A Dissertation

Entitled

Comparing Therapeutic Assessment and Traditional Assessment in SMI Adults

by

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Psychological assessments marked the advent of clinical psychologists into clinical work. Though reimbursement for assessments has proven to be increasingly difficult, clinicians still find them quite beneficial and enlightening. Stephen Finn (1996) and Constance Fischer (2000) among others have utilized and promoted collaborative methods to conduct assessments. With the clients as co-evaluators, research suggests that they can leave the assessment with a new sense of self or a better understanding of their feelings (Finn, 2003; Finn & Tonsager, 1992; Finn & Tonsager, 1997; Newman & Greenway, 1997). However, except for two studies with college counseling center populations (Finn, 1992; Newman & Greenway, 1997), this research has been limited to case studies and unpublished dissertations. In general, research results are mixed concerning therapeutic assessment and special populations. Nevertheless, in all of the studies, the therapeutic assessment group improved; but in some of them the control group improved as well. Furthermore, some of the previous studies had methodological problems (i.e., multiple examiners, examiners not trained in therapeutic assessment, and hectic data collection
sites), especially regarding a study using a population with serious mental illnesses (SMI; Houser, 2000). With SMI clients, research has shown that the quality of social support interactions has been crucial in determining the success of their mental health recovery. Individuals who have a positive view of their social support have better mental health outcomes.

The author of the current study posited that therapeutic assessment, as opposed to traditional, information gathering assessment, with an SMI population would prove to be more efficacious. Hypotheses were tested using the Structural Analysis of Social Behavior (Benjamin, 1974; 1996) medium form, the Brief Symptoms Inventory (Derogatis, 1983), and the Picture Projection Test - Revised (Ritzler & Ben-vi, 2005) as therapeutic assessment measures and the Rosenberg Self Esteem Scale (Rosenberg, 1965), the Mental Health Recovery Measure (Young & Bullock, 2003), and the Assessment Questionnaire – Revised (Finn, Schroeder, & Tonsager, 1994) as the outcome measures. Each participant was administered the outcome measures three times: before the assessment, immediately after the assessment but still during the first session, and three to five weeks after the assessment at a follow-up appointment. The author hypothesized that individuals in the therapeutic assessment group would demonstrate a larger change on the outcome measures than those in the information gathering group.

Nineteen participants diagnosed with a serious mental illness participated in the study. Ten participants were in the therapeutic assessment group and nine participants were in the information gathering group. The main hypotheses were not supported: Self-esteem increased in the therapeutic assessment group, but not more so than in the information gathering group. These results are congruent with previous studies that have
found therapeutic assessment to be beneficial, but not always more so than the control group. Limitations of the current study are discussed, including the small sample size.
Dedication

This dissertation is dedicated to my mother, who was a huge source of inspiration and motivation throughout my life. I also dedicate this work to my father, stepmother, and siblings who have always encouraged and supported my endeavors.
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Chapter 1

Introduction

Shortly after World War II, in the late 1940s and 1950s, assessment allowed psychologists to break into the clinical realm (Blatt, 1975). Traditionally, therapy and other clinical tasks had been the responsibilities of psychiatrists. Clinical psychologists were hired to work with clients if a psychological assessment was needed. Unfortunately, psychological assessment was not necessarily highly regarded; on the other hand, those who administered assessments believed they were essential (Blatt, 1975; Eisman et al., 2000).

Although the earliest application of clinical psychology was actually in assessment (Peterson, 1987), people typically think of psychotherapy when thinking of the duties of a psychologist (Callan, Peterson, & Stricker, 1986; Garfield & Kurtz, 1976; Peterson, Eaton, Levine, & Snepp, 1982). In 1982, Peterson and colleagues surveyed 184 graduates of Psy.D. programs and utilized data from another study by Garfield and Kurtz, who surveyed 855 Ph.D. graduates, to determine how clinical psychologists classify their main role (i.e., practitioner, academician, researcher, consultant, supervisor, administrator, other). About 82% of Psy.D. graduates and 59% of Ph.D. graduates considered themselves to be practitioners, percentages that were much higher than any of the other categories (e.g., academician, researcher, consultant, supervisor, and administrator). The most time consuming duty for both Psy.D.’s and Ph.D.’s was individual therapy at about 34% and 25%, respectively.
In a more recent study by Watkins, Campbell, Nieberding, and Hallmark (1995), 412 American Psychological Association (APA) members, who identified themselves as clinical psychologists, responded to a survey about assessment practices. The psychologists who conducted psychotherapy (96%) indicated that 51% of their professional time was devoted to psychotherapy. Those who conducted personality assessments and intellectual assessments (90% and 66%, respectively) spent a fair amount of their time doing so (12% and 8%, respectively). As in Peterson et al's (1982) study, psychotherapy was the most time consuming for the clinical psychologists surveyed.

Camara, Nathan, and Puente (2000) also surveyed 1,005 neuropsychologists, who were members of the National Association of Neuropsychology (NAN), and 1,500 clinical psychologists, who were members of APA, to discern the amount of time they spent in assessment practices. Sixty-eight percent of the NAN members indicated that they spend approximately 10 hours of their time administering, scoring, and interpreting individual psychological tests per week. On the other hand, only 16% of the APA members reported that they spend 10 or more hours per week for psychological assessment practices. This study also suggests that clinical psychologists do not spend the majority of their time conducting psychological assessments, although it is a more common task for neuropsychologists. However, as previously-noted, the earliest application of clinical psychology was actually not in therapy, but rather, in assessment (Peterson, 1987).

Psychologists use a variety of ways to gather clinical information from their clients (e.g., structured clinical interviews, unstructured interviews, behavioral
observations, countertransference reactions, and psychological tests). Though these methods allow clinicians to obtain valuable information, when used alone, important aspects about individuals are missed. In order to conduct a psychological assessment, clinicians gain information from multiple sources (e.g., tests, history, interview). That is, assessment uses a variety of information to understand the individual and their symptoms, whereas, testing simply compares an individual’s score on a single measure to other scores derived from a larger number of people. This is what distinguishes psychological assessment from psychological testing.

Psychological assessment does not have to be done routinely, but it is typically helpful when therapy is at a standstill or critical decisions regarding a client’s treatment need specific attention (Blatt, 1975). In these cases, clinical interviews alone do not seem sufficient. Assessment or consultation can be offered when the therapist and the client need a new perspective or a third party’s point of view to help them with their work (Blatt, 1975; Engleman & Frankel, 2002). For instance, Engleman and Frankel (2002) describe the story of Max. Max was a 68-year old male who was having difficulty speaking in public. He was a very successful businessman. Max’s history detailed a very traumatic childhood, having had to flee Rumania twice and in turn was always struggling economically. When he and his family finally settled in central Russia, the Nazis invaded his town, and Max lost his entire family to death as a result. When Max and his therapist came to a standstill in therapy, they decided to consult with another psychologist for a psychological assessment. The main questions revolved around Max’s inhibitions (i.e., difficulty speaking in public and difficulty making decisions about people he cares about). Max and his therapist differed in their explanations of what may have caused
these difficulties. Max believed that they were from the hardships he endured in his childhood, and his therapist believed that they were more specifically a result of the sudden and horrific loss of his family.

The assessment, which included the Rorschach (Exner, 1993) and the Thematic Apperception Test (TAT; Morgan & Murray, 1935), was beneficial and helped determine how Max and his therapist should work together (Engleman & Frankel, 2002). The results indicated that Max was an innovative and insightful person who gave himself little credit for his successes. His shyness seemed to have been prevalent from early childhood, and the inhibitions had prevented him from accruing success, which was contradictory to his actual prosperity. This discrepancy seemed very troubling to Max, as indicated by the assessment. However, the assessment results suggested that Max was open to considering new ways of dealing with his problems and that it would be important for him to allow himself the pleasure that he had earned. For Max’s therapist, the assessor suggested that current uncovering therapy was disorganizing. Supportive therapy, on the other hand, would allow Max a chance to feel safe expressing his emotions in therapy. In relaying the results to Max and his therapist, the assessor used language that Max was able to grasp and encouraged an open dialogue among them. Ultimately, based on the assessment results, Max’s therapist found himself being more willing to give supportive advice, which eventually helped Max open up. A follow-up assessment three years later indicated that Max was much more apt to take his own feelings into consideration, not just others’ feelings. This example shows how a third party assessment can be quite advantageous for clinical work.
Though many people consider psychologists as primarily conducting psychotherapy, psychological assessment is a large part of being a clinical psychologist. In fact, it is how psychologists began their work in the clinical realm. Nevertheless, today, assessment training is lacking. Even programs that provide clinical training seem to foster negative attitudes about assessment (Mihura & Weinle, 2002; Piotrowski & Zalewski, 1993).

Clinical Training in Psychological Assessment

Since assessment is a main element of clinical psychology, training of clinical doctoral students in assessment instruments is of particular importance. Piotrowski and Zalewski (1993) surveyed 158 Ph.D. and Psy.D. clinical training directors regarding course requirements for psychological assessment. Sixty-five percent of the programs required one course in intelligence testing. Forty-five percent of the graduate training programs did not require any coursework in behavioral assessment. For projective personality testing, 39% of the programs required completion of one course, and 42% of the programs required completion of one objective personality testing course. Piotrowski and Zalewski also asked the clinical training directors to predict the direction that psychological testing would take in the academic setting—would it increase, decrease, or remain the same. Forty-five percent stated that they believed that projective psychological assessment coursework would not only decrease, but it would decrease in the near future. Most directors (88%) thought that intelligence testing training would remain the same. While a good number of programs do require training classes in intelligence testing, most of them do not require more than one course, if that, and even less require courses in other types of testing; yet, practicing psychologists indicate that
assessments take up 10% of their time (Watkins, 1991). If this truly is the case, training is essential.

Often, clients engage in rigorous testing, expending much of their time and effort into completing psychological assessments. It seems only fair that the American Psychological Association (APA) ethical standards (2003) require clinicians to share the results with the clients. Unfortunately, little training goes into teaching young clinicians how to best discuss assessment results with clients. For instance, Mihura and Weinle (2002) surveyed 500 graduate students to determine their satisfaction with their Rorschach training. Of the 254 valid surveys returned, 212 students reported that they had indeed received Rorschach training. Unfortunately, 41% of those who had received at least introductory Rorschach training felt that they had not received adequate training in providing feedback for the Rorschach. Historically, much of the underlying assumption around extending feedback to clients is that the evaluator knows what is best, and therefore feedback is not necessary (Craddick, 1975; Vane, 1972). This lack of training in assessment and assessment feedback may be a result of the negative attitudes about psychological assessment that many people still share.

**Negative Attitudes about Assessment**

Despite the advantages of psychological assessment, many people still hold negative evaluations of the entire psychological testing process. Appelbaum (1990) describes some of the negative opinions that might be held about assessment. In general, psychological assessments are very expensive. The lofty prices of psychological assessment could deter people from utilizing them. Others think that psychological assessments are unnecessary (Appelbaum, 1990). The assumption being that a good
interviewer should be able to learn the necessary aspects of a client and thus not need to conduct an assessment.

Psychological assessment has also been thought of as counterproductive. Appelbaum (1990) is of the opinion that some practitioners believe that psychological assessment dehumanizes the client to be subservient to the assessor. Clients are also thought to be unable to take in and process the information presented to them, though empirical support to confirm this opinion is lacking. However, the aforementioned attitudes are used to espouse the idea that clients should not be collaborators in their own assessments. Even literature encouraging collaboration among assessor and client has been discarded. For instance, in the 1960s, Fischer’s articles regarding clients as co-evaluators were rejected until the 1970s (Fischer, 2000).

Health care providers are also perpetuating the negative view of psychological assessment. Much of the dissention is due to managed care organizations (MCOs; Eisman et al., 2000; Piotrowski, Belter, & Keller, 1998). Until recently, MCOs very seldom reimbursed psychologists for the amount of work they did regarding assessment. Psychologists essentially donated their time to administer, score, give feedback, and consult on assessments that they had administered. Sometimes, third parties, who are often not trained in psychological assessment, decide what tests to administer. This reduces the likelihood that necessary tests will be given, which is a detriment to ethical obligations, and confidentiality is lost (Eisman et al., 2000; Phelps, Eisman, & Kohout, 1998). This is a cause for concern among clinical psychologists.

Phelps et al. (1998) surveyed 15,918 psychologists in varying professional settings (e.g., independent practice, academic, government, and medical) about the
impact of MCO’s on the psychology profession. Seventy-nine percent of those surveyed thought that MCO’s were negatively impacting psychology. One of the negative impacts is the ethical dilemmas that are created by managed care—48% of all professionals were concerned about this. Some of the other concerns were that psychologists are losing clients to those who are less trained, such as master’s degree professionals (32% of professionals), being managed by individuals who are not psychologists and thus less trained (28% of professionals), being excluded from primary care (16% of professionals), and losing clients to physicians (6% of professionals). These concerns lend to the fear that the medical profession may view psychologists as unnecessary or easily replaceable in order to reduce the costs of psychological services, engendering ethical speculation regarding providing the best services for the clients.

*Positive Attitudes about Assessment*

Though there are many who feel that psychological assessment is a waste of time, there are also many who propose that assessment provides efficient and positive outcomes (Appelbaum, 1990). Those who support psychological assessment believe that psychological assessments are actually cost effective because the referral questions can be answered early on. An early answer to the referral questions also reduces the time of proper diagnosis and treatment. Unfortunately, empirical studies supporting this are sorely lacking. In other words, research has not supported nor denounced the benefits of psychological assessment however, the complexity of this issue contributes to the lack of evidence available.

Contrary to what some critics think, psychological assessments are reliable and valid, even when compared to medical tests (Meyer et al., 2001). Overall, neither
psychological tests nor medical tests are better than the other, but each vary in their accuracy of diagnosis. For instance, the MMPI Ego Strength scale has a similar effect size as compared to the dexamethasone suppression test in predicting response to treatment ($r = .02$ vs. .00). Likewise, MMPI scale scores and the ability to detect depressive or psychotic symptoms ($r = .37$) is similar to the degree that a home pregnancy test can correctly detect a pregnancy when the test is done at home ($r = .38$). So, some psychological tests have more accuracy than other psychological tests; likewise, certain medical tests are more precise than others. Table 2 in Meyer et al. (2001) shows a similar number of psychological and medical tests with validity coefficients in the .30-.50 range. Despite what some critics say, psychological testing and medical testing share similar validity.

Another beneficial aspect of psychological assessment is that it provides a guide for a therapeutic intervention (Appelbaum, 1990). Using psychological assessment as a basis, treatment decisions can be made including therapeutic modality, therapeutic prognosis, and whether or not to hospitalize the client. Without psychological assessment, people often resort to trial-and-error to make treatment decisions. In the Psychotherapy Research Project of the Menninger Foundation, Appelbaum (1977) established that psychologists demonstrated more accurate predictions regarding an individual’s treatment than did psychiatrists who performed interviews, even when they had all of the psychological testing readily available. Interpretations resulting from psychological assessment help psychologists obtain information about a client’s current concerns, whereas relying on information provided simply through psychological interviews may overlook important information about the client.
For instance, collecting solely self-reported information, while important, can overlook valuable information from other sources. John and Robins (1994) conducted an experiment with 102 participants. Participants were asked to complete a group discussion task and then rate their performance. Five peers in the group as well as 11 trained psychologists also rated each individual’s performance. The aggregated agreement of the staff and peer ratings was significant ($r = .81; p < .01$), indicating that peer ratings may be a good source of additional information of clients if need be. The correlation between the staff and the self-ratings were lower ($r = .42, p < .01$), but still significant. Similarly, the correlation between self-ratings and peer-ratings ($r = .42; p < .01$) was also lower than peer and staff ratings. These findings indicate that while self-rated performance is important, information from other sources can enhance the findings of a study.

Shedler, Mayman, and Manis (1993) have also conducted a study that purports the use of more than just self-report measures. They discuss the idea of illusory mental health which is the idea that individuals whose self-report measures do not support psychological distress should not be taken at face value. There are two kinds of individuals who do not report mental health symptoms: those who indeed are not experiencing symptoms and those who are but are too defensive to indicate their distress. The latter are deemed as having illusory mental health. The authors also suggest that even observers may be fooled by the feigned mental health. Despite an outwardly “healthy” profile, those with illusory mental health are paying physiologically (Shedler et al., 1993). That is, those who are defensive regarding their mental health symptoms may show signs of physiological stress. In order to test their hypotheses, they conducted three studies.
Shedler et al.’s (1993) first study consisted of 58 participants who were asked to complete the Eysenck Neuroticism scale and the Early Memory Test (EMT) for the psychological measures. The physiological measures that were gauged were heart rate (HR), systolic blood pressure (SBP), and diastolic blood pressure (DBP). In order to elicit stress, participants were asked to complete three tasks: (a) solving mental arithmetic problems, (b) telling stories to Thematic Apperception Test (TAT) pictures and (c) responding to a phrase association task. HR, SBP, and DBP were measured regularly throughout the experiment.

Results confirmed that individuals who reported distress (on the Neuroticism scale) were indeed judged as distressed by clinicians, but those who reported health, some were deemed healthy, and others were judged distressed (18 of 44; illusory mental health). For the physiological scores, the illusory mental health group showed significantly greater coronary reactivity than the two other groups. The illusory mental health participants were also higher than the other two groups on verbal defensiveness.

For the second study, Shedler et al. (1993) recruited two panels of undergraduate students (Panel 1 \( n = 37 \), Panel 2 \( n = 33 \)) to replicate the results in Study 1. The groups were made aware of the results from the previous studies. The ratings for Panel 1 and Panel 2 compared to the RPPs for Study 1, individuals with illusory mental health showed more physiological reactivity than the other two groups. Likewise, on verbal defensiveness, the illusory mental health group scores were higher than the genuinely healthy group and the distressed group (for Panel 2 only). Study 3 of Shedler et al. (1993) utilized data from the Block and Block longitudinal study (see Block & Block, 1980 for a study description). Data were available for 74 participants at the Age 23 stage of the
study. At age 23, participants were administered the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and an interview that included the EMT (which was videotaped). Based on the interview, a clinician provided a description of the participants via the California Adult Q-Sort (CAQ; Block, 1978). Participants were also exposed to physiological instruments, measuring SBP and DBP. The lab session included the sentence association test, counting backwards by 13s, the TAT, and an unstructured inquiry regarding the TAT cards administered. Participants judged as having illusory mental health had greater coronary reactivity than both the health participants and the distressed participants. Illusory mental health participants had higher DBP than the genuinely healthy participants.

The findings of the three Shedler et al. (1993) studies indicate that in judging distress, clinicians should not necessarily rely on self-report alone. Individuals who report good mental health may not be completely straightforward. Those who are defensive, or who have illusory mental health, may appear similar to the genuinely healthy individuals; however, their physiological signs show that they are having more coronary activity than those who are genuinely healthy and those who are presenting themselves as distressed. These studies only show further that multiple methods of gaining information are optimal for collecting data from individuals.

An exemplary case of utilizing multiple sources of information is demonstrated in a case study by Finn (2003), which will also be referred to later. Finn described a man, David, who came to him for help when he and his therapist were at a standstill. David had previously been diagnosed with Attention Deficit Disorder (ADD), and he had initially sought therapy for disorganization and problems with romantic relationships.
Though David had been diagnosed with ADD, he was not responding to the psychostimulants he was prescribed. At the time of his assessment, David had recently begun taking an antidepressant as his psychiatrist recognized that the ADD medication was not working. His psychiatrist also had questions about diagnosing David with a bipolar spectrum disorder. Upon the first meeting with David, Finn asked him how his symptoms have played a part throughout his life. David remembered having difficulties even when he was very young. His parents divorced, and at first, he lived with his father, who had financial difficulties, dated numerous women, and smoked marijuana. David then moved in with his mother, who was promiscuous and married a man who despised children. David, too, began to smoke marijuana and also drank heavily until high school. When he was in grade school, he was assessed by a speech pathologist, who reported that David had trouble with organizing information. Despite this assessment, David did not remember receiving a lot of help in school.

After collecting an extensive history of the problem, Finn and David began the psychological assessment. First, David was administered the Attention Deficit Scales for Adults (Triolo & Murphy, 1996) regarding his initial question about ADD. Then Finn interviewed David for bipolar disorder, inquired about current drug and alcohol abuse, and administered the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986) the Rorschach using the Comprehensive System (Exner, 1995), the Minnesota Multiphasic Personality Inventory – II (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), and the Thematic Apperception Test (TAT; Murray, 1943). The assessment was a mixture of self-report measures, interviews, and performance measures. Through the information obtained from all of these tasks, David and Finn were able to
answer his assessment questions. His concentration and relationship problems were probably a result from taking on more than he should have as a child. He had been experiencing difficulty concentrating because he had too many emotions that he had not dealt with until after the assessment. Gathering multiple pieces of information helped David come to new understandings about his problems and was necessary in order to provide the most effective treatment.

*History of Assessment Feedback*

Regardless of the positive or negative associations people have to psychological assessments, historically, many psychologists have approached feedback with a cautionary note of limiting the amount of information relayed to the client (Klopfer, Ainsworth, Klopfer, & Hold, 1954). In a survey study conducted in 1972 by Vane, 137 psychologists were asked a series of four questions regarding their feelings and use of reporting assessment results to clients. A majority of the psychologists surveyed did not provide a written report to clients, and some did not even give verbal feedback. However, it is important to note that this article is over 30 years old. Moreover, psychologists are not often trained to give test or assessment feedback (see Mihura & Wienle, 2002), and a limited number of studies assess the benefits of personality feedback (cf. Finn & Tonsager, 1992).

