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The Importance of Teaching and Learning Personality Assessment

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About midway into this chapter the reader will meet Maria, who lived in a shelter and was destitute because she couldn't hold a job. She had a ferocious temper and often would explode into violent rages, endangering herself and others. Through the use of personality assessment data, the therapist learned how the patient would treat him in the therapy sessions and what he had to do in the sessions to facilitate her treatment. As the reader will see, what the therapist learned through the assessment process was instrumental in guiding him to a successful outcome with the patient.

In a second example, explored later in this chapter, the therapist was not so fortunate, because although the assessment data could have pointed him in the right direction, he did not recall it, and the outcome was quite negative. After two frustrating and nonproductive sessions for both patient and therapist, the patient terminated her treatment.

These two case examples, as well as a number of other vignettes in this chapter, using a variety of assessment techniques (e.g., the Rorschach, Minnesota Multiphasic Personality Inventory [MMPI], Earliest Memories, the Wechsler Adult Intelligence Scale [WAIS]), present one argument among many that focuses on important reasons to learn and to teach personality assessment. We hope these examples illustrate that well-done assessments offer a quite unique window into the character structure and the subjective world of an individual. Assessment can offer an in-depth understanding of what many people have described as an "experience-near," three-dimensional view of the individual, explaining how he or she demonstrates the effects of his or her past and present life experiences through the vantage points of "self" and "other."

Overall, in this chapter we argue that the teaching and learning of personality assessment are quite important to the science and profession of psychology. Several avenues are taken to support this suggestion. At the outset, we articulate two visions of personality assessment: that of the *testing technician* and that of the *assessment clinician*. Our view is that personality assessment probably should *not* be taught to doctoral-level psychologists if the goal is to produce a testing technician. However, if the goal is to produce an assessment clinician, or an expert consultant skilled in understanding personality and in the use of particular tools for evaluation, there are a multitude of good reasons for teaching and learning assessment. As an arm of psychology, assessment regularly traverses the scientist-practitioner bridge, linking our nomothetic and ideographic traditions. Assessment is also the only arm of psychology that requires a practitioner to have expertise in all of the core areas of clinical psychology: psychopathology, child and adult development, treatment intervention, and psychometrics, to name a few. Further, the ability to perform knowledgeable and skilled assessment is what distinguishes clinical psychologists from all other mental health professionals, including psychiatrists, social workers, counselors of all stripes, and various paraprofessionals. Thus, assessment in general and personality assessment in particular should be a core feature of our professional identity. As we hope to make clear in this chapter, we believe it is imperative that psychology continues to train students in personality assessment in order to contribute unique skills to clinical practice and to advance theory and the scientific understanding of human nature (e.g., Westen, 1991b).

TWO VISIONS OF PERSONALITY ASSESSMENT

At the outset, we must clarify the important distinction between psychological testing and psychological assessment. They are hardly synonymous activities. Testing is a relatively straightforward process wherein a particular test is administered to obtain a specific score or two. Subsequently, a descriptive meaning can be applied to the score based on normative, nomothetic findings. For example, when conducting psychological testing, an IQ score of 100 indicates a person possesses average intelligence (Wechsler, 1981); a T-score of 67 on Scale 1 of the MMPI-2 indicates a self-centered, pessimistic, and cynical person who has multiple physical complaints that tend to be exaggerated (Butcher et al., 1989); and a score of 4 on the Weighted Sum of Cognitive Special Scores of the Rorschach indicates a person with average abilities to keep his or her thoughts and impressions organized in a logical fashion (Exner, 1993). Psychological testing is a relatively simple process that can be carried out by clinicians with relatively little training (depending on the test), by testing technicians, or even by computer.

Psychological assessment, however, is a quite different enterprise. The focus here is not on obtaining a single score, or even a series of test scores. Rather,

the focus is on taking a variety of test-derived pieces of information, obtained from multiple methods of assessment, and placing these data in the context of historical information, referral information, and behavioral observations in order to generate a cohesive and comprehensive understanding of the person being evaluated. These activities are far from simple; they require a high degree of skill and sophistication to be implemented properly.

As an example of the distinction between assessment and testing, reconsider the IQ score of 100 mentioned earlier. Let us assume this Full Scale score is derived from a person with above-average factual knowledge (i.e., crystallized intelligence), with this person having an average IQ of say 115 on tests that tap these abilities. However, this person also has below average ability when it comes to solving novel problems and thinking flexibly (i.e., fluid intelligence), with an average IQ of 85 on tests that tap these kinds of abilities. Assume also that this patient is a vascular surgeon who suffered a head injury during a car accident several months ago and appears at your office complaining of an inability to return to work, poor concentration, and impaired memory. Furthermore, the patient has difficulty following directions to your office and appears distracted and forgetful during your interview. In contrast to the conclusions that would be drawn from a psychological testing approach to the data, an assessment would not simply indicate the Full Scale IQ score of 100 denotes a person with average intelligence. Rather, the assessment clinician would probably also use the data to conclude this physician has suffered an intellectual decline from higher premorbid levels. This conclusion would be further bolstered if: (a) the clinician had prior test data indicating superior intellectual capacities (e.g., Medical College Admission Test [MCAT] scores, premorbid test data, college grade point average, etc.), (b) the clinician was able to use psychological tests sensitive to malingering to rule out the possibility that this physician was presenting herself in an impaired fashion in order to obtain financial compensation for her accident, and (c) the clinician had data from other tests that ruled out the possibility that this patient had a serious impairment in ego functions (i.e., a coincidental, late-life onset of psychotic-like functioning). Although members from other mental health disciplines could obtain information from the patient's history and behavior in the office, only a psychologist could employ the tests necessary to document and quantify all of the facets of this case and integrate the data in a meaningful way.

To further emphasize the distinction between testing and assessment, consider these processes in a medical context. The medical counterpart to psychological testing is found when technicians or medical personnel obtain scores on such instruments as a blood pressure gauge or a thermometer, or data such as a blood chemistry panel, deep tendon reflexes, and so forth. However, the medical counterpart to a psychological assessment is when a physician takes the information from these various tests and places them in the context of a patient's symptomatic presentation and history in order to accurately understand the full scope of his or her condition.

THE GOALS AND PURPOSES OF PERSONALITY ASSESSMENT

Testing data utilized in the assessment process assist the clinician in understanding a patient's conscious experiences and self-representations, his or her overt behaviors, and his or her unconscious dynamics. At the most intensive level, these data can provide a beacon for both apprentice and experienced clinician to negotiate uncharted waters in the journey into the depths of a patient's psyche, or, if the reader will forgive a poetic lapse, perhaps into his or her very soul. A high-quality assessment allows us to see behind the mask of mundane social intercourse, deep into the minds and hearts of our patients. A skillful assessor can explore and describe with empathic attunement painful conflicts as well as the ebb and flow of dynamic, perhaps conflictual forces being cautiously contained. The good assessor also attends to the facilitating and creative aspects of personality, and the harmonious interplay of intrapsychic and external forces, as the individual copes with day-to-day life issues.

