may not be the most salient outcome to patients with personality disorders, as it might not be sufficient predictive of better societal functioning. So-called ultimate outcome (relational or occupational functioning), as well as self-understanding and acceptance may have at least equal if not more importance to the individual client. Such considerations underscore the value of the shared decision making movement (Elwyn, Edwards, Kinnersley, & Grol, 2000; Elwyn, et al., 2010) and of a more nuanced view of what salient treatment outcome is.

Speculating on Mechanisms of Change

As Poston and Hansen (2010) also noted in their meta-analysis, how and why collaborative / therapeutic assessment is beneficial remains largely unknown. Early theorizing (Finn & Tonsager, 1997) proposed that client benefit occurred by addressing the basic human motives of (a) Self-Verification (i.e., to have our self-concept affirmed in a relationship, to maintain a stable and coherent sense of self), (b) Self-Enhancement (i.e., to be loved, praised, and think well of ourselves), and (c) Self-Efficacy / Self-Discovery (i.e., to grow, learn about ourselves and gain mastery over the world). We readily acknowledge that the present thesis did not specifically address
working mechanisms. That said, juxtaposing the RCT findings (Chapter 4) with the emergent themes from the patient interviews (Chapter 5) suggested that TA in PD patients works primarily on treatment readiness, and that clients attribute great value to the collaborative relational frame, and the sense of agency and self-awareness it brings forth. Taken together, these observations are highly consistent with a relatively new evolutionary based theory of epistemic trust and epistemic hypervigilance (Fonagy, Luyten, & Alison, 2015). Epistemic trust is the willingness to take in relevant interpersonally transmitted information and it is essential to the immediate success of psychotherapy and for its long-term impact. Kamphuis & Finn (2018) recently used the epistemic trust/hypervigilance framework as a lens to plausibly explain the efficacy of TA, and especially its influence on PD clients’ alliance and motivation for subsequent psychotherapy (Fonagy, Luyten, & Alison, 2015). In brief, the collaborative, intersubjective framework of TA and several of its specific techniques (e.g., generating personalized assessment questions, balancing/sequencing bottom-up versus top-down learning, scaffolding, use of tests as play) may be understood as highly relevant to restoring epistemic trust in clients, especially those with PD.

**Methodological Considerations**

This thesis featured a number of methodological strengths and weaknesses. To start with the strengths, our study added important data to the issue of treatment utility of clinical assessment, specifically in the context of TA, and even more specifically in patients with PD. Despite repeated lamentations by subsequent researchers (e.g., Hunsley & Nash, 2010; Meehl, 1959), there remains a scant body of evidence on the treatment utility of clinical assessment. Specifically, the question “does clinical assessment affect treatment processes and outcomes and, ultimately, yield meaningful benefits for clients?” still cannot be definitively answered. Or, as Meehl (1959) phrased it, […] what, if any, is the pragmatic advantage of a personality assessment being known in advance by the therapist”. To date, the greater than 30 years old Hayes, Nelson & Jarrett (1987) definition of treatment utility of assessment is still the most widely used: i.e., ‘the degree to which assessment [contributes] to beneficial treatment outcome. Our main study (Chapters 4 and 5) reported specifically on this question, and compared TA to a protocol-driven semi-structured intervention, that is often used in Dutch
primary health care. Moreover, this study utilized a modification of one of the more sophisticated research designs advocated by Hayes et al (1987): the manipulated assessment design. Specifically, we compared the direct treatment utility of TA to a short-term motivational psychotherapeutic intervention.

Another asset, we believe, was the qualitative follow-up study soliciting the patient perspective. Although inviting the patient perspective has lately received much more emphasis in both research (e.g., explicit inclusion of such guidelines in grant proposals) and practice (e.g., a focus on the benefits of ‘shared decision making’), Quin’s (1996) observation still holds: “...most of what is written and discussed about clients’ experiences is generated out of the perceptions and impressions of practitioners, researchers and theoreticians”. We surmised that explicitly inviting the client’s point of view might provide us with inspiration to nominate “missing links” in understanding the outcomes and mechanisms of psychological interventions. These patient interviews have indeed been important in subsequent (Epistemic Trust) theorizing about the efficacy of TA (Kamphuis & Finn, 2018).