Brodsky (1972) proposed several reasons why psychologists might be hesitant to give their clients this feedback. One of the ideas was that clinicians know best. Keeping reasons for conducting psychological testing and results of the testing secret reinforces the notion that clinicians are the sole decision-makers in the determination of the client’s problems and treatment. Another assumption is that clients who have participated in
assessment are fragile. They cannot experience such distressing feedback. The results of
the assessment must remain secretive in order for the client to take part in a successful
psychological adjustment. Another assumption is that either the clinician is fragile. If a
client is allowed to view results and obtain feedback, clinicians would have to act
differently about them. Clients may react negatively toward the clinician if they knew
what the psychologist had written about them. A fourth “drawback” of giving clients
feedback is that some clients are seen as manipulative. Whatever information is presented
to the client, they will use it to their advantage, which could be maladaptive. These
assumptions have not been empirically supported. In fact, many references about
assessments that were written at the time of this article ignore the feedback portion of the
process (Berg, 1985).

Other reasons that clients do not receive feedback from psychological assessment
include the idea that clients are submissive (Berg, 1985). They do not care about the
results. They submit to the expert, so they really have no need to discuss the results. The
understanding is that the client really does not have the capacity to understand the
material that is presented and therefore, would not be able to learn any new information.
This leads to the psychologist trying to “convince” the client about the results. Further, as
mentioned earlier, third parties who are responsible for providing compensation do not
take into account feedback sessions, so the clinicians do not get reimbursed for their time
spent relaying the assessment findings to the clients (Eisman et al., 2000). Unfortunately,
this may lead to a lackadaisical attitude regarding providing feedback.

Some clinicians hold onto the idea that feedback is unimportant (Dana, 1985).
This careless idea of feedback can lead to “Barnum” statements. These declarations are
generic and could be applied to almost anyone’s life. Barnum statements are proclamations that are universally true (Furnham & Schofield, 1987). Basically, information received by clients in this instance is somewhat deceptive because it is so generic.

Historically, views of psychological assessment feedback over the last 30 years have largely been negative. The overall scrutiny of assessment feedback seemed to view it as unnecessary because clients are uninterested, too fragile to take in the information, or will not understand the information anyway. Fortunately, these views are beginning to change.

Changing Attitudes of Feedback

An opposing view of feedback is that it can be quite beneficial for clients (Finn & Tonsager, 1992; 1997; Newman & Greenway, 1997). Psychological assessment feedback can actually instill hope, reduce symptomatic distress, and positively affect the course of treatment for clients and their families. For instance, Finn and Tonsager (1992) conducted a study of 61 students who were waiting for treatment at a university counseling center. Students were administered the MMPI-2, the Self-Esteem Questionnaire (Cheek & Buss, 1981), and the Symptom Check List – 90 – Revised (SCL-90-R; Derogatis, 1983).

Twenty-nine of these students only received attention from the examiner, while the others received attention according to a collaborative assessment model by Finn (1990), which includes feedback to the client. Groups of participants in this study did not vary on age, sex, days between contact with the examiner, and initial levels of distress. Results showed that participants who were given feedback showed more of a decrease in their global symptomatology at the two week follow-up than those that were in the attention-
only group \((r = .37, p < .01)\). Further, the assessment group showed more of an increase in self-esteem than did the attention-only group immediately after the testing \((r = .38, p < .01)\) and at the two-week follow-up \((r = .46, p < .001)\).

Newman and Greenway (1997) found similar results in their study. For this study, 60 students who were awaiting therapy at a university counseling center were randomly assigned to receive attention-only from the examiner \((n = 30)\) or to participate in the collaborative assessment model \((n = 30)\) as described in Finn and Tonsager (1992). All students were administered the MMPI-2, the Self-Liking/Self-Competency Scale (Tafarodi & Swann, 1995), the SCL-90-R, the Self-Consciousness Inventory (SCI; Fergstein, Scheier, & Buss, 1975), and the AQ-2. At Time 3, individuals in the collaborative assessment group reported significantly less symptomatic distress than the attention-only group \((r = .22, p < .01)\). For self-esteem, the two groups differed initially, with the experimental group displaying significantly lower levels of self-esteem \((r = .29, p < .05)\). By Time 3, the experimental group showed higher levels of self-esteem than the control group \((r = .14, p < .05)\). An analysis of covariance indicated that the increase in self-esteem of the experimental group was not necessarily affected by their pretreatment status.

Despite some of the previous hesitancy with providing clients with assessment results, recently, perspectives have been changing regarding ethical concerns for client rights and the belief that information given and received in the feedback sessions can be diagnostic and therapeutic (Berg, 1985). Some earlier views even regard assessment feedback as the examiner’s moral obligation (Brodsky, 1972; Craddick, 1972; Vane, 1972). The APA (2003) Ethical Guidelines section 9.10 also indicates this by saying:
“…psychologists take reasonable steps to ensure that explanations of the results are given to the individual or designated representatives unless the nature of the relationship precludes the provision of an explanation… and this fact has been clearly explained to the person being assessed in advance.” It is unethical not to provide assessment findings to the client. Further, when the results will not be presented to them, this has to be brought to their attention even before the beginning of the assessment.

Many clients, in fact, expect to receive feedback about the rigorous testing they had just completed (Butcher, 1992). To assess clients’ perspectives of assessments, Finn, Schroeder, and Tonsager (unpublished manuscript, 1994) modified the Assessment Questionnaire (AQ) that two of these authors (Finn & Tonsager) developed for an earlier study (1992). The AQ-2 was developed by utilizing questions from (a) the initial version of the AQ, (b) client’s written responses from outpatient assessments conducted by these two authors over the years, (c) Finn and Butcher’s (1991) observations regarding the effects of psychological assessment on individuals, and (d) items that were submitted by colleagues who perform assessments in practice. One hundred twenty-three college introductory psychology students were administered the Multidimensional Personality Questionnaire (MPQ; Tellegen, 1995) and the Marlowe-Crowne Social Desirability Index (Crowne & Marlowe, 1961). Later in the semester, the students were given verbal feedback about their MPQ scores. After receiving the feedback, the students were asked to complete several questionnaires, which included the AQ. For the AQ, they were asked to rate each of the items on a Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree).
The participants’ ratings on the 56-item AQ were correlated and then subjected to a principal components analysis. Eventually, four factors were found to account for 64% of the variance. Item-factor loadings, then, were considered when forming the AQ-2 subscales. Finn et al. (in press) assigned items to subscales if the loading on that factor was .35 or higher and at least .10 or higher than its loading on other factors. The subscales for the AQ-2 were as follows: New Self-awareness, Positive Mirroring, Positive Relationship, and Negative Feelings. Three subscales—Hope, Isolation, and Motivation—that were in the original AQ did not emerge as factors in the AQ-2. One factor, however, accounted for 70% of the variance. It loaded above .35 on all of the subscales—.46 on New Self-Awareness, .73 on Positive Mirroring, .71 on Positive Relationships, and -.44 on Negative Feelings. Finn and colleagues suggested that this higher order factor represents individuals’ overall positive vs. negative evaluation of their assessment experience.

Finn et al. (unpublished manuscript, 1994) then conducted another study with the AQ-2 in order to assess its reliability. Three different samples were used: low self-esteem college students (N=73), an inpatient sample (N=35), and an outpatient sample (N=41). The entire sample had participated in a psychological assessment—the undergraduates took the MPQ, and the inpatients, in addition to the psychological assessments that were part of their treatment, were given the AQ-2. The results of this study showed that among each sample (college student low self-esteem, inpatient, and outpatient), the four subscales demonstrated good internal consistency (New Self-Awareness: .84, .93, and .90, respectively; Positive Mirroring: .88, .88, and .89; Positive Relationship: .90, .89, and .90; Negative Feelings: .92, .79, and .88). Two-week test re-test correlations that
were computed among the college student sample showed good reliability coefficients (.78, .75, .84, and .81, respectively). The results of the two studies show that reactions to assessment fall on a multidimensional scale. Some may feel positively about the assessment because they gained new information (New Self-Awareness). Others may have benefited because attributes that they had already suspected about themselves were reflected back to them by the assessor (Positive Mirroring). Clients may have appreciated the assessment because they felt liked by the examiner (Positive Relationship). On the other hand, clients may feel negatively about the assessment because it did not have any of the aforementioned elements or they felt judged (Negative Feelings). The different reactions of the clients are correlated, suggesting that individuals form a global impression of an assessment experience. The positive experiences factor of the first study in the development of the AQ-2 suggests that impressions of assessment are largely based on obtaining positive and accurate feedback from the assessor, who respects and likes them. This also supports Finn and Tonsager's (1992) findings that clients’ positive experiences are dependent on the empathy and positive regard of the examiner. Not only is feedback crucial, so is the quality of the interaction between assessor and assessee.

*Rapport and Therapeutic Alliance in Assessment*

Based on Finn et al.’s (in press) findings, it is not surprising that rapport and alliance are important in a psychological assessment situation. These are not new concepts for psychotherapy (Greenson, 1965). The client-therapist relationship ideally is a full and equal partnership between the therapist and the client, each with their own roles (Clair & Pendergast, 1994; Greenson, 1965). The alliance begins when the client is committed to overcoming the illness and/or symptoms. For assessment, as demonstrated
by Finn et al., rapport and alliance are important aspects when determining a client’s positive experience with assessment. A method of assessment that will allow the clinician and the client to obtain a strong, collaborative working alliance has been called "therapeutic assessment" (Finn, 1996b; Finn & Tonsager, 1997)

Therapeutic Assessment

Therapeutic assessment is a collaborative method of assessment that contrasts from the medical model (Dana, 1985). It is a “semi-structured form of collaborative psychological assessment” (Finn & Tonsager, 2002). In other words, the process relies on the relationship of the assessor and the client to systematically answer the referral questions, which are also collaboratively developed. Clients are not submissive to the examiner, but rather, co-evaluators of sorts (Fischer, 1970). This method of assessment is characterized by clients’ seemingly having life-changing experiences as a result of psychological assessment. Clients who are an integral part of the psychological assessment have more profound experiences than those who are not.

Collaborative Assessment

The idea of a therapeutic assessment was predated by Fischer’s (1970) collaborative idea of assessment. The goals of therapeutic assessment are derived from collaborative assessment: to understand the individual client. For collaborative assessment, life events are the crucial components, with the test scores, categories, and research as secondary. Clients are viewed as collaborators. The intent is that both parties involved (i.e., therapist and client) will be able to alter their developing notions about the client’s distress. The assessor also contextualizes the client’s need for an assessment. That is, the information should be relevant to the client’s everyday life. The assessor will
contact the referring party or ask the client about specific examples that led to the referral. If the client was not self-referred, the assessor needs to ask if the client understands why he is going to partake in an assessment. As the client and the assessor work together, the assessor uses the client’s words and phrases so the client can deepen their experience in their own way. Fischer’s collaborative assessment encourages interventions within the assessment (Fischer, 2000). Fischer recommends that the assessor interrupt standardized testing during natural breaks for these interventions, such as the end of a subtest.

For example, Fischer (2000) was conducting an assessment with Ms. Seale, who wanted to know why she was slower than her co-workers at learning new procedures. Ms. Seale's behaviors during Digit Symbol Coding from the Wechsler Adult Intelligence Scale – Revised and the Bender-Gestalt indicated that she waited for others to take initiative. That is, she waited for others to give her instructions rather than asking for clarification or just spontaneously trying things out herself. Fischer and Ms. Seale also noticed that she was slower to act in unfamiliar circumstances. Fischer then asked Ms. Seale if there were times when she did not hesitate to act. Ms. Seale mentioned when she “roughhoused” with her nephews, argued with her sister, or arranged the display of the candy bars in the movie theater where she worked. They then devised a plan for Ms. Seale to practice asking questions in the assessment sessions as well as in her everyday life. These types of interventions not only allow for further understanding of the client’s responses, but also allow the assessor to encourage the client to explore alternatives. Collaborative assessment helped instigate the development toward a more therapeutic approach to assessment.
Collaborative Assessment versus Information Gathering

While collaborative or therapeutic assessment and information-gathering (IG) both target answering a referral question, the two approaches are very different. IG is used to collect data that will aid in the communication and decision-making about clients (Finn & Tonsager, 1997). The information, however, is meant for communication among professionals, not for the exchange of ideas among the client and the examiner. Data collection for the IG model involves a three-step process: collecting the data, deducing what it means according to the assessor, and providing recommendations to the client’s therapist or referring agency. The assessment instruments themselves in the IG model are used mainly to provide the examiner with standardized test results that can be compared to the “norm” or certain clinical populations.

Further, the impersonal nature of the interaction may give the client a negative view of the assessor (Schafer, 1954). In IG, the interviewers are considered objective observers that have little influence on how the data is collected. They are detached from the clients, and their main goal is to finish collecting the information from the tests (Finn & Tonsager, 1997). This may lead the client to think of the therapist as a voyeur, an autocrat, an oracle, or a saint (Schafer, 1954). In some respect, the assessor is “peeping” into the life and mind of the client without the option for a relationship. On top of this, the assessor is dominant when administering a test, telling the client what to do and when and how to do it. The view of the oracle comes from drawing conclusions and “seeing into” the messages given by the client. Finally, the assessor can also be viewed as “saintly” because the assessor’s role is to help the client. The overall IG method is a failure if this process leads to inaccurate information or faulty recommendations (Finn &
Tonsager, 1997). Overall, the IG method is not meant to be an intervention, per se, but rather the means to guide the intervention, or therapy.

On the other hand, the therapeutic method of assessment is meant to be an intervention (Finn, 1996b; Finn & Tonsager, 1992; 1997). The client should come away from the assessment with a new self-understanding and a new way of being. The process, then, of therapeutic assessment is first and foremost to develop an alliance with the client. The alliance is an important way to reduce the anxieties associated with a psychological assessment. Alliance also helps with the client’s attending to goal formulation and sharing information throughout the assessment process (Finn, 1996b; Finn & Tonsager, 1997; 2002). The individual tests help the therapist understand the client and are sometimes referred to as “empathy magnifiers.” They are used as an opportunity for the clients to discuss their experiences and the reasons behind their responses to the questions. In therapeutic assessment, the test results are not considered the absolute objective truth about clients. They are used to help the clinicians understand where the clients are coming from. All points of view are taken into account. In other words, the referral question, the client’s goals, the test data, the clinician’s own thoughts about the testing material, and the client’s thoughts about the material are all taken into account when interpreting the results (Fischer, 2001). In this way, the clinician and the client both gain a more profound understanding of the client’s personality.

The collaborative nature of the assessment allows the assessor to be viewed as an expert, demonstrating expert guidance and genuine caring, rather than a voyeur or an oracle. The assessor respects the client’s way of living and tries to understand it. Likewise, the clients are seen as collaborators and their responses are viewed in the
context of their questions in order to help them with understanding themselves better. A negative experience for the client is considered a failure in therapeutic assessment. Other failures include clients not learning anything new from the assessment or not experiencing a change brought about by a new understanding. This is in contrast to the IG method, for which a failure would be to obtain inaccurate information or to make erroneous recommendations.

The therapeutic method of assessment allows the assessor to share personal experiences and reactions regarding the assessment process with the client, thereby enhancing the therapeutic alliance. Assessors are not simply observers. If the clinician’s experiences might benefit the client, then they should be shared. Finn and Tonsager (2002) relayed that when they share their personal contexts with the clients, the clients have often commented that these instances were helpful points of clarification for them. For instance, in Finn and Tonsager (2002), Finn identifies an interaction with a client with whom he shared his own personal experience and his experience with the assessment:

**Finn:** So from what we’ve discussed so far, do you see any way to get more comfortable confronting other people?

**Client:** I guess I just need to learn that I won’t die if other people are mad at me.

**Finn:** Great idea! I remember starting with store clerks and people like that when I was working on this same issue.

**Client:** Oh, did you have problems with this same thing?
Finn: Oh, yes. I used to do all kinds of things to keep people from getting mad at me. You should have seen me!

Client: And now it’s better?

Finn: Yes, I’m not so scared of confrontation anymore.

Client: That makes me feel better—like there’s hope for me too.

Finn: I’m having a similar reaction—that both of us are getting better at this anger stuff, and its (sic) going to make our lives a whole lot better. (Finn & Tonsager, 2002, p. 17)

Finally, in therapeutic assessment, the assessor should believe that the assessment could engender a positive change in the client (Finn & Tonsager, 2002). The assessment is meant to show empathy to the clients, reduce their shame, and to aid them in changing their ways of being that might not have been previously successful. If clients believe that the clinicians trust that they will change, it could boost this belief in themselves. Finn and Tonsager give an example of a woman who had participated in a therapeutic assessment. She wrote: “If you thought I could change, maybe I could if I just started paying attention to my assumpshuns (sic). Now I know there are different ways to see things and its (sic) already starting to work.”

"Therapeutic Assessment" (Uppercase) versus "therapeutic assessment" (lowercase)

So far, the term therapeutic assessment has been used to describe a type of intervention and a collaborative method of assessment. There is, however, a distinction between therapeutic assessment and Therapeutic Assessment (TA) when it is capitalized. Therapeutic assessment (lowercase) is a more general term that describes assessments that are collaborative and ultimately advantageous in the treatment of clients. TA is a
method designed and used by Stephen Finn (1996b; 2003), that has specific components and is learned by attending training workshops conducted by Finn. TA was developed at the Center for Therapeutic Assessment in Austin, Texas, and is a semi-structured way to conduct collaborative assessments.

The procedure for TA is more systematic than in therapeutic assessment. In TA, the steps are as follows: the initial phone contact, an initial session, initial testing sessions, assessment intervention sessions, summary and discussion (not feedback), written report and follow-up questionnaire sent in the mail, and possibly a follow-up session (Finn, 1996b; 2003). The first published complete case study of TA was the aforementioned case of David (Finn, 2003). For the first step, phone contact, Finn briefly familiarized David with what they would be doing and then asked him to think about questions he would like answered. In the first session, Finn and David formed three assessment questions, In this particular case, the questions were regarding the ADD diagnosis, difficulty breaking up with girlfriends, and difficulty being alone. Finn also contacted other professionals (with David’s permission) who may have relevant information regarding David’s case (e.g., his therapist, his psychiatrist). The next step in TA is the testing. David was first administered the Attention Deficit Scale for Adults (Trio & Murphy, 1996) because it seemed most applicable to David’s main question. Finn and David examined the results in the same session. Finn also interviewed David about symptoms of bipolar disorder, inquired about drug and alcohol use, and administered the Dissociative Experiences Scale (Bernstein & Putnam, 1986) and the MMPI-2.
In the next session, David was asked about his experience with the MMPI-2. He was also administered the Rorschach, for which Finn and David went through each card after the administration to determine rationale behind some answers. After Finn had gathered and scored all of the assessment tests, he met with David for an assessment intervention session. Here, Finn and David could explore some of the working hypotheses based on David’s scores on the tests. The final meeting between David and Finn was the summary and discussion session. Finn changed the name of this session from feedback to summary and discussion because the former implies a one-dimensional flow of power. Both David and his therapist were very grateful for the help they received. Through the assessment, they were able to see that David’s difficulty with concentration and in relationships stems from his not being able to rely on others for help when he was growing up. Instead of having a healthy support, he learned to hold all of his emotions in, which would later leave him flooded with anxiety and distress that was unable to be released. Rather than simply describing an assessment as a therapeutic intervention, TA provides a systematic approach to answer specific questions about a client. However, both in TA and therapeutic assessment lowercase, the goal is to increase the client’s understanding of his or her character and problems. The main difference is the process by which this happens; TA is more structured than therapeutic assessment.

The General Process of a Therapeutic Assessment (lowercase)

The initial phase of the therapeutic assessment is for obtaining questions about the clients that they would like answered about themselves. The assessor needs to gather a history of the client and the referral questions, which includes previous testing data (Clair & Pendergast, 1994). It is important to note the focus of the referring therapist and reason
that the client, the therapist, or the referring agency is asking for an assessment. All this information helps determine how subsequent information that will be gathered from the assessment fits in the client’s life and self-perception. Though the questions are asked at the beginning, as the client and the assessor begin their journey in learning more about the client, the questions may change somewhat.

Understanding what the clients want to get out of the assessment also helps out with giving feedback. Accounts of clinical experiences indicate that clients are more open to receiving dissonant information when the information presented first is confirming or affirming based on levels (Berg, 1985; Finn, 1996b). Level 1 information is information that verifies the client’s thinking and will easily be accepted. Level 2 information includes information that will modify the client’s usual way of thinking but that will appear non-threatening. Finally, Level 3 information can be potentially threatening to the views that the client holds already and will likely have difficulty accepting. Careful management and placement of these different levels of information can affect the client’s experience with the assessment as well as the client’s willingness to accept or reject the information being presented.

The nature of therapeutic assessment and the administration of the tests also determines the client’s willingness to take in the information regarding the assessment (Berg, 1985; Blatt, 1975). The person who utilizes this intervention in practice does not necessarily need extensive clinical training, but does need training in the systematic procedure of therapeutic assessment (Finn, 1996a; 1996b). This is evident in the following case of Ms. C. How the information was tailored to her assessment question, her underlying personality features, Finn’s knowledge of the test and the way he used it
to relay Ms. C’s assessment results. This is only attainable through specialized training. Further, the assessor should be able to communicate the results to the client in a manner where he or she can understand it; sometimes this means preparing a separate summary for the client (Finn, 1996b; Fischer, 2000). Skill in both the administration of the assessment as well as in relaying the results is critical for the level of acceptance the client has for the feedback information.

As mentioned, both the qualifications of the examiner as well as how the resulting information is conveyed to the client are extremely important. For example, Finn (1996b) discussed the case of Ms. C, who was referred by her probation officer to participate in an MMPI-2 assessment. Her assessment questions were regarding problems that result from alcohol, her posed danger to society, and her degree of manipulation of others. Ms. C.’s results indicated that she answered the test in a forthright and consistent manner (VRIN = 7; TRIN = 9). She also was not defensive or overly unguarded; however, she did admit to common shortcomings (L: T = 52; F: T = 65; K: T = 54). Based on her code types (4-8, 4-3, and 4-6), some working hypotheses could be drawn regarding her assessment questions. Finn used the results of this assessment as well as Ms. C’s assessment questions to tailor the feedback session. Her MMPI-2 results indicate that she might not be apt to take responsibility for her actions. Finn also was aware of the questions that she derived. Based on these two things, Finn can determine Level 1 information, Level 2 information, and Level 3 information (findings that are discrepant from what the client already knows and are likely to be rejected). Finn suggests that Level 1 information be presented first. In the case of Ms. C, understanding that she had much conscious internal
anger allowed Finn to relay the test results in an empathic manner, thereby, reducing her
defensiveness as he moves from Level 1 to Level 2 to Level 3 information.

