QUESTION DEVELOPMENT BY INDIVIDUALS IN THERAPEUTIC ASSESSMENT: DOES IT RESULT IN MORE POSITIVE OUTCOMES?

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by

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CHAPTER 1

INTRODUCTION

Collaborative Models of Psychological Assessment

Collaborative models of assessment are client-centered approaches to psychological assessment that are generally rooted in the humanistic tradition. They emphasize complete client involvement in the assessment process and attempt to eliminate the power divide between an assessor and a client. Collaborative models are largely different from the historical view of assessment, which was based on the medical model. In the historical view of assessment, the client and assessor did not collaborate; the client was the patient, and the assessor, the scientist. Assessment was viewed as a highly standardized method to measure phenomena in clients that were not easily observed through psychotherapy. Moreover, assessment was not intended to serve a direct therapeutic function, but rather to answer questions and to provide additional psychological information about the client to referring professionals. At the conclusion of an assessment, clients were not informed of the results, even if clients had access to the assessment report, the highly technical jargon and reference to psychological constructs was likely incomprehensible to the layman (Fischer, 1985). Further, many professionals believed sharing results with clients could be potentially harmful, and thus it was deemed
appropriate to withhold test results so as to avoid emotional or psychological distress
(Baker, 1964; Butcher, 1992; Craddick, 1975; Klopfer, 1954).

Over time, many psychologists became disenchanted with testing and assessment
and questioned their value to psychology (Meehl, 1960; Rosenwald, 1965). There were
others who believed psychological assessment, particularly personality assessment, could
be therapeutic in its own right (Baker, 1964; Fischer, 1985; Handler, 2007). Although
many psychologists independently developed their own unique methods, each to some
degree sought to integrate humanistic ideals with testing, and fully embraced the concept
of assessment as a therapeutic tool. (Baker, 1964; Craddick, 1972, 1975). They generally
shared the goals of maintaining empathic connections with clients, collaborating on
assessment goals, and sharing and exploring test results with clients (Finn & Tonsager,
1997).

In the past two to three decades, collaborative models of assessment have gained
popularity, including a model developed by Constance Fischer (1979, 1985), which she
labeled individualized psychological assessment. Fischer’s early work (1970, 1972, 1979,
1985) on collaborative assessment has contributed significantly to such approaches, and
her 1985 book served to outline her methods and provided case examples of the
effectiveness of the approach. Despite the number of proponents and numerous case
accounts of positive client outcomes, published scientific research on collaborative
assessment is lacking. A potential reason for the lack of empirical studies in this area is
that experimental investigation of collaborative assessment is in direct contradiction to its
original goal. Collaborative assessment models were developed in response to critiques
about assessment as a rigid, nomothetic approach that denied client individuality. Manualization of individualized assessment would be contradictory to the idiographic, individualistic approach. After all, the purpose of individualized assessment was to move away from the natural-science assumption that people can be categorized, and move toward emphasizing the unique histories, struggles, and goals of each individual.

However, without structure and at least some standardization, collaborative assessment models like Fischer’s are not easily empirically tested. In order to conduct experimental studies of collaborative assessment it would be necessary to group individuals in randomized assessment conditions. There would have to be some level of standardization to the assessments administered to said groups, which would obviously confound the individualized nature of the approach. This could be why support for collaborative or individualized assessment techniques often comes from case studies or anecdotal accounts, rather than experimental designs, as the former allow for complete individualization. Unfortunately, non-experimental designs cannot provide information about causality of treatment effects, and thus the claim that collaborative assessment is effective remains unsupported by science. Without scientific investigation of the effectiveness of these approaches, it is impossible to understand if collaborative assessment is truly therapeutic and related to positive growth in clients. The issue of reliability and validity of psychological testing and assessment is particularly relevant in today’s society of reimbursement from third-party payers. In fact, many psychologists have found it increasingly difficult to get reimbursed for testing and assessment as third
party payers considered it to be too time-consuming and lacking in empirical support (Kubiszyn et al. 2000).

**Development of Therapeutic Assessment**

Even though collaborative models of assessment emphasize the uniqueness of each client and their own personal struggles or questions, it became clear to others that standardization of such approaches would make them easier to teach and utilize. A method developed by Stephen E. Finn and colleagues at the Center for Therapeutic Assessment (Austin, TX) serves as a compromise between completely individualized methods and highly standardized, manualized treatments. Finn and colleagues coined their method, Therapeutic Assessment (TA), which is very similar to the collaborative models mentioned above, and was primarily developed from Fischer’s individualized assessment model (Finn, 2007). However, Finn and colleagues designate the term Therapeutic Assessment (capital T, A) to describe their particular approach, which unlike other collaborative models, has standardized steps and techniques. The steps and techniques outlined by Finn and colleagues (1996, 2007) were developed with great consideration for the core values of TA and are also grounded in varying theoretical traditions.

**Core Values of Therapeutic Assessment**

The core values of TA are what provide the quality and quintessence of the entire approach. Each of the six steps of TA encompasses one or more of the core values. Even if one or more of the TA steps is not addressed in a particular assessment, the core values
must always be applied (Finn, 2007). Perhaps the most central core value in TA is *respect*. In regard to TA, respect includes the practice of truly informed consent; the assessor takes great care to ensure the client understands assessment procedures and that his or her participation is entirely voluntary. Additionally, clients are treated as experts on their own lives; the assessor does not behave as an all-knowing authority. Related to respect, is the core value of *humility*, which encompasses the understanding that assessors and psychological tests have limitations. Additionally, clinicians practicing TA apply humility by realizing that they, like their clients, are human, with similar struggles and a desire to grow and progress (Finn, 2009b).

Another of the most important aspects of TA is described by the core value of *collaboration*. Therapeutic Assessment relies on complete client involvement in the assessment, and this is practiced by engaging the client’s collaboration in goal setting, gathering collateral information, providing interpretations of test results, and applying test results to examples from everyday life. *Compassion*, another core value, is used in combination with psychological tests in order to gain an understanding of a client’s life. This combination allows the assessor to begin to understand behaviors or other puzzles the client may have with the test results, while also using empathy to decrease the client’s shame or confusion. The final core value of *openness and curiosity* entails that the assessor is open to, and interested in, every client who seeks TA. The assessor understands that each client is unique and welcomes feedback about how to improve the TA process.
Semi-Structured Steps of Therapeutic Assessment

The core values provide a framework for carrying out the specific steps in TA. Even though the steps provide a general structure for the technique, they do not necessarily have to be followed precisely. This is because not every step is feasible for clinicians to follow, or may not be applicable to all clients. Therapeutic Assessment can be used as an intervention for individuals, couples, and children, with the same steps being utilized for all clients. The semi-structured nature of TA, which allows for flexibility based on clients’ individual differences, is consistent with the idiographic ideology that is the basis for many collaborative assessment models. Due to the flexibility of the steps within TA, there is no set number of sessions to complete the process, but it is possible for TA to be conducted in as few as three sessions.

Step one: Initial session(s). Engaging the client as an active and voluntary participant in the assessment, regardless of the referral source, is paramount in Therapeutic Assessment. Finn states that the primary goal of psychological testing should always be to help the person being tested, rather than simply answering a referral source’s questions. This client-centered goal is accomplished in the first step in the Therapeutic Assessment process through the 30 to 60 minute clinical interview. The aims of the initial interview are: (a) to build rapport with the client, (b) present the assessment as a collaborative task, (c) aid the client in developing questions, (d) attain historical information relevant to the client’s questions, (e) inquire about past experience with
assessment, (f) allow the client to ask questions about the assessor; and (g) answer any questions or concerns about the assessment (Finn, 1996).

The first two aims of step one, building rapport and presenting the assessment as a collaborative task, help set the stage for the entire process by creating a collaborative and safe environment for the client to gain understanding about himself or herself. Perhaps one of the more difficult aspects of step one is the development of the client’s questions. Many clients are not familiar with acting as co-collaborators in assessment and may initially resist sharing, or be unprepared to develop their own questions. At this point it is important for the assessor to help the client develop questions that are within the scope of the assessment and can likely be answered by the types of assessment measures available to the assessor. As the client presents potential assessment questions, the assessor asks for historical information or elaboration, and helps reframe the question if necessary. After all questions are formulated, the assessor reads them aloud so the client can revise and/or confirm the final questions (Finn, 1996, 2007).

Careful formulation of assessment questions ensures not only that the assessor and client semantically agree on the questions, but it also serves as a method for the assessor to determine for which life areas the client is willing to receive feedback. This is particularly valuable for the fourth step of the process, the summary/discussion session, which will be described in more detail later. Another benefit of clients formulating their own questions is that they become more invested in the entire process because the results will be used to address their personal goals (S. E. Finn, personal communication, May 13, 2011). The final portions of step one include asking the client about past experience with
assessment, allowing the client to ask questions of the assessor, and answering any questions or concerns about the proceeding assessment. After the assessor learns about any past assessment experiences and questions of the assessor are answered, the assessor answers any questions or concerns the client has about the proceeding assessment process.

**Step two: Standardized testing session(s).** After the initial interview is completed and the assessor and client have agreed on appropriate questions the testing session(s) are scheduled. The battery of tests used in TA depends on the questions for the assessment as no predetermined test batteries are utilized. Often, multiple testing sessions are planned, even if only one or two inventories will be administered so as to not overwhelm the client. Additionally, taking the assessment process at a slower pace allows for the assessor to take time to communicate with the client about his or her experiences during the tasks, which keeps the assessment process client-centered and collaborative (Finn, 2007).

**Step three: Assessment intervention session(s).** This session was a later addition to the process and is one of the steps not always implemented with every client. If an assessment intervention session is utilized, it takes place after the standardized assessment session(s). The purpose of the assessment intervention session is to make observable clients’ problematic behaviors, cognitions, attitudes, etc. that contribute to their problems in living. This is accomplished by using psychological tests, which are samples of real-world behaviors, to produce an emotional state in a client that is related to
one or more of the assessment questions developed in the initial session (Fischer, 1985; Finn, 2007). In the assessment intervention step, psychological tests may not always be used according to standardization instructions but rather serve as an opportunity for clients to actively participate in developing new understandings of their usual methods or patterns of behaviors (Fischer, 1985). Finn (2007) states that assessment intervention sessions are based in gestalt therapy, which involves investigation of understanding and awareness by creating an “experience in which a client might learn something as part of his or her growth” (Brownell, 2009, p. 404). The specific steps for how to conduct an assessment intervention session with a client are outlined in Finn (2007). An example of such of session might be to help a client understand symptoms of confusion, distractibility and inattention that are not due to a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD). The assessor may come to the conclusion that the individual has difficulty processing information when emotionally aroused. Thus, in an assessment intervention session, the assessor would administer tests of processing speed or attention while the individual is under different emotional states (anxious, calm, angry, etc.). Through this process, the assessor would help the client realize the nature of his or her symptoms by pointing out any differences in test scores across the testing conditions (different emotional states).

**Step four: Summary/discussion session(s).** In the early development of TA this step was labeled as the “feedback session,” but was later changed to “summary/discussion session.” This is because the word “feedback” implies a unilateral
delivery of information from assessor to client, which is not consistent with the collaborative and therapeutic nature of TA (Finn, 2007). In this step of TA, the assessor allows for the client to provide input and alternative interpretations of the results of the assessment. The purpose of the summary/feedback session is to help clients change inaccurate self-views by using assessment results. Even though the summary/discussion session is collaborative and client-centered, there is a specific structure an assessor should follow when presenting assessment results. Changing clients’ beliefs about themselves does not happen easily, thus a particular model for how to deliver the assessment results must be utilized in order to promote change in clients’ self-views that is both therapeutic and collaborative (Finn, 2007).