In addition to such an understanding, the goal of clinical personality assessment is to provide expert consultation to patients seeking help and to the therapists or other professionals who refer them for evaluation. To be of value to the patient receiving an assessment, the description that emerges must answer some questions the person has about him or herself. As Finn (1996b, Finn & Tonsager, in press) has so clearly articulated, all people have some questions, fears, or concerns about their personality characteristics. Although it may generate mixed emotions, the feedback from an assessment must provide a mirror for the patient that helps to answer some of these questions. In essence, it must help the patient understand himself or herself better. That is, the assessment must simultaneously serve to expand the person's awareness as well as empathically resonate with his or her current identity, pointing out unrecognized or unappreciated strengths along with qualities that contribute to the trouble or symptomatology that brought the person in for an evaluation (Finn & Tonsager, in press; see also Finn, chap. 20 of this volume; Fischer, 1994; Fischer, chap. 19 of this volume).

To be of value to the person who referred the patient for an evaluation, the description emerging from an assessment must also address some important clinical questions. As with the client, the assessment must provide the referral source with a mirror of information that can be used to check and refine perceptions and hunches. The descriptive image generated from the assessment will confirm some of the referral source's suspicions while negating others, ultimately providing insight into the complex person seeking treatment so that optimal decisions can be made about the kind of help that should be provided.

Obviously, given these goals and the important role that the assessment description will serve, psychologists who aspire to be expert consultants must be sure the mirror they hold up for clients and referral sources is as accurate as possible. If it is not, the best that can be hoped for is that consumers will simply reject the assessment feedback. At worst, however, the social forces at play in the assessment setting may cause patients or referring clinicians to draw false

conclusions, embark on an ill-founded course of action, and/or experience themselves as stigmatized.

How then does a psychologist ensure assessment descriptions are as accurate as possible? Also, how does a psychologist inform while simultaneously recognizing the limitations of the mirror being offered? Further, how does psychological science assist with this process? To answer these questions, it is useful to first address the nature of the assessment process.

THE NATURE OF THE ASSESSMENT PROCESS

Many years ago personality assessment was considered to be the psychological equivalent of the X ray in medicine. This conceptualization offered entirely too little in many respects, and entirely too much in other respects. On the one hand, an X ray is a static picture, whereas an assessment is an ongoing process, alive with the dynamic interaction of patient and assessor. Many subtle factors affect and modify the interaction and the assessment results, such as the patient's and the assessor's age, gender, and racial and ethnic identity, as well as the patient's and the examiner's expectancies. The importance of the often subtle interpersonal transactions as a central variable in assessment becomes focal in this view (see Schaefer, 1954; see also Masling, chap. 8 of this volume, and Potash, chap. 9 of this volume). Assessment is carried out within an interpersonal context, where the clinician can evaluate this interaction as an additional source of diagnostic information. As part of this interaction there is an emphasis on the experience of the patient in the assessment process, especially as it relates to his or her real-world experience. Data to assist the examiner in the illumination of this experience come from an analysis of the structure, sequence, and content in a successive series of test responses, as well as from an understanding of the meaning of the various assessment tasks to the patient (see Handler, chap. 17 of this volume, and Handler, Fowler, & Hilsenroth, chap. 24 of this volume). Thus, because a personality assessment is an interactive process rather than an impersonal and static picture, the assessment clinician in many ways has a richer database of information to draw on than does the radiologist.

On the other hand, the X-ray analogy is overly optimistic because psychological test data are not as clear-cut and delimited as X rays. X rays, although limited in their own way, have the capacity to consistently peer within a person to reveal internal structures not otherwise evident to observers. Initially, testing data (and projective testing data in particular) were envisioned as having similar powers. However, this was an overly idealistic hope. As indicated previously, personality assessment is an interactive process. In addition, it is a collaborative enterprise that is not done "to" people but rather must be done "with" people. As a result, the quality of the data obtained from testing depends in large part on the characteristics of the person being evaluated and the characteristics of the evaluator. For ill or for naught, people can intentionally or unintentionally do many things that interfere with the accuracy of test-derived information.

The net result is that personality tests often end up quantifying more of these interference factors, known as method variance, than the actual personality characteristics one ideally hopes to measure (see Campbell & Fiske, 1959; Meyer, 1996b, 1997).

The impact of method variance is a major problem when one is conducting psychological testing (or when one is conducting research using test data), because psychological testing employs test scores that are taken at face value, treating the scores derived from many different kinds of patients in an equivalent manner. Method variance is a bit less problematic for psychological assessment because the sophisticated clinician can take these interference factors into account in an ideographic fashion when interpreting the conglomerate of assessment data (e.g., Ganellen, 1994; McClelland, Koestner, & Weinberger, 1989; Meyer, 1997; Rapaport, Gill, & Schafer, 1968; Shedler, Mayman, & Manis, 1993). In fact, every major text written about the clinical interpretation of test data includes at least some instruction on how the clinician should take these factors into account (e.g., Archer, 1992; Exner, 1993; Greene, 1991; Millon, 1991; Morey, 1991).

SCIENTIFIC CONTRIBUTIONS TO PERSONALITY ASSESSMENT

Unfortunately, the science of personality assessment is currently in a curious state. On the one hand, complex statistical methodologies such as factor analysis, multiple regression, and discriminant functions have contributed a remarkable amount to the technology of personality testing. These procedures have produced refined multidimensional tests like the Neuroticism-Extroversion-Openness Personality Inventory (NEO-PI-R; Costa & McCrae, 1992), the series of Millon Clinical Multiaxial Inventories (MCMI; Millon, 1991), or the Personality Assessment Inventory (PAI; Morey, 1991), and they have contributed to the development of refined scales that can be used for descriptive purposes, such as the Rorschach Schizophrenia Index, and the Hypervigilance Index, or the Harris and Lingoes subscales of the MMPI.

On the other hand, most personality research deals only with psychological testing, not with psychological assessment. Virtually all research investigations with purported relevance to personality assessment examine the nomothetic (i.e., across people) association between isolated test scores and criterion measures. In this approach, the data derived from one scale are treated out of context from the data derived from other scales or other sources of information. For example, in a nomothetic approach, researchers may investigate whether or not the average MMPI Depression score is higher in patients diagnosed with depression than in patients without a diagnosis of depression. Such a strategy is perfect for scale validation because it allows for an understanding of the strengths and limitations of a single scale, divorced from the array of other factors that impinge on any assessment.

However, such a strategy does very little for the assessment clinician, who is never concerned with just a single scale. For example, an assessment clinician would never want to make a diagnosis of depression based solely on a high score on the MMPI Depression scale. Rather, an assessment clinician works ideographically (i.e., focused on the uniqueness of the person) and tries to find a meaningful pattern of information within the data generated by many scales, drawn from several testing methods, along with observations of the patient and information drawn from his or her history. Although it is informative, the assessment clinician does not really want to know if the mean of the Depression scale is higher in patients with a depressive diagnosis than in those without such a diagnosis. Instead, for example, he or she wants to know things like the probability that a patient has a genuine depressive condition given the following information: (a) the MMPI Depression scale is unusually low, (b) the Rorschach Depression Index is elevated, (c) clinical observation with the Brief Psychiatric Rating Scale (BPRS) yields scores indicating emotional withdrawal, guilt feelings, and tearfulness—despite a denial of depressive mood, (d) the history is positive for the recent loss of a loved one and increased difficulty sleeping, and (e) the patient's sister reports that since childhood the patient consistently coped with problems by "looking on the bright side" and discounting emotional distress.