For Ms. C, Finn began with answering her question if alcohol would increase her
chances of problems with her parole. Given her 4-8 code type for Ms. C’s MMPI-2, Finn
was able to infer that drinking alcohol may cause problems as it might increase her anger
and increase behavior that would lead to legal problems. Because of her self-reported
anger problems on the MMPI-2, Finn relayed that Ms. C is a potential danger to society if
she engages in activities that are dangerous to herself or to society. Her code type also
indicated that she has an exaggerated need for attention and affection, but she may be
hesitant to ask for help, so she becomes manipulative. She is suspicious, passive-
aggressive, and sensitive to rejection in relationships, which could hinder a romantic
bond with men—another one of her questions. So, for Ms. C, Level 1 information was
regarding her anger and distrust in relationships and her tendency to act out. This was
information that she is already aware of. Level 2 information was indicative of the
amount of anger inside and its purpose of guarding against getting hurt. Examples of
Level 3 information were her underlying dependency and sensitivity to rejection.

Client as Co-Evaluator

A common thread in each of the collaborative and therapeutic assessment
element is the role of the client as the co-evaluator (Berg, 1985; Fischer, 1970). The
theme is co-advisement: the evaluator explains their own understanding of the goals of
the assessment while also inviting the client to explain their own understanding, for the
client is the best person to confirm or disconfirm the information provided by the
assessment (Clair & Pendergast, 1994; Finn, 1996b). For this reason, it is pertinent that
the assessor continually check-in with the client throughout the assessment to make sure the different steps involved make sense. It is also important that the client know the reason for the referral and what is to be gained from participating in an assessment.

If the client was not the main referral source, it is important to also include all parties involved in the co-evaluator role (Engelman & Frankel, 2002). Discussion of the technique and the different tests is very crucial in order for the intervention to be therapeutic rather than simply diagnostic. Clients and other collaborators who are actively engaged in the treatment process or clients who have potential for movement with treatment will likely benefit most with therapeutic assessment (Fischer, 2000). An actively involved client helps the therapist gain deeper empathy for them, which, in turn, positively affects the testing situation (Finn & Tonsager, 1997; 2002).

Additionally, the client is still a collaborator when it comes time to give them feedback. For this reason, the assessor should speak in the client’s language when presenting the results (Berg, 1985; Finn, 1996b; 2003; Fischer, 1970; 2000). For example, In the case of David (Finn, 2003), as mentioned earlier, rather than tell him that he had no Texture score, his COP score was only 1, his Isolation Index was high at .40, and his Pure H was only one on the Rorschach, Finn rephrased this information. He relayed to David that it appeared that he had never used others as support people to help him manage difficult emotions. Finn used an analogy of a saucer (emotional support) underneath an espresso cup (capacity to hold emotions) catching the overflow (emotions that are difficult to hold).
Feedback in Therapeutic Assessment

In therapeutic assessment, feedback does not necessarily only occur at the end of the assessment. Feedback that occurs along the way is referred to as “assessment intervention sessions” (Clair & Pendergast, 1994; Finn, 2003; Finn & Martin, 1997; Fischer, 1970). For instance, the assessor may choose to give a little feedback after the client completes a standardized test. Again, in the case of David (Finn, 2003), Finn noticed that David came in agitated about a fight he had with his girlfriend. Finn used the opportunity to give some number recall tasks to demonstrate how David became agitated and had difficulty concentrating when he was flooded with difficult emotions. For the initial recall task, David could only remember four digits forward and three backward. David, however, rated his agitation at a 10—the most agitated he has ever felt. After talking with Finn and being led in a relaxation task, David rated his agitation at a 5. They then did another digit recall task, and this time, David was able to remember seven digits forward and five backward. Finn and David then discussed how this type of inattention and lack of concentration might happen regularly when David becomes flustered. The assessment intervention sessions are times for the client and assessor to explore both of their working hypotheses and to collaboratively reach new understandings.

The end of the assessment feedback has a few purposes (Fischer, 1970). First, it is used to relay the information found by the assessment in “contextualized traits” or traits that directly relates to the client’s life (Fischer, 1970). The assessor reviews and checks the information obtained in the assessment with the client. From there, the client, the assessor, and all other parties involved can evaluate the options now that they have
answered the assessment questions (Fischer, 1970; 2000). After the options are weighed, the collaborators can now make more sound decisions about client care.

Assessment feedback is also important as an emotional contingency (Dana, 1985). This is the time that the results can reassure the client of their feelings or can allow the assessor to reassure the client. The assessor demonstrates empathy in the feedback, relaying the assessment results in a non-threatening manner given what they know about the client (Finn, 1996b). As mentioned earlier, this is the time where the examiner shares their own reactions at working with the client, shared experiences that they might have had with the client, support of the client, and instilling communication between the client and the client’s therapist by sharing the results (Dana, 1985; Finn & Tonsager, 2002; Fischer, 1970; 2000).

During the assessment feedback, the assessor transfers the power to the client (Dana, 1985; Fischer, 1970). The assessor is no longer the collaborating expert but gives the client the tools to take charge of his or her future. It is up to the client now to demonstrate healthy behaviors or to experience a personality change. It is important to check-in with the client to see if the information that he or she is receiving fits with what they know about themselves (Finn, 1996b). If it does not, then the client has the opportunity to either accept the possibility that it may be relevant, or to reject the idea. The client obtains ownership of the information and can apply it to their lives. In turn, this leads to self-efficacy.

Looking at feedback in this manner, then, provides the client with three things (Dana, 1985; Fischer, 1970). First, the client feels like a collaborator because they contribute to the assessment questions and the examiner looks to them to relay their
experiences. Second, the feedback allows the client to transform by interpreting the feedback into personal means. Finally, the client now owns the information and can help plan his or her own interventions.

After the assessor has summarized the important components of the assessment and the related findings in the feedback session, clients are more likely to leave with a renewed sense of self—a.k.a., self-esteem (Dana, 1985; Finn & Tonsager, 1992; Fischer, 1970). When the client plays an important role in the assessment procedure, this can lead to an increased sense of interpersonal growth. Whether information they already knew was confirmed or new information about them was presented, this process can result in an increased feeling of hope. At least they know what might be contributing to their distress and possibly some steps to alleviate their symptoms. This knowledge contributes to decreased symptomatology as well as client’s taking a more active role in treatment that they may already be involved in.

**Summary of Benefits of Therapeutic Assessment**

As we have seen, the different components of therapeutic assessment have their benefits. As would be expected then, the overall process also has advantages. Therapeutic assessment can be a source of interpersonal understanding for clients (Blatt, 1975; Finn & Tonsager, 1992). Given the relationship between the clinician and the client during the assessment and the information from some of the assessment instruments themselves, the client may be able to better understand how they deal with significant others in their life. For instance, one of the findings of Finn and Tonsager (1992) was that students had a positive experience of the assessment if they felt that the assessor liked them. It is helpful for the examiner to observe how the client acts in order to get a better understanding of
the client’s interpersonal strengths and weaknesses (Byers, 2002; Fischer, 1994). Overall, given what research has shown about therapeutic assessment, it seems that it should help the client satisfy their curiosity, alleviate their anxiety, contribute to their diagnosis, and fulfill ethical requirements (APA, 2003; Finn & Tonsager, 1997). Despite all of the benefits therapeutic assessment can offer, and although it is becoming more popular with workshops and symposia given by Finn, many people still use traditional methods of information-gathering. Further, in the published literature, populations that have been included in research projects have largely been undergraduates or case studies (Finn, 2003; Finn et al., in press; Finn & Tonsager, 1992). It would be beneficial to determine how other populations (e.g., seriously mentally ill clients) would respond to a therapeutic assessment.

**Therapeutic Assessment with Special Populations**

Little information regarding therapeutic assessment has been obtained from populations other than students who are seen in a counseling center setting and those who are presented as case studies. However, given these initial successes, and as therapeutic assessment is becoming more popular, some researchers have turned to other populations to assess its usefulness. All of the studies that look at special populations are unpublished (i.e., dissertations). Peters (2000) conducted Therapeutic Assessment with 80 women who were diagnosed through college screenings with binge-eating disorder. She compared the TA model with an IG control group. Three of Peters' anticipated results were that, compared to the IG group, participants in the TA group would (a) show more significant improvements on measures aiming at eating pathology, (b) be more likely to follow-up with further treatment, and (c) be more ready to change their eating habits. The
dependent variable measures, to measure progress from the assessment, were the Positive Mirroring subscale on the AQ-2 to assess self-verification, the Self-Liking/Self-Competency scale (SLSC; Tafarodi & Swann, 1995) to measure self-efficacy and self-enhancement, the Beck Depression Inventory – II, the Brief Symptom Inventory (Derogatis, 1983), the Eating Disorders Inventory (Garner & Olmstead, 1983), the UCLA Loneliness Scale (Russell, 1996), and the Stages of Change Questionnaire (McConnaught, Prochaska, & Velicer, 1983).

They were then administered the MMPI-2, and the TA group was given feedback two weeks later. Participants completed the dependent measures two and then six weeks later. The main difference for the IG group is that at time 2, the TA group received feedback and the IG group met to discuss any concerns that may have arisen from the first meeting.

Both groups showed positive change in eating disorder symptoms and general psychopathology symptoms, but neither group had better outcomes than the other immediately ($F[2, 55] = 1.36, F[6, 51] = 1.54$, respectively, $p > .05$) or on the follow-up measures ($F[2, 55] = .74, F[6, 46] = .82$, respectively, $p > .05$). Among the measures of change, no significant differences were obtained between the two groups on Precontemplation ($r = .17, p > .05$), Contemplation ($r = .02, p > .05$), Action ($r = .24, p > .05$), and Maintenance ($r = .14, p > .05$). The TA group was slightly more inclined to seek treatment than the IG group ($r = .35, p = .07$). After the assessment, results showed that women in the TA group significantly felt more feelings of increased self-awareness ($r = .49, p < .001$) and positive mirroring ($r = .31, p < .05$) than the women in the IG group. Remarkably, women in the TA group felt more exposed, judged, and hurt by the
assessment as indicated by the Negative Feelings subscale than the women in the control group \((r = .36, p < .01)\). This information shows that while the two groups seemingly did not differ on symptom reduction, women in the TA group were more likely to seek more treatment after the assessment and felt more self-aware than those who did not participate in a TA. This study differs from Finn and Tonsager (1992) because the participants were not at the beginning of or in any kind of treatment. It is possible that not having an outlet for discussion of the problems that came up was difficult for them. But importantly, results may have been affected by the fact that the study author did not control for the duration of the eating disorder, which was much longer in the TA group.

In a different study, Katrichak (2004) assessed if an individualized, collaborative assessment would help 350 individuals who were on welfare adhere to their service plan, make vocational progress, and to avoid sanctions for non-compliance. All participants were in the SonomaWORKS program, which was a program for all individuals seeking welfare in the county of Sonoma in the state of Washington to be offered assessments for learning disabilities. In this study, participants either participated in the typical learning disability assessment or a collaborative assessment. Those who had participated in a collaborative assessment had significantly lower sanctions than those who had not completed an individualized assessment \((r = .15, p < .01)\). Participants were also rated by an Employment and Training counselor regarding the progress they had made in their vocation. Participants who had completed a collaborative assessment were rated significantly higher than those who had not \((F[2, 126] = 15.27, p < .0001)\). Participants did not differ in the ratings that they gave to the assessment itself, as measured by the AQ-2. Though both groups rated the assessment experience equally high, participants in
the collaborative assessment demonstrated greater vocational progress and a lower amount of sanctions.

Kirby (2004) recruited individuals who had substance abuse problems to assess the benefits of discussing assessment results with patients. The participants were 72 adult individuals who were participating in a 21-day inpatient drug and alcohol dependence program. Participants were randomly assigned to one of three groups: an experimental (immediate feedback) group, a therapy control group, and a non-collaborative control group. All participants received the Personality Assessment Inventory (PAI). The dependent measures were the Symptom Checklist-90-Revised (SCL-90-R) and the Self-Liking/Self-Competence Scale (SLCS), which were given at three separate occasions. Participants in the first two groups (the immediate feedback and the therapy control groups) received an interview patterned after Finn’s (1996a) guidelines for establishing a collaborative environment. They were asked about information that they would like to learn from the PAI. The first meeting for the individuals in the non-collaborative control group consisted only of explaining the measures; there was no collaboration between the examiner and participant. At time two for the immediate feedback group, participants engaged in a summary and discussion of the PAI results and were encouraged to confirm or disconfirm the findings. They were then administered the dependent measures. Individuals in the therapy control group received a therapy session and took the outcome measures at the end of the session but did not receive feedback. Individuals who were in the control group simply met with the examiner to take the outcome measures. For the third meeting, participants in the experimental group were given the final administration of the outcome measures. The third session for the therapy and non-collaborative control
groups consisted of completion of the outcome measures and then a discussion of the PAI findings.

To assess group differences in initial symptomatology, Kirby (2004) conducted a one-way ANOVA using the Global Severity Index (GSI) from the SCL-90-R. Results of the analysis showed no significant group differences in symptom distress at Time 1 ($F[2, 69] = .358, p = .70$). Similarly, there were no significant group differences in self-esteem at Time 1 ($F[2, 69] = 1.64, p = .201$).

Using repeated measures ANOVAs, the authors compared the groups on both the GSI and SLCS scores. The analyses indicated that for the GSI, there was a significant main effect of Time ($F[2, 138] = 69.53, p < .001$) as well as a significant Group x Time interaction ($F[4, 138] = 7.4, p < .001$). GSI decreased and self-esteem demonstrated a significant main effect of Time ($F[2, 138] = 21.42; p < .001$). Similarly, for the SCLS, the Group x Time interaction approached marginal significance ($F[4, 138] = 2.34; p = .058$). In contrast to the GSI scores, the self-esteem scores showed a main effect of Group ($F[2, 69] = 5.81, p = .005$). However, this could primarily be due to the fact that both the immediate feedback and therapy control groups showed increased self-esteem while individuals in the non-collaborative control group did not. The participants gave permission for the author to contact the rehabilitation program in order to track those participants who continued their treatment in an aftercare program. They found that more individuals who were assigned to the immediate feedback group followed up (14 did, 10 did not). For the therapy control, 12 individuals participated in the continuing care, 12 did not. Finally, for the control group, only 9 people followed up for after care, while 15 people did not. Kirby’s (2004) study demonstrated that individuals in a drug and alcohol
treatment program can benefit from collaborative assessment that involves immediate feedback. Not only are the benefits in decreased symptomatology and increased self-esteem, but also in the likelihood to continue their recovery.

Houser (2006) conducted a study regarding therapeutic assessment and seriously mentally ill (SMI) clients. Houser postulated that SMI clients who were to partake in a therapeutic assessment would have reduced symptoms of depression, as measured by the BDI-II, have lower scores on the Behavior and Symptom Identification Scale (BASIS-32), and obtain a lower GAF by their sixth session of treatment than participants who did not participate in a therapeutic assessment. The therapeutic assessment was designed around Finn’s (1996b) model. One hundred SMI clients were recruited from an area community mental health center (CMHC).

Participants were first administered the BDI-II and the BASIS-32. Participants were randomly assigned to be in either the therapeutic assessment group (Group 1) or the nontherapeutic assessment group (Group 2). Participants who were in Group 1 received their scores from the BDI-II and the BASIS-32 as well as their GAF according to the therapist’s clinical assessment of their current GAF. The study procedures also called for the results from these measures to assist the therapist and the client in determining treatment goals, and for the therapists to have a collaborative discussion with the participants throughout this process. The participants in Group 2 did not receive a summary and discussion about the BDI-II and the BASIS-32. Their therapists also did not receive information about their scores. Treatment goals were still developed for this condition, however.
Results of this study showed found no significant difference between Group 1 and Group 2 on the BDI-II, the BASIS-32, or GAF ($r = .12, p = .252; r = 11, p < .281; r = .13, p < .202$, respectively). However, all three of these scores decreased for both groups ($r = .48, p < .0005, r = .40, p < .0005; r = .62, p < .0005$, respectively) over time. In other words, the group that the individuals were in did not seem to make a difference in their scores as all groups showed a favorable outcome. For all the groups, the scores increased due simply to the time between the pretest and the posttests. In other words, the study did not support the hypotheses that those who participated in a therapeutic assessment would have a greater reduction in symptoms than those who did not go through a therapeutic assessment process. However, a possible explanation for the seemingly lack of effect of the actual assessment process may be due to the skepticism that the author noted at the participating CMHC. The researcher noticed the resistance in the beginning of the study and then afterward in chart notes and audits. Thus, some possible reasons for the ineffectiveness of the treatment is that the sharing of the treatment information might not have been credible, the therapists’ expectancy of changes in clients was minimal, and the therapists did not have confidence in the involvement of the participant in the study. It is also not clear that the therapists engaged in the necessary components of therapeutic assessment either--the therapists were only given one training session on therapeutic assessment to begin with. Further research in therapeutic assessment with SMI clients might indicate that therapeutic assessment with this population would be beneficial given the right attitude and circumstances. Previous studies with SMI clients have indicated that clients do benefit from collaborative treatment (Carey et al., 2001; Husted & Ender, 2001).
SMI Clients and Collaboration in Assessment

Someone diagnosed with an SMI is considered to have a diagnosis of a non-organic psychosis, engaged in treatment for two or more years, and dysfunction as measured by the GAF (APA, 1994) that is below 70 (Ruggeri, Leese, Thornicroft, Bisoffi, & Tansella, 2000). Though Houser (2006) did not see a decrease in symptoms among SMI clients due to the type of assessment they participated in, other research has shown that SMI clients do benefit from collaborative treatment, especially when some form of social support is included.

Husted and Ender (2001) conducted a study of 32 SMI clients to determine what these individuals deemed crucial in their recovery. Participants were divided into two groups: those who were hospitalized within the last two years \( n = 16 \) and those who had stayed in the community for a longer time \( n = 18 \). Participants were given a 38-item questionnaire that assessed aspects in the clients’ lives that are important for positive adjustments. The six highest-ranked items were friends, using the community support worker to solve problems, taking medications, having fun with people important to me, having a community support worker in general, and where I live in my community. The items that were least frequently endorsed were having more roles in leadership, having a spouse or significant other, using my community support worker to budget money, having more work opportunities, having community activities, and my pastor. Four of the six that were highly rated included the presence and helpfulness of another person. The individuals who had not had a relapse for some time endorsed the highly rated items more often than the group who had relapsed within the past two years \( t_5 = 5.75, p > \)
It seems that the most important factor for positive adjustment in coping behavior is the development of non-formal, social relationships.

Carey et al. (2001) conducted a study to determine the experiences of SMI clients who were involved in a clinical assessment. Forty-five clients were asked to attend four assessment sessions, which occurred at an initial meeting, six weeks later, three months later, and six months later. The clients were assigned to one of three interventions: (1) an HIV-risk reduction assessment, (2) a substance-use reduction, or (3) a standard care control intervention. At the end of the six-month follow-up, participants were invited to take part in an “exit interview.” At this time, they were asked about their experiences in the sessions. These interviews were coded as five different categories: Recruitment and Retention, Individual Assessments, Group Intervention Sessions, Confidentiality, and Behavioral Change. All of these categories were then amalgamated into one overall perception of the intervention. A majority of the participants indicated that they initially took part in the study for the monetary reward. However, other participants took part because they wanted something positive in their lives. Part of the study was to take part in four individualized assessment sessions. Participants appreciated being able to be in a one-on-one situation. One woman indicated that it was “therapeutic” to be able to do the individual assessments. Participants who had attended group interventions stated that they indeed had positive experiences. The main positive experience for groups was the social support that other members gave. One participant noted that being in groups “makes you feel like you aren’t alone.” As for confidentiality, participants in the study seemed to really appreciate that they were reminded that whatever they say in group will stay in group. This also allowed for trust in revealing information about themselves.
When group members were asked about changes that they anticipated making, many who were in the substance groups or sexual behaviors groups said that they were considering reducing their risky behaviors. The overall impressions were positive. Carey et al. (2001) quoted one woman who eloquently summarized her experience with the collaborative interventions: “There’s a lot of fun in this project. You got the chance to really know yourself. This program taught me how to be on time. My self-esteem got built. I dress(ed) sharp just to come here. I felt good about myself, I felt really good about myself, like I was part of something I was helping…me…and you do a project. That meant a lot to me.” These two studies demonstrate that individuals who have been diagnosed with a severe and persistent mental illness can benefit from a collaborative intervention and appreciate the experience. They also show that the interaction with others has helped increase their feelings of competency and decrease their loneliness.

However, studies have also shown that over-involvement of family members or social supports perpetuate the likelihood of continued symptoms of SMI clients, especially those who have been diagnosed with schizophrenia. Individuals who return to families of high expressed emotion (EE; Brown & Rutter, 1966), or the degree of the emotional response of a carer toward a person with a health problem, have a 50% increase of relapse over nine months than those who do not (Kuipers, 2006). EE has primarily been based on criticism, over-involvement, and hostility. Bertrando et al. (2006) conducted a study with families of people with a diagnosis of schizophrenia. EE was used to determine the usefulness of a family intervention, the Milan Approach (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1977), on reduction of symptoms for the client diagnosed with schizophrenia. Ten families were treated with the circular interview
as suggested by the Milan approach and eight families were not receiving treatment. All families were assessed using the Camberwell Family Interview, which was then rated by using expressed emotion scales (Leff & Vaughn, 1985). Ratings were made on five scales: Criticism, Positive Remarks, Hostility, Emotional Over-Involvement (EOI), and Warmth. The first two scales are scored by counting the number of comments made during the interview. Hostility and EOI are scored on 0 to 5 scales. Hostility is rated on a 0 to 3 scale. Any families’ scores that exceed threshold (6 for Criticism, the presence or absence of Hostility, and 4 for EOI) are considered high in EE. Fifteen out of the 18 families were described as having high EE.

