This Report committee for Jamie Thomas Kuhlman

Certifies that this is the approved version of the following report:

Therapeutic Assessment with Adolescents: An Efficacy Study

APPROVED BY

SUPERVISING COMMITTEE:

Supervisor: _____

Deborah Tharinger

Supervisor: _____

Alissa Sherry

Therapeutic Assessment with Adolescents: An Efficacy Study

by

Jamie Thomas Kuhlman, B.A.

Report

Presented to the Faculty of the Graduate School

of the University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

Master of Arts

The University of Texas at Austin

December, 2009

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by

Jamie Thomas Kuhlman, M.A.

The University of Texas at Austin, 2009

SUPERVISOR: Deborah Tharinger

Therapeutic Assessment (TA) is a semi-structured hybrid of assessment and intervention methods that aims to promote positive change in clients through collaboration. Studies have shown it to be an effective therapeutic intervention, but few studies have focused on adolescents. This comparative study examines the effects of TA, compared with assessment as usual, with an adolescent population. Dependent measures include symptom reduction and components of the assessment experience, specifically self-knowledge, feeling understood by the assessor, positive relationship with the assessor, and negative feelings about the assessment. A repeated measure ANOVA will examine the group effects on symptom reduction, while a MANOVA will be used to determine the effects of TA on the variables of assessment experience.

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Introduction

Traditionally, psychological assessments have focused on collecting data to describe clients, make diagnoses and provide recommendations for treatment (Finn & Tonsager, 1997). This approach creates a primary focal point around *test results*, while interviews, behavioral observations, and information from other sources are secondary. Traditional assessment also views the assessor as the expert, with the client compliantly providing responses to questions asked. While this form of assessment serves a purpose, it limits the effectiveness of the assessment process. Fischer discovered that when administered in a collaborative manner, assessment could serve as a psychological intervention in and of itself (Fischer, 1973). Built on principles drawn from humanistic and phenomenological theories, Fischer developed a collaborative framework from which to approach assessment (Fischer, 1973, 1979, 2006). Collaborative assessment allows the clinician to work with the client as a co-collaborator to gain a better understanding of the client and their environment (Fischer, 2000). The assessment can serve as a catalyst for self-exploration and growth rather than solely a diagnostic tool.

Concurrently, Finn noticed the therapeutic potential of assessment and created a semi-structured model of collaborative assessment, which he named Therapeutic Assessment (TA) (Finn, 1996). TA is based on intersubjectivity, systemic, humanistic, and phenomenological theories (Finn, 1999, 2002, 2007). It consists of a series of five or six steps designed to engage the client as a collaborator in the assessment process, with the goal of facilitating positive growth. TA has been applied, with variation, to work with adults, couples, adolescents, and children.

TA has shown, through case studies and an increasing body of empirical evidence, to be a powerful intervention. These studies typically have used abbreviated or brief models of TA,

primarily focused on the impact of providing collaborative feedback. This has likely been due to the challenges inherent in studying the complete TA model, as well as the importance ascribed to the collaborative and feedback aspect of TA. These studies have shown that TA can result in symptom reduction, high assessment satisfaction, increased self-knowledge, and the development of more positive therapeutic relationships both with the assessor and future therapists (El-Shaieb, 2005; Finn & Tonsager, 1992; Hanson, Clairborn, & Kerr, 1977; Lance & Krishnamurthy 2003; Newman & Greenway, 1997; Rogers, 1954). Unfortunately, most studies have examined the effects of TA with adult or children populations. Adolescents, despite being highly prone to various psychological challenges, remain the population with the least amount of literature regarding TA.

The opportunity for TA with adolescents (TA-A) lies in the fact that adolescence is often characterized as a developmental period wrought with harsh transitions stemming from heightened biological, cognitive, and psychological changes, like gaining metacognition-- the ability to think abstractly (Beauchaine & Hinshaw, 2008; Dusek, 1977; Holmbeck & Updegrove, 1995; Muuss, 1988). One notable phase of adolescence is the transition from basing their identity on that of their parents to developing a personal identity and self-concept (Holmbeck & Updegrove, 1995; Muus, 1988; Tierney & Herman, 1973). Adolescents seek out situations in which they can test out their new desire for autonomy and resist situations in which they continue to feel treated like a child. As a result, conflicts often arise when authority figures create rules or boundaries that the adolescent does not agree with or feels stifled by. Because of this, mental health professionals are often seen initially as authority figures and, subsequently, as people who do not respect their new autonomy.