With the assessment data construed in this fashion, it would not be hard for the clinician to draw the conclusion—firmly based in the data—that this person is currently struggling with an underlying depressive condition (as evident on the Rorschach and portions of the BPRS) brought about by his recent loss (as evident from the history). However, his generally effective coping strategies (as evident from observer description) preclude conscious acknowledgment of this state (as evident from the MMPI and BPRS), most likely because full recognition of his underlying emotions would leave him in a state of precarious psychological balance. Note that in this instance the MMPI scale has valid utility despite the counterintuitive finding that it is lower than expected in a patient who has genuine depressive struggles. The score is low in this instance because it reflects the patient's efforts to adapt by consciously denying depression. Also note that the interpretive value and accuracy of a low score like this is completely lost when a nomothetic analysis is conducted on simple scale scores that do not take into account the full complexity of many clinical conditions.

Embedded in the preceding example is an important point for teaching and learning personality assessment: Different methods of assessment provide qualitatively different kinds of information. One fact that has been consistently supported in the research literature is that methods of assessment generally disagree with each other more than they agree, at least when nomothetic associations are examined across heterogeneous groups of people. In other words, when a group of patients fills out a self-report measure of depression, these scores are minimally correlated with scores of depression that are measured by the Rorschach or by observer ratings (e.g., Achenbach, McConaughy, & Howell, 1987; Archer & Krishnamurthy, 1993a, 1993b; Meyer, 1996b, 1997;

Perry, 1992; Zimmerman, 1994). Although there are certainly some exceptions to this general principle (Fowler, Hilsenroth, & Handler, 1996, 1997; Meyer, 1997), the basic independence between methods is a robust phenomenon. Although some may fear that these findings challenge the validity of all assessment methods, the relative independence of methods is not cause for concern. Rather, it is a phenomenon that demands understanding and recognition of the unique strengths (and limitations) possessed by each assessment method.

As Miller (1987) and others (e.g., Achenbach et al., 1987; McClelland et al., 1989; Meyer, 1996a) have articulated, unstructured interviews elicit information relevant to thematic life narratives; structured interviews and self-report instruments elicit information relevant to conscious self-schema; performance-based personality tests (i.e., Rorschach and Thematic Apperception Test [TAT]) elicit information relevant to implicit dynamics and underlying templates of perception and motivation; and observer ratings elicit perceptions of behavior that are bound by the parameters of particular observational settings. Students who are learning assessment should be taught to understand the distinctions among these methods and should be instructed in ways to exploit these distinctions in order to obtain qualitatively unique sorts of information from each method and more fully understand the complexity of the person seeking an evaluation (e.g., Finn, 1996a; Ganellen, 1994; Meyer, 1997; Shedler et al., 1993).

Unfortunately, there is very little good science to help the assessment clinician navigate the process of drawing inferences from cross-method assessment data. In fact, the disparities that arise from different assessment methods have caused considerable consternation and confusion among personality assessment researchers. Furthermore, it is very rare for researchers to examine the interplay of multiple assessment methods. Finally, and perhaps because the task is so daunting, most researchers appear uninformed about how personality test data drawn from multiple methods of assessment should be integrated into a research design in a clinically meaningful manner. Thus, at least for the foreseeable future, personality assessment will remain an art and clinicians engaged in personality assessment will have to rely on their clinical judgment to guide the process.

JUDGMENT AND INFERENCE IN THE PROCESS OF CLINICAL ASSESSMENT

As a caveat, however, those who are interested in teaching and learning personality assessment skills must be forewarned about the pitfalls and lapses in reasoning that accompany the judgment process. Also, it is important to recognize that the available literature, flawed though it may be, does not consistently support the value of clinical judgment in the assessment process. Each of these issues is discussed briefly, although other sources should be consulted for more detailed arguments and findings (e.g., Dawes, Faust, &

Meehl, 1989; Garb, 1984, 1989; Garb & Schramke, 1996; Holt, 1970, 1986; Kleinmuntz, 1990).

A considerable literature that documents common errors in human reasoning has developed within cognitive psychology. Clinicians are not immune to these problems. Although clinicians can and do make judgments that are more valid than lay persons', in general, clinicians conducting assessments can err in at least five common ways. First, clinicians may inadvertently elicit only that information that confirms their hypotheses and hunches, neglecting the questions or findings that would challenge their assumptions. Second, when making diagnostic judgments, clinicians may recall prototypical examples of diagnostic categories and make judgments about how similar or dissimilar their patient is to these prototypes rather than systematically evaluating their patient on specific diagnostic criteria. Third, some clinicians are prone to err by being overconfident in their judgments rather than appropriately tentative. Alternatively, some other clinicians may err by being underconfident in their judgments rather than appropriately decisive and conclusive. Fourth, once a result or an outcome is known (e.g., a patient did eventually attempt suicide), clinicians may err by using this outcome information to retrospectively and falsely conclude that they could have predicted the results in advance. This cognitive error is commonly made by all people, not just clinicians, and is known as the "hindsight bias." Fifth, clinicians may err by making judgments or predictions without considering the relative frequency of the events they are judging. For example, clinicians may judge a patient to be suicidal without recognizing that suicide attempts are (fortunately) rare events.

All of the preceding judgment pitfalls should be highlighted and studied in assessment classes in order to prevent or minimize their occurrence. In addition, these errors can be minimized by employing several corrective strategies. First, clinicians should not embark on an assessment unless they can systematically identify the characteristics of the clinical condition they wish to diagnose or describe. Subsequently, they must systematically link test indicators (and their absence) to these characteristics. Second, as clinicians develop test-derived impressions, they should systematically challenge them by considering test data that may temper or counter their hypotheses. Third, when appropriate, clinicians should take into account the base rates of events they are trying to predict (e.g., dropping out of treatment) and should employ empirically validated statistical predictions when possible (e.g., the Goldberg Index from the MMPI, the Schizophrenia Index from the Rorschach, etc.). Fourth, clinicians should anticipate making errors of judgment and should be open to corrective feedback from patients and referral sources. Fifth, assessment clinicians should actively solicit this corrective feedback (again from both patients and other clinicians) in order to maximize the accuracy of their test-derived impressions. The latter is particularly important in order to gain an understanding of the strengths, limitations, and peculiarities associated with various tests.

Although the empirical literature does not consistently support the utility of test-derived judgments, Holt (1970, 1986) has vigorously and eloquently defended the role of clinical reasoning in the assessment process. In addition, he

has pointed out many limitations in the general literature on this topic (e.g., irrelevant judgment tasks using nonclinical criteria, use of artificial pieces of information rather than data that are typically used in clinical practice, etc). By and large, these limitations are as germane today as they were when Holt first raised these points almost 40 years ago. In addition, even when clinicians are asked to make determinations about reasonable clinical matters, there are many problems with the available literature. The most fundamental problem is the absence of "gold-standard" validation criteria that would allow us to describe with certainty the "truths" and "fictions" regarding a patient's personality. As noted earlier, the literature suggests that clinical judgments are often inaccurate. However, it is exactly these judgments (or the judgments of lay raters) that are often used as the criteria for "validating" the accuracy of inferences drawn from assessment data. It does not take much to see the flaw in this arrangement. If the criterion construct itself is invalid or defective—and it almost always is—then there is no way to determine whether assessment-derived judgments are more accurate or less accurate than the criterion. Currently, in the research literature, one could easily argue that assessment-derived inferences are actually more valid than the criterion judgments against which they are evaluated.