The model used for delivery of assessment results in TA is based on Swann’s (1983) self-verification theory. Self-verification theory provides the starting point for the summary/discussion session as it helps organize the order of the information to be presented to the client by determining which pieces of information will be acceptable to the client based on his or her self-view. Self-verification theory posits that humans aim to verify and confirm their self-view in order to predict the reactions of others, to guide their own behavior, and to organize their conceptions of reality. According to self-verification theory, individuals seek information that verifies their self-views, or stories, and view confirming evidence as congruent and valid, whereas information contrary to their self-view is not easily accepted and may produce anxiety.

The order in which feedback information is delivered to clients depends on the particular quality of the information, which Finn (1996, 2007) describes as different
“levels” of information. Level one information includes results that clients would easily accept as true, whereas level two information includes findings that are consistent with clients’ usual way of thinking about themselves but also modifies their typical self-views. The majority of the results shared in the summary/discussion session are level one and level two as these results will ease clients’ anxieties and allow for continued discussion. The last level of information is level three information, which refers to results that are entirely novel, or even contradictory to clients’ views of themselves. Findings that fall within this third level are shared sparingly with clients because of the potential for rejection by the client as well as the likelihood that intense feelings of anxiety will be provoked.

**Step five: Written feedback.** In the weeks immediately following the in-person summary/discussion session, the assessor provides a letter to the client outlining the results as well as the client’s personal input and interpretations during the summary/discussion session. This written feedback may be given to the client in lieu of, or in addition to, a formal psychological report. The feedback letter is written in informal language and is structured around the client’s assessment questions in the same way as for the summary/discussion session. Even this step of TA is collaborative; the assessor often uses the client’s own language within the letter, such as the client’s words used to describe symptoms, or even specific responses to test items. Additionally, the letter includes the client’s reactions to the findings during the summary/discussion session.
Finn (2007) acknowledges that although this step is time consuming, it is worthwhile as he believes it contributes to the therapeutic value of the process.

**Step six: Follow-up session(s).** The final step of TA was the last added to the process. Like assessment intervention sessions, it is a step that may not be necessary for all clients and thus is not used in every case of TA. During the summary/discussion session the client is told that it may be useful to meet in two or three months to again discuss the assessment and any developments that may have occurred since. Follow-up sessions are treated as periodic consultations that examine progress and elucidate future steps. Finn (2007) posits that follow-up sessions may be a therapeutic alternative for clients who do not pursue ongoing psychotherapy after TA.

**Empirical Investigations of the Effectiveness of Therapeutic Assessment**

A benefit of the development of Therapeutic Assessment was the semi-structured steps that make the model more easily taught and more easily researched. This semi-structured model provided needed standardization to the techniques many assessors were already practicing individually, as the steps made it more likely that any two clinicians utilizing the technique were implementing similar procedures. But even with the addition of the semi-structured approach to psychological assessment, little published research has been conducted on TA, and the research that has been conducted has not addressed every step of the process.

One reason for the lack of research could be that even though TA is semi-structured, it is still more individualized and non-standardized than traditional assessment
and therefore poses a similar challenge to research as the other collaborative assessment models. Consequently, many of the studies Finn (2007) references in support of TA are case studies, qualitative studies, or studies presented at professional conferences but not published in peer reviewed journals. In regard to the aforementioned studies used in support of TA, Finn and Tonsager (1997) have stated, “…although these case reports are not based on controlled research, they too represent a kind of empirical evidence” (p. 380). Though case reports may provide some evidence for the effectiveness of TA, they do not allow one to reach explicit conclusions about whether or not TA is a therapeutic intervention. Regardless of the inherent difficulties in regard to empirical investigation of TA, there are studies that examine different aspects of the approach in relation to therapeutic benefits. Notably, neither of the studies in the subsequent review measured TA in its entirety, but rather included a few of the semi-structured steps.

A study most often referenced in support for Therapeutic Assessment was conducted by Finn and Tonsager (1992). This study was conducted early in the development of TA so it did not examine every step of Therapeutic Assessment. Regardless, the study included a variant of the TA initial session (step 1), as well as an assessment session (step 2), and a version of the TA summary/discussion session (step 4). The authors investigated the therapeutic effects of sharing MMPI-2 results with outpatient clients at a university counseling center. During the initial session, individuals in the control condition (attention-only) had a 30-minute interview with an examiner to discuss their presenting problems and then completed a measure of self-consciousness and other outcome measures. Participants in the experimental condition (feedback
condition) met with the examiner at the initial session and developed questions they wanted answered by the assessment.

The authors hypothesized that individuals who received MMPI-2 feedback would have a greater decrease in symptomatic distress and greater increase in self-esteem as compared to individuals who only received attention from the examiner. They posited that the reduction in symptomatic distress after receiving feedback is a product of the individual feeling understood by another person, which can often produce feelings of relief (Lewak, Marks & Nelson, 1990). Results indicated that participants in the experimental condition who received MMPI-2 feedback had a statistically significant decrease in symptomatic distress as compared to the control group. In regard to self-esteem, participants in the experimental condition had a significant increase in self-esteem immediately following feedback and at the two week follow-up. Both groups felt very well liked and attended to by the examiner so it was suggested that the therapeutic benefits of the feedback condition were not simply a result of feeling well liked or attended to by the examiner.

Newman and Greenway (1997) replicated the Finn and Tonsager study but controlled for the possibility that just taking the MMPI-2 resulted in the therapeutic benefits. Both the experimental and control conditions completed the MMPI-2, but only the experimental condition received feedback about the MMPI-2 results. Like Finn and Tonsager, the TA steps included in the study were a variant of the initial session in TA, an assessment session, and a summary/discussion session. Participants (N =60) were from a university counseling service and were randomly assigned to either the
experimental (feedback) condition or the control (attention-only) condition. All participants completed individual interviews with an examiner during which they discussed presenting concerns, and developed questions that could be answered throughout the assessment. Two weeks later, participants in the experimental group met with the examiner for a feedback session regarding the MMPI-2 results, while participants in the control condition met with the examiner at time two to clarify or add questions to be answered by the assessment, but did not receive MMPI-2 feedback. An additional two weeks later, both participant groups received the dependent measures in the mail, which included a symptom checklist, a measure of self-esteem, and a measure that evaluated their feelings about the assessment.

Newman and Greenway hypothesized that participants who received MMPI-2 feedback as compared to individuals in the control condition would experience a significant decrease in symptomatic distress, and an increase in self-esteem. The results indicated that individuals who received MMPI-2 feedback had a significantly larger decrease in symptoms as compared to individuals in the control group at follow-up (time three). In terms of self-esteem, results indicated that individuals in the experimental condition had a significant increase in self-esteem by time three, whereas individuals in the control group had a significant decrease in self-esteem by time three. As was found in Finn and Tonsager, the participants in both conditions felt similarly attended to, and liked by the assessors, which indicates that improvement in the experimental condition was not likely a result of experimenter effects.
The studies by Finn and Tonsager, and Newman and Greenway provide initial evidence that sharing MMPI-2 feedback with clients can result in increases in self-esteem and decreases in symptomatic distress. However, because these studies were conducted in the early to mid 1990’s, not every step in Therapeutic Assessment was utilized as the approach had not been fully developed. So even though the studies do provide evidence that aspects of Therapeutic Assessment result in therapeutic benefits, they do not provide empirical support the entire approach. Additionally, the changes in symptomatic distress and self-esteem across time were statistically significant, but may not necessarily be clinically or practically meaningful. Therefore, it is important that controlled studies continue to be conducted on Therapeutic Assessment, with more diverse samples and outcome measures, as these two studies alone do not provide enough evidence that TA is an effective therapeutic intervention.

**Core Components of Therapeutic Assessment**

Thorough examinations of the effectiveness of Therapeutic Assessment that include every step of the process while manipulating one step at a time would be valuable. However, studies of that nature would be difficult to conduct. First, it is difficult to independently examine one of the TA steps without including others, as they are all interrelated. Second, studies that analyze each step one by one may eliminate aspects of TA that contribute to its effectiveness. After all, assessors who practice Therapeutic Assessment believe that the combination of the core values, techniques, and steps is what makes TA transformative for clients. That is, it is not each specific step that
adds incrementally to the therapeutic effectiveness of the approach, but rather a combination of the steps, core values, and theoretical principles that leads to therapeutic benefits. Thus, a better way to examine the effectiveness of TA would be to identify and empirically investigate comprehensive components of TA that result in the positive therapeutic outcomes experienced by clients.

In order to determine which components of TA are thought to be effective, one could refer to the Finn’s many writings on the techniques of and theories behind Therapeutic Assessment (1996, 2003, 2007, 2009a, 2009b; Finn & Tonsager, 1992, 1997). Finn’s writings often mention which aspects of TA he has found to be particularly effective for clients, or aspects for which he hypothesizes result in positive outcomes. Additionally, designated effective components should be able to be experimentally manipulated so that future controlled studies could examine the actual effectiveness of the component. Based on Finn’s writings six effective components that can be experimentally examined can be identified. The proposed effective components of TA are: (a) feedback, (b) sharing of different levels of information (c) therapeutic attitude, (d) assessor-client relationship, (e) client collaboration/ client involvement; and (f) evoking and processing problem behaviors in session. Some of the identified components refer to specific steps within TA while others represent an overall method used throughout a Therapeutic Assessment case. It should not be assumed that all of the components are related to treatment outcome to the same degree, as it is likely that the combination of two or more of the components is what influences the effectiveness of the approach.
Moreover, some of the proposed components are likely interrelated and may potentially be better conceptualized as one single component.

**Feedback**

Feedback is proposed as an effective component of TA because it is the main pillar of the entire approach. Furthermore, Finn (2007) has directly stated that assessment feedback can lead to positive change in clients’ lives. The proposed component of feedback refers to the information about test results that is shared with the client during the summary/discussion session, as well as in the written feedback letter received after the summary/discussion session. This component is specifically referring to the information about test results, and not the organization or order of the information shared in the TA approach, which is conceptualized as a separate component. Furthermore, this component excludes the collaborative aspect of feedback used in the summary/discussion session and is again simply referring to the sharing of test of results with clients.

**Sharing of Different Levels of Information**

Feedback is very important to the TA process and as previously mentioned is assumed to result in therapeutic benefits to clients. However, within TA it is the careful organization and delivery of the test result information that is proposed to maximize client benefits. In Therapeutic Assessment the information shared with clients is organized according to the theoretical assumptions of self-verification theory proposed by Swann (1983), in addition to the concept of disintegration anxiety proposed by Kohut (1977). The organization of the information shared with the client allows the client to
receive the information in a manner that is not overwhelming and is more easily accepted as valid and reliable. Because the information is presented to clients in this way, the client is likely to incorporate the information into his or her life and/or treatment goals which may result in therapeutic change.

**Therapeutic Attitude**

As previously mentioned, not every step outlined by Finn must be, or can be, conducted in all cases of Therapeutic Assessment. But one aspect of TA that is consistent across all cases of TA is the therapeutic attitude held by the assessor. According to Finn (2007), “…above all, it is important to maintain the therapeutic attitude… to treat clients with kindness and respect…” (p. 15). The component of therapeutic attitude is comprised of several of the core values of TA. It is multi-faceted, so in addition to kindness and respect, the assessor must also believe that the client is the expert on his or her own functioning and that test scores are not necessarily the truth.