Specifically with psychological assessment, adolescents are often brought in without explanation or their consent (Braski, 1999; Oetzel, & Scherer, 2003), making it more difficult for clinicians to create trust and engage adolescent clients in the process. This can also prevent the clinician from obtaining important information within the limited time the assessment is conducted. In addition, the adolescent likely ignores any benefit or new knowledge they could have gleaned from the process. Church (1994) found that adolescents respond better to a collaborative egalitarian relationship than a directive one. Hence, techniques involving TA are needed to involve the adolescent as a collaborator and encourage a positive working relationship with the assessor to create an environment where the adolescent feels safe to share personal information.

TA-A provides an avenue to engage adolescents in the assessment process and also serve as an intervention. With this approach, adolescent clients are asked from the beginning of the assessment to participate as a collaborator. They are asked to generate their own questions, usually private ones, and provided with tailored feedback, also usually privately. Additionally, throughout testing, the assessor seeks their opinion regarding the process, their experiences, and even the results themselves (Finn, 2007). These techniques uniquely fit their developmental needs and likely will result in increasingly meaningful therapeutic results.

To test this hypothesis, this study will compare two groups of adolescents receiving psychological assessment. The first will experience a model of "assessment as usual" and the other, a brief model of TA-A. Developmentally, adolescents are trying to develop their own identity and achieve more independence and autonomy (Beauchaine & Hinshaw, 2008; Dusek, 1977; Holmbeck & Updegrove; Muuss, 1988). Therefore, specific components of TA-A were chosen that emphasize the promotion of autonomy and privacy. These include, as introduced

above, private assessment questions and individualized confidential feedback (not included in the assessment as usual condition). Based on the developmental and TA literatures, outcomes will include symptom reduction and increased satisfaction based on components of the assessment experience, specifically gaining self-knowledge, feeling understood by the assessor, experiencing a positive relationship with the assessor, and feelings about the assessment process.

Integrative Analysis

History of Psychological Assessment

The mindset towards psychological assessment has fundamentally shifted throughout time. It began as a tool for learning about the whole individual but quickly shifted into an increasingly clinical role with little focus on the client as an individual. When psychological tests were first introduced, psychologists were intrigued at learning about "the whole, dynamic individual- the perceiving/thinking/feeling/defending/acting person." (Fischer, 1992 p. 319). Many professionals viewed testing as a means to gain insight about the person and their lived world (Harrower, 1956; Kelly, 1955; Klopfer, 1954). However, as the development of norms, procedures, and standardizations increased in importance, the focus on the individual client became less valued (Fischer, 1992) than the "information model" of assessment. Finn (1997) noted the similarity of this type of testing to blood tests, in that they were used to "extract information" without regard to whether the client fully understood the results. It even became unnecessary to tell the "patient" the results. Rather, the results were used to communicate with other professionals to describe the patient. In this tradition, professionals conducted assessments in a manner that did not prioritize the client as an individual and did not give clients access to process or, in many cases, findings.

Vane (1972) conducted a survey of psychologists using assessments and found that 88% rarely or never gave clients access to the reports. Half of those surveyed reported they would not give clients verbal feedback even if directly requested. The rationale was that clients were not able to understand or handle the type of information that a psychological assessment would produce (Fischer, 1992, 2000). With that mindset, it was considered borderline unethical to allow clients access to their findings. In addition, psychologists were concerned about the integrity of

clinical psychology wherein writing reports for clients would lessen the scientific and professional status of the psychologist, who cannot, and perhaps should not try to, describe psychopathology and dynamics in a nontechnical manner (Fischer, 1992, 2000).

As humanistic principles gained prominence in the field of psychology, they also affected the traditions of assessment (Fischer, 1992). The field began to recognize that clients were able to receive feedback and that the results could actually be powerful and positive (Finn, 2007; Fischer, 1973, 2000). Assessors were urged to view testing as a means for learning about the client and even to invite clients to discuss their own views and opinions (Leventhal et al., 1962; Rosenwald, 1968). Currently, it is common practice to at least discuss findings with clients and even expected in many cases by the client (Fischer, 1992). However, the manner in which the client receives feedback and/or becomes a part of the process varies by assessor. In some settings, assessors still conduct assessments in a manner close to the traditional model, while in other settings, they use more therapeutic and collaborative models. Many clinicians can anecdotally see benefits in more collaborative and individualized assessments, but studies are needed to measure the utility or therapeutic value of varying styles of psychological assessment (Finn, 2007).