Individuals and families who were in the treatment group were asked a series of questions emphasizing the relational aspects of all of the observed and verbal behaviors of the family members, including the client. There was not a significant difference on levels of EE for either group before the assessment. At the end of the experiment, those in the treatment group had lower levels of Criticism ($Z = -2.66, p = .007$) and higher levels of Warmth ($Z = 2.238, p = .02$). High EE families at baseline observed a 66.6% relapse rate; however, families that shifted from high to low EE had no relapses. Although the result was not statistically significant, the control group showed twice the rate of relapse as compared to the treatment group (62.5% vs. 30%). This study not only shows that high EE families can increase relapse rates in individuals with schizophrenia, but it also shows that interventions with the client and his or her family members can help reduce some aspects of EE, thereby reducing relapses.

Rosenfarb, Goldstein, Mintz, and Nuechterlein (1995) also examined EE in families that include an individual diagnosed with schizophrenia. They examined whether
individuals from high EE families ($N = 34$) and low EE families ($N = 14$) who had been recently discharged from the hospital differ in the level of symptomatology during an intervention task. Individuals from high-EE homes showed significantly more odd and disruptive behaviors with family members than individuals from low-EE families. When family members in a high-EE group were critical after a first unusual thought in the interaction, there was an 80% probably that the individual would produce another aberrant thought. After a mild criticism, the chance was only 56%, and only a 14% chance when high-EE families did not comment after the first unusual thought. For low-EE families, none of the families were critical after the first unusual thought, and only one participant had an unusual thought after the first one. In sum, individuals who encounter harsh criticism in a highly expressive family showed more symptomatology than those who were not. It seems clear that social support is a major factor in the recovery from their illness.

*Interpersonal Relatedness in Psychology*

The idea of focusing on interpersonal relatedness in psychology is not a new concept in clinical psychology. Inspired by the interpersonal theory of Harry Stack Sullivan (1953) and others, Leary (1957) proposed and applied a model entitled the Interpersonal Circumplex (IPC; see Figure 1) to a description of and a diagnostic tool for personality. The IPC is a model for personality that is based on two axes: Autonomy-Control for the vertical axis and Affiliation-Attack for the horizontal. The IPC is comprised of eight clusters.
Clusters 1 (Emancipate/Separate), 3 (Active Love/Reactive Love), 5 (Control/Submit), and 7 (Attack/Recoil) are the poles of the circumplex. Cluster 2 is labeled Affirm/Disclose, Cluster 4 is Protect/Trust, Cluster 6 is Blame/Sulk, and Cluster 8 is Ignore/Wall-Off. Clusters adjacent to each other are conceptually similar and positively correlated with each other. Clusters that are 90° apart are conceptually not related. Clusters that are 180° apart are conceptual opposites and are negatively correlated with each other. The SASB short form clusters are divided into four positive interpersonal behaviors with affiliation and autonomy (clusters 1, 2, 3, and 4), and four negative interpersonal behaviors with negative affiliation and control (clusters 5, 6, 7, and 8) (Schedin, 2005).
The principle of complimentarity also suggests that one’s interpersonal behaviors evoke certain classes of behavior from others, where correspondence occurs on the affiliation axis (e.g., friendliness evokes friendliness) and reciprocity on the interdependence or autonomy axis (e.g., dominance evokes submission). Leary’s model has served as the basis for many measures that are used in clinical practice. The Structural Analysis of Social Behavior (SASB; Benjamin, 1974; 1996) and the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureño, Villaseñor, 1988) are among two of these measures. This model also appears in a popular, multiscale personality test, the Personality Assessment Inventory (Morey, 1991).

The interpersonal measures are indeed fairly popular (particularly the SASB; Benjamin, 1974). For example, Wonderlich, Klein, and Council (1996) measured how parental relationships relate to self-concept in individuals who have bulimia. Sixty-seven women and their parents participated in this study. The authors utilized the SASB short form to assess participants’ perception of their relationships with their mothers and fathers as well as their own self-concepts. As compared to a control group, those who were diagnosed with bulimia indicated more self-attack when they feel at best about themselves ($r = .36, p < .01$) and when they feel the worst ($r = .34, p < .01$). The women who were diagnosed with bulimia also indicated that they felt like their mother withdrew from them ($r = .29, p < .01$), they withdrew from their mother ($r = .28, p < .01$), their father withdrew from them ($r = .25, p < .01$), and that they withdrew from their father ($r = .25, p < .01$). The SASB was proficient in distinguishing two groups, one with a psychological disorder, in how their symptoms related to relationships with social support people. In many other studies, the SASB has been used to understand interactions in
everyday life and in therapy (e.g., Alpher, Henry, & Strupp, 1990; Constantino, 2000; Henry, Schacht, & Strupp, 1990; Quintana & Meara, 1990; Schedin, 2005; Svartberg & Styles, 1992). The SASB is a good tool to use in order to measure individuals’ perceptions about their significant interpersonal relationships.

Statement of the Problem

A thorough method for formulating a helpful course of treatment can be to conduct an assessment. Likewise, the client and the referring agency have the right to know the outcomes of the assessment. Finn and Tonsager (1992) demonstrated that feedback is welcomed and beneficial for those who are participating in a psychological assessment. Butcher (1992) found that clients actually expect to receive some sort of feedback from the tasks that they have just undertaken. In fact, research using the AQ-2 indicates that people who partake in assessment seem to have a better experience when the feedback they receive is either supportive or positive, in that it confirms what they suspected or it gives them new ways to view themselves (Finn et al., unpublished manuscript, 1994; Finn & Tonsager, 1992). Another important factor of the assessment experience is the experience with the assessor, for which little information is available. Yet, even though assessments and the feedback from them can be so beneficial and crucial in a client’s therapeutic experience, traditional psychological assessment has been thought of as primarily information gathering for the clinician wherein there is no need to give feedback to the clients (Applebaum, 1990; Berg, 1985; Brodsky, 1972; Finn & Tonsager, 1992). Given previous research about collaborative assessment, the traditional view of assessment is not considered very therapeutic for the client.
An up-and-coming strategy for assessment is to include a therapeutic aspect to it. Finn (1996b) developed a model of Therapeutic Assessment (TA) that is a systematic way to conduct collaborative psychological assessments. TA was formulated to use at the Center for Therapeutic Assessment and provides specific steps in how to conduct an assessment that also constitutes a helpful therapeutic intervention. Fischer (1970; 1984) predated TA with a similar strategy in conducting collaborative assessments. Nowadays, assessments that use more collaborative and empathic approaches are referred to as therapeutic assessments.

In a therapeutic assessment, a client should feel like a co-evaluator and obtain a new sense of self. The therapeutic assessment is different from the typical information-gathering model in that it encourages the client to take a more active role in his or her assessment. Few studies have been conducted with regards to therapeutic assessment. Finn’s first documented case study of a complete TA was published in 2003. Studies that he and colleagues have conducted with undergraduate students seeking university counseling center services have been quite successful (Finn et al, in press; Finn & Tonsager, 1992; Newman & Greenway, 1997). Therapeutic assessment has been used with some special populations such as those who are receiving welfare support, women who have been diagnosed with an eating disorder, patients going through drug and alcohol rehabilitation, and individuals who have been diagnosed with a serious mental illness (SMI; Houser, 2006; Katrichak, 2004; Kirby, 2004; & Peters, 2000). Results of these studies were mixed; significant findings were presented in all studies. However, in Houser (2006) and Peters (2000), both the therapeutic assessment and control groups experienced significant changes—so both groups improved whereas they had
hypothesized only the therapeutic assessment group would improve. In the Katrichak (2004) and Kirby (2004) studies, the therapeutic assessment group demonstrated significant changes, while the control groups did not—although, in Kirby, a third group that included a traditional assessment plus therapy also showed significant changes. Furthermore, the significant differences between the groups were mainly for increasing self-esteem and self-awareness and not as much for symptom reduction, as was a hypothesis for two of the dissertations. Because the benefits of collaborative assessment in special populations have fallen upon mixed results, more research needs to be conducted in this area. The current study attempts to account for shortcomings in previous studies. For instance, the therapists in Houser’s study were not motivated and only received one session of training in therapeutic assessment. To determine the efficacy of therapeutic assessment with an SMI population, the current study tries to amend some of the inadequacies of the Houser study and adds a dimension that is crucial for recovery in an SMI population: interpersonal relationships. SMI clients deem that social support is crucial for recovery and may benefit from a therapeutic assessment that helps them figure out their interpersonal relationships.

Research Hypotheses

In the current study, the therapeutic assessment model was extended to individuals who have been diagnosed with an SMI. This population particularly benefits from healthy interpersonal interactions and relapse with unhealthy relationships (Bertrando et al., 2006; Carey et al., 2001; Husted & Ender, 2001; Rosenfarb et al., 1995). Therefore, in the current study, in the experimental condition adults diagnosed with an SMI formulated assessment questions about their interpersonal relationships,
took part in a therapeutic assessment, and received a summary and discussion regarding how they perceive others and themselves acting in their interpersonal relationships. In the control condition, adults diagnosed with an SMI received the same assessment battery. The instruments that were used as part of the therapeutic intervention were the Structural Analysis of Social Behavior medium form (SASB; Benjamin, 1974; 1996), the Brief Symptom Inventory (BSI; Derogatis, 1983), and the Picture Projection Test (PPT; Ritzler & Ben-Zvi, 2004). The outcome measures were the Rosenberg Self Esteem Scale (SES; Rosenberg, 1965), the Mental Health Recovery Measure (MHRM; Young & Bullock, 2003), and the Assessment Questionnaire – 2 (Finn et al., unpublished manuscript, 1994).

Below are hypotheses pertaining to the utility of therapeutic assessment versus traditional assessment in an SMI population.

Hypothesis 1

Participants who receive a therapeutic assessment will have a larger increase in their SES scores than those who receive a traditional assessment. In other words, they will have a greater amount of self-esteem after the assessment as compared to the traditional assessment group.

Hypothesis 2

Participants in this experimental group will also have a larger increase of their MHRM scores, or stronger gains toward their mental health recovery, than individuals who are receiving a traditional assessment from the examiner.
Exploratory Analysis

An exploratory analysis will be conducted to determine if clients in the experimental group change their attitudes about the assessment process at the end of the whole experience and also as compared the experience of the traditional assessment group.
Chapter 2

Method

Participants were required to be seriously mentally ill (SMI) individuals and were recruited from community organizations in a medium-sized Midwestern city in Ohio and from a Midwestern Veteran Affairs Medical Center (VAMC). Recruitment included fliers placed at the community organizations or the VAMC mental health clinics. The author also regularly visited VAMC skills groups in order to obtain and encourage participation. No limits were placed on gender or ethnicity for eligibility. Participants were required to be at least age 18 and able to read at a level where they can understand the measures. To assess this, participants were asked to read aloud and then answer the first two questions on the Structural Analysis of Social Behavior before they began the assessment. Participants also needed to be legally competent (i.e., without a guardian).

Outcome Measures

*Rosenberg Self-Esteem Scale* (SES; Appendix D). The SES (Rosenberg, 1965) is a 10-item self-report measure of global self-esteem. The SES is likely a unidimensional scale (Rosenberg, 1965). It shows good item consistency (.88). Test-retest correlation for the SES was .82. The SES has correlated with similar global self-esteem measures. It was shown to have a correlation coefficient of .88 with the Cheek and Buss (1981) Self-Esteem Questionnaire. It has also correlated significantly with the Self-Regard subscale (.78) of the Self-Rating scale (Fleming & Courtney, 1984). Each question on the SES is
on a four-point Likert scale ranging from strongly agree to strongly disagree. The total amount of time to complete the test is five minutes.

_The Mental Health Recovery Measure_ (MHRM; See Appendix C). The MHRM (Young & Bullock, 2003) is a 30-item self-report measure that aims to quantify the recovery experience of those who have been diagnosed with an SMI, such as major depression, bipolar disorder, and schizophrenia (Bullock, 2005; Bullock & Young, 2003). The expected amount of time to complete the MHRM is five minutes. The items are on a 5-point Likert rating scale ranging from “Strongly Disagree” to “Strongly Agree.” The first 24 items of the MHRM encompass six subscales (Overcoming Shyness, Self-Empowerment, Learning and Self-Redefinition, Basic Functioning, Overall Well-Being, and New Potentials). Questions 25 and 26 pertain to the role of an individual’s spirituality in recovery, and the last four questions pertain to advocacy and enrichment and target people who are further along in the recovery process. The conceptual model of the MHRM is based on the experiences of those with psychiatric difficulties.

Psychometric properties of the MHRM are impressive (Bullock, 2005). The MHRM’s total alpha is .93. Each subscale also demonstrates internal consistency, although it is a little low for some subscales. The following are the Cronbach’s alphas for each subscale: Overcoming Stuckness (.60), Self-Empowerment (.82), Learning and Self-Redefinition (.79), Basic Functioning (.62), Overall Well-Being (.86), New Potentials (.62), Advocacy/Enrichment (.66), and Spirituality (.89), though Spirituality is not established as a subscale (Bullock, 2005). Test-retest reliability is also high. For a one-week test-retest reliability, \( r = .92 \), and over a two-week interim, \( r = .91 \). The MHRM also shows good convergent validity with other scales of empowerment and recovery.
(Breedlove, 2005). The correlation coefficient of the relationship between the MHRM and the Empowerment Scale (Rogers, Chamberlin, Ellison, & Crean, 1997) is .70.

Assessment Questionnaire – Revised (AQ-2). The AQ-2 (Finn et al., unpublished manuscript, 1994) is a 48-item self-report measure comprised of four subscales: New self-awareness/understanding (13 items), Positive accurate mirroring (12 items), Positive relationship with assessor (12 items), and Negative feelings about the assessment (11 items). Finn et al. (in press) found the alpha consistency coefficients for each of the scales was .89, .87, .87, and .85, respectively. Items on the AQ-2 are rated on a 5-point Likert scale ranging from Strongly Disagree to Strongly Agree. This measure takes approximately five to ten minutes to complete.

The initial administration of the AQ-2 was slightly altered. Since the AQ-2 measures the respondent’s experience of the assessment, the altered version of the AQ-2 was reworded to include the word “I expect.” For example, the question “The assessment did not teach me anything new about myself” was reworded to say “I expect that the assessment will not teach me anything new about myself.” This allowed for a comparison between the participants’ assumption of the assessment experience and their actual experience to help determine attitude changes regarding psychological assessment. The Cronbach’s Alphas of the scales in the order mentioned above were .95, .82, .91, and .63 (Finn et al., unpublished manuscript, 1994).

Psychological Tests/Assessment Measures

Structural Analysis of Social Behavior (SASB) Intrex Questionnaire. The SASB Intrex questionnaires (Benjamin, 1993; 2000) are based on the SASB interpersonal model (Benjamin 1974; 1993). The medium-form questionnaire will be used, which consists of
160 items rated on increments of 10 on a scale of 0-100 as to the degree that the respondent agrees with the statement. The items are rated twice because the respondent is asked to rate the items at the best and worst times of the relationship. The questionnaires are designed to measure how a person views their behaviors in relation to a significant other (Self-to-Other; 32 items), how they view the others’ behaviors toward them (Other-to-Self; 32 items), and the respondent’s relationship with herself (Introject; 16 items). Participants in this study were asked to answer 128 of the 160 questions, leaving out the Introject questions. The SASB medium-form is expected to be completed in 20 to 25 minutes. The SASB questionnaire is also scored for both transitive and intransitive states. Transitive states gauge how the respondents view themselves as the agents of their own actions. In other words, how they act towards others rather than react towards others actions. An intransitive state, on the other hand, pertains to how an individual reacts towards others’ behaviors. The latter is a more immature interpretation of an individual’s behavior.

*The Picture Projection Test* (PPT). The PPT (Ritzler & Ben-Zvi, 2004) is a performance personality measure that is comprised of cards depicting ambiguous situations. It is similar to other card projective measures, such as the Thematic Apperception Test (TAT), which do not have normative scoring criteria but are used in clinical settings and research. It consists of black and white pictures of an ambiguous situation (usually involving people), from which a subset of cards is selected to administer to a client. In this study, two cards were used. Both cards depicted one male and one female interacting in some way. The participants told a story to both cards and relationship themes were used to initiate a discussion with the experimental group.
participants. The participants were asked to answer four questions about each card:

“What is happening in the picture,” “What led up to what is happening,” “What are the characters thinking and feeling,” and “What is the outcome of the scene?”

There is formal scoring for the PPT, and although there is no published reliability data, Ritzler (2008) has found support for PPT scales in relation to Rorschach data. Because the current student will not be using the scoring system, the specific findings of this study will not be reported. For example, as would be expected, PPT Distorted Form significantly negatively correlated with the Rorschach X+% ($r = -.40, p < .001$). Affect Modulation significantly correlated with WSumC ($r = .35, p < .001$). Emotional Tone significantly negatively correlated with both DEPI ($r = -.30, p < .01$) and V ($r = -.20, p < .05$). Affect Suppression negatively correlated with Lambda ($r = -.39, p < .001$). Loss significantly correlated with DEPI ($r = .35, p < .001$), C’ ($r = .19, p < .05$) and T ($r = .26, p < .01$). For the purpose of this study, thematic content regarding relationships was pulled from the two PPT cards that were administered to the participants. The completion time for responding to two PPT pictures is approximately 5 minutes.

The Brief Symptom Inventory (BSI). The BSI (Derogatis, 1983) is a 53-item self-report measure that was designed as a shorter alternative to the Symptom Checklist – 90 (Derogatis & Melisataros, 1983). The BSI gauges an array of psychological symptoms including somatization, obsessive-compulsiveness, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Items on the BSI are arranged on a 5-point Likert scale ranging from Not At All to Extremely. The BSI items are averaged to yield a score referred to as the General Severity Index (GSI). The BSI demonstrated 2-week retest reliability of .90 (Derogatis, 1993). A coefficient alpha
of .94 was reported for the GSI by Moradi and Subich (2004). The BSI anxiety and depression subscales show reasonable correlations with similar scales on the MMPI (.57 for anxiety and .72 for depression) (Bowen, Baetz, & D’Arcy, 2006). The BSI takes approximately 15 to 20 minutes to complete.

Procedure

Community and veteran outpatients were recruited through fliers placed at community mental health centers, area organizations that provide employment to SMI individuals, veteran mental health clinics, and facilities that advocate for SMI individuals. Participants were adults over the age of 18, and they were required to have an SMI diagnosis. Community participants were invited to come to the University of Toledo Psychology Clinic to engage in the collaborative assessment. Veteran participants were invited to take part in the collaborative assessment at the veteran mental health clinics.

Much like the empirical studies regarding therapeutic assessment such as Finn and Tonsager (1992) and Newman and Greenway (1997), participants were randomly assigned to two groups, an experimental group that participated in a therapeutic assessment and a control group, which received attention only from the assessor where the experimental group received a summary and discussion portion. All participants were first given a consent form they were required to sign in order to participate in the study (see Appendix A). The consent form explained the expectations of the study, the expected time commitment, the anonymous nature of the data, potential risks and benefits from the study, and their right to withdraw from the study without penalty at any time. The consent form also included consent to video record the first session. Each participant’s first session was videotaped so that a rater blind to the study information
could score the session for number of smiles, leans, and head nods to assess for possible nonverbal factors that may have an effect on the study outcome.

After the initial introduction to the experiment and the consent form had been signed, all participants completed a demographics questionnaire (See Appendix B). This assessed the participants’ age, sex, ethnicity, diagnosis, date of diagnosis, number of hospitalizations, date of most recent hospitalization, medications, and previous assessment experience. Next, all participants were administered the MHRM, the AQ-2, and the SES. All participants were thereafter involved in a 15-20 minute discussion with the examiner about their relationships (see Appendix E); however the “ta” group formulated relationship assessment questions with the examiner. This differs from the Finn and Tonsager (1992) and Newman and Greenway (1997) studies in that the current study specifically asked people to focus on interpersonal relationships. Through this discussion, participants and the examiner determined one to two assessment questions pertaining to their relationship with the person they consider their main support for their well-being. This corresponded to the relationship that they rate while taking the SASB. Each participant was then administered the SASB, the PPT, and the BSI. The procedures for the two groups differ after the administration of the assessment measures (See Figure 2). This design differs from the procedures for the Finn and Tonsager study. In the current study, all participants completed the assessment measures, whereas in Finn and Tonsager only participants in the experimental group completed the MMPI-2.

The collaborative assessment model used in this study is based on Finn’s (1996b) Therapeutic Assessment model. Because the author had only participated in one workshop for Therapeutic Assessment training, the method is referred to as a therapeutic
assessment (i.e., lowercase). The experimenter was trained and supervised by a psychologist who had taken part in two Therapeutic Assessment workshops led by Finn, and who has taught a practicum class in therapeutic assessment, in which the lead experimenter partook. After the completion of the assessment measures, the individuals in the experimental group were allotted a 25 minute break during which time the examiner scored the SASB and BSI as well as interpreted the PPT. A licensed clinical psychologist was present to review the interpretations with the examiner during the break. Following the break, the individuals in the experimental group participated in a summary and discussion of the interpretations of the assessment measures as they pertained to the assessment question. After the summary and discussion, participants were administered the MHRM, the SES, and the AQ-2 for a second time.