Another facet of therapeutic attitude described by Finn is genuineness. The assessor should be authentic with every client and share his or her own reactions with the client as well as provide “judicious contained self-disclosure” to the client (S. E. Finn, personal communication, May 13, 2011). Therapeutic attitude is proposed as an effective component of TA because the combination of kindness, respect, and genuineness is a vital element and “if you keep those things in mind…your clients and you will benefit” (Finn, 2007, p.15).
Assessor-Client Relationship

This component expands on the concept of the therapeutic attitude by also considering the interpersonal contributions of the client to the assessment process. The therapeutic attitude outlines the ways the assessor presents to the client, whereas the assessor-client relationship refers more to the interactions *between* the assessor and the client. The therapeutic attitude of the assessor likely serves as a mechanism for the development of the assessor-client relationship. The assessor-client relationship is necessary in TA because it is what allows the client to revise the beliefs and attitudes about him or herself without experiencing a disintegration experience (Kohut 1977).

Evoking and Processing Problematic Behaviors in Session

This component is one that may not be present in every TA case, but it is believed to add incrementally to the effectiveness of TA when utilized. This component refers to what takes place in an assessment intervention session. This is proposed as one of the effective components because it allows for level two, or even level three information, to be more readily share with clients, which can be particularly therapeutic for some clients. As previously mentioned, level three information is very novel and difficult to share with clients. Thus, the assessment intervention session is one method for bringing problem behaviors into a client’s awareness and allows him or her to observe the behavior in a safe environment and that may lead to “profound, positive shifts on the part of clients” (Finn, 2007 p. 36).
Client Collaboration/Client Involvement

The component of client collaboration/client involvement is present throughout every step of Therapeutic Assessment. During the initial session the client is engaged by developing questions and goals for the assessment, and also aids in collecting collateral information. The client is obviously an active participant in the assessment session(s) as well as the assessment intervention session(s) as his or her involvement is necessary for the completion of these steps. Additionally, the client collaborates in the summary/discussion session, providing insight, and offering alternate interpretations of the test results, which is also true of any follow-up sessions that occur in the future. The client is even involved in the written feedback section of the assessment (albeit, indirectly) because his or her interpretations and reactions during the summary/discussion session are included in the feedback letter. Therefore, because client collaboration/client involvement is such an integral aspect in TA, it has been proposed as a component that likely contributes to the therapeutic benefits of the approach.

Support for Proposed Components from Psychotherapy Literature

Not only does identifying the effective components of Therapeutic Assessment promote future scientific investigations of TA, it also makes it possible to examine existing literature for related studies. Traditionally, psychotherapy and psychological assessment have been dichotomized, but the development of Therapeutic Assessment has sought to integrate the two fields so as to produce therapeutic benefits for clients. Even though there is a lack of empirical support for TA specifically, it is plausible that some of
the components presently proposed as effective in TA, have already been investigated in other psychotherapeutic contexts. Therefore, it is possible that findings from traditional psychotherapy outcome studies could be applied to the Therapeutic Assessment approach, which would garner empirical support for the untested components.

Studies used to provide evidence for the proposed effective components (e.g., feedback, client collaboration) were required to include some measure of treatment outcome (e.g., success in treatment), or another measure of therapeutic benefit, such as symptomatic reduction, or improved client functioning. When possible, direct parallels were be made between the proposed effective components within Therapeutic Assessment and the same constructs studied in other psychological contexts (e.g., feedback in TA as compared to feedback in other psychological contexts). However, some of the components proposed to be effective in TA are unique to the approach and have not been directly examined in other psychological contexts (e.g., levels of information, assessment intervention sessions). In such instances, (and when possible), comparisons were made between TA components and related constructs in other psychological studies. All components are first reviewed individually, and in a later section a more comprehensive discussion reviews the overall support for each of the TA components.

**Supported Components**

**Feedback.** Sharing test feedback with participants has been tested in a very comprehensive manner and in general, the association between sharing feedback with
clients and therapeutic benefit is a medium effect (Lundahl et al., 2010; Poston & Hanson, 2010; Riper et al., 2009). Lundahl, Kunz, Brownell, Tollefson, and Burke (2010) conducted a meta-analysis of 119 studies of Motivational Interviewing (MI) or a variant of MI called Motivational Enhancement Therapy (MET), which is similar to MI but includes structured assessment feedback (Miller, Zweben, DiClemente, & Rychtarik, 1992). The results indicated that MET was more strongly associated with positive change in clients than traditional MI. More specifically, the authors found a small-to-medium effect for MET in regard to positive change \( (g = .32) \) as compared to the trivial-to-small effect size for typical MI and positive change \( (g = .19) \). Lundahl et al. implied that the differences of effect in outcome between MI and MET were primarily due to the feedback component of MET, as the two methods are otherwise largely similar. This suggests that sharing assessment feedback with clients adds incrementally to the effectiveness of other therapeutic approaches.

The link between receipt of assessment feedback and positive outcome has also been generalized to individuals with alcohol use problems. A meta-analysis by Riper et al. (2009) summarized the effects of brief personalized-feedback interventions. The included studies were unique in that no therapeutic guidance was provided to participants; they simply received feedback about their drinking behavior patterns and information about their behaviors as compared to a normative population. The average effect size across 14 randomized clinical trials as measured by Cohen’s \( d \) for reduced alcohol consumption after the intervention was .22. The results of this meta-analysis
provide evidence for the effectiveness of assessment feedback to clients, even without any guidance from a therapist or other health provider.

A 17-study meta-analysis by Poston and Hanson (2010) provides the most support for the feedback component of TA because it examined if feedback presented to individuals in a collaborative manner resulted in greater therapeutic benefits as compared to individuals who did not receive feedback collaboratively. The procedure used in 10 of the 17 included studies involved sharing psychological assessment results with one group of participants (experimental condition), while withholding psychological assessment results from another group (control condition). However, in five of the studies, the control group did not even complete a psychological assessment. The remaining study used a multi-study design which examined both feedback as compared to no feedback conditions, and different modes of feedback delivery (e.g., written feedback, computerized feedback).

Poston and Hanson’s meta-analysis of 17 studies (total N =1,496) resulted in an overall cohen’s $d$ of .42, which is a medium effect (Cohen, 1988). Unfortunately, the different methodologies were not separated into independent meta-analyses, so there is not an individual effect size for the studies that compared the therapeutic effectiveness of receiving feedback to not receiving feedback, which would have provided more information about the effects of sharing feedback as compared to withholding feedback. Regardless, the medium effect size suggests that sharing assessment results with clients does impact outcome in a meaningful way.
Aldea, Rice, Gormley, and Rojas (2010) used a feedback approach modeled after Finn and Tonsager (1992) and Newman and Greenway (1997) with a sample of maladaptive perfectionists. It should be noted that although the Aldea et al. study met the inclusion criteria for Poston and Hanson’s meta-analysis, it was not included as it was published after their literature review was conducted. In regard to procedures, all participants completed the measure of perfectionism and other dependent measures. Individuals in the experimental condition received information about their individual results on the measure of perfectionism and were encouraged to be actively involved in the feedback by asking questions and sharing reactions. However, participants in the control condition did not receive any information about their individual scores. The authors found that participants who received feedback about their perfectionism scores had less distress symptoms and were less emotionally reactive at two week follow-up as compared to individuals who did not receive feedback. The authors concluded that receipt of assessment feedback resulted in less distress and emotional reactivity as compared to non-receipt of feedback.

Overall, the studies on the therapeutic effectiveness of feedback suggest that sharing feedback with clients results in greater therapeutic benefits as compared to withholding feedback information. In particular, feedback that is delivered in a collaborative manner appears to be particularly therapeutic as the effect size calculated by Poston and Hanson was larger than the effects found in the other studies (Aldea et al., 2009; Lundahl et al., 2010; Riper et al., 2009). This suggests that the feedback delivered in TA is as effective as, or perhaps more effective than other methods of feedback.
delivery. However, the incremental validity of sending written feedback to clients is one aspect of TA feedback for which there is not published support. An unpublished study (Lance & Krishnamurthy, 2003) provides initial support for the use of written feedback, as the authors found that combined verbal and written feedback resulted in higher levels of client satisfaction with assessment and higher levels of self-awareness as compared to verbal or written feedback alone. However, additional controlled studies are needed in order to establish support for the verbal and written feedback utilized in TA. Taken as a whole, it is considered that the feedback component of TA does influence the therapeutic benefits experienced by clients, such as increased self-esteem, satisfaction, and symptom reduction. Thus, feedback is judged as an effective, empirically supported component of Therapeutic Assessment.

**Therapeutic attitude.** Another TA component for which there appears to be significant empirical support is the therapeutic attitude. In the psychotherapy literature, this component is conceptualized as being comprised of the constructs of empathy and congruence. Although the constructs are examined separately in the literature, they are used in combination in TA. Empathy has been defined in several ways, and there is no single agreed upon definition in the psychotherapy literature. Some therapists view empathy as a display of support and compassion for clients, which is commonly achieved by developing empathic rapport for clients. Other therapists view empathy as an active process, which requires the therapist be observant of the client’s thoughts and emotions throughout the course of therapy. Despite the different conceptualizations of empathy,
most definitions consider the construct to be a higher-order variable that encompasses both of these definitions (Bohart, Elliott, Greenberg, Watson, 2002; Elliot, Bohart, Watson & Greenberg, 2011). In regard to congruence, therapists are considered to be congruent when they present themselves as they really are within the given moment (Rogers, 1957). That is, a congruent therapist would be aware of his or her feelings during a session with a client and would be open to expressing feelings, thoughts, and even insecurities. The term congruence is sometimes used interchangeably with empathy, but congruence is more about therapist self-awareness and sharing with the client, rather than being attuned to the client’s current emotional state (Klein, Kolden, Michels, Chisholm-Stockard, 2002).

Generally, the association between empathy and outcome is a medium effect (Elliott et al., 2011) with larger effects found for less experienced therapists, in group therapies, and for more distressed clients. It is possible that fledgling therapists produce a larger empathy-outcome effect as they are just starting out and are not “burned out,” though any explanation is just speculation until further investigation is completed. In regard to TA, it may suggest the importance of practicing empathy with every case, no matter how long one has been practicing. In regard to the larger effects with more distressed clients, it seems plausible that these clients would experience larger gains (in terms of change scores) at the end of treatment as compared to individuals with less distress, and subsequently less room for improvement.

The research on congruence, which is analogous to the genuineness facet of the therapeutic attitude, is less conclusive than the research on empathy. For instance, a
review by Orlinsky, Grawe, and Parks (1994) indicated an association between therapist congruence and client outcome, though most studies did not find a significant effect. However, a meta-analysis by Kolden, Klein, Wang, and Austin (2011) that examined 14 studies resulted in a small effect for the association between congruence and outcome, which indicates that these two variables are related to some degree. It was found that clients with lower levels of education and therapists with more experience moderated the congruence and outcome association, making that association stronger. Furthermore, the relationship between congruence and outcome was greater when clients rated the therapists’ congruence. Even though the congruence to outcome relationship is not as compelling as the association between outcome and other constructs, it is important to remember that the therapeutic attitude in TA combines congruence and empathy, which could be expected to strengthen the association. Overall, the literature on empathy and congruence provide evidence that the therapeutic attitude is an empirically supported effective component of TA.

**Assessor-client relationship.** The assessor-client relationship component of TA is highly related to the working alliance construct in the psychotherapy literature. Two meta-analyses on the alliance and outcome association (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000) provide evidence that the alliance between client and therapist influences treatment outcome, with both studies reporting small, but practical effect sizes. An additional meta-analysis (Karver, Handelsman, Fields, & Bickman, 2006) provides evidence that this association generalizes to youth samples, which is
important information as TA is also used with child and adolescent clients (Handler, 2007). Furthermore, studies by Ackerman, Hilsenroth, Baity, and Blagis (2000), and Hilsenroth, Peters, and Ackerman (2004) provide evidence that a strong alliance can also be formed within the context of psychological assessment, which suggests that similar positive outcomes could be achieved. Taken together, these findings provide substantial support for a positive effect of alliance on positive treatment outcome for clients. Furthermore, the designation of the alliance as a “demonstrably effective” construct by the APA taskforce (Norcross & Wampold, 2011) provides confirmation that the alliance is meaningful and results in therapeutic benefits. Thus, the assessor-client relationship (i.e., working alliance) is considered to be an empirically-supported TA component.