Current Assessment Practices with Adolescents

Just as psychological assessment practices vary depending on the assessor and the model for assessment, practices also vary depending on the population. Assessment with a child is different than with an adolescent, which is different still from assessment with an adult. Since the scope of this report is adolescent assessments, this section will focus on a discussion of current assessment practices with adolescents.

Assessments with adolescents typically begin with a thorough investigation of the referral (Gumbiner, 2003). If possible, the assessor contacts the referral source to better understand the context of the assessment. For example, a court ordered assessment is a vastly different context than one referred by the school system. Next, background information is collected from multiple sources (Gumbiner, 2003) to help form initial hypotheses that will guide the process. This typically includes a clinical interview with the parents/guardians, an interview with the adolescent, and any other sources of information deemed necessary, such as teacher reports, medical reports, and counselor reports, if available. The adolescent testing portion begins with standardized testing that strictly adheres to administration procedures (Gumbiner, 2003). According to traditional assessment, if standardized procedures are not completely followed, the test results cannot be considered accurate. It is also important to administer developmental appropriate and statistically valid tests. Typically, parents are not involved during this part of the assessment. That is, the assessor only meets with the adolescent.

All of the information from the interviews, testing, and outside sources is then gathered and synthesized in order to form a case conceptualization and provide feedback (Gumbiner, 2003). Generally, this information is conceptualized as a diagnosis with appropriate recommendations. APA ethics guidelines state that reasonable effort should be taken to give accurate feedback to the individual and responsible parties (APA, 2002). Feedback should be provided in a manner that makes sense to the client and gives the client time to ask questions. Feedback is typically provided to the parents and the adolescent (Gumbiner, 2003); however, there is variation in how this is done. Sometimes parents and adolescents are given feedback separately, but more often they are given the feedback together. In addition, feedback is often focused towards the parents rather than the adolescent. Written feedback in report format

highlights background information, test results, interpretations, diagnoses, and recommendations (Gumbiner, 2003). However, the report often uses clinical jargon that is directed towards other professionals more than to the parents and the adolescent, rendering a document that can be confusing for the client.

Collaborative Assessment

Collaborative assessment involves working with the client in order to gain a better understanding of the client as a whole person and to provide clients with the opportunity to an understand themselves (Craddick, 1972; Leventhal et al., 1962; Rosenwald, 1968). This entails explaining procedures to the client, seeking the client's opinions, and providing thorough and individualized feedback. By discussing procedures and results with the client leads to genuine responses, rapport-building, and examining how the client wants to portray himself (Craddick, 1972). Conducted this way, assessments should be viewed as not merely diagnostic tools but therapeutic interventions (Young, Anderson, & Steinbrecher, 1995). As reforms were being called concerning the way traditional assessments were conducted (Craddick, 1972; Leventhal et al., 1962; Rosenwald, 1968), Fischer initiated the development of collaborative assessment.

Fischer's Collaborative Assessment

Fischer found that allowing clients to work with her to develop a better understanding of themselves, with or without a diagnosis, provided an extremely powerful catalyst for personal growth and exploration (Fischer, 1973, 1979, 1980). From this mindset, the whole assessment process can be viewed as a collaboration between the assessor and the client (Fischer, 1973, 1979, 2000). Collaboration, in this context, is working with the client to set goals for the

assessment, understand test data, recognize patterns within the client's life, and agree upon recommendations based on multiple sources of information (Fischer, 2000). By working together, elements of social-constructivist learning theory are implemented (Fischer, 1973), which theorize that the interactions between people create knowledge (Resnick, 1991). From this collaborative viewpoint, the assessment process, recommendations, and written feedback become individualized for each client.

Through this process, the client is no longer seen only through the lens of test results but in the context of his or her life. Collaborative assessment, based on phenomenological psychology, maintains that all facets of clients' lives, not just test data, give an indication of the whole person (Fischer, 1979). Behaviors occur in a context; therefore, to understand clients' behaviors, it is vital to understand the context in which they occur. The assessor wants to understand under which situations do certain behaviors occur, and under which situations they do not, the "when/when nots" of the client (Fischer, 1973, 1979, 1980, 2000). This allows the assessor to see a better picture of clients' lives and how the test data uniquely fits with their experiences. Collaborative assessment acknowledges that concepts of traditional assessment, such as diagnostic categories and normative data, are human constructions used to better understand people (Fischer, 1980) but as secondary sources of information. Test activities can, subsequently, be viewed as key metaphors for how clients act or think in the outside world (Fischer, 1973, 1979, 1980, 2000). Giving someone a diagnosis based solely on test data without exploring how it fits into their self-conceptualization, could potentially limit the effectiveness of the assessment process as a learning experience.