Participants in the control group, rather than taking a break and then participating in a summary and discussion of the assessment measures, participated in a 15-minute discussion with the examiner about the course of their illness, how family and friends have responded to their diagnosis, and how their social life is in general (See Appendix E). This group completed the outcome measures for a second time after the 15-minute discussion with the examiner.

All participants were asked to return three to five weeks after the assessment to complete follow-up measures, which included the MHRM, SES, and the AQ-2. Prior to the follow-up, participants in the “ta” group received a summary letter, which included information from the assessment and from the discussion of the results. Also, participants in the IG group received assessment feedback during this session after the completion of
the outcome measures, after which they also received a summary letter (See Appendix H for sample letters).

Though participants were recruited via fliers placed around the hospital, other providers with whom they had contact, and were approached to participate when they were already on the premises, approximately two-thirds of those who initially expressed interest in the study did not consent to participate. Due to difficulty with recruitment, the study protocol was changed on January 28, 2009 for the veterans to receive $5 coupon books, which they could redeem at the hospital cafeteria or gift shop, at the end of each session, for a possible total of $10. Only four participants in a four month period consented to take part after the amended protocol and received this remuneration. Given that the exertion of extra time and money was not resulting in more participation, the decision to cease data collection was made on May 31, 2009.

Figure 2

*Diagram of the Group (2) X Time (3) Design; Outcome Measures: AQ-2, MHRM, SES*

**Experimental (“ta”) Group (n = 10)**

- Outcome Measures
  - Interview
  - SASB, BSI, PPT

- Summary/Discussion
- Outcome Measures

- Letter

**Control (IG) Group (n = 9)**

- Outcome Measures
  - Interview
  - SASB, BSI, PPT

- General Discussion
- Outcome Measures

- Summary/Discussion
- Letter
Chapter 3

Results

Data Integrity

All analyses were conducted using the Statistical Package for Social Sciences (SPSS, version 17.0). The scoring syntax for each of the outcome measures accounted for missing items by using the mean of the scale for which there was a missing item. Though some missing data were present, they did not compromise data integrity. For the AQ-2, at each administration, there were at most five participants who missed one or two questions—there was no pattern of missing data per subscale. For the MHRM, two of the individuals missed one question at the second administration, and one person missed one question at the third administration. There were no missing data for the SES. The author also checked the data for entry errors. Following are the results of the analyses.

Power Analysis

A power analysis was done using G*Power version 3.0.10, statistical computer software that aids in the calculation of power. The software was used to determine the necessary sample size for repeated measures, within-between interactions F-test. The sample size was determined a priori given alpha, power, and effect size. Using the $f$ statistic as an effect size, the targeted effect size was .25, a medium effect. Power was set at .8 and alpha at .05. The number of groups was 2, and the number of repetitions of the repeated measures design was 3. The lowest correlation among the repeated measures was .59. Given this information, the G*Power program resulted in a target sample size of
24. However, as noted in the Procedures section, data collection was terminated at a sample size of 19. When a G*Power analysis was conducted to determine expected power given a sample size of 19 and an effect size of .25, the expected power was .64

Participants

Twenty-five people consented for participation. The assessor discontinued one person’s participation in the “ta” group due to the participant’s symptom exacerbation and inability to focus on the assessment materials. Two participants in the IG group did not return for the follow-up appointment, and three—two in the IG group and one in the “ta” group—discontinued their participation before the end of the first meeting. Of the five individuals who withdrew their participation on their own volition, four of them were from the IG group. The format of both of the assessment groups at the points at which the IG participants dropped out was similar; however, the consent forms for the IG group did not give an explicit indication that they would be receiving feedback at the completion of their participation. This may have affected the participants’ motivation to complete the study and may have made it more likely that they would give in to the fatigue of participating for approximately two hours with no known return for their participation. The recruitment fliers indicated that participation would include learning more about social relationships; however the consent forms for the IG group did not confirm this indication. Excluding the aforementioned participants resulted in a sample size of 19 (10 in the experimental group, 9 in the control group).

Table 1 shows frequencies of participants’ demographics and Table 2 indicates for additional descriptive statistics for the participants.
Table 1

Frequencies of Participant Demographics for the Overall Sample, the Therapeutic Assessment Group (‘ta’), the Information Gathering Group (IG), and the Attrition Group

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Overall N=19</th>
<th>“ta” N=10</th>
<th>IG N=9</th>
<th>Attrition N=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>11</td>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E/A</td>
<td>13</td>
<td>7</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>A/A</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Hisp.</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>10</td>
<td>6</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Married</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Divorced</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bipolar</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Schizoaffective</td>
<td>7</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: *European American; *African American; *Latin American/Hispanic.
Table 2

Mean, Standard Deviation, and Range of Age, Number of Hospitalizations, Years Since Diagnosis for the Overall Sample, the Therapeutic Assessment Group ("ta"), the Information Gathering Group (IG), and the Attrition Group

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Overall</th>
<th>&quot;ta&quot;</th>
<th>IG</th>
<th>Attrition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 19</td>
<td>N = 10</td>
<td>N = 9</td>
<td>N = 6</td>
</tr>
<tr>
<td>Age</td>
<td>M = 51.63, SD = 7.52</td>
<td>M = 51.50, SD = 8.80</td>
<td>M = 51.78, SD = 6.32</td>
<td>M = 47.00, SD = 13.78</td>
</tr>
<tr>
<td>Hospitalizations⁵</td>
<td>12.87, SD = 16.89</td>
<td>14.67, SD = 20.34</td>
<td>11.05, SD = 10.17</td>
<td>6.00, SD = 10.17</td>
</tr>
<tr>
<td>Years Diagnosed⁶</td>
<td>18.93, SD = 12.85</td>
<td>17.30, SD = 13.13</td>
<td>22.20, SD = 13.03</td>
<td>10.75, SD = 9.00</td>
</tr>
</tbody>
</table>

Note: ⁵not all participants reported this: N = 15; n "ta" = 9; n IG = 6; n Attrition = 3. ⁶not all participants reported this: N = 15; n "ta" = 10; n IG = 5; n Attrition = 4.

To determine if there were any significant differences between the participants per group regarding the demographic variables, a crosstabulation of the data was conducted. See Tables 3 and 4.

Table 3

Demographic Crosstabulation of Participants Who Completed the Study and Those Who Did Not

<table>
<thead>
<tr>
<th></th>
<th>Pearson Chi-Square</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>group x completion⁷</td>
<td>2.39</td>
<td>1</td>
<td>.12</td>
</tr>
<tr>
<td>group x gender</td>
<td>1.28</td>
<td>1</td>
<td>.26</td>
</tr>
<tr>
<td>group x ethnicity</td>
<td>5.22</td>
<td>3</td>
<td>.16</td>
</tr>
<tr>
<td>group x marital status</td>
<td>2.07</td>
<td>2</td>
<td>.36</td>
</tr>
<tr>
<td>group x diagnosis</td>
<td>4.59</td>
<td>3</td>
<td>.20</td>
</tr>
</tbody>
</table>

Note: N = 25; ⁷d = .74, ⁸d = .54.

For age, number of hospitalizations, and years since diagnosis, independent samples t-tests were conducted to determine if there were differences between these variables regarding participants who completed the study and those whose participation was discontinued. Regarding age, the t-test under the assumption that the variances were
not equal\(^1\), showed that there were no significant differences between the two groups \((t[5.97] = .79, \ p = .46, \ d = .52)\). For the number of hospitalizations, 14 people who completed the study and 3 people who did not complete the study answered this question on the demographic form. Those who did not stated that they could not remember how many hospitalizations or there were too many to count. The t-test statistic for the following analysis assumed that the variances were equal. Again, there were no significant statistical differences between the two groups regarding number of hospitalizations \((t[15] = .73, \ p = .48, \ d = .51)\). Similarly, 14 people who completed the study and 3 people who did not complete the study answered the question regarding number of years since diagnosis. Those who did not fill in this information gave the same reasoning as those who did not indicate the number of hospitalizations: they did not remember when they were diagnosed, or it has been too many years to count.

Homogeneity of the variances was again assumed for the t-test statistic. The results indicated that there were no significant differences for number of years since diagnosis among the individuals who completed the study versus those who did not \((t[15] = .65, \ p = .53, \ d = .44)\).

Table 4

_Demographic Crosstabulation of the Therapeutic Assessment Group and the Information Gathering Group_

<table>
<thead>
<tr>
<th></th>
<th>Pearson Chi-Square</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>group x gender</td>
<td>.04</td>
<td>1</td>
<td>.85</td>
</tr>
<tr>
<td>group x ethnicity</td>
<td>3.03</td>
<td>3</td>
<td>.39</td>
</tr>
<tr>
<td>group x marital status</td>
<td>1.55</td>
<td>2</td>
<td>.46</td>
</tr>
<tr>
<td>group x diagnosis</td>
<td>2.57</td>
<td>3</td>
<td>.46</td>
</tr>
</tbody>
</table>

*Note: N = 19.*

\(^1\) Equal variances were determined by using Levene’s Test of Equal Variances.
To determine if there were differences between the therapeutic assessment group and the information gathering group with regards to age, number of hospitalizations, and years since diagnosis, independent samples t-tests were conducted. For each of the following t-tests, equal variances were assumed. Regarding age, all 19 participants completed this question. Between the groups, there were no significant differences with regards to age ($t[17] = .08; p = .94, d = .04$). For the number of hospitalizations, 9 people from the therapeutic assessment group and 6 people from the information gathering group were able to answer this question. Again, no significant differences were found between the two groups ($t[13] = .49, p = .63, d = .28$). Ten participants in the therapeutic assessment group and 5 people in the information gathering group answered the question regarding number of years since diagnosis. For this question, participants between the two groups did not significantly differ in how long they have been diagnosed with a mental illness ($t[13] = .68, p = .51, d = .40$).

**Descriptive Statistics**

Descriptive statistics were calculated for the assessment measures, the SASB\(^2\) (Table 5) and the BSI (Table 6), as well as for each of the outcome measures, which include the MHRM, the AQ-2, and the SES, at each of the three administrations (Table 7).

\(^2\) Scores of the norms were not reported in terms of Affiliation and Autonomy, so they were converted using the equation found in Pincus et al. (1998). The scales used in the conversion equation were Emancipate/Separate, Affirm/Disclose, Active Love/Reactive Love, Protect/Trust, Control/Submit, Blame/Sulk, Attack/Recoil, and Ignore/Wall-off.
Psychological Tests/Assessment Measure Descriptive Statistics

Table 5

Descriptive Statistics for the Mean Scores on the Structural Analysis of Social Behavior for Overall, Therapeutic Assessment ("ta") Group, and the Information Gathering (IG) Group of the Autonomy and Affiliation Scores

<table>
<thead>
<tr>
<th>Vector</th>
<th>Affiliation</th>
<th>Autonomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO\textsuperscript{a} Acts</td>
<td>&quot;ta&quot;</td>
<td>IG</td>
</tr>
<tr>
<td>At Best</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>SO Acts</td>
<td>236.55</td>
<td>353.58</td>
</tr>
<tr>
<td>SO Reacts</td>
<td>533.85</td>
<td>474.47</td>
</tr>
<tr>
<td>Self Acts</td>
<td>542.85</td>
<td>388.28</td>
</tr>
<tr>
<td>Self Reacts</td>
<td>369.30</td>
<td>507.92</td>
</tr>
<tr>
<td>At Worst</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>SO Acts</td>
<td>159.60</td>
<td>431.18</td>
</tr>
<tr>
<td>SO Reacts</td>
<td>546.00</td>
<td>515.48</td>
</tr>
<tr>
<td>Self Acts</td>
<td>370.80</td>
<td>288.17</td>
</tr>
<tr>
<td>Self Reacts</td>
<td>445.35</td>
<td>499.89</td>
</tr>
</tbody>
</table>

Note: n "ta" = 10; n IG = 9; \textsuperscript{a}Significant Other.

To determine if there were differences between the “ta” and IG groups regarding how they viewed a significant person in their life as acting towards them and how they reacted to their significant other at the best and worst times of their relationship, independent samples t-tests were conducted. Results of the t-tests yielded three statistically significant differences between the groups. Individuals in the IG group reported that at the worst times of their relationships, they viewed their significant other as acting and reacting more autonomously with them ($t[17] = 2.27, p = .04, d = 1.10$; $t[17] = 2.26, p = .04, d = 1.10$, respectively); furthermore they viewed themselves as reacting more autonomously towards their significant other ($t[17] = 2.49, p = .02, d = 1.21$). No other statistically significant differences were found between the groups with regards to the SASB scores.
Table 6

Descriptive Statistics for T-Scores on the BSI for the Overall, Therapeutic Assessment (“ta”) Group, and the Information Gathering (IG) Group

<table>
<thead>
<tr>
<th>BSI Subscale</th>
<th>Overall M</th>
<th>SD</th>
<th>“ta” M</th>
<th>SD</th>
<th>IG M</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>Internal Consistencya</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSI</td>
<td>51.53</td>
<td>13.60</td>
<td>53.20</td>
<td>9.40</td>
<td>49.67</td>
<td>17.59</td>
<td>23</td>
<td>78</td>
<td>.96</td>
</tr>
<tr>
<td>SOM</td>
<td>53.84</td>
<td>10.95</td>
<td>54.40</td>
<td>8.72</td>
<td>53.22</td>
<td>13.54</td>
<td>35</td>
<td>73</td>
<td>.79</td>
</tr>
<tr>
<td>O-C</td>
<td>54.00</td>
<td>12.08</td>
<td>55.60</td>
<td>8.95</td>
<td>52.22</td>
<td>15.21</td>
<td>28</td>
<td>80</td>
<td>.91</td>
</tr>
<tr>
<td>I-S</td>
<td>49.47</td>
<td>10.20</td>
<td>49.40</td>
<td>6.72</td>
<td>49.56</td>
<td>13.53</td>
<td>33</td>
<td>69</td>
<td>.85</td>
</tr>
<tr>
<td>DEP</td>
<td>47.42</td>
<td>10.11</td>
<td>49.10</td>
<td>6.78</td>
<td>45.56</td>
<td>13.08</td>
<td>29</td>
<td>62</td>
<td>.86</td>
</tr>
<tr>
<td>ANX</td>
<td>48.05</td>
<td>11.83</td>
<td>48.90</td>
<td>8.32</td>
<td>47.11</td>
<td>15.33</td>
<td>28</td>
<td>67</td>
<td>.87</td>
</tr>
<tr>
<td>HOS</td>
<td>50.47</td>
<td>11.22</td>
<td>51.80</td>
<td>9.36</td>
<td>49.00</td>
<td>13.43</td>
<td>32</td>
<td>71</td>
<td>.88</td>
</tr>
<tr>
<td>PHOB</td>
<td>53.32</td>
<td>10.60</td>
<td>53.50</td>
<td>9.98</td>
<td>53.11</td>
<td>11.86</td>
<td>38</td>
<td>71</td>
<td>.82</td>
</tr>
<tr>
<td>PAR</td>
<td>54.95</td>
<td>10.11</td>
<td>56.60</td>
<td>7.14</td>
<td>53.11</td>
<td>12.87</td>
<td>34</td>
<td>71</td>
<td>.84</td>
</tr>
<tr>
<td>PSY</td>
<td>54.26</td>
<td>10.79</td>
<td>56.30</td>
<td>8.38</td>
<td>52.00</td>
<td>13.12</td>
<td>34</td>
<td>75</td>
<td>.63</td>
</tr>
</tbody>
</table>

Note: N Overall = 19; n “ta” = 10; n IG = 9. GSI = Global Symptom Index; SOM = Somatization; O-C = Obsessive-Compulsiveness; I-S = Interpersonal Sensitivity; DEP = Depression; ANX = Anxiety; HOS = Hostility; PHOB = Phobic Anxiety; PAR = Paranoid Ideation; PSY = Psychoticism. aCronbach’s Alpha.

T-tests were used to determine if there were differences between the groups regarding the BSI global scale and subscales. For GSI and two other subscales—I-S and ANX—the variances were not assumed to be equal. In contrast to the results with the SASB, no significant differences were observed between the two groups regarding symptomatology. Furthermore, both groups averaged within the normal range on the BSI scales, suggesting they were not reporting a high level of psychopathology at Time 1.
Outcome Measures Descriptive Statistics

Table 7

Descriptive Statistics for the Total Scores on the SES, the MHRM, AQ-2 modified, and AQ-2 for Overall, Therapeutic Assessment (“ta”) Group and the Information Gathering (IG) Group across Time 1, Time 2, and Time 3

<table>
<thead>
<tr>
<th>Measure</th>
<th>Overall</th>
<th>“ta”</th>
<th>IG</th>
<th>Internal Consistency&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Time 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SES&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2.39</td>
<td>.64</td>
<td>2.38</td>
<td>.43</td>
</tr>
<tr>
<td>MHRM&lt;sup&gt;c&lt;/sup&gt;</td>
<td>3.36</td>
<td>.70</td>
<td>3.35</td>
<td>.59</td>
</tr>
<tr>
<td>AQ-2 mod&lt;sup&gt;d&lt;/sup&gt;</td>
<td>3.52</td>
<td>.58</td>
<td>3.54</td>
<td>.66</td>
</tr>
<tr>
<td>Time 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SES</td>
<td>2.43</td>
<td>.72</td>
<td>2.57</td>
<td>.52</td>
</tr>
<tr>
<td>MHRM</td>
<td>3.37</td>
<td>.70</td>
<td>3.40</td>
<td>.59</td>
</tr>
<tr>
<td>AQ-2</td>
<td>3.60</td>
<td>.63</td>
<td>3.69</td>
<td>.64</td>
</tr>
<tr>
<td>Time 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SES</td>
<td>2.57</td>
<td>.66</td>
<td>2.63</td>
<td>.43</td>
</tr>
<tr>
<td>MHRM</td>
<td>3.43</td>
<td>.72</td>
<td>3.44</td>
<td>.58</td>
</tr>
<tr>
<td>AQ-2</td>
<td>3.65</td>
<td>.48</td>
<td>3.64</td>
<td>.55</td>
</tr>
</tbody>
</table>

Note: N = 19; N “ta” = 10; N IG = 9. <sup>a</sup>Cronbach’s alpha. <sup>b</sup>Converted to Likert Scale used (1 [Strongly Disagree] to 4 [Strongly Agree]). <sup>c</sup>Converted to Likert Scale used (1 [Strongly Disagree] to 5 [Strongly Agree]). <sup>d</sup>Assessment Questionnaire – 2 modified. <sup>e</sup>Converted to Likert Scale used (1 [Strongly Disagree] to 5 [Strongly Agree]).

T-tests were used to determine if there were differences between the group means for each of the measures at Time 1. There were no significant differences between the groups at Time 1 for the SES (t[17] = .07, p = .95, d = .03), the MHRM t[17] = .08, p = .93, d = .04) or the AQ-2 (t[17] = .16, p = .87, d = .07).

Correlations were used to determine the relationship between the two outcome measures in the main hypotheses—the SES and the MHRM. For each administration, except for the first administration for the IG group (Time 1: r = .66 p = .06), the SES and the MHRM significantly correlated (all p’s < .01) for the overall sample (Time 1: r = .73;
Time 2: $r = .90$; Time 3: $r = .81$), the “ta” group (Time 1: $r = .95$; Time 2: $r = .78$; Time 3: $r = .70$), and the IG group (Time 2: $r = .98$; Time 3: $r = .86$).

**Examiner Integrity**

Because the examiner was not blind to the participants’ assigned groups, each participant’s initial session was videotaped to investigate potential examiner bias regarding general friendliness across the two groups. A female undergraduate coder, who was blind to the study data and the group of each participant, rated the examiner in each video for number of smiles, amount of time spent smiling, time spent leaning, and number of head nods (See Appendix G). Differences between the groups may indicate that the examiner, who was not blind to the study or the groups of the participants, was acting in such a way that could confound the results. Two graduate students piloted the measure by rating a therapy session. Two videos from the “ta” group were not coded. The two participants signed a version of the consent form that did not include information about a third party coding the tapes. Because they had not signed the version of the consent form that indicated this, the Institutional Review Board (IRB) would not give permission to include these videos in the coding process. Therefore, these two videos could not be coded, so a total of 17 videos were coded. Table 8 shows the descriptive statistics of the video ratings.
Table 8

Descriptive Statistics of the Nonverbal Behaviors of the Examiner

<table>
<thead>
<tr>
<th>Nonverbal Behavior&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Overall</th>
<th>“ta”</th>
<th>IG</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td># Smiles&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.26</td>
<td>.15</td>
<td>.28</td>
<td>.16</td>
</tr>
<tr>
<td>Smile Time&lt;sup&gt;c&lt;/sup&gt;</td>
<td>.02</td>
<td>.01</td>
<td>.03</td>
<td>.01</td>
</tr>
<tr>
<td>Lean Time&lt;sup&gt;c&lt;/sup&gt;</td>
<td>.12</td>
<td>.07</td>
<td>.15</td>
<td>.07</td>
</tr>
<tr>
<td># Nods&lt;sup&gt;b&lt;/sup&gt;</td>
<td>3.36</td>
<td>2.57</td>
<td>4.28</td>
<td>2.37</td>
</tr>
<tr>
<td>Session Time&lt;sup&gt;d&lt;/sup&gt;</td>
<td>81.88</td>
<td>25.10</td>
<td>90.71</td>
<td>33.71</td>
</tr>
</tbody>
</table>

<sup>a</sup>behavior was corrected for session time; <sup>b</sup>per minute; <sup>c</sup>in minutes; <sup>d</sup>Because one tape from the “ta” group was cut off after 16 minutes, it was not included in the mean for the session time for the Overall sample or the “ta” group.

Note: N Overall = 17; n “ta” = 8; n IG = 9; *behavior was corrected for session time; *per minute; *in minutes; *Because one tape from the “ta” group was cut off after 16 minutes, it was not included in the mean for the session time for the Overall sample or the “ta” group.