**Client collaboration/client involvement.** In the psychotherapy literature, the construct of client collaboration/involvement is considered to be a component of the alliance between the therapist and client, and is thought to be a combination of client involvement, client collaboration, as well as goal consensus between the client and assessor (Tryon & Winograd, 2001, 2002). According to Tryon and Winograd (2001) this conceptualization of client involvement and goal consensus is similar to the proposed component in TA, though given the short timeframe of TA, goals are discussed in relation to goals for the assessment (i.e., questions client wants answered from the assessment), rather than long-term goals for psychotherapy.

Two studies (Gomes-Schwartz, 1978; Kolb et al., 1985) found that a client’s involvement in treatment was significantly associated with positive treatment outcome. In
the Gomes-Schwartz study, client involvement was defined as the client’s engagement in
the therapeutic interaction, as measured by a seven-item scale. Kolb et al. measured client
involvement by having therapists rate the client’s involvement in the therapeutic
exchange using a subscale of the Psychotherapy Process Inventory (PPI; Baer et al.,
1980). Both studies found that involvement was more strongly associated with outcome
than other client variables such as personality traits, and therapist variables such as
professional status. Two meta-analyses within the same article (Tryon & Winograd,
2011) also provide support for the association between client collaboration/client
involvement and client treatment outcome. They found significant associations between
goal consensus and outcome and client collaboration and outcome, with both producing
medium effect sizes.

It is likely that there is some overlap between the component of client
collaboration and the component of assessor-client relationship (i.e., working alliance),
and it may be more parsimonious to combine these constructs into a single component.
However, the facet of goal consensus may be considered comparable to client
development of assessment questions in TA, and thus belongs in the discussion of the
client collaboration/ client involvement component. Overall, there appears to be enough
research support to consider client collaboration/client involvement as an effective
component in TA that is likely to result in therapeutic benefits.
Unsupported Components

Some of the components proposed as effective in TA do not have comparable constructs in psychotherapeutic contexts to which they can be compared. Therefore, empirical support for these components was impossible to establish as there were no studies available for review. This does not mean that these components are not effective or do not contribute to therapeutic benefits, but rather, their status as effective components is unknown at this time.

Sharing of different levels of information. The concept of sharing different “levels” of information is a unique element of Therapeutic Assessment and has not been directly investigated in other psychotherapeutic contexts. Numerous research studies have investigated how people react to different types of self-information (self-discrepant vs. self-verifying), and which types of information they prefer (positive vs. negative), but there is a lack of studies examining the effects of different types of information shared during feedback on actual therapeutic outcome. Given the lack of controlled studies between level of information and treatment outcome or therapeutic benefit, the research support behind self-verification theory (Swann, 1983) can be examined instead, as it provides the basis for the organization of feedback shared in TA.

Kwang and Swann (2010) conducted a meta-analysis which included studies of participants’ reactions to evaluative comments. The authors were interested in the association between participants’ responses to information consistent with their self-views (self-verifying), and information that was indiscriminately positive, despite the
participants’ self-view (self-enhancing). Results indicated that participants considered self-verifying information to be more accurate and applicable ($r = .30$) than information that was enhancing but inconsistent with a participant’s self-view ($r = .18$). This suggests that initially presenting self-verifying (i.e., level one) information with clients will increase their acceptance and may allow them to be open to other types of information. Additionally, the authors examined participants’ affective responses to the evaluative information. Results generally indicated a small effect size between self-verifying information and affective responses. As the information was more self-verifying, general affect, attraction, negative affect, satisfaction, and task-liking increased. However, more self-verifying evaluative information was associated with decreases in positive affect, though the effect size was small. This may suggest that receiving self-verifying information is less emotion-provoking for individuals, perhaps because they are already aware of the information being provided to them. Although Kwang and Swann’s findings provide information about the reactions of individuals to different types of information, their findings do not allow one to reach conclusions about the therapeutic effectiveness of sharing feedback in a manner consistent with the principles of self-verification theory, particularly since Kwang and Swann did not include an intervention or measure of outcome.

An unpublished study by Schroeder, Hahn, Finn, and Swann (1993) examined the relationship between levels of information and therapeutic benefits and provides some support for the organization used in TA feedback. They found that mildly discrepant (level two) personality information resulted in higher levels of self-learning and a greater
impact on the clients as compared to information that was congruent or very discrepant to their self-view. Additional controlled, peer-reviewed studies of this nature are needed to provide evidence of the effectiveness of this particular component of TA. Thus at this time, the effectiveness of the sharing of different levels of information component of TA is not empirically supported.

**Evoking and processing problematic behaviors in session.** This component of TA is perhaps the most unique to the approach, and therefore has not been investigated in broader psychotherapeutic contexts. Other approaches in psychotherapy that seemed to be remotely similar to this component were not reviewed as they were not comparable enough to serve as a reference point. Evoking and processing problematic behaviors in session through assessment intervention sessions in TA is posited by assessors as being therapeutic to clients (Finn 2003, 2007; Fischer, 1985). However, controlled studies providing proof of this are lacking and thus, this component cannot be considered as an empirically supported component of TA.

It should be noted that there is one published case study that includes the process of evoking and processing problematic behaviors in session through use of an assessment intervention session (Finn, 2003). Controlled studies are preferable to case studies, but in the absence of experimental designs the case study can provide some information about the effectiveness of the component of interest. In this study, Finn presented the case of David, a 28-year-old man who was referred for Therapeutic Assessment by his therapist for diagnostic clarification. At the beginning of the Therapeutic Assessment process,
David believed that he had Attention-Deficit Hyperactivity Disorder (ADHD) as he had problems with concentration and attention. As the assessor, Finn hypothesized that David might be anxious and depressed and had a tendency to “shut down” when in emotionally-arousing situations, which resulted in others seeing him as inattentive and forgetful. To test this hypothesis, Finn conducted an assessment intervention session and had David complete simple attention tasks (i.e., digit recall) during states of agitation and calm. Agitated states were induced by having David tell stories about Thematic Apperception Test (TAT; Murray, 1943) cards that typically provoke emotionally-arousing states, while states of calm were induced by engaging in short relaxation exercises. David and the assessor spoke about the differences between his scores depending on his level of agitation, and discussed possible strategies for reducing agitation.

Later, David stated he did not think he had ADHD, but rather had trouble processing emotions. David reported an instant sense of relief and felt he knew which direction he and his therapist should take in treatment. Two weeks following the session David rated himself as highly satisfied with the assessment and specifically reported he found the assessment intervention session to be very educational.

Although the case study does not provide evidence that evoking and processing problem behaviors in session is any more therapeutically effective than treatment as usual or no treatment, it does provide evidence that in this particular instance, the exercise was helpful and resulted in therapeutic benefits. Fischer (1985) and Finn (2007) provide other successful narrative accounts of evoking problem behaviors with assessment measures in
session, so it does appear that this approach can be helpful to clients. Nevertheless, controlled studies are needed to elucidate the effectiveness of the approach.

**Summary**

Taking into consideration the findings in the psychotherapy literature, there are many directions for future research on Therapeutic Assessment. One such direction would be to garner support for TA components for which there is no support in the psychotherapy literature. Another direction for research would be to further examine components of TA that were generally supported, but were not examined in a manner that truly represents the techniques used in Therapeutic Assessment. An additional possibility would be to focus on components of Therapeutic Assessment that are particularly specialized or require some sort of special training on the behalf of the assessor, so as to provide validation for the specific techniques utilized. Investigation of such a component would be valuable in order to justify methods used in Therapeutic Assessment as compared to more traditional means for sharing assessment feedback with clients.

One such component in TA is the client collaboration/client involvement component. Client collaboration in Therapeutic Assessment is more complex than the construct examined in the reviewed psychotherapy studies. In particular, client collaboration and involvement is an integral component of the initial session of TA and is more multifaceted than simple engagement in the session. Much of the focus of this session is on the client to create personally-relevant questions that can be answered within the scope of the assessment. This collaborative process also affects the
summary/discussion portion of the Therapeutic Assessment as the assessor determines what assessment feedback will be shared based on the formulated questions. However, it has not yet been demonstrated that client development of questions is necessary for the process to be therapeutic.

Finn and Tonsager (1997) posit that client development of questions serves several functions and as a result produces greater therapeutic benefits than non-collaborative feedback methods. In general, the collaborative process that takes place during the question development phase helps to develop and maintain an emphatic connection between client and assessor. It serves to initiate the collaborative working alliance that is necessary for the assessment. Furthermore, when clients develop their own questions, they become more engaged in the entire process because they have a personal stake in the assessment, which helps cultivate the collaborative nature of TA.

According to Finn and Tonsager (1997), different theories provide explanations for why client development of questions in TA results in greater therapeutic outcomes as compared to more traditional models that do not involve client question development. One such theory is self-verification theory, which states that individuals are more likely to accept information that is consistent with his or her own self-view. In addition, information that is discrepant with one’s self-view is unpleasant for individuals and may result in an extreme form of anxiety, which Kohut (1977) called disintegration anxiety. Given the threat of disintegration anxiety, it is important for assessors to be aware of which types of information may produce anxiety in clients. The initial session in TA promotes open discussion about clients’ presenting concerns and self-views, which alerts
the assessor to potential sources of disintegration anxiety. With this information, the assessor is able to organize the feedback in a way that will reduce anxiety and increase the client’s acceptance of the feedback information. Consequently, a client who receives feedback in this manner is expected to generally feel better about the assessment process and experience greater therapeutic benefits.

Another explanation for the therapeutic effectiveness of client development of assessment questions provided by Finn and Tonsager is the human motive of self-enhancement. This motive refers to the human desire to feel good about oneself, and to maintain a positive self image. The collaborative component within TA, particularly the question development portion, allows the assessor to identify areas in which clients possess particularly negative or distorted self-views. The assessor can then reframe the distortion using information from the assessment, which often results in the client developing a more positive view. This process would not necessarily occur in non-collaborative assessments, as the assessor would be unaware of the client’s presenting concerns or self-views and would instead only offer feedback regarding the referral question. Further, the collaborative nature of TA is an overall positive experience in which the client is treated as a respected collaborator who can make valuable contributions to the assessment process. Naturally, this collegial atmosphere fulfills the motive of self-enhancement and promotes increased self-esteem and satisfaction with the assessment (Finn & Tonsager, 1997).

The increase in therapeutic benefits as a result of clients collaboratively developing assessment questions can also be explained by self-efficacy theory (Bandura,
Self-efficacy theory proposes that individuals’ thoughts, behaviors, and feelings are largely affected by their feelings of self-efficacy and control. Individuals high in self-efficacy feel able to master difficult situations or problems, are more engaged in their activities, and are better able to recover from disappointments or failures. Whereas individuals low in self-efficacy feel insecure and unable to work through challenges, feel incapable, and generally have low self-confidence (Bandura, 1977). When examined in the context of TA, the collaborative question development in the initial session allows for the client to take a leading role in the assessment process and to work with the assessor in order to reach a common goal. As a result, a client receives feedback information that is directly related to the goals he or she developed and potentially helps the individual to work through presenting concerns.