Since the goal of collaborative assessment is not simply behavior explanation but helping clients better understand themselves, the client is given a chance to discuss, and even disagree,

with any and all findings, especially where legitimate ambiguities exist (Fischer, 1973, 1980, 2000). In addition, it is important to discuss findings with the client using their words (Fischer, 2000). Diagnostic, clinical language can intimidate and distance clients. It could leave them feeling as if they are subjects in an experiment. One way of alleviating this problem is to provide concrete immediate examples of behaviors and patterns in a manner in which the client can understand. For example, adopting the word 'sad' as opposed to 'depressed' and pointing out that many of their Rorschach responses consisted of 'sad' images. This helps the client to better understand their outlook on life in their own language and gives them a chance to see this pattern demonstrated. The hope is that by discussing findings throughout the testing, they should not be as surprising during the final feedback session.

In Fischer's model, active collaboration with the client begins with the first session to demonstrate to the client that he or she is an active, informed participant who is the expert of his or her own life (Fischer, 1973, 1979, 1980, 2000). The pair begin to develop the "when/when nots" of the client's behaviors (Fischer, 1973, 1979). Not only does this give the client an opportunity to feel included in the process, but it allows the assessor to begin to contextualize the problem behaviors and gain a glimpse into client's lived world. The collaboration continues throughout the assessment as the assessor asks the client for input and suggestions when developing themes and hypotheses concerning behaviors.

In addition, the clinician can have some liberty in the conduction of the tests in order to better examine the individual client's needs and behaviors (Fischer, 1973, 2000). According to Fischer, standardized procedures can be interrupted in order to discuss the process and find viable alternatives to unproductive patterns (Fischer, 1980). For example, it might be important to stop the after the administration of the WICV-IV Block Design subtest to discuss an

adolescent's performance if they were able to complete the tasks but not in the time allotted. This could provide valuable information in understanding the client's academic struggles. The score on the test, while important, becomes secondary to the reason behind the score. It would be important to explore this with the client before the moment passes and an opportunity, to gain timely useful insight, is missed.

According to Fischer (1980), writing a psychological report is a creative process that should invoke both the reader's and assessor's individuality and reflect that a client is multidimensional (Fischer 1980). A good collaborative report includes a contextualized description of the referral questions including the "when/when-nots", actual test performance, and the relationship between test performance and the client's real life. The assessor should effectively show how the client in the process of shaping his world while also being shaped by it (Fischer, 1980). With a collaborative assessment, recommendations become more than a list of behavioral suggestions, but rather, detailed description of the rationale behind the recommendations rooted in observable behaviors (1973). This allows for both the client and the reader to better understand the recommendations, increasing the likelihood that they will be followed.

Therapeutic Assessment

During Finn's work with assessment, he began to see the transformative power of test feedback when done in a collaborative manner (Finn, 2007). However, few studies existed on the utility or therapeutic value of psychological assessment (Finn, 2007). This prompted further inquiry into the assessment process and elements that could be used to make assessment more therapeutic for the client. Over time, Finn and his colleges developed a semi-structured approach to collaborative assessment that he named Therapeutic Assessment, capital "T" and capital "A"

(Finn, 1996, 1997, 2003; Finn & Kamphuis, 2006; Finn & Tonsager, 1997, 2002). This section describes the basic founding principles of TA, the semi-structured steps of TA, and the research on TA.

Founding Principles

As in collaborative assessment, TA is based primarily on principles of phenomenological, intersubjective, and interpersonal psychological theories (Finn, 2002). These theories help describe the different motivations that bring clients in for assessments and redefine the aspects of psychological assessment. Various theories on human change provide a lens for understanding three client motivations: self-verification, self-enhancement, and self-efficacy/self-discovery.

Self-psychology and intersubjectivity theory introduced the idea of self-verification; people will strive to maintain their self-schemas and will discount any conflicting information. (Finn & Tonsager, 1997). In psychological testing, this means that people prefer finding information that confirms their self-concept and aids them in maintaining a coherent view of themselves (Swann 1997). They usually come for assessment when they are experiencing "disintegration anxiety", which is the uncomfortable and possibly disorienting feeling associated with receiving information contrary to an existing self-concept. The second motivation, self-enhancement, discussed by object-relations psychology, is the need to feel loved and accepted by others and by oneself (Fairbairn, 1952; Winnicott, 1957, 1975). Clients come in for a psychological assessment in order to increase praise and love from others and themselves. The third and final motivation of self-efficacy/discovery, posited by self-efficacy theory and ego psychology, describes the need for humans to increase their knowledge and control of themselves and their world (Freud, 1936; Hartmann, 1958; Hartmann, Kris, & Lowenstein,

1946). In terms of psychological assessment, clients want to grow creatively, gain self-knowledge, and obtain more control over their world through the assessment process.