No differences between the groups were found in the number of smiles (t[15] = .48, p = .63, d = .21), time spent smiling (t[15] = .87, p = .40, d = .106), the number of head nods (t[15] = 1.45, p = .17, d = .75), and the time spent with each group (t[15] = 1.65, p = .12, d = .89). Though the differences between the “ta” and the IG groups on these three variables were not statistically significant and the sample size is small, there seems to be a slight relationship in between being in the “ta” group and the number of smiles and a larger relationship between being in the “ta” group and the number of nods and time spent with each group. There was a significant difference between the “ta” group and the IG group, for which the rater noted that the examiner spent more time leaning toward participants in the “ta” group than with individuals in the IG group (t[15] = 1.45, p = .04, d = 1.15).

However, to determine if the examiner was responding to the participants’ nonverbal behaviors rather than behaving differently due to the randomly assigned group, the participants’ scores on the SASB autonomy (AUT) self with other at best, both acting and reacting scores, were correlated with the lean time. Lean time was significantly negatively correlated with both the SASB AUT self with other at best acting scores (r = -
.58, $p = .02$) and the SASB AUT self with other at best reacting scores ($r = -.69, p = .002$). This suggests that the examiner was responding to the participants’ cues; that is, she was likely mirroring their interpersonal cues that indicated a preference for interpersonal distance (e.g., leaning back). Using the SASB AUT self acting with other at best score as a covariate, no differences were found between the “ta” and IG groups with regards to lean time ($F[1, 13] = 1.51, p = .24, d = .68$). Therefore, it is not necessary to use the lean time as a covariate in the main analyses.

Another check to the examiner integrity between the two groups was a comparison of the AQ-2 Positive Relationship with the Examiner Scale. Since the assessor was not blind to the assigned group of the participants, this AQ-2 subscale had potential to serve as a check to make sure that the assessor was not treating the participants differently based on the group that they were assigned. For example, if the “ta” group’s mean scores were significantly higher than the IG group’s, this could indicate that the assessor was treating the “ta” participants more positively than the IG participants. Table 9 indicates the descriptive statistics for the total sample and each group.

Table 9

Descriptive Statistics for the AQ-2 Positive Relationship with the Examiner Scale at Time 2, and Time 3

<table>
<thead>
<tr>
<th>AQ-2 Admin</th>
<th>Overall</th>
<th>“ta”</th>
<th>IG</th>
<th>Internal Consistency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time 2</td>
<td>$M = 4.05, SD = .63$</td>
<td>$M = 4.13, SD = .62$</td>
<td>$M = 3.96, SD = .66$</td>
<td>$Min = 2.92, Max = 5.00, .87$</td>
</tr>
<tr>
<td>Time 3</td>
<td>$M = 4.16, SD = .52$</td>
<td>$M = 4.13, SD = .56$</td>
<td>$M = 4.19, SD = .50$</td>
<td>$Min = 3.25, Max = 5.00, .87$</td>
</tr>
</tbody>
</table>

Note: $N = 19$; $N_{ta} = 10$; $N_{IG} = 9$. *Converted to Likert Scale used (1 [Strongly Disagree] to 5 [Strongly Agree]).
Differences between the groups regarding the second and third administrations of the Positive Relationship with the Examiner subscale were assessed by using independent samples t-tests. Because participants rated their expectations of the assessment for Time 1, and the examiner had not been interacting with the participants at Time 1, comparisons between the groups at Time 1 were not necessary for an examiner integrity check. The scores on this subscale did not differ between groups at Time 2 ($t[17] = .55, p = .59, d = .27$) nor for Time 3 ($t[17] = .21, p = .83, d = .10$). Paired-samples t-tests were used to determine if differences existed in the Positive Relationship subscale within the groups at the different administrations. Again, since the assessment had not yet begun at the first administration, only paired-samples t-tests were analyzed for Times 2 and 3. In the overall sample, the difference between Time 2 and Time 3 was not statistically significant ($t[18] = 1.12, p = .28, d = .26$). Within the “ta” group specifically, no significant statistical differences were found between Times 2 and 3 ($t[9] = .10, p = .93, d = .03$). For the IG group, differences were also not statistically significant between Times 2 and 3 ($t[8] = 1.20, p = .27, d = .42$).

It should be noted that fidelity checks were not instituted in the examiner integrity check. In other words, the examiner was not rated on how closely she followed the therapeutic assessment protocol. Including a check for fidelity was not initially considered for the current study. Because the videos were recorded without sound, a fidelity check could not be instituted later on.
Main Hypotheses

Hypothesis 1

It was anticipated that the participants’ SES scores in the experimental group would significantly increase more so than individuals in the traditional assessment group. To test this hypothesis, the same design was used as in Finn and Tonsager (1992) and Newman and Greenway (1997)—a 2 (Group) × 3 (Time) repeated-measure analysis of variance (ANOVA) design. For the current study, both the main effect of time ($F[2,16] = 2.82, p = .09$) and the group-time interaction ($F[2,16] = 3.36, p = .06$) approached but did not reach statistical significance. Due to the near statistical significance of these effects, paired samples t-tests were used to determine if significant statistical differences occurred for the group-time interaction. Table 10 shows the results of the t-test comparisons between the first and second administrations and the first and third administrations.

Table 10

SES Group x Time Paired-Samples T-test Comparisons

<table>
<thead>
<tr>
<th>Group</th>
<th>Time (i)</th>
<th>Time (j)</th>
<th>t</th>
<th>p</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>“ta”</td>
<td>1</td>
<td>2</td>
<td>-3.77</td>
<td>.004</td>
<td>.42</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3</td>
<td>-2.27</td>
<td>&lt;.05</td>
<td>.61</td>
</tr>
<tr>
<td>IG</td>
<td>1</td>
<td>2</td>
<td>1.13</td>
<td>.29</td>
<td>.16</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3</td>
<td>-.99</td>
<td>.35</td>
<td>.14</td>
</tr>
</tbody>
</table>

Note: $n$ “ta” = 10; $n$ IG = 9.

Figure 3 shows a graph of the mean scores per group across the three administrations of the SES.
Hypothesis 2

It was also posited that the experimental group will show more progress in mental health recovery as compared to the control group as measured by the MHRM. To test this hypothesis, a 2 (Group) X 3 (Time) repeated-measure ANOVA design was conducted. For the group and time interaction, any differences did not approach significance ($F[2,16] = .27, p = .76$). The main effect of time was also not statistically significant ($F[2,16] = .40, p = .68$). The main effect of Group for the MHRM scores was not statistically significant ($F[1,17] = .004, p = .95, d = .03$).

Figure 4 demonstrates the mean MHRM scores across times for each group.
Figure 4

*Mean MHRM Scores for Group and Time*

![Graph showing MHRM scores for Group and Time](image)

*Note:* $n$ “ta” = 10; $n$ IG = 9; MHRM = Mental Health Recovery Measure; “ta” = therapeutic assessment group; IG = Information Gathering Group; Scores are reported on the Likert Scale 0 (Strongly Disagree) to 5 (Strongly Agree). Time 1 and Time 2 = same day; Time 3 = 3-5 weeks later.

*Exploratory Analysis*

Since little information is known regarding client’s perceptions of psychological assessment, the AQ-2 comparisons were exploratory. To determine group and time differences among and between the groups, a 2 (Group) X 3 (Time) repeated-measure ANOVA were again used. Similar to the previous analyses, no significant differences were found for the main effect of time ($F[2, 16] = .70, p = .51$) or the group-time interaction ($F[2, 16] = 1.77, p = .20$). The main effect of Group for the AQ-2 scores was not statistically significant ($F[1, 17] = .09, p = .77, d = .08$).

Figure 5 is a graph of the mean Likert scores of the AQ-2 for the “ta” and IG groups.
Figure 5

*Mean AQ-2 Scores for Group and Time*

![Graph showing mean AQ-2 scores for Group and Time]

*Note: n “ta” = 10; n IG = 9; AQ-2 = Assessment Questionnaire - 2; “ta” = therapeutic assessment group; IG = Information Gathering Group; Scores are reported on the Likert Scale 0 (Strongly Disagree) to 5 (Strongly Agree). Time 1 and Time 2 = same day; Time 3 = 3-5 weeks later.*
Chapter 4

Discussion

Research using collaborative assessment has primarily been limited to case studies, two published empirical studies, and unpublished dissertations (Finn, 2003; Finn & Tonsager, 1992; Fischer, 1994; Houser, 2006; Katrichack, 2004; Kirby 2004; Newman & Greenway, 1997; Peters, 2000). Furthermore, the populations that have been used in empirical studies have been undergraduate students who were receiving psychological care at university counseling centers. Four unpublished dissertations utilized special populations (i.e., women with eating disorders, people who are on welfare, individuals struggling with drug and alcohol addiction, and individuals with an SMI), three of which found statistically significant differences, demonstrating that therapeutic assessment can be efficacious in special populations (Katrichack, 2004; Kirby, 2004; Peters, 2000). One of the aforementioned dissertations did not find statistically significant differences between the therapeutic assessment group and traditional assessment group when examining therapeutic assessment’s impact on symptom reduction in an SMI population; both groups improved (Houser, 2006). Some reasons this may have been that multiple examiners who were not trained in therapeutic or collaborative assessment were used, and the site of data collection was busy, which did not allow for much time to perform a therapeutic assessment in addition to their regular work. In other words, confounds within the experiment were not accounted for.
The current study intended to account for the pitfalls of the Houser (2006) study as well as to add to the research of therapeutic assessment with special populations. Consequently, participants in this study were adults who were diagnosed with a serious mental illness. For purposes of uniformity among the interaction with the participants, one assessor was the examiner for all of the assessments. She had attended a Therapeutic Assessment workshop with Stephen Finn and also took an advanced assessment practicum taught by a clinical psychologist who had attended two Therapeutic Assessment workshops and whose practicum was guided by that approach. Furthermore, because the assessor was not blind to the randomly assigned groups, she was rated for nonverbal behaviors that may confound the results. The rated nonverbal behaviors of the examiner in this study may have influenced the results as the “ta” group ratings indicated that the examiner spent significantly more time leaning with these participants, and there was also some relationship, though not significant, between number of head nods and the number of smiles. Possible differences in the participants’ feelings of closeness with the examiner were taken into consideration as well. Additionally, though the research with an SMI population has been limited, the studies that have been conducted indicate that clients’ well-being depends greatly on the quality of their social support (Bertrando et al., 2006; Carey et al., 2001; Husted & Ender, 2001; Kuipers, 2006; Rosenfarb et al., 1995); therefore, rather than focus the therapeutic assessment around symptom reduction, it seemed appropriate to use a therapeutic assessment to help SMI clients understand their relationships in hopes of increasing self-esteem and mental health recovery.
Main Hypothesis 1: Comparing Self-Esteem of “ta” and IG Groups

Based on the information above, two main hypotheses were tested. The first main hypothesis was that therapeutic assessment ("ta") participants would have a larger increase in scores in self-esteem (SES) as well as recovery (MHRM) than the informational group (IG) participants. The main effect of time and the group-time interaction approached significance. Post hoc tests indicated that individuals in the “ta” group did in fact have increases in self-esteem from before the assessment to follow-up (higher scores on the SES at Time 3 than Time 1 ($t[9] = 2.27, p < .05, d = .42$), and the IG group did not ($t[8] = .99, p = .35, d = .14$). Similar increases in self-esteem with Therapeutic Assessment have been seen in clinical college samples as well as one dissertation that utilized a substance abuse population. In the studies that included a college student population, there were differences between the groups at the final administration of the self-esteem measures (Finn & Tonsager, 1992; Kirby, 2004; Newman & Greenway, 1997). That is, as hypothesized, the “ta” group seemed to improve more than the IG group. For the Therapeutic Assessment college sample studies, the effect sizes for Finn and Tonsager study, the effect size was $d = .84$, and Newman and Greenway’s results had an effect size of $d = .28$. The Kirby dissertation, which included three groups of individuals involved in substance abuse treatment—an immediate feedback group, a delayed feedback-therapy group, and a control, attention only group—had effect sizes of $d = 1.19$ for the difference between the immediate feedback and control, and $d = .92$ for the difference between the therapy group and the control group.

Kirby (2004) also noted differences in pairwise comparisons between Time 1 and Time 2 for both the immediate feedback and the therapy group for self-esteem, which is
similar to the current study. For the current study, though, the second outcome measures were administered the same day as the first, approximately an hour and a half to two hours later. Finn and Tonsager (1992) and Newman and Greenway (1997) designed their studies to have Time 1 and Time 2 two weeks apart, as well as Time 2 and Time 3. Kirby (2004) did not indicate the time between the first, second and third administrations of the outcome measures, but all sessions took place in a 21-day period. Regardless, all of these results indicate that there seems to be a relationship between participating in a psychological assessment which includes feedback and an increase in self-esteem.

Part of the reason that the hypothesis for the group differences on self esteem was not supported could be that there was not much room for improvement on this construct. The overall sample did not differ from where one would typically expect self esteem to be—a score between 25 to 35 on the SES (Rosenberg, 1965). This ceiling effect is also discussed later as well.

Main Hypothesis 2: Comparing Mental Health Recovery of “ta” and IG Groups

The second main hypothesis anticipated that individuals in the “ta” group would have greater increase in their sense of mental health recovery by the completion of the study than those who were in the IG group. In this case, mental health recovery does not assess symptoms or symptom management, but rather the individual’s overall sense of the ability to overcome feeling stuck, empowerment, basic functioning, learning, overall well-being, and obtaining new potentials. The results showed that there were not differences in the scores on the MHRM between or within the groups. Though social support and positive relationships have been shown to contribute to overall well-being (which is a concept included in the MHRM), decreased hospitalizations, and reduced
relapses (Carey et al., 2001; Husted & Ender, 2001; Kuipers, 2006; Rosenfarb et al., 1995). Social support has also been linked to mental health recovery as measured by the MHRM (Hupp 2008); however, in Hupp (2008), the changes were assessed after a 10-session recovery-oriented program, and again at a 3 to 6 month follow-up. It is possible that current study’s focus on social support was not long enough in duration to make an impact on mental health recovery.

Additionally, studies that have used the MHRM (Wesp, Bullock, Wilcox, Smith, Rich, & Pieples, 2009; Hupp, 2008) have focused on clients’ long-term participation in treatment that specifically targets the behaviors and attitudes included in the MHRM subscales (i.e., overcoming stuckness, self-empowerment, learning & self-redefinition, basic functioning, well-being, new potentials, advocacy, and spirituality). The current study focuses solely on understanding and perceiving interpersonal relationships, which has not been a focus of a study using the MHRM.

Furthermore, and similar to the issue with the self-esteem, participants in this study began with an overall mean MHRM score that is approximately two standard deviations above other studies that have used the MHRM (Hupp, 2008; Wesp et al., 2009). Again, this indicates that the current sample may not necessarily have had much room to improve. In other words, the initial relatively high MHRM scores could have created a ceiling effect.

In spite of the above explanations as to why the MHRM scores for the “ta” group were not statistically significantly different from the IG group’s at the 3-5 week follow-up, it is still important to keep in mind the differences between the groups in the SASB. Because the “ta” group’s perceptions of their significant others appeared to have higher
expressed emotion than the members of the IG group, their experience of their mental health recovery and understanding of their recovery process, which does not include symptom or symptom progress management, but rather specific behaviors that an individual engages in to further his or her recovery, may be impacted by their discernment of the behaviors of their significant others.

*Exploratory Analysis: Attitudes about Assessment*

An exploratory analysis of the AQ-2 was conducted to determine if there were differences between the two groups regarding how they viewed assessment after participating in a therapeutic assessment or undergoing a traditional assessment. Similar to mental health recovery, there were no differences between the groups in how they viewed the assessment. Current research regarding attitudes about psychological assessments is scarce. It is possible that participants who volunteered to participate in a psychological assessment had already had an idea what to expect from a psychological assessment. Moreover, all individuals participated in an assessment regardless of the group they were in. Therefore, the expectation of receiving feedback regardless of their group assignments may have led to the assessment experience and expectations to be similar between the groups.

Another factor that may have contributed to the lack of significant change of the attitudes about the assessment is that participants in the current study were not required to be in outpatient psychological treatment. They were asked if they wanted to share the information with a third party (e.g., a therapist), but this was not a prerequisite for participation. In Finn and Tonsager (1992) and Newman and Greenway (1997), all participants were participating in outpatient psychotherapy at the university counseling
centers. These studies found significant positive changes in the participants' assessment experiences. Having the opportunity to discuss assessment summaries with a therapist may have impacted the follow-up responses on the AQ-2 in these two studies.

Study Limitations and Future Directions

Participant Consent and Attrition. One of most noticeable limitations of the study is the small sample size. Though the 19 people completed participation in the study, data collection was not without its difficulties. Through 17 months of data collection, 62 people expressed interest in participating. Of those 62, 25 people consented. Furthermore, data collection was delayed at the VAMC due to IRB changes as well as several cancelled IRB meetings. To prepare the IRB application and ultimately have the study pass took 15 months, which restricted the number of participants that could be recruited before the completion of the study.

Given that little empirical research has been done with either therapeutic assessment or with treatment outcomes in an SMI population, it seemed fitting to take a look at the attrition factor to determine if this completion rate was comparable to other studies utilizing similar populations. In the current study, there were no statistical differences in demographics (age, gender, marital status, ethnicity, number of hospitalizations, and years since diagnosis) between those who completed the study after consenting and those who did not complete the study after consenting. Unfortunately, no data was able to be collected from those who expressed interest but did not consent. However, the sample size to test differences in the attrition group versus the study participants was small. Though no statistical differences were found between the demographics of these groups, the attrition group actually looked less chronic (as noted
by number of years since diagnosis [Completed: $M = 18.93$, $SD = 12.85$; Attrition: $M = 10.75$, $SD = 9.00$; $d = .51$]) and less severe (as noted by number of hospitalizations [Completed: $M = 12.87$, $SD = 16.89$; Attrition: $M = 6.00$, $SD = 6.00$; $d = .44$]).

Nomamiukor and Brown (2009) measured the attrition of individuals who were diagnosed with co-morbid bipolar disorder and substance use who consented to a clinical drug trial. Participants were asked to participate in a drug trial for 12 weeks. The attrition rate for this study was 69% (55/80) in the 12 weeks. In Houser (2000), 315 individuals dropped out of the study while 100 individuals completed. This amounts to a 76% attrition rate. With consenting individuals, the current study had a 24% (6/25) attrition rate; however, 62 people expressed interest, which means 60% (37/62) of the individuals who were interested in participating did not consent. Sixty-nine percent (43/62) of those who expressed interest did not complete the study; included in that number are those who consented and dropped their participation. This is the same percentage as the Nomamiukor and Brown study and a lower percentage than the Houser dissertation.

Vanable, Carey, Carey, and Maisto (2002) measured attrition rates of psychiatric outpatients who were recruited for a health promotion trial. Eight hundred ninety-five people were eligible, but 67% ($n = 601$) consented to participate, and 69% ($n = 415$) of those who consented completed the study. In other words, 54% of eligible individuals did not complete the study. Interestingly, Vanable et al. (2002) determined that individuals with diagnoses that were more severe than adjustment disorder were more likely to consent and complete the study. They interpreted this as individuals who might benefit most from interventions were more likely to consent. Though data of all eligible individuals are not available for the current study, it might be that the outpatients who
decided to participate felt more like they could benefit from the intervention than those who did not.

Also notable with regards to attrition in the current study is that five of the six individuals who consented but did not complete the study were randomly assigned to the IG group. Though there were no differences in the AQ-2 Positive Relationship with the Examiner subscale between the “ta” and IG groups for those who completed the study, nor was the difference between study completion and assigned group statistically significant, it is interesting that those who eventually decided to discontinue participation were randomly assigned to the control group. Andersen (2007) examined a number of medical trials to determine what seemed to impact retention rates the most, despite typical incentives (e.g., money). She found that many individuals, when interviewed after participation in a study, stated that the altruism or collaboration with the study staff is what they appreciated most. If the IG participants who dropped-out before completion of the study felt as though they were not collaborating with the assessor, this may have impacted their desire to follow-through to completion.

Additionally, the attrition rate may have contributed to the lack of significant differences between the “ta” group and the IG group. The individuals who dropped out may have produced lower outcome measure scores as well as lower scores on the AQ-2 scale. Should they have completed the study, this may have resulted in different statistical output and conclusions. Furthermore, the higher attrition rate in the IG group itself can be considered a more negative outcome for that group compared to the “ta” group.

Volunteer Bias. As with most studies, the individuals who participate are not required to be taking part in the experiment. In SMI research, volunteers tend to have less
hospitalizations, experience less psychotic symptoms, and are less likely to be diagnosed with schizophrenia (Haapea, Miettunen, Veijola, Lauronen, Tanskanen, & Isohanni, 2007; Lundberg, Thakker, Hallstrom, & Forsell, 2005). Differences might not have been found between the two groups on the MHRM because those who participated may have already felt like they were working towards their recovery—participants in the current study had higher scores on the initial administration of the MHRM than in other studies that utilized and noted significant pre and post test difference (Bullock, 2005; Hupp, 2008; Wesp et al, 2009). As mentioned before, due to the relatively healthier sample population, there may not have been much room for improvement. The lack of statistically significant results may be a factor of a ceiling effect, limiting the actual improvements that were possible in the study.

Hasson-Ohayon, Roe, and Kravetz (2006) noted that individuals with an SMI tend to participate in psychosocial interventions because they are anticipating a certain understanding or increase in their quality of life. Again, it may be that those who volunteered to participate already anticipated gaining something from it and thus, their mental health recovery as well as perceptions of the assessment did not change at the three different points of outcome measure administration.