**Present Study**

The purpose of the present study was to examine client collaboration within Therapeutic Assessment, specifically in regard to client development of assessment questions during the initial session. Given the time-consuming and complex nature of this process, it is important to determine if the effort put into the process results in significant increases in therapeutic benefits. Direct examination of the component of client collaboration and client involvement as specifically utilized in Therapeutic Assessment is particularly important given the assumed significance of the component to the entire process. In particular, the questions that are developed by the client in the initial session
determine the way in which feedback information will be delivered in the summary/discussion.

Moreover, the development of the questions involves some expertise on behalf of TA assessors as they must be able to facilitate the process in an empathic and collaborative manner. The process can be “tricky” (Finn, 1997, p. 8) as the assessor must encourage the client to reflect on his or her own questions, while also ensuring that the question can be meaningfully addressed by the assessment measures. This can be particularly challenging as many clients are resistant to coming up with their own questions, and may be anxious about the process (Finn, 1996). This method is more time-consuming than non-collaborative assessment and standard feedback models, where the assessor relies on referral sources’ questions or shares information that he or she considers to be important.

Non-collaborative methods for sharing feedback with clients are much less involved, and do not require the assessor to have training beyond test interpretation, and it does not require significant client involvement. As a result of the controversy over sharing test results with clients, much research was conducted on the effects of sharing feedback. As previously mentioned, the results overwhelmingly indicate that sharing feedback with clients using collaborative and noncollaborative methods results in more positive treatment outcomes. This effect was found for clinical and non-clinical samples, with diverse presenting problems, and suggests that sharing feedback generally results in therapeutic benefits. Thus, simply receiving assessment feedback is enough to result in
therapeutic benefits and therefore it is important to determine if adding client
development of questions results in more positive outcomes than feedback alone.

**Research Questions**

Several research questions were developed to examine the therapeutic benefits of
receipt of feedback based on client-developed questions as compared to the therapeutic
benefits of receipt of feedback based on a generalized model of feedback delivery. There
were four specific research questions of interest and they are as follows:

1) Do participants who receive feedback based on their own assessment questions
have a greater decrease in mood and anxiety symptoms as compared to
individuals who receive feedback not based on personally developed questions?

2) Do participants who receive feedback based on their own assessment questions
have a greater increase in self-esteem and self-efficacy as compared to
individuals who receive feedback not based on personally developed questions?

3) Do participants who receive feedback based on their own assessment questions
describe more positive feelings about the assessment process as compared to
individuals who receive feedback not based on personally developed questions?

4) Do participants who receive feedback based on their own assessment questions
describe a more positive relationship with the assessor as compared to individuals
who receive feedback not based on personally developed questions?
CHAPTER 2

METHOD

Participants

The study sample was comprised of 39 undergraduates recruited from a large Midwestern university. A college student sample was deemed adequate for this analogue study as Therapeutic Assessment can be utilized with a variety of populations and the benefits from this approach are not limited to a particular age group or setting. Furthermore, a significant degree of psychopathology is not required in order for Therapeutic Assessment to be effective, and individuals with some depressive and/or anxiety symptoms were appropriate participants for this study. Participants were pre-screened through mass testing using the total score on the Mood and Anxiety Symptom Questionnaire (MASQ; Watson & Clark, 1991). Participants selected for the present study achieved scores at or above the 70th percentile rank as compared to their peers on all five subscales of the MASQ. Pre-screening of participants was necessary to increase the likelihood that selected participants had psychological areas of concern which could be examined through personality assessment. Individuals without psychological symptoms might have been less able to develop goals for the assessment, which was necessary for this study.
Participants received course credit in exchange for their participation in the pre-screening portion of the study, as well as for participation in the actual study. Eligible participants were invited to participate in the study by e-mail (see Appendix A). Prior to inclusion in the study, participants answered demographic questions, including a question pertaining to current and past psychological treatment. Individuals who indicated they were currently engaged in treatment (N = 7) were not allowed to participate given the therapeutic nature of the study. All participants were at least 18 years old (M = 21, SD = 4.2). Each participant was allowed to complete the study one time.

All participants were screened for missing data and only participants with data for all measures at all three time periods were included in final analyses. One participant from each condition (N = 2) did not complete any of the Time 3 measures and were excluded from final analyses. All participants had valid MMPI-2-RF profiles according to standard Validity scale cutoffs outlined in the MMPI-2-RF manual (Ben-Porath & Tellegen, 2008). No other criteria were used for screening participants.

**Measures**

**MMPI-2-RF**

The Minnesota Multiphasic Personality Inventory, Second Edition, Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2008) is a 338-item true/false measure of personality and psychopathology. Although Finn (1996) outlines specific procedures for how to apply to steps of Therapeutic Assessment to the MMPI-2, (Butcher, Graham, Ben-Porath, Tellegen, Dahlstrom, Kaemmer, 2001), the MMPI-2-RF was used as it is briefer,
and the steps outlined by Finn can be applied to the MMPI-2-RF. Generally, feedback delivered to the participants was based on scale score information from the Validity scales, Higher-Order scales, RC scales, Specific Problems scales, and the PSY-5 scales. The MMPI-2-RF has been found to be a reliable and valid measure of personality and psychopathology. Extensive information about reliability and validity coefficients is summarized in Graham (2011).

AQ-2

The Assessment Questionnaire-2 (Finn, Schroeder & Tonsager, 1995) is a 48-item questionnaire developed to measure client reactions to psychological assessment (see Appendix B). The AQ-2 is comprised of four subscales that tap into the multidimensional construct of a client’s subjective experience of psychological assessment. The items were created to assess elements specific to Therapeutic Assessment. The first subscale, New Self-Awareness / Understanding, measures the degree to which the individual learned new information about himself or herself. The second subscale, Positive Accurate Mirroring, assesses the degree to which individuals felt their assessor reflected back positive characteristics they recognized in themselves. The third subscale, Positive Relationship, measures the degree to which clients liked and felt liked by the assessor. The fourth subscale, Negative Feelings, measures negative aspects of the assessment experience, such as feeling judged and/or uncomfortable. The subscales have been found to be moderately inter-correlated ($r = .33$ to $.55$), with the exception of the New Self-Awareness / Understanding and Negative Feelings ($r = .08$, $p > .05$). Finn, Schroeder, and Tonsager (1994) administered the AQ-2 to three samples
(college students, adult psychiatric inpatients, and outpatient clients) and the subscales were found to be internally consistent ($\alpha = .84$ to $.93$), and reliable across a two week interval ($r_{12} = .74$ to $.84$).

**MASQ**

The Mood and Anxiety Symptom Questionnaire (Watson & Clark, 1991) is a 90-item inventory that assesses symptoms characteristic of depression and anxiety as well as non-specific symptoms of general distress (see Appendix B). Participants are asked to rate how much they have felt or experienced a particular symptom over the past week, using a five-point Likert scale (not at all to extremely). Watson and Clark rationally divided 77 items into five subscales (de Beurs, den Hollander-Gijsman, & Zitman, 2007): General Distress: Mixed Symptoms (GDM), General Distress: Anxious Symptoms (GDA), Anxious Arousal (AA), General Distress: Depressive Symptoms (GDD), and Anhedonic Depression (AD). Only the 77-items that comprise the five subscales were administered to participants in the present study.

Reliability coefficients were conducted with the current sample as the original manuscript for the MASQ is unpublished and subsequent studies on the psychometric properties focused on factor structure and validity. Based on the mass testing sample, the MASQ demonstrates good internal consistency ($\alpha = .88$), with inter-correlations between the five subscales ranging from $r = .42$ (AD and AA) to $r = .80$ (GDD and GDM). The data on the inter-correlations between the subscales are consistent with findings from Watson et al. (1995) who found that conceptually related scales were more strongly inter-correlated than conceptually weakly related scales. Watson et al. (1995) reported that the
MASQ demonstrated convergent validity as the depression subscales were strongly associated with other measures of depression, whereas the anxiety subscales were strongly associated with other measures of anxiety. Watson et al., and Keogh and Reidy (2000) found that a three-factor solution best fit MASQ data. However, both studies reported some inconsistencies with the item structure of the MASQ as some items were found to be better markers for subscales other than for those which they belonged. Despite the discrepancies between scales and items, the MASQ was considered an appropriate measure for the present study as it assesses common symptoms of distress.

**SLCS**

The Self-Liking/Self-Competence Scale (Tafarodi & Swann, 1995) is a 20-item measure of self-esteem (see Appendix B) that assesses two underlying factors of self-esteem; social worth (self-liking) and self-efficacy (self-competence). Newman and Greenway (1997) utilized the SLCS rather than the Self-Esteem Questionnaire (Check & Buss, 1981) used by Finn and Tonsager (1992) as they argued the two factors of self-esteem could not be reliably measured by the six-item Check and Buss measure. Given specific hypotheses about self-efficacy in the present study, it was deemed important to select a measure that assessed both factors of self-esteem; thus, the SLCS was the appropriate choice as compared to self-esteem measure used by Finn and Tonsager. Consistent with Newman and Greenway’s procedures, participant scores were converted separately for men and women to linear T-scores based on sample mean and standard deviation at Time 1. This procedure was utilized as norms are not available for an undergraduate sample.
Reliability coefficients for the subscales of the SLCS indicated good internal consistency for both subscales of the SLCS scale, with a Cronbach’s coefficient alpha of .92 for the self-liking scale, and .89 for the self-competence scale (Tafarodi & Swann, 1995). Additionally, Bosson and Swann (1999) found even higher internal consistency estimates for their sample of 74 undergraduates, with Cronbach’s coefficient alphas of .90 for the Self-Competence subscale and .95 for the Self-Liking subscale. Despite moderate inter-correlations between the self-liking and self-competence subscales \( r = .69 \), Tafadori and Swann stated that their results provided evidence that their measure of self-esteem was comprised of related but distinct factors of self-liking and self-competence.

**Design and Procedures**

The study utilized a two (group) by three (time) repeated measures design (see Figure 1), based on the designs used in studies by Finn and Tonsager (1992) and Newman and Greenway (1997). Unlike the designs in Finn and Tonsager and Newman and Greenway, participants in both the experimental and control groups received assessment feedback at Time 2. Participants were randomly assigned to either the control (feedback only) group \( N = 20 \) or experimental (question and feedback) group \( N = 19 \). There were 12 women and eight men in the control group, and 10 women and nine men in the experimental group. Participants in both conditions met with the same assessor at Time 1 and Time 2. The assessors were two doctoral candidates (one male, one female) trained in the techniques of Therapeutic Assessment. Each assessor attended at least a one-day workshop on the use of Therapeutic Assessment with MMPI instruments, and
also read at a minimum Finn’s (1996) manual on using Therapeutic Assessment with the MMPI-2. One of the assessors was the author of this study.

**Figure 1.** Experimental design: 2 (Group) x 3 (Time). MMPI MMPI

**Time one.** Participants in the experimental condition met with the assessor for 30 minutes to formulate questions to be answered by the assessment. This process followed the initial session procedures outlined by Finn (1996, 2007). Individuals in the control condition also met with the assessor for 30 minutes to discuss how psychological testing was going to proceed, but the participants did not formulate assessment questions. Following the interview, participants in both conditions completed a computerized administration of the MMPI-2-RF and the other dependent measures.
Time two. MMPI-2-RF feedback was delivered in both conditions approximately one week following Time 1 ($M = 7.82$ days). The experimental condition received feedback following the Summary/Discussion Session using procedures outlined by Finn (1996, 2007), and all assessment feedback was centered on the questions developed at Time 1. The control condition received feedback according to general feedback recommendations outlined in Graham (2011). Each group received an average of two pieces of assessment feedback based on the results of the MMPI-2-RF. Some variability in the amount of feedback existed depending on the number of questions developed by individuals in the experimental condition, and the amount of interpretable information available from test results. In terms of session length, the feedback process lasted approximately 30 minutes for all participants. Although the amount of feedback shared during the session was limited, the information was presented collaboratively to both conditions in the manner described by Finn (1996, 2007).