Developing a Therapeutic Mindset

The theoretical underpinnings of TA help the assessor view various aspects of psychological assessment, such as the goal of the assessment, test data, and the influence of the assessor, in a collaborative and therapeutic manner. Traditional models of assessment view the process as a means to gather information about the client in order to better describe the client in diagnostic terms, help make decisions about the client, and to communicate this information with other professionals (Finn & Tonsager, 1997). Review of these goals show that the client's involvement and personal growth, to a large extent, are not considered, and descriptions, decisions, and discussions are formulated without input. In contrast, the goals of TA are primarily concerned with how clients grow from this experience in their understanding of themselves, others, and their world (Finn & Tonsager). These new understandings should therefore help enact change in the client and provide a new way to approach their problems. In reality, these goals more closely parallel those for psychotherapy rather than traditional assessment (Finn & Tonsager). These goals subsequently frame the entire process and mindset involved in TA.

In traditional assessments, test data consists of results from various tests with some observations from the session. However, standardized tests results in TA are viewed in a similar manner as in collaborative assessment (with the exception, that unless noted, standardization is followed and only when a test is completed is it used for an intervention). They are merely starting points for discussions and a means of communication between the assessor and client (Finn & Tonsager, 2002; Tharinger, Finn, Wilkinson, & Schaber, 2007). Data and observations

are “empathy magnifiers” allowing the assessor to better understand what it means to be the client and in their world (Finn, 2007, 2002, 1997, 1992; Tharinger, et al., 2007). For example, a client on the Thematic Apperceptions Test (TAT) might tell a very depressing story but tie it up quickly with a positive ending. While this might provide information to back up a depression diagnosis, it is more important to note that this client may not be comfortable with their negative emotions.

In TA, the assessor’s influence and reactions are acknowledged and often used to further understand clients and aid in their growth. Drawing from Sullivan’s “one-genus hypothesis”, it is believed that there are more universal similarities between people despite individual differences (Crowley, 1984). This means that there are more similarities between the assessor and the client than there are differences, allowing for better connection and understanding of where the client is. In addition, the assessor’s countertransference reactions can provide important information about case dynamics and about how others may perceive the client (Tharinger, et al., 2007). Hypotheses generated could then be discussed and provide both the client and the assessor with greater insight into the client’s life.

Steps of TA

Finn and colleagues created a series of semi-structured steps in order to apply the principles of both collaborative assessment and TA (Finn, 1996, 1997, 2003; Finn & Kamphuis, 2006; Finn & Tonsager, 1997, 2002). At first, TA was developed primarily for adults. Subsequent work created TA models for children and adolescents based on the adult version but with differences based on developmental considerations (Finn, 2007). Adolescent Therapeutic Assessment (TA-A), the focus of this report, will be specifically discussed in Section 5. Table 1.0 shows the sequence of TA with adults and will be illuminated in this section (Finn, 2007).

Table 1.0 Steps of TA

Step 1	**Initial Phone Contact; Written Information Sent**
Step 2	Initial Session(s)
Step 3	Standardized Testing Session(s)
Step 4	Assessment Intervention Session(s)
Step 5	Summary/Discussion Session(s)
Step 6	Written Feedback Sent
Step 7	Follow-Up Session (if needed)

Initial Session. There are several goals of the initial sessions: inform the client of the assessment purpose and procedures, create assessment questions, and gather background information relevant to the questions developed (Finn, 2007). This sets the stage for the rest of the assessment to be collaborative and begins to strengthen the therapeutic relationship (Fischer, 1973, 2000). Most importantly is the process of working with the client to develop assessment questions. These questions will serve as goals for the assessment and guide the choice of tests and interventions. Allowing the client to set their own individual goals for the assessment by means of assessment questions is an important aspect of TA that differs from an information-gathering model. This process parallels elements of interpersonal and humanistic psychology, which stress the importance of helping clients meet their own goals (Finn, 2007) and encourages honesty, since they are now collaborators in determining the course of the assessment. Clients are given a sense of power and control at this early stage, which should continue throughout the

process. The collaborative approach to goal-setting will also increase their curiosity and engagement (Finn & Tonsager, 2002).