Possible Confounds

The design of the current study was based the Finn and Tonsager (1992) and the Newman and Greenberg (1997) studies regarding therapeutic assessment in a clinical college student population. The present study differed from Finn and Tonsager’s study, however, in that in the present study participants in the control group received an assessment and delayed feedback, whereas in Finn and Tonsager’s study they received
attention only and were not anticipating feedback. The Newman and Greenberg design is more similar to the current study in which participants in the control group received an assessment and therefore eventually were given feedback about the assessment. The anticipation of hearing feedback about the results of the assessment may have impacted the information gathering (IG) group’s outcome measure scores. In fact, it could account for the difference in the IG group’s SES scores between Time 2 and Time 3.

Another possible confound to the study is the difference between the groups on the SASB, before any intervention had taken place. Participants in the IG group were more likely to view their significant others as acting and reacting more autonomously during the worst times of their relationships. These interactions may be reminiscent of expressed emotion research, which implies that individuals who see their significant others as having high EE have more relapses, more re-hospitalizations, increased symptoms, and feel more criticized than individuals who have social supports with low EE (Bertrando et al., 2006; Brown & Rutter, 1996; Kuipers, 2006; Leff & Vaughn, 1985; Rosenfarb et al., 1995). It is hard to say if these differences impacted the results, but they should not go without mentioning. Essentially, the “ta” group may have had more difficult relationships with their significant others. The differences found on the outcome measures may have been more amplified if the groups were not different with respect to their relationship perceptions. Additionally, more differences may have been found in areas where they were not if both groups were similar how they felt their relationships were going.

Similarly, the groups appeared to differ in how difficult they were to engage in the assessment. The significant differences between the groups for lean time (the lean
time was less for the IG group) and the significant negative association between lean time and the SASB AUT scores suggest that the examiner was mirroring the behavior of the participants. Therefore, it appears that there was a lower level of interpersonal engagement in the IG group, but that this was largely accounted for by the participants’ own preference for interpersonal distance.

**Single Assessor.** Another possible limitation to the study is that only one person was collecting the data. Though this may have provided some uniformity throughout the assessment process, it may have also interfered with some of the data. The limiting factor for involving only a single assessor is that the findings may not be generalizable. Future studies may want to focus on having multiple, trained assessors. This may help determine if the lack of significant differences for the MHRM and the AQ-2 was due to a single person collecting the data and interacting with the participants.

**Limitations of Therapeutic Assessment in General.** Though Therapeutic Assessment has been shown to be helpful in research, a possible limitation to the process concerns developing the assessment questions. The questions that are formed by the examiner and the client are restricted to the tests that are available for the assessment. In other words, the questions need to be formed in such a way that the tests on hand can answer. Because of this, clients’ questions need to be reworded to fit what the assessment tools can measure. This may run a risk of losing some of the meaning of the questions in the translation.

**Future Ideas.** Given that there was such a difference between the “ta” group participants and the IG group participants with regard to how they viewed their relationships, future studies regarding therapeutic assessment in an SMI population may
benefit from including a short, social support measure in the outcome measures. For instance, Hupp (2008) recently developed the Wellness Management and Recovery (WMR) Social Support Questionnaire—a 7-item social support measure to assess SMI clients’ perceptions of the number and quality of their social supports—which was used in Hupp’s master’s thesis and found increased social support for individuals diagnosed with an SMI after a recovery-focused treatment. It would be interesting to observe differences between the perceptions or changes in their social support after participating in a summary discussion session of a therapeutic assessment or not receiving feedback at all.

Furthermore, a focus of research may be to include significant others or therapists in the assessment. Participants in the current study were given the choice to include other individuals but no one signed consent forms for their therapists or a third party to review the results. Though they were encouraged to share the information with others, this was not built-in to the study. As mentioned earlier, participants in Finn and Tonsager (1992) and Newman and Greenway (1997) were involved with or awaiting outpatient counseling, which might have made a difference. Furthermore, given that some research has shown that for social support to significantly impact mental health recovery the positive interactions with social support need to be in place for 12 months, the time with the assessor may not have been long enough in this case (McCorkle et al., 2008). Were individuals included that have been a part of the participants lives for longer, larger differences between the groups may have been seen.

Thirdly, research with SMI and self-esteem has shown that if psychosocial intervention is not implemented, then self-esteem plummets. It is clear that more research
needs to be done with both the SMI population as well as with therapeutic assessment. The results of the current study indicated that therapeutic assessment regarding social support may positively impact self-esteem. Future studies should be conducted to attempt to replicate this finding.

Finally, forthcoming studies may desire to include a third control group similar to the third group in Kirby (2004) and the control group in Finn and Tonsager (1992)—a control group where the participants do not participate in an assessment at all. It would be interesting to determine if simply participating in an assessment, let alone a collaborative assessment, impacts individuals diagnosed with an SMI.
References


Appendix A: Consent Forms
Purpose: You are invited to participate in the research project entitled, Therapeutic Assessment with Interpersonal Measures, conducted at the University of Toledo under the direction of Joni L. Mihura, Ph.D., and Erin Farrer, M.A. In order to participate in this study, you must have a diagnosis of bipolar disorder, schizophrenia, major depression, panic disorder, or obsessive compulsive disorder. The purpose of this study is to evaluate the effectiveness of a particular method of assessment on your understanding of your relationships. The assessment will provide you with the chance to work collaboratively with the assessor to obtain answers to questions that you have about your relationships. This will hopefully give you new insight into your relationships.

Description of Procedures: This research will take place in the University of Toledo Psychology Clinic. It is occurring for one year. This will be limited to two meetings.

We are going to ask you to come up with assessment questions regarding a relationship.

Then, you will be asked to take a total of five questionnaires and one storytelling task for which you will evaluate your expectations and experience of your participation, your view of your mental health recovery, your self-esteem, the quality of your relationships, and the symptoms that you are experiencing, and describe a story that would go with two pictures presented to you. You will complete three of these measures a total of three times.

After you complete second set of measures, you will participate in a 30-minute discussion of your responses to the questions. At this time, you will complete three of the questionnaires for a second time.

You will then return for a second meeting to complete the three questionnaires for a third and final time.

Your participation will take about three hours total. We will be meeting for two hours today and for one hour a month from now. If you have any questions before our next meeting regarding what we discuss today, you may call me to discuss the information. I will also be videotaping our sessions; however, the focus will be on me, not on you.

Permission to record: Will you permit the researcher to video record during this research procedure?
After you have completed your participation, the research team will debrief you about the data, theory and research area under study and answer any questions you may have about the research.

**Potential Risks:** There are minimal risks to participation in this study, including loss of confidentiality. You may also find the process difficult and feel a rise in anxiety because you will be disclosing information about a personal relationship. You will also be answering questions about yourself, which may lead to some short-term anxiety. However, the assessor you will be working with is trained to encourage and support you in obtaining a positive experience through your participation.

**Potential Benefits:** The only direct benefit to you if you participate in this research may be that you will learn about how psychology experiments are run and may learn more about your relationships. Others may benefit by learning about the results of this research.

In addition to the research benefits from this study, you will be entered into a drawing for a prize (e.g., a $25 gift certificate to a local store).

**Confidentiality:** The researchers will make every effort to prevent anyone who is not on the research team from knowing that you provided this information, or what that information is. The consent forms with signatures will be kept separate from responses, which will not include names and which will be presented to others only when combined with other responses. Although we will make every effort to protect your confidentiality, there is a low risk that this might be breached.

You may choose to share the information from the assessment session with a third party (e.g., therapist, case manager, social worker, psychiatrist). If you would like the information sent to a third party, please indicate below:

_____ I would like to participate in the study, and I would like the information sent to:

_____ I would like to participate in the study; however, I do not want my information sent to a third party.

**Voluntary Participation:** Your refusal to participate in this study will involve no penalty or loss of benefits to which you are otherwise entitled and will not affect your relationship with The University of Toledo or any of your classes or activities in which you are involved. In addition, you may discontinue participation at any time without any penalty or loss of benefits.
**Contact Information:** Before you decide to accept this invitation to take part in this study, you may ask any questions that you might have. If you have any questions at any time before, during or after your participation, or experience any physical or psychological distress as a result of this research, you should contact a member of the research team (Dr. Joni L. Mihura at 419-530-2716, or Erin Farrer at 419-530-7280). If you have questions beyond those answered by the research team or your rights as a research subject or research-related injuries, please feel free to contact Dr. Jeffrey Busch, research compliance coordinator at (419) 530-2844, or the Chairperson of the SBE Institutional Review Board, Dr. Barbara Chesney, in the Office of Research on the main campus at (419) 530-2844.

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

**SIGNATURE SECTION – Please read carefully**

You are making a decision whether or not to participate in this research study. Your signature indicates that you have read the information provided above, you have had all your questions answered, and you have decided to take part in this research.

The date you sign this document to enroll in this study, that is, today's date must fall between the dates indicated at the bottom of the page.

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**THE UNIVERSITY OF TOLEDO**  
**SOCIAL, BEHAVIORAL & EDUCATIONAL INSTITUTIONAL REVIEW BOARD**

The research project described in this consent form and the form itself have been reviewed and approved by the University of Toledo Social, Behavioral & Educational Review Board (SBE IRB) for the period of time specified below.

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__________________  
Barbara Chesney, Ph.D., Chair  
UT Social Behavioral & Educational IRB
ADULT RESEARCH SUBJECT - INFORMED CONSENT FORM
Therapeutic Assessment with Interpersonal Measures (Form B)

Principal Investigator: Joni L. Mihura, Ph.D., Chair, 419-530-2716
Erin Farrer, M.A., Graduate Student, 419-530-7280

Purpose: You are invited to participate in the research project entitled, Therapeutic Assessment with Interpersonal Measures, conducted at the University of Toledo under the direction of Joni L. Mihura, Ph.D., and Erin Farrer, M.A. In order to participate in the study, you must have a diagnosis of bipolar disorder, schizophrenia, major depression, panic disorder, or obsessive compulsive disorder. The purpose of this study is to evaluate the effectiveness of a particular method of assessment on your understanding of your relationships. The assessment will provide you with the chance to work collaboratively with the assessor to obtain answers to questions that you have about your relationships. This will hopefully give you new insight into your relationships.

Description of Procedures: This research will take place in the University of Toledo Psychology Clinic. It is occurring for one year. This will be limited to two meetings.

Then, you will be asked to take a total of five questionnaires and one storytelling task for which you will evaluate your expectations and experience of your participation, your view of your mental health recovery, your self-esteem, the quality of your relationships, and the symptoms that you are experiencing, and describe a story that would go with two pictures presented to you. You will complete three of these measures a total of three times.

After you complete the second set of measures, you will participate in a 30-minute interview with the examiner about current concerns in your life. At this time, you will complete three of the questionnaires for a second time.

You will then return for a second meeting to discuss your responses to each of the measures and to complete the three questionnaires for a third and final time. Your participation will take about three hours total. We will be meeting for two hours today and for one hour a month from now. I will also be videotaping our sessions; however, the focus will be on me, not on you.

Permission to record: Will you permit the researcher to video record during this research procedure?
After you have completed your participation, the research team will debrief you about the data, theory and research area under study and answer any questions you may have about the research.

**Potential Risks:** There are minimal risks to participation in this study, including loss of confidentiality. You may also find the process difficult and feel a rise in anxiety because you will be disclosing information about a personal relationship. You will also be answering questions about yourself, which may lead to some short-term anxiety. However, the assessor you will be working with is trained to encourage and support you in obtaining a positive experience through your participation.

**Potential Benefits:** The only direct benefit to you if you participate in this research may be that you will learn about how psychology experiments are run and may learn more about your relationships. Others may benefit by learning about the results of this research.

In addition to the research benefits from this study, you will be entered into a drawing for a prize (i.e., a $25 gift certificate to a local store).

**Confidentiality:** The researchers will make every effort to prevent anyone who is not on the research team from knowing that you provided this information, or what that information is. The consent forms with signatures will be kept separate from responses, which will not include names and which will be presented to others only when combined with other responses. Although we will make every effort to protect your confidentiality, there is a low risk that this might be breached.

You may choose to share the information from the assessment session with a third party (e.g., therapist, case manager, social worker, psychiatrist). If you would like the information sent to a third party, please indicate below:

_____ I would like to participate in the study, and I would like the information sent to:

_____ I would like to participate in the study; however, I do not want my information sent to a third party.

**Voluntary Participation:** Your refusal to participate in this study will involve no penalty or loss of benefits to which you are otherwise entitled and will not affect your relationship with The University of Toledo or any of your classes or activities in which you are involved. In addition, you may discontinue participation at any time without any penalty or loss of benefits.
**Contact Information:** Before you decide to accept this invitation to take part in this study, you may ask any questions that you might have. If you have any questions at any time before, during or after your participation, or experience any physical or psychological distress as a result of this research, you should contact a member of the research team (Dr. Joni L. Mihura at 419-530-2716, or Erin Farrer at 419-530-7280). If you have questions beyond those answered by the research team or your rights as a research subject or research-related injuries, please feel free to contact Dr. Jeffrey Busch, research compliance coordinator at (419) 530-2844, or the Chairperson of the SBE Institutional Review Board, Dr. Barbara Chesney, in the Office of Research on the main campus at (419) 530-2844.

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

**SIGNATURE SECTION – Please read carefully**

You are making a decision whether or not to participate in this research study. Your signature indicates that you have read the information provided above, you have had all your questions answered, and you have decided to take part in this research.

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**THE UNIVERSITY OF TOLEDO**
**SOCIAL, BEHAVIORAL & EDUCATIONAL INSTITUTIONAL REVIEW BOARD**

The research project described in this consent form and the form itself have been reviewed and approved by the University of Toledo Social, Behavioral & Educational Review Board (SBE IRB) for the period of time specified below.

SBE IRB #: ____________________ Approved Number of Human Subjects: ______

Project Start Date: ____________ Project Expiration Date: ______________

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Date: ______________

Barbara Chesney, Ph.D., Chair
UT Social Behavioral & Educational IRB
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<td>Principal Investigator: <strong>Erin Farrer, M.A</strong>.</td>
<td>VAMC: <strong>Cleveland (541)</strong></td>
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<td>Consent Version Date: <strong>4/3/2009</strong></td>
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**DESCRIPTION OF RESEARCH BY INVESTIGATOR**

**NOTE:** The consent form should include the following section headings:

I. Purpose of the Study                      VI. Alternative Procedure(s)/Treatment(s)
II. Description of the Study                 VII. Privacy, Confidentiality, and Use of Research Results
III. Inconveniences                         VIII. Special Circumstances
IV. Discomforts/Risks/Side Effects          IX. Contact Information
V. Benefits

**TO POTENTIAL PARTICIPANTS:** Federal regulations require written informed consent before participation in a research study. This is to be certain that research volunteers know the nature and risks of the study, so they can make an informed decision about participation. You are asked to read the following information and discuss it with the investigator, so that you understand this research study and how it may affect you. Your signature on this form means that you have been fully informed and that you freely give your consent to participate. It is also important that you read and understand these principles that apply to all individuals who agree to participate in the research project below:

1. Taking part in the research is entirely voluntary.

2. You may not personally benefit from taking part in the research but the knowledge obtained may help the health care professionals caring for you to better understand the disease/condition and how to treat it.
3. You may withdraw from the study at any time without anyone objecting and without penalty or loss of any benefits to which you are otherwise entitled.

4. If, during your participation in the research project, new information becomes available concerning your condition (disease) or concerning better therapies, which may affect your willingness to continue in the research project, your doctor will discuss the new information with you and will help you make a decision about continuing in the research.

5. The purpose of the research, how it will be done, and what your part in the research will be, is described below. Also described are the risks, inconveniences, discomforts, and other important information, which you need to make a decision about whether or not you wish to participate. You are urged to discuss any questions, concerns, or complaints you have about this research with the research staff members.

I. PURPOSE OF THE STUDY:

You are invited to participate in the research project entitled, Comparing Therapeutic Assessment and Traditional Assessment in Seriously Mentally Ill (SMI) Adults, conducted at the Louis Stokes Cleveland Department of Veteran Affairs Medical Center (LSCDVAMC), under the direction of Julie Harmon, Ph.D., and Erin Farrer, M.A. In order to participate in this study, you must have a diagnosis of bipolar disorder, schizophrenia, or schizoaffective disorder. The purpose of this study is to evaluate the effectiveness of a particular method of psychological assessment. The assessment will provide you with the chance to work collaboratively with the assessor to obtain answers to questions that you have about your relationships. This may give you new insights into your relationships.

II. DESCRIPTION OF STUDY:

This research will take place at the LSCDVAMC. It will take place over one year and involve two meetings.
You will be asked to complete a total of five questionnaires and one storytelling task. You will evaluate your expectations and experience of your participation in this study, your view of your mental health recovery, your self-esteem, the quality of your relationships, the symptoms that you are experiencing, and describe a story that could explain two pictures presented to you. You will complete three of these measures a total of three times, twice in the first session and once in the second session.

Prior to completing the questionnaires regarding your social relationships and symptoms, the examiner will ask you to come up with assessment questions regarding a significant relationship in your life. You will participate in a 15 to 30 minute discussion with the examiner regarding these questions.

After you complete a set of measures regarding your social relationships and symptoms, you will participate in a 15 to 30-minute discussion of your responses to the questions. At this time, you will complete three questionnaires for a second time.

You will then return for a second meeting to complete three questionnaires for a third and final time.

Your participation will take about three hours total. We will be meeting for two hours today and for one hour three to five weeks from now. If you have any questions before our next meeting regarding what we discuss today, you may call me to discuss the information. The examiner will be videotaped without sound during the sessions. You will not be videotaped.

After you have completed your participation, the research team will debrief you about the data, theory and research area under study and answer any questions you may have about the research.

**Randomization/Study Intervention**
You will be randomly assigned (like the flip of a coin) to one of two groups: the experimental group (therapeutic assessment group) or control group (standard assessment). You will have a 50% chance of being assigned to either group.
Subjects assigned to the control group will receive a standard assessment.

**Follow-up Procedures**

The follow-up meeting (three to five weeks from today), will consist of completing three of the questionnaires for a final time.

### III. INCONVENIENCES:

You will need to provide your own transportation to and from LSCDVAMC.

### IV. DISCOMFORTS / RISKS / SIDE EFFECTS:

There are minimal risks to participation in this study, including loss of confidentiality. You may also find the process difficult and feel a rise in anxiety because you will be disclosing information about a social relationship. You will also be answering questions about yourself, which may lead to some short-term anxiety. However, the assessor you will be working with is trained to encourage and support you in obtaining a positive experience through your participation.

### V. BENEFITS:

The only direct benefit to you if you participate in this research may be that you will learn about how psychology experiments are run and may learn more about your relationships. Others may benefit by learning about the results of this research.

### VI. ALTERNATIVE PROCEDURE(S) / TREATMENT(S):

You have the alternative to not participate.

### VII. PRIVACY, CONFIDENTIALITY, AND USE OF RESEARCH RESULTS:

Any information obtained about you in this study will be treated as confidential and will be safeguarded in accordance with the Privacy Act of 1974.
When your information is given to other researchers working with this study, your information will be labeled with a unique code. Only Erin Farrer, the principal investigator, will be able to identify you. The paper research records will be kept in a locked filing cabinet in a locked office. Any electronic research records will be kept on a password-protected computer. The researchers will make every effort to prevent anyone who is not on the research team from knowing that you provided this information, or what that information is. The consent forms with signatures will be kept separate from responses, which will not include names and which will be presented to others only when combined with other responses. Although we will make every effort to protect your confidentiality, there is a low risk that this might be breached.

Your identity will not be disclosed unless you give specific, separate consent to this or if it is required by the law. The law requires us to keep study records for six years following the end of the study.

In order to comply with federal regulations, research records identifying you may be reviewed by the following:

- Authorized representatives of the LSCDVAMC Institutional Review Board and VA
- Federal Agencies such as the Government Accounting Office (GAO), the Food and Drug Administration (FDA) [if applicable], the Office for Human Research Protections (OHRP)
- The Medical Research and Education Foundation [if subject reimbursement is administered by the Foundation]

“Because this research involves articles regulated by the FDA, the FDA may choose to inspect and copy medical or research records that identify individual research participants”.

VIII. SPECIAL CIRCUMSTANCES:

Financial Considerations
Your participation in this research study will be done at no cost to you. For your participation, you can receive up to a total of $10 in VA Canteen Coupons ($5 for completing each of two sessions).
Ending Participation

The investigators may stop your participation in this study without your consent, for example, if they think that it will be in your best interest, if you do not follow the study plan, if you experience a study-related injury, or for any other reason.

Voluntary Participation

If you are a student, resident, or employee of (LSCDVAMC, UH, Case, etc.), your scholastic or employment evaluations will be conducted by a rater who is not involved with, and most likely totally unaware of this study. In no way will your job or position be affected by your decision to join or not join this study.

Compensation for Research-Related Injury

If you sustain physical injury as a direct result of your study participation, medical care will be provided by the LSCDVAMC at no cost to you. Financial compensation for such things as lost wages, disability, or discomfort due to an injury is not available.

VIII. CONTACT INFORMATION

The following is a list of contact names and phone numbers.

To obtain answers to questions about the research contact the following:

- During the Day: Erin Farrer (440-526-3030 ext. 6900)
  Julie Harmon, Ph.D. (440-526-3030 ext. 6923)
- After Hours: Psychology Services (440-526-3030 ext. 7823)
  Ask to speak with or leave a message for Dr. Julie Harmon

To voice concerns or complaints about the research contact the following:

- The Research Compliance Office at (216) 791-3800 ext. 4625
- The LSCDVAMC Patient Representative at (216) 791-3800 ext. 4026

To obtain answers to questions about their rights as a research participant contact the following:
• The Research Compliance Office at (216) 791-3800 ext. 4625

In the event that you sustain a research related injury contact the following:

• During the Day: Erin Farrer (440-526-3030 ext. 6900)
  Julie Harmon, Ph.D. (440-526-3030 ext. 6923)
• After Hours: Psychology Services (440-526-3030 ext. 7823)
  Ask to speak with or leave a message for Dr. Julie Harmon

In the event the study staff could not be reached contact the following:

• During the Day: Psychology Services (440-526-3030 ext. 6900)
• After Hours: Psychology Services (440-526-3030 ext. 7823)
  Ask to speak with or leave a message for Dr. Julie Harmon

In the event the you wish to talk with someone other than the study staff contact the following:

• The LSCDVAMC Institutional Review Board Office at (216) 791-3800 ext. 4658

To provide input concerning the research process contact the following:

• The LSCDVAMC Institutional Review Board Office at (216) 791-3800 ext. 4658

To check whether a study is being conducted at the LSCDVAMC and whether study staff are permitted to represent the study contact the following:

• The LSCDVAMC Institutional Review Board Office at (216) 791-3800 ext. 4658
**RESEARCH SUBJECTS' RIGHTS:** I have read or have had read to me all of the preceding information.