Garb (1984) has noted that this problem with the literature "is especially intractable" (p. 651). In many respects, in the face of such a core methodological problem, it is surprising that good scientists continue to place faith in the available data. Nonetheless, despite problems with some of the research literature, it is clear that clinicians make errors in judgment. Because clinical assessment requires judgment, students must be educated about these constraints and both sides of the issues regarding judgment validity must be discussed. In addition, the five strategies mentioned previously for minimizing judgment pitfalls should be actively reviewed when learning and subsequently practicing assessment.

LEARNING ASSESSMENT SKILLS

As we have indicated already, we believe that assessment can inform the therapist and the patient about personality problem areas, the presence or absence of conflictual issues, and the severity of a patient's disturbance, if any. In addition, assessment can identify a patient's areas of strength, abilities to cope with intrapsychic and external stress, and adaptive level of object relations (the thoughts and feelings one has about others, and the interactions one has in his or her relationships with others). Assessment data can also illuminate various aspects of cognitive and affective functioning. We can utilize assessment to help identify the process and the outcome of treatment, the types of treatment that are likely to be beneficial, and the potential problems a therapist and patient will have in their ongoing relationship. Assessment data may also be helpful in the choice of a therapist—an older or younger person, man, woman, and so on. Assessment data, in conjunction with a thorough history and observational information, can also be used for diagnosis (see Ritzler, chap. 23 this volume,

for a somewhat different view). Finally, assessment data are quite useful in determining whether there has been any actual therapeutic change during and following treatment (e.g., Blatt, & Ford, 1994; Kadera, Lambert, & Andrews, 1996; Toman & Padawer, 1995; Weiner & Exner, 1991).

Naturally, it is difficult to achieve the level of understanding that is required for the skills just discussed. This is especially true for students because learning about the various tests and techniques, learning how to integrate a complex array of information, and learning how to report the data are so very time consuming. Given the additional interpersonal demands, it is also no wonder that students typically find communicating the data to the patient almost as difficult to learn as crafting the written reports. Understandably, they feel frustrated when they spend countless hours doing their first assessments, collecting, scoring, analyzing, and integrating the data. However, when they have produced a report that captures the uniqueness of the individual they have assessed, they become quite proud of their work. There is no doubt, though, that the time commitment for learning to do even a journeyman's job is rather daunting, and often quite frustrating.

Understandably, as well, most students find learning assessment emotionally taxing because it is the first time in their training that they are required to integrate so many diverse areas of knowledge and so many technical skills. It is perhaps just for this reason that learning assessment skills is an important task in graduate students' training and development. Until that time students master diverse subjects by taking a variety of clinical and nonclinical courses; integration is not typically stressed, either in conceptual material or in the consideration of individual functioning. It is one thing to integrate abstract concepts; it is quite another type of task to integrate knowledge about a person who is asking for clinical services. Thus, whereas clinical psychologists in some academic settings are decreasing assessment demands, other psychologists utilize assessment in their clinical training programs as a focal point to train students in clinical conceptualization. This is because the assessment task calls for students to organize their knowledge in many areas (e.g., life-stage development, psychometrics, interviewing, psychopathology, learning theory, cross-cultural psychology, ethics, etc.). In the assessment process, with a patient and a referring clinician requesting expert input, all this knowledge is brought to bear in a far more complex and compelling manner than can be effected in the typical doctoral preliminary examination.

Some faculty members do not recognize this function of assessment and they are quite critical of courses in this area, as well as of the techniques taught. Unaware of the function assessment serves in the real-life integration and application of psychological skills and information, some have voted either to limit the number of assessment courses in the graduate curriculum or to remove them completely from the curriculum. Not only does this rob the student of the opportunity to apply his or her psychological knowledge directly, but it produces clinical psychologists who are poorly trained for applied work (Hilsenroth & Handler, 1995). The implication for recent doctoral psychologists of this negative attitude among academic psychologists is that a self-fulfilling prophecy is

established. That is, if the assessment process is viewed as irrelevant, unreliable, or invalid, students will be poorly taught to do assessments, particularly with projective methods. By diminishing knowledge and interest in assessment techniques, subsequent research becomes poorly conceived and poorly executed, with the complexity of the assessment process often reduced to the investigation of single variables, unguided by theory, using oversimplified methods and small numbers of subjects to study complex relationships. The resultant research could not hope to validate aspects of the assessment process effectively. Ultimately, with enough research like this, the clinical assessment process would sink into a morass of disrepute. In turn, academic psychologists could point to the resultant poor validity studies to bolster the claim that scientists should abandon assessment efforts. Fewer students would then be taught these procedures, fewer would be prepared to make sophisticated contributions, and the downward spiral would continue (Handler & Meyer, 1996; Riehmiller & Handler, in press a, in press b).

The remainder of this chapter is devoted to a more detailed discussion of the important reasons to learn assessment, all of which follow from the major point presented earlier, that assessment provides a focus for the student to understand a patient's world, both in applied settings and in research settings.

ASSESSMENT IDENTIFIES THE PATIENT'S STRENGTHS AND WEAKNESSES

The assessment process illuminates for the student the very wide range of strengths and weaknesses people do not readily show in ordinary situations, or in an intake interview. The traditional assessment procedure is typically quite stressful for the patient, thereby stimulating responses that are not usually seen in their initial psychotherapy sessions, even though they are often typical of their responses to stressful situations in their everyday world. In other words, students who conduct assessments get to experience firsthand a variety of psychopathological conditions, coping styles, and defensive maneuvers that they ordinarily do not experience in face-to-face psychotherapeutic conversations with patients.

For example, a 35-year-old man refused to continue with the Rorschach because its unstructured nature stimulated fear of losing reality contact. He stated, "I'm stretched like a rubber band. I have to come back to reality so my imagination doesn't run away with me. I have to check out my imagination—with some proof, some facts. Two and two is four." Still another patient, straining to achieve cognitive control over disturbing impulses, at one point in testing took a matchbook cover from his pocket and wrote down the number of the Bender-Gestalt designs he was unable to recall from memory to "take it home and do them over more times, so I can prove I can do it, and so I will always remember it." Another patient, who initially seemed quite normal in his approach to the examiner, defined a thermometer as "the temperature of a

certain reading—a guidance inasmuch as determining the fever of an individual, illustrating his inability to think clearly and logically, and to express himself in a less strained and overly pedantic manner. Another patient, when asked "Why does land in the city cost more than land in the country?" replied, "Because people want to be populated," also illustrating his disturbed thought processes.