Time three. Approximately two weeks ($M = 15.41$ days) following the feedback session, participants in both conditions completed dependent measures using an electronic survey format. In addition, all participants were sent an e-mail thanking them for their participation.
CHAPTER 3

RESULTS

Research Question One

Mean scores and standard deviations for each group on the MASQ total score across time are shown in Table 1; the same information is shown graphically in Figure 2.

To assess whether receiving MMPI-2-RF feedback based on client-developed questions resulted in greater reductions in mood and anxiety symptoms than receipt of standard feedback, a Mixed Factorial Repeated Measures ANOVA was conducted. The dependent variable for the analysis was the total score from the MASQ at each of the three time points. The between-subjects variable was condition (question development + feedback vs. standard feedback), the within-subjects variable was time (Time 1, Time 2, or Time 3), and the interaction term represented the extent to which there was a change in total MASQ scores over time, based on condition.

ANOVA results indicate that there was not a statistically significant between-subjects main effect for condition, \( (F(2, 36) = 0.14, p = .71) \). This suggests that the total MASQ scores summed across time did not differ between conditions. In regard to the effect of time and condition, the interaction term was not statistically significant \( (F(2, 36) = .67, p = .52) \). This suggests that MASQ scores did not change to a different degree across conditions.
Table 1.

Mean Total Scores on the MASQ Across Time by Condition

<table>
<thead>
<tr>
<th>Time</th>
<th>Experimental M</th>
<th>Experimental SD</th>
<th>Control M</th>
<th>Control SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time 1</td>
<td>168.84</td>
<td>32.89</td>
<td>161.40</td>
<td>41.63</td>
</tr>
<tr>
<td>Time 2</td>
<td>177.16</td>
<td>34.23</td>
<td>169.80</td>
<td>32.21</td>
</tr>
<tr>
<td>Time 3</td>
<td>149.68</td>
<td>31.85</td>
<td>153.35</td>
<td>38.49</td>
</tr>
</tbody>
</table>

*Note.* There are no between group mean differences.

*Figure 2.* Mean MASQ total score over time by condition

When examining the effect of time, there was a statistically significant main effect, $F (2, 36) = 16.23, p < .01$. The effect size (partial eta squared) was .47, which is a medium effect. This finding indicates that when the total MASQ scores from all participants were averaged, there was a statistically significant change in scores over time, and 47% of the variability in scores is attributable to time (Becker, 1999). Post-hoc
analyses were conducted using dependent samples t-tests to determine at which time point(s) participants’ MASQ scores differed. The results of the t-tests indicate that there was a statistically significant increase in scores from Time 1 to Time 2, \( t(38) = -2.97, p = .005 \), while there was a statistically significant decrease in MASQ scores summed across groups from Time 2 to Time 3, \( t(38) = 4.60, p < .001 \). Results from the third t-test indicated that there was a statistically significant decrease in mean MASQ scores summed across conditions from Time 1 to Time 3, \( t(38) = 2.34, p = .025 \). Overall, these findings indicate that when MASQ scores were summed across conditions, participants experienced a significant increase in symptoms at Time 2 (feedback), but these scores significantly decreased by Time 3 (two week follow-up), to a level that was significantly lower than their Time 1 scores.

**Research Question Two**

Table 2 shows the mean T-scores and standard deviations for both groups on the two subscales (self-liking, self-competence) across time by condition.

To examine whether individuals who received feedback based on their own questions experienced an increase in self-esteem following feedback as compared to individuals who received standard feedback, two separate Mixed Factorial Repeated Measures ANOVAs were conducted. The analyses for this research question were similar to the ANOVA completed for research question one; the only difference was the dependent variables. For the first ANOVA, the self-liking subscale of the SLCS was entered as the dependent variable, and for the second ANOVA, the self-competence subscale of the SLCS was the dependent variable. Following the procedure in Newman
Table 2.

*Mean T-Scores on the SLCS across Time by Condition*

<table>
<thead>
<tr>
<th>Time</th>
<th>Control T</th>
<th>Control SD</th>
<th>Experimental T</th>
<th>Experimental SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Liking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>49.86 (.103)</td>
<td>50.14 (.94)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>49.88 (.99)</td>
<td>50.03 (.94)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>50.03 (1.00)</td>
<td>50.16 (1.03)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Competence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>49.83 (.95)</td>
<td>50.18 (1.02)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>49.94 (1.05)</td>
<td>49.86 (1.09)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>49.85 (.98)</td>
<td>49.67 (.88)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* No means differed significantly from one another. Standard deviations in parentheses.

and Greenway (1997), linear T-scores for all time points were calculated for men and women using the Time 1 score for each SLCS subscale; for the first analysis, the mean self-liking subscale T-scores at all three time points were entered as the dependent variable. In these analyses, the between-subjects variable was condition (question development + feedback vs. standard feedback), the within-subjects variable was time (Time 1, Time 2, or Time 3), and the interaction term represented the extent to which there was a change in total SLCS subscale scores over time based on condition.

In regard to the between-subjects variable of condition, results indicate that there was not a statistically significant main effect \(F (2, 36) = .40, p = .53\). This suggests that participants’ scores on the self-liking subscale were not statistically different based on condition. There was also not a statistically significant main effect for the within-subjects variable of time, \(F (2, 36) = 1.16, p = .33\), which indicates that regardless of condition,
participants scores on the self-liking subscale did not change over time (see Table 2). Upon examination of the interaction, results indicate that there was not a statistically significant interaction between time and condition in regard to scores on the self-liking subscale, \((F(2, 36) = .98, p = .66)\). This suggests that in general feedback, regardless of the format, did not influence participants’ self-esteem scores over time.

The second ANOVA was conducted in the same manner, but instead used T-scores from the self-competence subscale as the dependent variable. The results for the between-subjects variable of condition indicate that there was not a statistically significant main effect \((F(2, 36) = .01, p = .93)\). This suggests that participants’ scores on the self-competence subscale were not statistically different based on condition. There was also not a statistically significant main effect for the within-subjects variable of time, \(F(2, 36) = 1.56, p = .22\), which suggests that participants in both groups did not experience changes in self-competence over time. The interaction term indicates the degree to which there was a change in self-competence subscale scores over time based on condition. Results show that there was not a statistically significant interaction effect, \(F(2, 36) = 2.31, p = .11\), indicating that type of feedback received did not influence participants’ levels of self-efficacy over time.

**Research Question Three**

To answer whether participants felt more positive about the assessment process based on feedback condition, a bootstrapped independent samples t-test was conducted using the Time 2 mean scores from the Negative Feelings AQ-2 subscale interpreted in the reversed direction. Bootstrapped t-tests were conducted because of the small sample
sizes of 19 and 20 in the experimental and control groups, respectively. Given the small group sizes, the sample could not be assumed to be normally distributed. Bootstrapping is a non-parametric re-sampling technique that leads to less biased significance value estimates when a normal distribution cannot be assumed, so long as the original sample of individuals is representative of the population (Mooney & Duval, 1993). With this method, re-sampling occurred 1,000 times with replacement to create a normally distributed sample. Results of the bootstrapping analysis indicate that there was not a statistically significant difference between the conditions in regard to their feelings about the assessment, \( t(37) = -0.62, p = .96 \). This finding suggests that participants in both conditions had similar feelings about the assessment process despite the different feedback models. In regard to mean scores by condition, individuals who developed questions and received feedback based on those questions had an average score of 15.26 (SD = 3.51) on the Negative Feelings subscale of the AQ-2, while individuals who received standard feedback had an average score of 15.20 (SD = 3.32) on the same subscale.

**Research Question Four**

To assess for differences between conditions regarding the perceived relationship between the assessor and participants, a bootstrapped independent samples t-test was conducted using mean scores at Time 2 for the Positive Relationship with the Assessor (PRA) subscale of the AQ-2. Results indicate that there was not a statistically significant difference between the groups in regard to their relationship with the assessor \( t(37) = -0.87, p = .08 \). Individuals who developed questions and received feedback based on those
questions had an average score of 54.95 (SD = 3.78) on the Positive Relationship with the Assessor subscale of the AQ-2, while individuals who received standard feedback had an average score of 52.70 (SD = 3.80) on the same subscale. This indicates that participants who received standard assessment feedback had similar perceptions about the assessor as participants who received feedback based on their own questions. This is consistent with the findings from Finn and Tonsager (1992) and Newman and Greenway (1997), and suggests that any differences between the groups are not likely due to the participants in one group feeling more liked or accepted by the examiner than participants in the other group.
CHAPTER 4

DISCUSSION

Overall, the results of this analogue Therapeutic Assessment study indicate there are no differences in feedback style in regard to therapeutic benefits. Individuals who developed personally-relevant questions and received feedback based on those questions did not differ in terms of therapeutic benefits from individuals who received feedback using standard procedures. Although feedback style did not differentially affect depression and anxiety symptoms, the present study indicated that feedback in general was related to changes in symptomatology over time. More specifically, results suggest that individuals, regardless of method of feedback, experienced a statistically significant increase in anxiety and depressive symptoms immediately after feedback, but by two week follow-up reported anxiety and depressive symptoms that were significantly lower than their scores at the initial session. This suggests that feedback resulted in reductions in depression and anxiety symptoms, even though there was an increase in symptoms immediately after receiving MMPI-2-RF feedback.

In regard to self-esteem, the groups did not statistically differ in scores on a measure of self-confidence and self-efficacy at any of the time points. This indicates that participants who received feedback based on their own questions reported similar levels of self-esteem as individuals who received standard feedback. Not only did the groups
not differ in levels of self-esteem, but also participants in both conditions did not vary in levels of self-esteem over time. This indicates that feedback, regardless of style, did not impact self-reported levels of self-confidence and self-efficacy from the start of the study to the end of the study.

In the present study, participants in both groups rated their perceptions of the assessment/feedback process immediately following feedback and two weeks after receipt of feedback. Overall, results indicated that participants in both groups had positive feelings about the assessment process. Feedback style did not influence participants’ perceptions of the experience immediately following the feedback or at two week follow-up, as participants did not statistically differ on a subscale assessing feelings about the assessment across time or based on group membership. Given that participants who received feedback based on personally-developed questions worked more collaboratively with the assessor during the initial session to develop said questions, there was the potential for those participants to have a closer, more positive relationship with the assessor as compared to participants who received standard feedback without developing questions. However, the present study indicated that individuals who received feedback based on their own questions did not describe having a more positive relationship with the assessor than individuals who received standard feedback. This suggests that participants in both groups felt equally liked and well attended to by the assessor, which is consistent with the findings from Finn and Tonsager (1992) and Newman and Greenway (1997).
Another important indicator of participants’ engagement/satisfaction with the assessment process (though not a variable specifically analyzed in this study) is the finding that there were no invalid MMPI-2-RF protocols for any of the participants. This shows that participants were engaged with the process and took the measure in a careful and thoughtful manner, regardless of feedback condition. This is particularly striking as individuals from undergraduate student samples often invalidate MMPI-2/MMPI-2-RF protocols at a rate of approximately 25% to 33% when completing the measure as a part of a study for which they receive course credit. Even though participants in the experimental condition were the only individuals who provided input regarding the type of information about which they would receive feedback, participants in the control condition were told they would receive individualized feedback about their test results.

A clinical implication of this finding is that simply telling an individual prior to test-taking that he or she will receive feedback regarding the results may be a motivator for individuals to put time and care into their responses. Communication between clinicians and clients regarding assessment results is required by the American Psychological Association code of ethics (2010), and the present study provides evidence for the clinical utility of letting clients know prior to testing they will indeed receive feedback.