Dr./Mr./Ms. ___________________________ has explained the study to me and answered all of my questions. I have been told of the risks or discomforts and possible benefits of the study. I have been told of other choices of treatment available to me.

I understand that I do not have to take part in this study, and my refusal to participate will involve no penalty or loss of rights to which I am entitled. I may withdraw from this study at any time without penalty or loss of VA or other benefits to which I am entitled.

The results of this study may be published, but I will not be identified in publications by name, photograph, or other identifiers. My records, including my name and results of my participation, may be revealed as required by laws and regulations of state and federal agencies.

I understand my rights as a subject, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I will receive a

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**REMOVE THIS SECTION IF YOUR STUDY WILL ONLY ENROLL SUBJECTS THAT HAVE THE CAPACITY TO PROVIDE INFORMED CONSENT**

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<th>Signature of Witness (not associated with study)</th>
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<th>Signature of Investigator</th>
<th>Date</th>
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</table>
Subject Name: ______________________________  Date: ______________

Title of Study: Comparing Therapeutic Assessment and Traditional Assessment in SMI Adults (Form IG)

Principal Investigator: Erin Farrer, M.A.  VAMC: Cleveland (541)

Consent Version Date: 4/3/2009

DESCRIPTION OF RESEARCH BY INVESTIGATOR

NOTE: The consent form should include the following section headings:

I. Purpose of the Study  VI. Alternative Procedure(s)/Treatment(s)

II. Description of the Study  VII. Privacy, Confidentiality, and Use of Research Results

III. Inconveniences  VIII. Special Circumstances

IV. Discomforts/Risks/Side Effects  IX. Contact Information

V. Benefits

TO POTENTIAL PARTICIPANTS: Federal regulations require written informed consent before participation in a research study. This is to be certain that research volunteers know the nature and risks of the study, so they can make an informed decision about participation. You are asked to read the following information and discuss it with the investigator, so that you understand this research study and how it may affect you. Your signature on this form means that you have been fully informed and that you freely give your consent to participate. It is also important that you read and understand these principles that apply to all individuals who agree to participate in the research project below:

1. Taking part in the research is entirely voluntary.

2. You may not personally benefit from taking part in the research but the knowledge obtained may help the health care professionals caring for you to better understand the disease/condition and how to treat it.
3. You may withdraw from the study at any time without anyone objecting and without penalty or loss of any benefits to which you are otherwise entitled.

4. If, during your participation in the research project, new information becomes available concerning your condition (disease) or concerning better therapies, which may affect your willingness to continue in the research project, your doctor will discuss the new information with you and will help you make a decision about continuing in the research.

5. The purpose of the research, how it will be done, and what your part in the research will be, is described below. Also described are the risks, inconveniences, discomforts, and other important information, which you need to make a decision about whether or not you wish to participate. You are urged to discuss any questions, concerns, or complaints you have about this research with the research staff members.

I. PURPOSE OF THE STUDY:

You are invited to participate in the research project entitled, Comparing Therapeutic Assessment and Traditional Assessment in Seriously Mentally Ill (SMI) Adults, conducted at the Louis Stokes Cleveland Department of Veteran Affairs Medical Center (LSCDVAMC), under the direction of Julie Harmon, Ph.D., and Erin Farrer, M.A. In order to participate in this study, you must have a diagnosis of bipolar disorder, schizophrenia, or schizoaffective disorder. The purpose of this study is to evaluate the effectiveness of a particular method of psychological assessment. The assessment will provide you with the chance to work collaboratively with the assessor to obtain answers to questions that you have about your social relationships. This may give you new insights into your relationships.

II. DESCRIPTION OF STUDY:

This research will take place at the LSCDVAMC. It will take place over one year and involve two meetings.
You will be asked to take a total of five questionnaires and one storytelling. You will evaluate your expectations and experience of your participation in this study, your view of your mental health recovery, your self-esteem, the quality of your relationships, the symptoms that you are experiencing, and describe a story that could explain two pictures presented to you. You will complete three of these measures a total of three times, twice in the first session and once in the second session.

Prior to completing the questionnaires regarding your social relationships and symptoms, you will participate in a 15 to 30 minute discussion with the examiner regarding these questions.

After you complete the set of measures regarding your social relationships, you will participate in an interview with the examiner about current concerns in your life. At this time, you will complete three questionnaires for a second time.

You will then return for a second meeting to discuss your responses to each of the measures and to complete three questionnaires for a third and final time. Your participation will take about three hours total. We will be meeting for two hours today and for one hour three to five weeks from now. The examiner will be videotaped without sound during the sessions. You will not be videotaped.

After you have completed your participation, the research team will debrief you about the data, theory and research area under study and answer any questions you may have about the research.

**Randomization/Study Intervention**

You will be randomly assigned (like the flip of a coin) to one of two groups: the experimental group (therapeutic assessment group) or control group (standard assessment). You will have a 50% chance of being assigned to either group. Subjects assigned to the control group will receive a standard assessment.

**Follow-up Procedures**

The follow-up meeting (three to five weeks from today), will consist of completing three questionnaires for a final time.
III. INCONVENIENCES:

You will need to provide your own transportation to and from LSCDVAMC.

IV. DISCOMFORTS / RISKS / SIDE EFFECTS:

There are minimal risks to participation in this study, including loss of confidentiality. You may also find the process difficult and feel a rise in anxiety because you will be disclosing information about a social relationship. You will also be answering questions about yourself, which may lead to some short-term anxiety. However, the assessor you will be working with is trained to encourage and support you in obtaining a positive experience through your participation.

V. BENEFITS:

The only direct benefit to you if you participate in this research may be that you will learn about how psychology experiments are run and may learn more about your relationships. Others may benefit by learning about the results of this research.

VI. ALTERNATIVE PROCEDURE(S) / TREATMENT(S):

You have the alternative to not participate.

VII. PRIVACY, CONFIDENTIALITY, AND USE OF RESEARCH RESULTS:

Any information obtained about you in this study will be treated as confidential and will be safeguarded in accordance with the Privacy Act of 1974.

When your information is given to other researchers working with this study, your information will be labeled with a unique code. Only Erin Farrer, the principal investigator, will be able to identify you. The paper research records will be kept in a locked filing cabinet in a locked office. Any electronic research records will be kept on a password-protected computer. The researchers will make every effort to prevent anyone who is not on the research team from knowing that you
provided this information, or what that information is. The consent forms with signatures will be kept separate from responses, which will not include names and which will be presented to others only when combined with other responses. Although we will make every effort to protect your confidentiality, there is a low risk that this might be breached.

Your identity will not be disclosed unless you give specific, separate consent to this or if it is required by the law. The law requires us to keep study records for six years following the end of the study.

In order to comply with federal regulations, research records identifying you may be reviewed by the following:

- Authorized representatives of the LSCDVAMC Institutional Review Board and VA
- Federal Agencies such as the Government Accounting Office (GAO), the Food and Drug Administration (FDA) [if applicable], the Office for Human Research Protections (OHRP)
- The Medical Research and Education Foundation [if subject reimbursement is administered by the Foundation]

“Because this research involves articles regulated by the FDA, the FDA may choose to inspect and copy medical or research records that identify individual research participants”.

VIII. SPECIAL CIRCUMSTANCES:

Financial Considerations
Your participation in this research study will be done at no cost to you. For your participation, you can receive up to a total of $10 in VA Canteen Coupons ($5 for completing each of two sessions).

Ending Participation

The investigators may stop your participation in this study without your consent, for example, if they think that it will be in your best
interest, if you do not follow the study plan, if you experience a study-
related injury, or for any other reason.

Voluntary Participation

If you are a student, resident, or employee of (LSCDVAMC, UH, 
Case, etc.), your scholastic or employment evaluations will be 
conducted by a rater who is not involved with, and most likely totally 
unaware of this study. In no way will your job or position be affected 
by your decision to join or not join this study.

Compensation for Research-Related Injury

If you sustain physical injury as a direct result of your study 
participation, medical care will be provided by the LSCDVAMC at no 
cost to you. Financial compensation for such things as lost wages, 
disability, or discomfort due to an injury is not available.

VIII. CONTACT INFORMATION

The following is a list of contact names and phone numbers.
To obtain answers to questions about the research contact the following:

- During the Day: Erin Farrer (440-526-3030 ext. 6900) 
  Julie Harmon, Ph.D. (440-526-3030 ext. 6923)
- After Hours: Psychology Services (440-526-3030 ext. 7823) 
  Ask to speak with or leave a message for Dr. Julie 
  Harmon

To voice concerns or complaints about the research contact the 
following:

- The Research Compliance Office at (216) 791-3800 ext. 4625
- The LSCDVAMC Patient Representative at (216) 791-3800 ext. 
  4026

To obtain answers to questions about their rights as a research 
participant contact the following:

- The Research Compliance Office at (216) 791-3800 ext. 4625
In the event that you sustain a research related injury contact the following:

- During the Day: Erin Farrer (440-526-3030 ext. 6900)
  Julie Harmon, Ph.D. (440-526-3030 ext. 6923)
- After Hours: Psychology Services (440-526-3030 ext. 7823)
  Ask to speak with or leave a message for Dr. Julie Harmon

In the event the study staff could not be reached contact the following:

- During the Day: Psychology Services (440-526-3030 ext. 6900)
- After Hours: Psychology Services (440-526-3030 ext. 7823)
  Ask to speak with or leave a message for Dr. Julie Harmon

In the event you wish to talk with someone other than the study staff contact the following:

- The LSCDVAMC Institutional Review Board Office at (216) 791-3800 ext. 4658

To provide input concerning the research process contact the following:

- The LSCDVAMC Institutional Review Board Office at (216) 791-3800 ext. 4658

To check whether a study is being conducted at the LSCDVAMC and whether study staff are permitted to represent the study contact the following:

- The LSCDVAMC Institutional Review Board Office at (216) 791-3800 ext. 4658
RESEARCH SUBJECTS' RIGHTS: I have read or have had read to me all of the preceding information.

Dr./Mr./Ms. ___________________________ has explained the study to me and answered all of my questions. I have been told of the risks or discomforts and possible benefits of the study. I have been told of other choices of treatment available to me.

I understand that I do not have to take part in this study, and my refusal to participate will involve no penalty or loss of rights to which I am entitled. I may withdraw from this study at any time without penalty or loss of VA or other benefits to which I am entitled.

The results of this study may be published, but I will not be identified in publications by name, photograph, or other identifiers. My records, including my name and results of my participation, may be revealed as required by laws and regulations of state and federal agencies.

I understand my rights as a subject, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I will receive a

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<tr>
<th>Subject's Signature</th>
<th>Date</th>
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<tr>
<th>REMOVE THIS SECTION IF YOUR STUDY WILL ONLY ENROLL SUBJECTS THAT HAVE THE CAPACITY TO PROVIDE INFORMED CONSENT</th>
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<tr>
<td>Signature of Subject’s Representative</td>
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<tr>
<td>Date</td>
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<td>(if subject not competent)</td>
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<tr>
<th>Signature of Witness (not associated with study)</th>
<th>Date</th>
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<tr>
<th>Signature of Person Obtaining Consent</th>
<th>Date</th>
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<tr>
<th>Signature of Investigator</th>
<th>Date</th>
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Appendix B: Demographic Information

Demographic Information

Please respond to the following questions by either filling in the blank or circling the appropriate response.

Age: ________  Gender: ________

Ethnicity:
A) European-American  
B) African American  
C) Latin American/Hispanic  
D) Native American  
E) Asian American  
F) Arab American  
G) Other ___________________

Marital Status:
A) Single  
B) Married  
C) Divorced/Separated  
D) Widowed  
E) Co-habitating

Diagnosis (circle all that apply):
A) Bipolar Disorder  
B) Schizophrenia  
C) Schizoaffective Disorder  
D) Other ___________________

Date Diagnosed: ____________

Medications:
___________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Number of Hospitalizations: _________ Date of last hospitalization: _________

Have you ever participated in a psychological assessment? ___________________

If so, what tests were you administered?
________________________________________________________________________
Appendix C: Mental Health Recovery Measure

**Mental Health Recovery Measure (MHRM)**
*(Young & Bullock, 2003)*

The goal of this questionnaire is to find out how you view your own mental health recovery process. There are no right or wrong answers. Please read each statement carefully and indicate how much you agree or disagree with each item by filling in the appropriate circle. If more than one response seems to fit, pick the one that seems to fit best most of the time. (Fill in only one answer for each question.) Thank you.

**SD = Strongly Disagree  D = Disagree  NS = Not Sure  A = Agree  SA = Strongly Agree**

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<thead>
<tr>
<th></th>
<th></th>
<th>SD</th>
<th>D</th>
<th>NS</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I work hard towards my mental health recovery.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>2.</td>
<td>Even though there are hard days, things are improving for me.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.</td>
<td>I ask for help when I am not feeling well</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>4.</td>
<td>I take risks to move forward with my recovery.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>5.</td>
<td>I believe in myself.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>6.</td>
<td>I have control over my mental health problems.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>7.</td>
<td>I am in control of my life.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>8.</td>
<td>I socialize and make friends.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>9.</td>
<td>Everyday is a new opportunity for learning.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>10.</td>
<td>I still grow and change in positive ways despite my mental health problems.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>11.</td>
<td>Even though I may still have problems, I value myself as a person of worth.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>12.</td>
<td>I understand myself and have a good sense of who I am.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>13.</td>
<td>I eat nutritious meals every day.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>14.</td>
<td>I go out and participate in enjoyable activities every week.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>15.</td>
<td>I make the effort to get to know other people.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>16.</td>
<td>I am comfortable with my use of prescribed medications.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>17.</td>
<td>I feel good about myself.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>18.</td>
<td>The way I think about things helps me to achieve my goals.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>19.</td>
<td>My life is pretty normal.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>20.</td>
<td>I feel at peace with myself.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>21.</td>
<td>I maintain a positive attitude for weeks at a time.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>22.</td>
<td>My quality of life will get better in the future.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>23.</td>
<td>Every day that I get up, I do something productive.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>24.</td>
<td>I am making progress towards my goals.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>25.</td>
<td>When I am feeling low, my religious faith or spirituality helps me feel better.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>26.</td>
<td>My religious faith or spirituality supports my recovery.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>27.</td>
<td>I advocate for the rights of myself and others with mental health problems.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
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</table>
28. I engage in work or other activities that enrich myself and the world around me.

29. I cope effectively with stigma associated with having a mental health problem.

30. I have enough money to spend on extra things or activities that enrich my life.

Thank you for completing this measure.

The MHRM was developed with the help of mental health consumers by researchers at the University of Toledo. This research was supported through a grant from the Ohio Department of Mental Health, Office of Program Evaluation and Research. For further information, please contact Wesley Bullock, Ph.D. at (419) 530-2721 or email: wesley.bullock@utoledo.edu
Appendix D: Rosenberg Self-Esteem Scale

**Rosenberg Self-Esteem Scale**
(Rosenberg, 1965)

Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle **SA**. If you agree with a statement, circle **A**. If you disagree, circle **D**. If you strongly disagree, circle **SD**.

<p>| | | | | |</p>
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<tbody>
<tr>
<td>1.</td>
<td>On the whole, I am satisfied with myself.</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>2.</td>
<td>At times, I think I am no good at all.</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>3.</td>
<td>I feel that I have a number of good qualities.</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>4.</td>
<td>I am able to do things as well as most other people.</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>5.</td>
<td>I feel I do not have much to be proud of.</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>6.</td>
<td>I certainly feel useless at times.</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>7.</td>
<td>I feel that I’m a person of worth, at least on an equal plane with others.</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>8.</td>
<td>I wish I could have more respect for myself.</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>9.</td>
<td>All in all, I am inclined to feel that I am a failure.</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>10.</td>
<td>I take a positive attitude toward myself.</td>
<td>SD</td>
<td>D</td>
<td>A</td>
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Appendix E: Relationship Interview

**Questions for Relationship Interview**

1. What problems do you see in your relationship that you would like to understand better?

2. When do these problems seem to arise? Give me an example.

3. How long has it been going on?

4. What have you tried to do that has worked?

5. What have you tried that hasn’t worked?

6. How would you like things to change?
Appendix F: Questions for Information Gathering Group

Questions for IG Group

1. What is your diagnosis?

2. What medications are you taking for the diagnosis?

3. What has been the course of your illness? (i.e., when did you first notice symptoms, when was your first hospitalization, how many hospitalizations, etc.).

4. Has anyone that you know of in your family been diagnosed with a mental illness? If so, who?

5. How have your family and friends reacted to your illness?

6. Tell me a little bit about your social relationships.
Appendix G: Non-Verbal Rating Scale

*Measuring Nonverbal Behavior of Examiner*

1. Length (time) of smiles and number of smiles (if observable)
   __________________________

2. Leaning time toward participant __________ min.

3. Number of head nods _______________________________
Text from a “ta” participant letter:
I would like to thank you for participating in the study Comparing Therapeutic Assessment with Traditional Assessment in Seriously Mentally Ill Adults. I appreciate your time and openness in answering the questions during our meeting. As we discussed, I would be providing you with a summary letter regarding the information we talked about throughout our meetings.

You mentioned that you would like to improve your relationship with your wife. You reported that throughout the last two years, your relationship with your wife has felt a great deal of strain. You reported that you would like to figure out a way to take initiative without things “backfiring” on you. You also mentioned that you can act somewhat passive aggressively to your wife if she disapproves of your actions. Given this information, in our discussion, and in completing the assessment activities, the questions we were working with were:

**How can I become more aware of the things that I do? How do I contribute to the stress?**

Based on our discussion and how you responded to the various activities, it seems that you are working hard to monitor your symptoms and seem to be doing well as far as symptoms go. Regarding the best time of your relationship with your wife, you feel as though she tends to give you some healthy space. You also see her as acting protective and affirming towards you. You also feel that she can sometimes be controlling. In response to her actions, you try to show loving, positive actions toward her. You also are able to open up and trust her; however, you see yourself as being submissive to her. At the worst times of your relationship, you see your wife as attacking, blaming, controlling, and ignoring. When she acts like this, you tend to wall off from her, although sometimes you try to either submit to her wishes or to show positive actions.

With regards to how you act towards your wife, when things are going well, you primarily try to give her some distance as well as provide an environment where she can feel protected and safe to disclose how she feels. In response to those actions, you see your wife as taking the healthy distance at times, but also trusting you and showing positive actions in return. Sometimes, you still see her as sulking around you, though. During the worst times of your relationship, you tend to give your wife distance. In response to your actions, you see her as separating and walling off from you.

In putting all of this information, it might be helpful if you check with your wife to make sure that things do not “backfire” on you. Letting her know that you did something to help out, may help with feeling like you have contributed rather than feeling like you have let your wife down. Also, by checking in with her, you will know what she needs or wants and vice versa rather than feeling like you have to guess. Also, it seems like working on being assertive would help you be less passive aggressive toward your wife. Assertiveness may also help you feel like you are sharing control rather than your wife.
being in control and your being submissive to her. Finally, it appears like you put a lot of energy into making sure that you are doing right by your wife. One thing that may help you feel more in control of your own actions is if you found something that you felt mastery over. When we discussed this at our meeting, you mentioned that you would like to start swimming again. This may allow you to build the confidence needed for being assertive and will allow you to demonstrate initiative. Each of these suggestions would likely be best optimized by working with your individual provider to come up with strategies to help you with these recommendations.
Text from an IG participant letter:
I would like to thank you for participating in the study Comparing Therapeutic Assessment with Traditional Assessment in Seriously Mentally Ill Adults. I appreciate your time and openness in answering the questions during our meeting. I wanted to take the time to go over a summary of the information you gave during our discussion and by completing the questionnaires.

At our initial meetings, you mentioned that you would like to improve your relationship with your stepson. You had mentioned that your stepson does not want a relationship with you, but you do. You said that it had been about a year since you had contact with him. Your family is important to you, and you would like to mend some of the problems that you may have had a part of while your stepson was growing up. Given this information, in our discussion, and in completing the assessment activities, the questions we were working with were:

What can I do to change this relationship? Is there anything I can do?

Based on our discussion and how you responded to the various activities, it seems that you are working hard at monitoring your symptoms and that things are going pretty well for you as far as symptoms go. Regarding when your relationship with your stepson is at its best, you see him as acting distant from you. Sometimes he may be affirming and supportive, but for the most part, you see him as ignoring and blaming you. In response, you pull away from him and give him his space. However, you do also try to act in a loving and caring way towards him. During the worst time, you see your stepson as acting similarly as during the best time. You respond by pulling away and walling off from him.

When things are good in the relationship, you may have difficulty knowing how to act around your stepson. It seems that you fluctuate between being attacking, blaming and controlling of him. In response, he recoils and separates himself from you. At the worst time of your relationship, you again, attack and blame him. He responds by pulling away from your relationship; however, he may also open up to you.

In sum, there seems to be tension regardless of whether things are going well or not. It may be helpful to work with a provider on how to break the cycle that your relationship seems to be in. It may be that you are converting the feelings of guilt you have for how you treated him in the past to actions that are attacking and blaming toward your stepson. An individual provider would be able to help you work with those feelings so you can outwardly display the caring emotions that you would like.