It is one thing, for example, to state abstractly that a patient's thinking may be loose. It is quite another thing to witness an otherwise intact looking 30-year-old college-educated man respond to the Comprehension WAIS item, "What does this saying mean: 'Strike while the iron is hot?'" with the following: "Strike is to hit. Hit my wife. I should say push, and then pull the cord of the iron. Strike in baseball—one strike against you. This means you have to hit and retaliate to make up that strike against you—or if you feel you have a series of problems—if they build up, you will strike." Not only does this response tell a story of this man's failure in maintaining clear thinking, but it also indicates his difficulty in containing angry, aggressive impulses. Primitive aggressive intrusions into logical secondary process thinking are obvious here, as are the signs of disturbed thinking. This psychotic patient, who had been inappropriately placed in classical psychoanalysis, in which the therapist used free association, understandably became significantly worse in this treatment program. His pretreatment response to the preceding WAIS item was "You should attack at the proper and logical time." Given the change in this response, which was also evident in other assessment data, the examiner recommended a significant change in the treatment approach, one with increased boundaries, more activity on the part of the therapist, less stimulation of primary process material, and a significantly more structured holding environment.

ASSESSMENT ILLUMINATES THE EXPERIENTIAL PROCESS

Often, sequences seen in testing illuminate dynamic processes in the patient's life. An example of the interpretation of changes in a patient's experiential processing comes from a man who appeared quite disturbed when he was presented with Card II on the Rorschach. He made a peculiar inhaling sound, indicating discomfort, and he produced a response that was rather dysphoric and poorly defined by form, suggesting problems with emotional control: "a bloody wound." His next response was "a rocket, with red flames, blasting off." This response, although it is good form quality, nevertheless illuminates the patient's style in dealing with troubling emotions—to become angry and to quickly and aggressively leave the scene with a dramatic show of power and force. However, the next response, given more slowly, with some care and detail, described "two people, face to face, talking to each other—discussing." It is possible to picture a sequence of intrapsychic and interpersonal events in these responses. The patient's underlying dysphoric emotions seem to be close to the

surface, and perhaps poorly controlled. When they break through, they cause him immediate but temporary disorganization in thinking and in the ability to manage his emotions. The patient soon recovers control, however, and there is the desired rapprochement, indicating that with time, rather quickly in fact, he is capable of a more positive connection with a significant other. After careful exploration several months into therapy, this explosive pattern followed by the desire for the reestablishment of a satisfying relationship was first unearthed and discussed as a response pattern in the patient's work and family settings.

Again and again we encounter responses that illuminate significant emotional problems, and patients' ability to cope with them. For example, it is one thing to believe that a certain man is angry, but it is quite another thing to hear that person's Rorschach, filled with extremely primitive hostile and sexual content, as you become aware that this person's mental life is filled with images of sexually attacking and cruelly killing people. On the other hand, there is the opposite experience of seeing a person become overwhelmed with affective stimuli on the Rorschach, only to then see that person deal effectively with those impulses in subsequent responses or in their pattern of scores on more structured tests. Often, this can allow the examiner to feel comfortable predicting that such a person can cope more effectively than he or she thinks they can. For example, one patient expressed significant doubt in the interview that she could cope effectively with her emotions. However, the examiner felt more certain that she could, based on her demonstrations of coping on the Rorschach and other projective tests. She proved the prediction correct and the hospitalization that was being considered was unnecessary. However, despite rather benign interviews, several of the other patients discussed previously demonstrated that protective hospitalization was necessary, both for themselves as well as for the protection of others. We know of no procedure other than assessment that offers such a window through which to view the wide range of human functioning, from adaptive and healthy to maladaptive, pathological, and possibly dangerous, with the attendant opportunity to facilitate those who seem to need such facilitation.

ASSESSMENT ILLUMINATES UNDERLYING CONDITIONS

Learning assessment often allows the student to recognize the difference between a patient's public presentation and possible underlying emotional problems. For example, a somewhat reserved 21-year-old male patient did not present any overt signs of a thought disorder or any gross pathology during the initial interview. His presenting complaint was that he was having problems with his relationships, and was finding it difficult to establish intimacy. His Rorschach was unremarkable until he came to Card IX. With no delay, he responded: "It looks like, um, the skull of a really decayed or decaying body with, like, the physical representation of some noxious fume or odor coming out

of it. It looks like blood and other fluids are dripping down onto the bones of the upper torso and the eyes are glowing, kind of an orange-purplish glow." In the inquiry he stated that the skull was hidden behind fumes that were seeping out of it and that the blood was dripping all over the body.

The patient's first response to Card X was not unusual ("an undersea garden"), but his next response was an even more direct expression of this young man's extreme disorganizing emotions that were of crisis proportions: "It looks like someone crying for help, all bruised and scarred, with blood running down their face." What a jarring experience it was for the student to witness the quiescent presentation of his interpersonal problem, juxtaposed with this desperate dysphoric response. The student abruptly changed her stance with this patient, providing him with much more rapid access to treatment than would have been the case otherwise.

In a second example we see an illustration of a brain-damaged patient's inability to deal with the demands of everyday work and interpersonal situations, as well as his desire to depend on others to satisfy his needs. In telling a story about the picture of a cat he drew, this 43-year-old man stated: "Herman, the cat. Not neat and clean; doesn't have a place to stay; the people who had him got tired of him and turned him loose. He's in the forest, trying to live and he's poor, hungry—needs food. He'll just have to live the best way he can, out there alone in the forest." Subsequently, the patient said of the male figure he drew, "He's run down, broke, lacks shoes. Somebody will give him money because he's happy and jolly."

ASSESSMENT FACILITATES TREATMENT PLANNING

Treatment planning has taken on a position of prominence in recent years, in part because such planning makes psychotherapy more efficient and cost effective, and in part because insurance companies have become quite unhappy "with open-ended forms of psychotherapy without clearly defined goals ... Today there are [many] treatment options whose potential value must be studied in great detail and depth. The search for the 'right' therapy for the 'right' patient continues" (Strupp, cited in Butcher, 1990, p. iii).

Not only is assessment useful for treatment planning for the individual patient, but it is also a vehicle for assisting patients to learn about themselves, and to facilitate communication between patient and therapist. It can enhance the likelihood of favorable treatment outcome (Strupp, cited in Butcher, 1990) and it may serve as a guide or reference point during the course of treatment (Applebaum, 1990; Mortimer & Smith, 1983).

Although evidence for the predictive utility of assessment is limited almost exclusively to testing data (i.e., single scores divorced from contextual factors), and although many attempts to predict outcome have proved unsuccessful, this is not true for all measures. For example, Klopfer and his associates (Klopfer,

Ainsworth, Klopfer, & Holt, 1954) constructed the Rorschach Prognostic Rating Scale (RPRS) to predict which patients would be successful in psychotherapy. This scale is composed of a number of variables, including the type and quality of human, animal, and inanimate movement, the use of color and shading within responses, and the form quality of perceptions. Meyer and Handler (1997) performed a meta-analysis on the existing literature that used the RPRS to predict subsequent outcome. They found the RPRS had a powerful ability to predict outcome. When data from the primary research studies were corrected to take into account all patients, all RPRS scores and all outcome scores, the estimated effect size was $r = .56$. The authors also demonstrated that the magnitude of this relationship was much larger than the predictive validity coefficients that have been found for a variety of other medical, psychological, or educational tests (e.g., the Dexamethasone Suppression Test, the Cardiac Stress Test, the Scholastic Achievement Test, etc.).