Testing sessions, The testing sessions are geared around the individual assessment questions developed in Step 1. In essence, there is no "standard battery" of tests for TA. Instead tests are chosen based on the individual needs of each client. Extended inquiry procedures are then used to increase the utility of the tests (Finn, 2007). For example, after the Rorschach is given, a discussion about themes presented might open up doors that would have remained shut. Thus, the Rorschach provides not only its object test data but also a chance to further explore the client's life.

Assessment intervention sessions. Assessment Intervention Sessions are pivotal in creating situations for the client to discover some of the assessment findings on their own (Finn, 2007). The assessor can facilitate discovery by examining his or her working conceptualization of the client and determining which results to focus on during the assessment intervention session (Finn). These sessions should be planned in order to surface problems in the session to help the client solve them in that context (Finn). It also provides an excellent opportunity to work with the client to imagine solutions, test them, and revise them until the client feels success and confidence (Finn). Also, the successes and failures of the session can be explored immediately to discover their context. This session is designed to reveal greater insight to the client so that subsequent feedback becomes easier for the client to integrate. It also gives the assessor an idea of what feedback the client is willing to hear at this point, which helps in organizing it.

Summary/Discussion Session: One of the first aspects of psychological assessment examined for its therapeutic properties was the feedback session, which Finn has named the summary/discussion session in TA. Other researchers, in addition to Finn, found that altering the

feedback session to be more collaborative could create greater change and satisfaction for clients (Finn, 2007). According to Swann's self-verification theory, people will cling to ideas about themselves even if they are negative (Ackerman, Hilsenroth, Baity, & Blagys, 2000; Finn, 2007; Finn & Tonsager, 1992; Swann 1997). When test results contradict a self-concept, clients often do not integrate the information discovered or even dismiss it altogether. However, if presented collaboratively and therapeutically, feedback can often be the most transformative aspect of an assessment and enhances the likelihood that the information will be understood and adopted (Finn, 2007). In addition, the client is given a chance to review, discuss, and even disagree with the assessor's findings, similar to the ideas posited by collaborative assessment (Fischer, 1979, 2006; Finn, 2007; Finn & Tonsager, 2002). This form of interactive feedback has been shown to have a larger impact than simply presenting results.

To better conceptualize the amount of feedback a client could integrate, Finn developed a model of three levels of feedback information (Finn, 2007). Each of the levels increases in dissonance from the client's self-awareness and self concept. Level 1 feedback contains information that the client already believes. By hearing this information, the client begins to open up to the assessment process and believe in its utility and validity. Level 2 feedback is information that reframes or amplifies the client's typical thoughts of themselves. While this information is more informative and requires more insight, it should not really challenge self-esteem or self-perception. Level 3 feedback actively conflicts with the client's thoughts about him or herself and while likely rejected at first, will hopefully be assimilated at a later point.

One of the values of TA is that it tries to incorporate feedback through the entire testing process, creating a better environment for more difficult feedback later. This gives the client working examples of behaviors rather than discussing them later in the assessment. For example,

during the TAT with a client suffering from depression, it might be beneficial to recognize that their stories involving relationships often have sad qualities to them. This could demonstrate that the test results are showing how they are experiencing the world and possibly factors, such as interpersonal relationships, that are contributing to depressive feelings.

Written Feedback and Follow-Up Sessions. Reports in TA are similar to those reports described by Fischer (1973, 1980) in previous sections. Reports are written in a letter format directly to the client in language that the client will understand (Finn, 2007). The report is formatted according to the assessment questions and provides the answers discussed during the Discussion/Summary Session. This allows the client to have a written account of their assessment to continue to review and glean insight from after the assessment is concluded. Follow-up sessions are then given if more explanation is needed.

Research on TA

Due to the complex and lengthy nature of TA, few quantitative studies have been conducted on the comprehensive model, although case studies have provided poignant examples of its effects (Handler, 2006; Michel, 2002). Most quantitative studies have examined only particular aspects of TA. The complexity of comprehensive TA hinders the ability to conduct studies with large sample sizes while still maintaining adequate control for confounding variables, such as varying lengths of time. In addition, there are some processes in the steps of TA that might create change for a client, making it important to study the impact of specific components of TA.