Taken at face value, results of this study would indicate that although there are some therapeutic benefits of receiving personality assessment feedback, individuals do not experience a greater degree of benefits as a result of receiving feedback based on questions they developed prior to the assessment. In general, the finding that feedback results in positive therapeutic outcomes is consistent with the psychotherapy literature
that provides evidence for the therapeutic utility of feedback about assessment (Lundahl et al., 2010; Miller et al., 1992; Riper et al., 2009) and the collaborative involvement of clients within a therapeutic process (Gomes-Schwartz, 1978; Kolb et al., 1985). In addition, controlled studies of feedback delivered within a collaborative assessment framework have provided evidence of the therapeutic effectiveness of feedback (Finn & Tonsager, 1992; Newman & Greenway, 1997; Poston & Hanson, 2010). Due to difficulties related to sample size, the present study did not include a no-feedback condition to which to compare the question-development and standard feedback conditions. However, Newman and Greenway administered the MMPI-2 to all participants and gave feedback to half of participants while the other half did not receive MMPI-2 feedback. The results of their study indicated that individuals who received feedback experienced decreased distress and increased self-esteem, while individuals who did not receive feedback remained essentially unchanged in distress levels and self-esteem. This seems to suggest that feedback in general is superior to no-feedback, though future studies would benefit from comparing different feedback styles to a no-feedback condition.

There are several possibilities as to why differences in therapeutic outcomes (decreases in depression and anxiety and increases in self-esteem) were not found between the two feedback conditions. Although the studies by Finn and Tonsager (1992) and Newman and Greenway (1997) provided the precedent for the current study, a significant difference between the method used in those studies and this study was that the present study used an analogue design; participants were recruited based on
elevations on a measure of mood and anxiety symptoms as compared to their peers. Even though this procedure resulted in the inclusion of individuals with higher levels of distress as compared to their peers, these individuals were not treatment seeking, while the participants in Finn and Tonsager and Newman and Greenway were treatment-seeking. Therapeutic Assessment is typically conducted with individuals who are self-referred or referred by clinicians with whom they have an ongoing therapeutic relationship. In both cases, there are often questions or challenging situations that led to the Therapeutic Assessment. Individuals who enter a Therapeutic Assessment by choice rather than by chance (as in this study) are likely to already have questions about their psychological functioning that they are eager to have answered. In contrast, individuals in the present study were randomized into the question development condition and may not have had any specific concerns or questions about their personality and emotional functioning. Thus, these particular individuals may not have been able to develop questions that would result in information that expanded their self-understanding any more than would be expected from standard feedback. This could potentially explain why there were not any significant differences between the amounts of therapeutic gains experienced by the different feedback groups.

Although not an explanation for the lack of difference between the two feedback groups, the treatment-seeking status of the participants may explain the increase in symptoms across all participants following MMPI-2-RF feedback. There is the potential that individuals who are not treatment-seeking may already be satisfied with their current understanding of themselves and their personality structures (S.E. Finn, personal
communication June 2013), and thus may not be particularly open to receiving feedback. Moreover, receiving feedback may actually result in some discomfort, and could lead to increased depressive and anxiety symptoms. Both Finn and Tonsager (1992) and Newman and Greenway (1997) found similar distress scores (as measured by SCL-90) at the initial session and following feedback, while in the present study, there were statistically significant increases in depression and anxiety symptoms in both groups following MMPI-2-RF feedback. This finding was somewhat unexpected given the ample psychotherapy literature that demonstrates the therapeutic effectiveness of feedback. It is possible that the process of talking with the assessor and subsequently taking the MMPI-2-RF predisposed the participants to think about their symptoms and endorse more items, or at least endorse them at more severe levels than during the initial session. It is often assumed that there are inherent risks to taking psychological measures such as the MASQ and MMPI-2-RF, and as such, researchers mention these risks in the informed consent to participants. Therefore, it is possible that as a result of taking the MASQ, SLCS, and the MMPI-2-RF the participants experienced an increase in symptomatology, which subsequently decreased to the lowest level by two week follow-up. However, the viability of this explanation is put into question given that the studies by Finn and Tonsager and Newman and Greenway had similar designs as the present study but did not find an increase in symptoms following feedback. If the increase in symptoms following feedback was due to the non-treatment-seeking status of the participants in the present, future studies that include both treatment-seeking and non-
treatment seeking participates may help elucidate whether the increase in distress following feedback was due to the treatment-seeking status of participants.

Consistent with the methodological designs used by Finn and Tonsager (1992) and Newman and Greenway (1997), the present study included a follow-up time period of two weeks post feedback. At follow-up, individuals in both conditions reported significant reductions in symptoms of anxiety and depression. However, there is potential that two weeks was too short of a time period to detect the full extent of therapeutic gains from feedback. Feedback delivered within Therapeutic Assessment is hypothesized to result in continued gains in self-understanding and acceptance, which may outlast those achieved by standard feedback (Finn, 2007). This is because individuals who receive feedback based on their own questions are more likely to be told information specifically tied to challenges in their everyday lives, while feedback not based on questions may simply confirm individuals’ perceptions about themselves and not necessarily further their understanding of themselves. Therefore, it is possible that a longer follow-up period may reveal that individuals who receive feedback based on their own questions experience continued reductions in depression and anxiety over time while individuals who receive standard feedback stay the same (or return to baseline). It is also possible that the therapeutic gains observed at the two week follow-up in the present study were not stable over time and that individuals’ depression and anxiety symptoms returned to baseline levels. Future studies would benefit from including a longer follow-up period to see if not only there are differences in therapeutic gains between feedback conditions, but also to examine whether gains achieved are stable over time.
Additional findings from the present study suggest that individuals’ perceptions and subjective experiences of the assessment process did not differ based on feedback style, as participants who received feedback based on the procedures outlined in Therapeutic Assessment experienced similar levels of satisfaction as individuals who received standard feedback. Although previous studies by Finn and Tonsager (1992) and Newman and Greenway (1997) found that individuals who participated in a collaborative assessment process experienced high levels of satisfaction, it should be noted that the subjective experiences of those individuals were compared to the experiences of individuals who did not receive any assessment feedback. A larger effect would be expected when comparing the experiences of people who received feedback to the experiences of individuals who did not receive feedback than when comparing the experiences of two groups who were subject to different feedback methods. Consequently, the lack of difference between the subjective experiences of participants in the two groups of the present study may not be all that unexpected, given that previous research on feedback suggests that individuals generally feel satisfied when receiving feedback. Furthermore, the size of the effect when comparing the experiences of people who received feedback based on individually-developed questions to the experiences of people who received standard feedback may actually be quite small and could account for the lack of statistically significant findings. Additionally, the relatively small sample size did not provide enough statistical power to detect a trivial-to-small effect and a larger sample would help determine if there are statistically significant and clinically meaningful differences between feedback styles in regard to therapeutic benefits.
The measures used in the present study were largely consistent with those used in Finn and Tonsager (1992) and Newman and Greenway (1997). In the present study, the MASQ was used as a measure of general distress as opposed to the SCL-90-r used by Finn and Tonsager and Newman and Greenway. Similar to Newman and Greenway, the present study utilized the SLCS as a measure of self esteem, while the study by Finn and Tonsager used a different 6-item measure. The studies by Finn and Tonsager and Newman and Greenway found that participants who received feedback had greater increases in self-esteem than participants who did not receive feedback, whereas no differences in self-esteem were found between the groups in the present study. Moreover, there were essentially no changes in self-esteem scores over time for participants in either group. The lack of differences in self-esteem scores between groups could be explained by a trivial-to-small effect that was not detected with the small sample size of the present study. However, it would be expected that feedback in general would result in some gains in self-esteem over time. Within a Therapeutic Assessment context, it is hypothesized that changes in self-esteem occur in part as a result of increases in self-efficacy as individuals are actively engaged in the process and have a say about which types of information they receive feedback. Thus, it may be more appropriate to use a survey that specifically measures self-efficacy rather than a measure like the SLCS which only contains 10 items that assess self-efficacy. Focusing specifically on self-efficacy would be particularly important when distinguishing the therapeutic benefits of one feedback style as compared to another (as in the present study), as feedback in general
might be expected to result in gains in self confidence as a result of new self-understanding and self-acceptance.

The lack of evidence for increased therapeutic benefits for feedback delivered utilizing a TA model could also be explained by the relative inexperience of the assessors who delivered the different feedback conditions. Although both assessors attended at least one full-day workshop by Dr. Stephen Finn and read his writings that explain the TA procedures in detail, neither assessor completed the certification process through the Center for Therapeutic Assessment in Austin, TX. It is possible that the assessors in the present study did not maintain treatment integrity, which implies that the effective components of Therapeutic Assessment were not adequately applied during the study. Although efforts were made to ensure the assessors were consistent in their feedback style (e.g., random sessions were recorded for each assessor and viewed for assessor consistency, and the assessors collaboratively discussed feedback for every case), there is the potential that neither assessor delivered Therapeutic Assessment according to the specifications set forth by Finn and the Center for Therapeutic Assessment. If this study were to be replicated, it would be important that the assessor(s) be more adequately trained and certified to deliver Therapeutic Assessment, to control for the possibility of protocol drift.

In conclusion, the results of the present study suggest that feedback based on client-developed questions following a Therapeutic Assessment model does not result in a larger magnitude of therapeutic benefits as compared to feedback delivered in a standard manner. However, feedback regardless of style was associated with positive
outcomes; on average, participants in both groups experienced a decrease in anxiety and depressive symptoms two weeks after receiving feedback. Contrary to previous studies, individuals did not experience any changes in self-esteem as a result of the feedback intervention. The findings of the present study may be best accounted for by the analogue design of the study, small sample size, and the general inexperience of the assessors in regard to Therapeutic Assessment rather than the therapeutic ineffectiveness of feedback in general. If these findings were to be replicated, it would indicate that developing questions and receiving feedback based on those questions does not result in greater outcomes as compared to standard feedback.

Even though this study did not provide empirical evidence for the utility of client-developed questions in the context of Therapeutic Assessment, it is not assumed that this component of TA is ineffective or not worthwhile to clients. Individuals in the present study were engaged in the assessment process, which was evidenced by the 100% valid MMPI-2-RF profile rate, and on average, all individuals experienced therapeutic benefits by the end of the study. Findings from this study present important clinical implications for the assessment process and feedback. This study suggests that when individuals are aware from the outset of the assessment process that they will receive feedback based on their testing results, they are engaged in the assessment process, which likely enhances the therapeutic relationship as well as the interpretability of the testing results. In addition, the finding that feedback in general resulted in reductions of anxiety and depression provides additional evidence that psychological testing feedback is therapeutic and should be reimbursable by third-party payers. Future controlled research is necessary
to determine what aspects of collaborative assessment are most helpful for clients so that clinicians may focus their efforts on strategies that result in the best possible outcomes for clients.
APPENDICES
APPENDIX A

SOLICITATION LETTER
APPENDIX A

SOLICITATION LETTER

Dear (Student):

Thank you for your participation in (semester) mass-testing. Based on a measure you took during mass-testing, you are invited to participate in a study examining different ways of sharing personality test results with individuals. I will examine how receiving feedback about test results affects people’s feelings about themselves. If this invitation has reached you by mistake, please contact Lesley Hiebing at lhiebing@kent.edu so that you do not receive future e-mails.

Would you like to receive personalized feedback based on your scores on a well-known measure of personality and emotional functioning? Are there personal strengths or weaknesses you would like to explore one-on-one with an assessor?