Other research has examined which types of patients will do best in particular forms of treatment or with particular kinds of therapists (e.g., Beutler et al., 1991). Another example of the utility of assessment for treatment planning comes from its application in the treatment of patients with asthma. Here, in a series of studies by Dirks and his colleagues, psychological assessment data have been instrumental in predicting length of hospitalization, rehospitalization rates, and subsequent medication dosages, among other criteria (e.g., Dirks & Kinsman, 1981).

Currently, there are a number of large-scale projects under way that are designed to determine the value of assessment measures for predicting psychotherapy, medical, and criminal outcomes. For example, Meyer, Handler, and Hilsenroth are conducting a meta-analysis (sponsored by the Society for Personality Assessment and Rorschach Workshops) of those studies in which selected assessment instruments have been used in this manner (Handler & Meyer, 1996). Other somewhat similar projects are under way in Finland (Lindfors, 1996) and in Sweden (Carlsson, Nygren, Clinton, & Bihlar, 1996).

ASSESSMENT IS THERAPEUTIC IN AND OF ITSELF AND IT ALSO FACILITATES THERAPY

Another important reason to learn assessment is that it can be therapeutic in and of itself when the patient is approached in a facilitative manner (e.g., Finn & Tonsager, 1992, in press; see also Finn, chap. 20 in this volume). Students conducting assessments learn to provide support, praise, and encouragement in a somewhat structured paradigm, which provides an easy entry to the psychotherapeutic process. In addition, although a course in interviewing helps the student learn how to say "hello" to a patient, so to speak, it is the assessment courses that help the student feel more comfortable in the constructive interaction with the patient. The interviewing task, as well as the job of obtaining responses to the various tests in the battery, help both patient and therapist

adapt to each other, measure each other, and evaluate each other, just as the therapist and patient might do over a much longer period in psychotherapy.

An example of test data used to facilitate therapy can be found in a recent article about the diagnostic efficiency of the Early Memories Procedure. Fowler, Hilsenroth, and Handler (1995) described the case of Maria, referred to at the beginning of this chapter. Maria, a 38-year-old divorced Hispanic woman, was destitute and living in a shelter when she came to therapy. She entered therapy to gain some control over her ferocious temper, which frequently placed her life in danger because of her tendency to explode into violent and impulsive rages. Her hair-trigger temper, extreme sensitivity to coercion, and pervasive paranoia made it impossible for her to keep a job for more than a few weeks. In response to the transitional object query (i.e., what is your earliest memory of a favorite blanket or stuffed animal?), she produced the following early memory:

I had a blue doll—a Chatty Cathy—and I would dress her up like myself. But the blue doll had a beautiful blue dress and blue eyes. I remember drawing the blue marks on her arms, and I remember my mother took her away, and I remember having a fit and telling her that she was my doll ... I remember saying to the doll when I would put her to bed, "Now close your eyes," and I would expect her to close her eyes. And when I would pick her up, I would expect them to open. But sometimes they would not work and I would ask myself, "Why?" I expected the doll to go through a lot of punishment—to share the punishment I got. She shared my punishment. I had a lot of emotional punishment. (p. 95)

The interpretation of this memory as it relates to transitional objects and to therapy implications is as follows: "Maria is capable of imaginative fantasy and of using something outside herself to soothe herself over the abuses in the world. She is also looking to the therapist to fill this role (the therapist has blue eyes). Unfortunately, she ruthlessly controls and abuses the soothing object and expects this sharing of misery to create a special bond" (Fowler et al., 1995, p. 95).

Fowler et al. (1995) expected that the therapist would be used as a transitional object and would be subjected to the same kind of attacks. In fact, these anticipated attacks quickly developed and persisted for the first 9 months of treatment. The authors continued:

As Winnicott ... made clear, the therapist had to survive these attacks without retaliation, thus becoming for Maria a dependable and reliable object with whom she could identify. But more important, the memory gave the therapist some hope of instilling in Maria an ability to use him in a more healthy manner.

Prior to analyzing this early memory, the therapist had little hope of finding a way into Maria's extremely paranoid character. In light of this early memory,

the therapist believed it was necessary to teach Maria how she might best use him by imagining what he would say as she got herself into a potentially violent argument with anyone. Naturally, this training could not take place until she had made a strong positive connection with the therapist and generally viewed him as a good object. By being taught to control her violent outbursts through reflecting on the therapist's advice, Maria made progress beyond expectation. Although her paranoia was still quite intact, she was able to gain psychological distance and develop a capacity for delaying violent impulses. As a result, she was not only able to maintain employment for a year, but she was also promoted to a supervisory position in the company. (pp. 95-96)

THE ROLE OF ASSESSMENT IN QUALITY CONTROL, COST REDUCTION, AND QUANTIFYING OUTCOME

Maruish (1994) asserted that psychological assessment "can play an important role in the delivery of mental health care in the future" (p. 10). He emphasized the role of assessment procedures to ensure continuous quality improvement through more adequate treatment planning and outcome assessment. He also focused on assessment as a vehicle through which "clinicians and third-party payors ... communicate with and among each other with a common language" (p. 11). It is expected that in the near future all types of service delivery practitioners will be required to demonstrate their effectiveness, not only in the area of psychotherapy, but in the treatment of related problems, such as drug and alcohol abuse (Maruish, 1994). In addition, those who purchase and contract for insurance coverage are beginning to seek "meaningful, measurable assurances of quality" (Maruish, 1994, p. 13) from those who supply these services. Such assessment information will also be necessary to impress legislators with the importance of providing financing for clinical services, training funds, and necessary research. Whether or not the impetus for accountability is coming from third-party payers or from patients themselves, outcome assessment measures have assumed a great deal of importance for practitioners who wish to provide "the highest level of performance and the best care for the patient" (Maruish, 1994, p. 14).

Newman (1991) described an example of how personality assessment data, initially used to determine progress or outcome, "can be related to variables such as treatment approach, costs, or reimbursement criteria, and thus can provide objective support for decisions regarding continuation of treatment, discharge, or referral to another type of treatment (e.g., from outpatient to inpatient treatment" (Maruish, 1994, p. 15).

A number of surveys or studies are available that indicate how the major assessment instruments for adults and children can be used for outcome

assessment (e.g., Blatt & Ford, 1994; Kadera et al., 1996; Maruish, 1994; Toman & Padawer, 1995; Weiner & Exner, 1991). However, it should also be noted that the field has not yet developed an understanding of how unique methods of assessment can and should be used together to quantify the psychological changes that are occurring as a function of treatment. For example, since psychologists began doing psychotherapy research, it has been fairly common to find that self-ratings of psychotherapeutic change are not strongly correlated with therapist ratings of change, and that each of these are not strongly correlated with ratings of change made by independent observers or projective test data (e.g., Cartwright, Kirtner, & Fiske, 1963). Given the issues discussed earlier in this chapter, the reader should not find this surprising. However, these findings have direct implications for practicing in today's managed-care environment: In order to fully quantify change or outcome, a simple and brief self-report instrument will not be sufficient. Rather, multiple methods of assessment must be utilized to map changes accurately in overt symptoms, observable behavior, internal structure, relational templates, and underlying dynamics.