Despite abbreviations, TA has been shown to increase overall client satisfaction with psychological assessment (El-Shaieb, 2005; Finn & Tonsager, 1992; Lance & Krishnamurthy in Fischer & Finn, 2008; Newman & Greenway, 1997). Finn and Tonsager (1992) conducted a

study examining the effects of MMPI feedback using a brief TA model for college students compared with a group receiving the test with traditional feedback. Results found that those in the brief TA group showed higher self-esteem and satisfaction with the assessment. Newman and Greenway (1997) replicated the Finn and Tonsager study and found similar results. Other studies have found that a collaborative approach to feedback produces greater satisfaction than a unilateral approach (Rogers, 1954; Hanson, Clairborn, & Kerr, 1977; El-Shaieb, 2005). Lance and Krishnamurthy (in Fischer & Finn, 2008) found that those given written and oral feedback following the TA model rated the experience as more satisfying than those getting either the written or oral feedback alone. They also discovered that combined collaborative feedback left clients feeling more positive about the therapeutic relationship and as if they learned more about themselves during the process. Finn and Brunner (in Finn & Martin, 1997) found that inpatient clients who received collaborative verbal feedback, contrasted with, those who did not receive feedback, rated themselves more satisfied with the assessment process, having gained more self-knowledge, feeling more understood by the assessor, and being more positive about the assessment.

TA has also been found to positively impact future psychotherapy progress in adults. In particular, it has been found to reduce the rate of premature termination, enhance clients' positive alliance to the therapist and increase the likelihood that this positive alliance will have a lasting impact on the therapeutic relationship (Cromer & Hilsenroth, 2006; Hilsenroth, Akerman, Clemence, Strassle, & Handler, 2002; Hilsenroth, Peters, & Ackerman, 2004; Weil & Hilsenroth, 2006). Millon, Weiss, Millon, and Davis (1994) showed that those who had collaborative feedback increased their self-esteem and rapport with the assessor.

While no group or comparative studies have examined a full implementation of TA, numerous case studies have demonstrated the effects of TA. Finn (2003) presented a case of a man, David, referred by his therapist after the pair had become stuck in therapy. Finn completed a full TA with the man, and, at the Summary/Discussion session, David actually guided the time by explaining the insights he had gained throughout the process. David was then able to listen and agree with additional information from Finn. David completed the AQ-2, which reported that he was significantly satisfied with the experience, and later both David and the original therapist reported that their relationship had improved.

Other case studies have shown similar results in that clients leave the assessment satisfied and with new self-awareness. Finn and Martin (1997) describe a case in which a middle age woman came in to learn more about her anger. She left the assessment feeling more understood by the assessor and, more importantly, herself. She decided to continue psychotherapy and began communicating her feelings more smoothly. Finn and Kamphuis (2006) found TA to be beneficial for a client with more severe pathology, borderline personality disorder. The client in this case reported feeling understood and supported, which is something she rarely felt. In an example from Finn and Fischer (2008), Fischer described a case in which the man continued to report benefits of the assessment, in terms of satisfaction and subsequent psychotherapy success, over four years after it was conducted.

While these case examples have been of TA with adults, there have also been case studies analyzing TA with children (TA-C) and TA-A. TA-C works with parents and children to positively impact both as individuals as well as their relationship together. Tharinger, et al, 2007) describe a case in which two grandparents, Mr. and Mrs. Sanchez, bring in their 11-year old granddaughter, Christina, for psychological assessment regarding her defiance and anger

outbursts. At the end of the TA-C process, the grandparents were able to understand the tailored feedback focusing on the systematic nature of their problem. Subsequently, Mr. and Mrs. Sanchez reported a decrease in Christina's externalization behaviors on the BASC-2 after the assessment process. They also reported feeling satisfied with the assessment and an increase in family communication and peace. These findings were upheld during the four-month follow-up. Michel (2002) conducted a brief TA-A with an inpatient adolescent, C., who was suffering from bulimia nervosa, purging type. C reported that the test results made sense to her and later this new knowledge gave greater insight during individual therapy. The test results also helped in the family's acceptance of the seriousness of the situation, and they agreed to enter into family therapy to examine systematic issues that were at play. Longitudinal results indicate a decrease in depressive and eating disorder symptoms and improvements in her family relationships. Throughout his clinical practice, Handler (2006) discovered that TA-A not only provided context for success and failures but increased their self-confidence and eased their discomfort with standardized testing. In addition, TA-A can be used to quickly form a working alliance, view problems systemically, and ease the transition from assessment to future treatment.

Overall, studies on TA have shown it to be an effective therapeutic intervention. Empirical research has found that brief models of TA increases assessment satisfaction, enhances self-esteem, alleviates clinical symptoms, increases self-knowledge, and improves the therapeutic relationship both with the assessor and future therapists. Case studies have illuminated the positive results of a full TA, TA-A, and TA-C. While more research is still needed, especially on TA-A, TA appears to be a promising therapeutic assessment intervention.