On the other hand, several limitations of the presented body of work warrant explicit mention, particularly with respect to the RCT. First and foremost, our final sample size ($N = 74$) was associated with only modest power, such that even medium effect-sizes (e.g. $d = .46$, patient alliance ratings) yielded only trends. This speaks to the complexity of organizing such RCTs in clinical practice, but clearly future work should aim for larger sample sizes. Second, working with patients already awaiting treatment had a number of inherent and unfortunate consequences. Primary among these was that there was no transfer of the findings of TA to subsequent treatment. More specifically, treatment selection had already occurred, and the Evidence Based Therapy followed protocol as usual. In other words, TA operated somewhat in a vacuum, without opportunity to inform subsequent interventions. Treatment utility was accordingly limited to the direct gains associated with TA (as compared to GFPTI) only, i.e. testing TA as an intervention by itself. In this context it made little sense to conduct follow-up assessments, but in general, such information is very much what the field needs. Finally, and anecdotally, it has been observed at De Viersprong that clients derive quite some relief and hope from being assigned to treatment by itself. We speculate that this observation may imply that our pre-treatment assessment reflected
this relief and hope, and as such allowed for less symptomatic improvement of the TA and GFPTI interventions.

Presumably, we were not fully exempt to the limitations frequently posited and disputed for RCTs (Westen, Novotny, & Thompson, 2004; Westen, Stirman, & DeRubeis, 2006); i.e. possibly limited external validity as a consequence of strong experimental control procedures. Furthermore, given that the large majority of our sample consisted of patients with cluster C or B diagnoses, the results of our study cannot be generalized to patients with Cluster A (eccentric or odd) PD diagnoses. Finally, adherence to the TA model was informally tracked by supervision forms, but no formal measurement took place.

Future Directions

Research

Several priorities for research into TA (in PD) can be formulated. Cross-validation of the presented results is of course desirable, but it is perhaps even more desirable to adapt or amplify the design of future studies. An important contribution would be to allow TA to actually inform subsequent treatment, both in terms of treatment selection (what treatment for this patient), as well as treatment planning (what focus, direction for this client). If the design would allow for this, both direct effects (topic of this dissertation) and indirect effects (mediated by treatment) might be assessed. Accordingly, clients would experience the progression from assessment to intervention as more cohesive. Such designs could also aim for the assessment of more long-term outcome. Second, several relevant innovations in clinical assessment and clinical psychology at large have occurred over the course of this dissertation. In terms of instrument development, new and presumably improved versions of frequently used instruments in TA have been introduced such as the MMPI-2-RF (see Chapter 6), and the Rorschach Performance Assessment System (RPAS) version of the Rorschach Inkblot Assessment (Mihura & Meyer, 2018). As TA considers tests 'empathy magnifiers', the incremental utility of these tests, and the presumably sharper case conceptualizations they help generate, might be tested in so-called Manipulated Assessment Designs (Hayes et al., 1987), in which patient outcome based on TA with the new instruments is compared to outcome of TA with the older versions. Likewise, the DSM-5 Alternative
Model of Personality Disorders (AMPD) provides TA with a new, theory-based and experience-near framework to provide feedback to PD patients, as compared to the classic model that is rooted in behavioral classification. Other directions might be to extend and test TA interventions to adolescent PD, or PD as encountered in forensic settings. With respect to these research pursuits, recent TA modifications that are either shorter (e.g., the less or equal than 3-session TA_Ultra-Brief protocol; Finn, Kamphuis, & De Saeger, 2017), or more extended versions that blend into intermittent group treatment (TA_extended protocol; Kamphuis et al., in preparation) are available (for empirical testing).

**Teaching personality assessment**

The specific TA intervention tested in the present RCT was based on Multi-Method Assessment, as it included both self-report data (MMPI-2), performance-based data (Rorschach), and data from idiographic behavioral experiments (Assessment Intervention Session). We hold that multi-method assessment is essential in patients who have marked introspective limitations and/or who hold on to often rather extreme and stylized representations of themselves, others, and the world — i.e. patients with significant personality pathology. It is our observation that very few clinical psychology programs in the Netherlands and Belgium (and internationally; Evans & Finn, 2017) still offer performance-based assessment training, and the same seems to hold for Dutch post-doctoral training programs. It may be good to reconsider the curricula of these programs in this light.

**Conclusions**

Taken together, we concur with the conclusions as formulated in the Poston and Hanson (2010) meta-analysis: “...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. Clinicians might do well to seek continuing education in collaborative and/or therapeutic assessment models and the associated most frequently used clinical instruments. Possibly, and suitable for empirical testing, merely integrating the 'easier' components of the TA model (e.g., collaboratively developing the personalized
assessment questions) may yield meaningful client benefit (e.g., by stimulating agency and investment and/or relaxing epistemic hypervigilance). In fact, an important question for future research may be to figure out what patients really need / benefit from such extensive dosing of assessment, and who may also thrive with a lesser dose (i.e., the question of Stepped Assessment). Regardless, we propose that the interpersonal stance of TA - collaborative, equal, and geared to model and stimulate self-curiosity - is likely to benefit all clients.
References


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