As an example of these distinctions, consider the following. Numerous studies have demonstrated a dose-response effect in psychotherapy, such that a greater proportion of patients improve with increasing numbers of psychotherapy sessions (e.g., Exner & Andronikof-Sanglade, 1992; Howard, Kopka, Krause, & Orlinsky, 1986; Kadera et al., 1996; Seligman, 1995; Weiner & Exner, 1991). However, research relying on self-report data (which are presumably more responsive to conscious symptomatic distress) indicates that about half of the patients in treatment will be improved after 12 to 14 sessions, and about 75% of the patients will be improved after about 26 sessions (Howard et al., 1986; Kadera et al., 1996). Furthermore, this effect is often nonspecific, with self-reported improvement occurring across the spectrum of problems (Exner & Andronikof-Sanglade, 1992; Seligman, 1995). However, structural personality change, at least as measured by the Rorschach, appears to occur much more slowly and also in a much more differentiated manner. For example, if one calculates improvement rates using the data presented by Weiner and Exner (1991) and Exner and Andronikof-Sanglade (1992), it can be seen that brief treatment (with a mean of 14 sessions) generates improvement rates of 50% or more in only a few areas of symptomatology (i.e., emotional distress, loneliness, careless processing, and emotional withdrawal). Additional areas of functioning show this extent of relief after about a year of treatment (e.g., general coping deficits, inaccurate perceptions, poor emotional control, poor self-regard, interpersonal passivity). However, it is only after long-term and intensive treatment that one observes salient structural change across the full range of functioning that is measured by the Rorschach (e.g., limited internal resources, inconsistent coping styles, limited awareness, disjointed thinking, poor understanding of others, overreliance on fantasy, intellectualization, lack of relatedness, etc.).

ASSESSMENT PROVIDES PROFESSIONAL IDENTITY

As indicated earlier in this chapter, it is important to know assessment skills because they distinguish us from other disciplines. The psychiatrist is distinguished from other mental-health professionals because he or she can write prescriptions for drugs. Comparatively, psychologists are the only professionals who are typically trained in assessment. This provides us with a personal identity and with some level of separation and distinction in the crowded field of mental-health providers (e.g., psychologist, psychiatrist, social worker, marriage and family therapist, counselor, psychiatric nurse, mental-health specialist, etc.), a field that confuses many people. We are often called on by other mental-health professionals to provide assessment services, as well as by school personnel, physicians, attorneys, the court, government, and even by business and industry. Each time we submit a report to a professional or to an agency, or give expert testimony in court, we demonstrate our knowledge of assessment science, our practical application of this knowledge, and our unique perceptiveness in applying this knowledge in a meaningful manner.

ASSESSMENT REFLECTS PATIENTS' RELATIONSHIP PROBLEMS

Assessment also helps us understand patients' real-world relationships and their real-world patterns of functioning. For example, it is easy to understand why a person has difficulty with intimate relationships when the subjects in his TAT stories do not interact, when they interact in an aggressive manner, or when his stories reflect a simplistic, unemotional conceptualization of people (Westen, 1991a). In similar fashion, his Rorschach may contain certain responses in which people either ignore each other or are engaged in hostile or unproductive interactions (Urist, 1977).

It becomes easy, for example, to see what function a man's wife has in their relationship when the angry responses in his individual Rorschach are not present in the couple's consensus Rorschach (where the couple take the test again, this time deciding on the answers together). The cost of this control to the man was also evident, as his many creative and imaginative responses were absent in the consensus record (Handler, 1997). In a similar consensus procedure, where the Rorschach was given simultaneously to all the members of a family, including a schizophrenic adult child, the mother enthusiastically encouraged the child's confabulated responses rather than endorsing her husband's more normal responses (Singer, 1977). Frequent observations of such destructive interactions in a series of studies were used to support a family systems theory explanation for the genesis of schizophrenia.

ASSESSMENT IS USED IN WORK-RELATED SETTINGS

Even our understanding of the dynamic reasons behind someone's professional choice can be illuminated through the use of assessment techniques. For example, Church, Hilsenroth, and Handler (1996), studied the Rorschachs of poets/novelists, journalists, and technical writers. They found significant depressive content in the records of the poets/novelists (8 of the 10 fiction writers had significantly elevated scores on the Depression Index), but not in the records of the other groups. The journalists and fiction writers gave significantly more Deviant Responses than technical writers, who gave almost none, suggesting that the first two groups are more creative. The technical writers also gave fewer responses that were scored as blends and had lower Complexity Index scores, suggesting that the technical writer's world is more simple and straightforward than the worlds of other two groups. The creative writers embellished their responses in unusual ways, leading to a significantly higher proportion of unusual or creative responses (Xu%). Finally, the journalists scored significantly higher on the Egocentricity Index compared with the other two groups, suggesting a strong need for recognition. This finding, in concert with the finding of a significantly higher Holt Level 2 Libidinal Content score, indicating the expression of socially acceptable primary process, suggests that the journalists seek to express themselves in a somewhat sensationalistic manner, focusing on recognition. The creative writers are seeking, in their writing, to work out depressive affect, whereas the technical writers seem to be focusing on control through the simplification and clarification of their world.

There are many additional studies devoted to the investigation of vocational choice and/or preference using personality assessment instruments (e.g., Krakowski, 1984; Muhlenkamp & Parsons, 1972; Payne & Sabaroch, 1985; Rasenfosse, 1975; Rezier & Buckley, 1977). There is also a large literature in industrial-organizational psychology, in which assessment is used as an integral part of the study of individuals in various work settings, in the study of work-related dynamics, and in the selection and promotion of various workers. For meta-analytic reviews demonstrating the utility of personality tests as predictors in these settings, see Barrick and Mount (1991), Tett, Jackson, and Rothstein (1991), and Robertson and Kinder (1993). For an interesting study on the value of assessment rather than testing in this context, see Dicken and Black (1965).

ASSESSMENT PROVIDES A RAPID WINDOW OF UNDERSTANDING

Although we have advocated for the assessment clinician to utilize multiple methods for obtaining information, at times it can even be helpful to employ a circumscribed approach to testing that relies on data from just one method. For

example, including some testing in an initial psychotherapy interview can provide a relatively rapid way to identify levels of symptomatic difficulty (i.e., the self-report method) or to obtain an alternate view of the patient and his or her major problem areas. These procedures can help reduce errors in understanding the patient. Fowler et al. (1995) described just such an error in assessment for therapy, using the Early Memories Technique:

Sheila, a 22-year-old divorced nursing student was seven months pregnant. Her presenting complaint was a reemergence of long-standing depressive symptoms and a fear of a psychotic break. Precipitating events included the sudden end of her relationship with her boyfriend (the father of her child) and the fear of having to rear a child by herself. In response to the question, "What is your earliest memory of being fed, feeding, or eating?" Sheila responded:

At the ranch house ... I wouldn't eat ... It was Hamburger Helper, and I wouldn't eat it. And my dad took a fork of it and shoved it down my throat. I think he whipped me or kicked me after that. (p. 91)