If you answered “yes” to either or both of the questions above, you have the opportunity to participate in a three time-point study. If you agree to participate, you will meet individually with an assessor on two occasions, and complete brief online measures at a third time-point. The anticipated amount of participation time is two and a half hours (150 minutes). As a result of your participation you will receive personalized feedback about your personality characteristics and emotional functioning. Participation is voluntary, and you are free to discontinue your participation at any time. You will receive up to five participation points upon completion of the study.

If participating in a three time-point study is of interest to you, please contact the principle investigator, Lesley Hiebing, M.A., by (date) to set-up an appointment. If you have any questions about the study, please contact to Lesley Hiebing by e-mail at lhiebing@kent.edu.
APPENDIX B

STUDY MEASURES
APPENDIX B

STUDY MEASURES

Assessment Questionnaire

Instructions:
This questionnaire deals with your thoughts and feelings about your psychological assessment. Please read each statement carefully. Once you decide how much you agree or disagree with a statement, circle the number that best matches how the statement applies to you. Be as honest and as accurate as possible. Please do not skip any item and circle only one number for each statement.

Use the following scale to rate each statement:

Strongly Disagree (1) Disagree (2) Neutral (3) Agree (4) Strongly Agree (5)

1. The assessment did not teach me anything new about myself.
   1   2   3   4   5

2. The assessment made me proud of who I am.
   1   2   3   4   5

3. The assessor earned my respect.
   1   2   3   4   5

4. I felt I was under a microscope.
   1   2   3   4   5

5. The assessor introduced me to new aspects of myself.
   1   2   3   4   5

6. The assessment made me feel good about myself.
   1   2   3   4   5
7. It was easy to trust the assessor.
   1 2 3 4 5

8. The assessment hurt me.
   1 2 3 4 5

9. I gained a new understanding of myself.
   1 2 3 4 5

10. The assessment captured the “real” me.
    1 2 3 4 5

11. The assessor seemed to like me.
    1 2 3 4 5

12. The assessment was unsettling to me.
    1 2 3 4 5

13. The assessment confirmed parts of me that I had only suspected.
    1 2 3 4 5

14. The assessor said nice things about me.
    1 2 3 4 5

15. I felt very close to the assessor.
    1 2 3 4 5

16. The assessment was a humiliating and degrading experience.
    1 2 3 4 5

17. The assessment made me think of myself.
    1 2 3 4 5

18. The assessment made me feel important.
    1 2 3 4 5

19. The assessor treated me warmly.
    1 2 3 4 5
20. The assessment was emotionally draining.
   1 2 3 4 5

21. I am more aware of how I behave with other people.
   1 2 3 4 5

22. I felt special.
   1 2 3 4 5

23. I really connected with the assessor.
   1 2 3 4 5

24. At times during the assessment, I felt like I did when I was a child.
   1 2 3 4 5

25. The assessment helped me organize my thoughts about myself.
   1 2 3 4 5

26. The assessment confirmed how I see myself.
   1 2 3 4 5

27. I liked the assessor.
   1 2 3 4 5

28. The assessment made me feel that my life is nothing but problems.
   1 2 3 4 5

29. I have changed the way I think about my problems.
   1 2 3 4 5

30. I feel more sure of who I am.
   1 2 3 4 5

31. The assessor was interested in what I had to say.
   1 2 3 4 5
32. I felt judged by the assessor.
   1 2 3 4 5

33. I am more aware of how I am feeling.
   1 2 3 4 5

34. I felt my strengths were recognized.
   1 2 3 4 5

35. The assessor treated me as an equal.
   1 2 3 4 5

36. The assessor made me feel inadequate.
   1 2 3 4 5

37. The assessment will make a difference in my upcoming decisions.
   1 2 3 4 5

38. The assessment made me think about where I am headed in my life.
   1 2 3 4 5

39. I felt that the assessor respected me.
   1 2 3 4 5

40. The assessor insulted me.
   1 2 3 4 5

41. I am more aware of why people react to me the way they do.
   1 2 3 4 5

42. I know that how I see myself is really true.
   1 2 3 4 5

43. The assessor and I worked as a team to learn more about me.
   1 2 3 4 5
44. I felt exposed.  
   1  2  3  4  5  

45. I can think of myself as I never had before.  
   1  2  3  4  5  

46. The assessment described thoughts and feelings I have about myself.  
   1  2  3  4  5  

47. The assessor was on my side.  
   1  2  3  4  5  

48. The assessment made me rethink the way I already viewed myself.  
   1  2  3  4
Below is a list of feelings, sensations, problems, and experiences that people sometimes have. Read each item below and mark the appropriate choice on the SCANTRON. Use the choice that best describes how much you have felt or experienced this way during the past week, including today. Use this scale when responding:

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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>not at all</td>
<td>a little bit</td>
<td>Moderately</td>
</tr>
<tr>
<td>1.</td>
<td>Felt cheerful</td>
<td>25.</td>
<td>Seemed to move quickly and easily</td>
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</tr>
<tr>
<td>2.</td>
<td>Felt afraid</td>
<td>26.</td>
<td>Felt dissatisfied with everything</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Startled easily</td>
<td>27.</td>
<td>Looked forward to things with enjoyment</td>
<td></td>
<td></td>
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<tr>
<td>4.</td>
<td>Felt confused</td>
<td>28.</td>
<td>Had trouble remembering things</td>
<td></td>
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<tr>
<td>5.</td>
<td>Slept very well</td>
<td>29.</td>
<td>Felt like nothing was very enjoyable</td>
<td></td>
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<tr>
<td>6.</td>
<td>Felt sad</td>
<td>30.</td>
<td>Felt like something awful was going to happen</td>
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<tr>
<td>7.</td>
<td>Felt discouraged</td>
<td>31.</td>
<td>Felt like I had accomplished a lot</td>
<td></td>
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<tr>
<td>8.</td>
<td>Felt nauseous</td>
<td>32.</td>
<td>Felt like I had a lot of interesting things to do</td>
<td></td>
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</tr>
<tr>
<td>9.</td>
<td>Felt like crying</td>
<td>33.</td>
<td>Did not have much of an appetite</td>
<td></td>
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<tr>
<td>10.</td>
<td>Had diarrhea</td>
<td>34.</td>
<td>Felt like it took extra effort to get started</td>
<td></td>
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</tr>
<tr>
<td>11.</td>
<td>Felt worthless</td>
<td>35.</td>
<td>Felt like I had a lot to look forward to</td>
<td></td>
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<tr>
<td>12.</td>
<td>Felt really happy</td>
<td>36.</td>
<td>Felt pessimistic about the future</td>
<td></td>
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<tr>
<td>13.</td>
<td>Felt nervous</td>
<td>37.</td>
<td>Felt like there wasn’t anything interesting or fun to do</td>
<td></td>
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<tr>
<td>14.</td>
<td>Felt depressed</td>
<td>38.</td>
<td>Had pain in my chest</td>
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<tr>
<td>15.</td>
<td>Felt irritable</td>
<td>39.</td>
<td>Felt like a failure</td>
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<tr>
<td>16.</td>
<td>Felt optimistic</td>
<td>40.</td>
<td>Had hot or cold spells</td>
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<tr>
<td>17.</td>
<td>Felt faint</td>
<td>41.</td>
<td>Was proud of myself</td>
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</tr>
<tr>
<td>18.</td>
<td>Felt uneasy</td>
<td>42.</td>
<td>Felt very restless</td>
<td></td>
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<tr>
<td>19.</td>
<td>Felt really bored</td>
<td>43.</td>
<td>Had trouble falling asleep</td>
<td></td>
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<tr>
<td>20.</td>
<td>Felt hopeless</td>
<td>44.</td>
<td>Felt dizzy or lightheaded</td>
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<tr>
<td>21.</td>
<td>Felt like I was having a lot of fun</td>
<td>45.</td>
<td>Felt unattractive</td>
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<tr>
<td>22.</td>
<td>Blamed myself for a lot of things</td>
<td>46.</td>
<td>Was short of breath</td>
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<tr>
<td>23.</td>
<td>Felt numbness or tingling in my body</td>
<td>47.</td>
<td>Felt sluggish or tired</td>
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<tr>
<td>24.</td>
<td>Felt withdrawn from other people</td>
<td>48.</td>
<td>Hands were shaky</td>
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### MASQ (cont.)

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<tbody>
<tr>
<td></td>
<td>not at all</td>
<td>a little bit</td>
<td>Moderately</td>
<td>quite a bit</td>
<td>extremely</td>
</tr>
<tr>
<td>49</td>
<td>Felt really “up” or lively</td>
<td>64. Felt tense or “high strung”</td>
<td></td>
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<tr>
<td>50</td>
<td>Was unable to relax</td>
<td>65. Felt hopeful about the future</td>
<td></td>
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<tr>
<td>51</td>
<td>Felt like I was choking</td>
<td>66. Was trembling or shaking</td>
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<tr>
<td>52</td>
<td>Had an upset stomach</td>
<td>67. Had trouble paying attention</td>
<td></td>
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<tr>
<td>53</td>
<td>Felt inferior to others</td>
<td>68. Muscles were tense or sore</td>
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<tr>
<td>54</td>
<td>Had a lump in my throat</td>
<td>69. Felt keyed up, “on edge”</td>
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<tr>
<td>55</td>
<td>Felt really slowed down</td>
<td>70. Had trouble staying asleep</td>
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<tr>
<td>56</td>
<td>Had a very dry mouth</td>
<td>71. Worried a lot about things</td>
<td></td>
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<tr>
<td>57</td>
<td>Muscles twitched or trembled</td>
<td>72. Had to urinate frequently</td>
<td></td>
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<tr>
<td>58</td>
<td>Had trouble making decisions</td>
<td>73. Felt really good about myself</td>
<td></td>
<td></td>
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<tr>
<td>59</td>
<td>Felt like I had a lot of energy</td>
<td>74. Had trouble swallowing</td>
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<tr>
<td>60</td>
<td>Was afraid I was going to die</td>
<td>75. Hands were cold or sweaty</td>
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<tr>
<td>61</td>
<td>Disappointed in myself</td>
<td>76. Thought about death or suicide</td>
<td></td>
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<tr>
<td>62</td>
<td>Heart was racing or pounding</td>
<td>77. Got tired or fatigued</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>Had trouble concentrating</td>
<td></td>
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</table>
1. Owing to my own capabilities, I have much potential.
2. I feel comfortable about myself.
3. I don’t succeed at much.
4. I have done well in life so far.
5. I perform very well at a number of things.
6. It is often unpleasant for me to think about myself.
7. I tend to devalue myself.
8. I focus on my strengths.
9. I feel worthless at times.
10. I am a capable person.
11. I do not have much to be proud of.
12. I’m secure in my sense of self-worth.
13. I like myself.
14. I do not have enough respect for myself.
15. I am talented.
16. I feel good about who I am.
17. I am not very competent.
18. I have a negative attitude toward myself.
19. I deal poorly with challenges.
20. I perform inadequately in my many important situations.
REFERENCES


and therapy process variables relating to dropout and change in psychotherapy.
*Psychotherapy, 22*, 702-710.

*Psychotherapy, 48*, 65-71.


Kwang, T., & Swann, W. B., Jr. (2010). Do people embrace praise even when they feel

three modes of MMPI-2 test feedback*. Paper presented at the Society for
Personality Assessment Annual Meeting, San Francisco, CA.

MMPI-2: Providing feedback and treatment*. Muncie, IN: Accelerated
Development, Inc.

Lundahl, B. W., Kunz, C., Brownell, C. Tollefson, D., & Burke, B. L. (2010). A meta-
analysis of motivational interviewing: Twenty-five years of empirical studies.