Ultimately, Sheila produced three early memories of her father behaving in a physically abusive manner. Two of these memories, including the one just described, had particular clinical value because they involved dramatic physical punishment that occurred in the context of eating. The authors continued:

The eating memories provided a very focused interpretation regarding her likely reaction to a supportive male therapist. These memories were interpreted as prototypical examples of Sheila's experience of any type of supportive, nurturant relationship with men. [Because of her experiences with her father] Sheila experiences nurturance and support from men as an invasive, cruel and abusive impingement; when a man acts to support her, she feels like he is literally trying to shove something down her throat. (p.92)

Relying on these memories, the therapist anticipated that Sheila would not do well with a male therapist, would experience support from the environment as harsh and controlling, and would drop out of treatment early. Unfortunately, she could not be assigned to a female therapist and a man was assigned by default. The authors stated:

The course of treatment in this case was extremely brief. Sheila attended two sessions before disappearing; yet during that time, the transference to her therapist was established, the predicted conflict arose, and her predicted reaction to it all came to fruition. Sheila began her first session by informing her therapist that she had been admitted to the emergency room two days earlier for vaginal bleeding and dangerously low blood pressure, both warning signs of overexertion during her final trimester of pregnancy. With shocking indifference, she explained that she had ignored these dangerous symptoms

and instead went to work. Once there, she collapsed and was rushed to the emergency room.

Sheila's indifference to this imminent risk left the therapist with the distinct impression that this was, in fact, a passive suicide attempt. Taking into account the serious pressing nature of the situation, the therapist interpreted this to her. She reflexively denied it, but added that she suspected that this interpretation would be made. The therapist then began to cautiously broach the subject of her work load and other practical matters that needed serious and immediate attention. What ensued was a foray into a most exacerbating rejection of each interpretation and each attempt at ego support. The therapist, having forgotten the assessment report, helped create just the transference relationship that Sheila had described in her feeding/eating early memory. By the end of the session, any semblance of rapport seemed to have dissolved, and Sheila had become extremely suspicious of the therapist. The session ended in a stalemate.

The second session was less destructive because the therapist had returned to the projective data and found just what had been forgotten—that Sheila could not accept the therapist's support, experiencing it as something being shoved down her throat. Returning to the interaction of the previous week, the therapist noted Sheila's difficulty in hearing any support from him. She disagreed: "When you told me what to do, it makes me think that you think I'm stupid ... That's like my mother and father treat me!" In the end, the damage done to the rapport in the first session was too great to be repaired. Sheila canceled her next two appointments, then moved from her apartment, leaving no forwarding address or telephone number. (pp. 91-93)

This vignette illustrates the predictive value of a brief assessment in the context of a theoretically driven interpretation. Unfortunately, the therapist's handling of this interaction was not informed by the assessment data, and a poor outcome was the result. Without this critical information, the countertransference and role responsiveness went unchecked. Thus the destructive conflict emerged immediately, and was the major cause of the failed therapy.

ASSESSMENT IS USED IN FORENSIC AND MEDICAL SETTINGS

There are a variety of settings in which assessment is used to answer legal questions or medically related questions. For example, in cases that involve custody determination for minor children, both parents are often assessed to determine their emotional soundness as parents. These assessment results are often used by judges to determine which parent will be granted custody. In addition, assessment is often used to determine whether or not someone charged with a crime is competent to understand the charges brought against

him or her, or to determine whether the person is competent to stand trial, or to determine if a person is malingering psychiatric deficits in order to avoid criminal responsibility. Assessment is also used by state and federal agencies to determine if a person is emotionally disabled, and therefore should receive some type of disability pension. Finally, attorneys sometimes request assessment evaluations to determine the emotional effects of various physical and/or mental traumas.

Concerning the use of assessment in medically related problems, assessments are sometimes requested by physicians or insurance company representatives to determine the emotional correlates of various physical disease processes, or to make a differential diagnosis between emotionally caused physical symptoms and those symptoms caused by medical disease. Recently, an approach to the treatment of "the whole person" has resulted in the birth of a more inclusive approach, now called *biopsychosocial*, in which personality assessment is one part of a total assessment of the person, so that treatment can target emotional factors along with physical problems. Another relatively new term, *psichoneuroimmunology*, refers to the complex relationship among various psychological and physical factors in the person's ability to be disease-free. Each of these orientations has spawned new psychological assessment instruments, in an attempt to measure the various personality components involved in the "whole-person" approaches.

In addition, the field of health psychology has become quite important recently, and assessment is used in a variety of health-related issues, such as smoking cessation, medication compliance, chronic pain treatment, recovery from surgery, and so on. This has resulted in the construction of many new assessment measures that are not traditionally taught in graduate courses in assessment. We expect that this trend will continue in the future. For example, Dana (1984) indicated that there is a need for measures of coping behaviors and measures of other emotional resources because of the recent emphasis on the importance of the amelioration of stress effects on people. He asserted that assessment for health psychology is a new national mandate. Dana also suggested the construction of such new measures as one's belief in their personal efficacy, as well as indicators of partial mediators between stress and one's reactions to stress. Therefore, it is important that students begin to search the literature and become familiar with those measures that relate to their treatment and/or research interests with patients.

ASSESSMENT DEVICES FACILITATE RESEARCH

Finally, we note that another important reason to learn personality assessment is for its applications in research. Clinical assessment techniques are often used to test a variety of theories or conceptual relationships. Those psychologists who are intimately familiar with these methods can choose among them to find the most appropriate way to quantify the variables that interest them. Thus, both in clinical application and in research sophistication, in assessment for the

patient's treatment, or for agency- or court-based assessment, knowing personality assessment techniques, their application, and their associated reliability and validity allows the researcher to make better choices in the use of instruments to measure various constructs, to measure possible change, or to analyze complex relationships. In these and countless other situations, those who know assessment are at a distinct advantage, compared with those who do not.

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The Trouble With Learning Personality Assessment

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This chapter focuses on the largely unspoken, often minimized aspects of the student's difficulties in learning assessment skills that lie beyond the normal concerns of proper scoring and administration of tests. It has been my experience that learning personality assessment, is quite similar, in many ways, to the tasks of learning to be a psychotherapist. In both endeavors there are complex psychic and interpersonal processes, like projection and projective identification, that must be slowly disentangled from subjective experience so that the student can gain a sense of what conflicts belong to the patient and what belongs to the student as therapist or as psychological examiner. Furthermore, students' intrapsychic wishes, fears, and defenses against the task can further inhibit the full articulation of interpretive skills. These processes must be brought into conscious awareness for the student to gain confidence and clarity of thought as he or she moves through the assessment courses.

It is my contention that for students to use the formal aspects of testing, to use their intuitions, affective, and cognitive capacities to the fullest, personal defenses and resistances must be recognized, confronted, and worked through. Just as student therapists are encouraged to undergo psychotherapy in order to aid in their development as therapists, students may need help getting beyond personal biases and fears to be free to use their total psyche in the inference-making process. This process of working through resistances may be the most challenging aspect of learning and teaching assessment skills. Therefore, this chapter explores some of the conflicts in learning assessment—from a student's perspective.