Overview of Adolescent Development

The nature of adolescence makes it a difficult period to define; age alone does not suffice. Being a developmental period, there is a significant variance between individuals as to when they begin and end this period. From a psychological standpoint, adolescence is a time where youth can discover their own sense of self and explore different adult roles (Dusek, 1977). Dusek describes adolescence as, "the stage in which the individual is required to adapt and adjust childhood behaviors to the adult forms that are considered acceptable in his or her culture" (p. 2). According to Rubenstein (2003, p. 1170), "if variables such as financial independence, emotional separation, biological changes, social maturity, and educational level are applied, the beginning of adolescence can be as low as age 9 and as high as age 25." Change is the only real "litmus" characteristic of this period, but the onset and track of this change is extremely difficult to uniformly describe due to individual differences (Holmbeck & Updegrove, 1995).

Primary changes in adolescence include: biological, cognitive, and social change (Holmbeck & Updegrove, 1995). Biologically, the youth develops faster than they do socially or psychologically (Dusek, 1977). Therefore, adolescence becomes a time when they can catch up emotionally and socially to the physiological changes that are occurring. Socially, adolescents begin to develop the skills needed to function as an adult (Dusek). Cognitively, adolescents are developing the ability to engage in abstract thinking (Beauchaine & Hinshaw, 2008; Dusek; Muuss, 1988). They also gain the ability to develop a sense of self and become aware of their value, skills, and interests (Tierney & Herman, 1973), which influence many aspects of the adolescent's life, such as interpersonal relationships and self-concept.

According to Erikson, the main goal of adolescence is to gain a sense of personal identity (Beauchaine & Hinshaw, 2008; Muuss). This requires evaluating the self and creating a self-

concept based on the past, present, and future (Beauchaine & Hinshaw; Muuss). In addition, identity formation occurs across many domains (Holmbeck & Updegrove, 1995). For example, a youth might feel comfortable in his or her identity in terms of academic performance but not in social relationships. Often adolescents try to determine who they are through social feedback; they replace the sense of identity they gained from their parents with a sense of identity from their peers, which relates to attachment theory (Muuss). During this period adolescents become increasingly self-sufficient as they become an adult. The attachment relationship between parents and adolescents shift from one of authority to one of cooperation and mutual respect (Holmbeck & Updegrove).

Sullivan argues that people have as many personalities as they do interpersonal relationships. He argues that the self is defined and developed by social, interpersonal, and cultural relationships. It consists of "reflected appraisals", which are how the self adopts appraisals based on how significant others judge them (Beauchaine & Hinshaw, 2008; Muuss, 1988). Thus, adolescents are preoccupied with what others think of them. This idea leads to the idea of selective inattention, related to Swann's (1997) self-verification theory, meaning people discount information that contradicts their self-system (Muuss). A healthy identity forms when they are able to gain their sense of identity from themselves and not their parents or peers.

According to Piaget, this period is when adolescents develop the capability for formal operational thinking, which includes propositional thinking, combinatorial analysis, and abstract reasoning (Beauchaine & Hinshaw, 2008; Holmbeck & Updegrove, 1995; Muuss, 1988). They also gain the abilities to form theories or "think about thinking." They can start to understand numerous possibilities, the consequences of actions, and that others have thoughts and opinions.

This way of thinking affects many other aspects of their lives outside of the cognitive and intellectual realm, such as their socio-cognitive world.

In light of the developmental considerations, adolescence must be viewed and treated as a separate period from both childhood and adulthood (Oetzel & Scherer, 2003). However, many researchers do not take these differences into account sufficiently when working with adolescents (Holmbeck & Updegrove, 1995).

Adolescent Therapeutic Assessment

Due to the unique developmental characteristics of adolescence, Finn and colleagues recognized the need to alter TA practices to better fit with the unique aspects of the adolescent population. TA-A involves the parents in the assessment process, as in TA-C, while at the same time giving the adolescent more of the privacy and autonomy seen in adult TA. In TA-C, for example, the parents observe and process the child's testing session with another clinician; however, in TA-A, parents do not. Additionally, in TA-A, similarly to TA, the adolescent has an individual assessment intervention session but also participates in a family intervention session, characteristic of TA-C. Table 2.0 on the subsequent page shows the outline of a typical TA-A.

Steps in TA-A

Initial Contact: The initial phone contact with the parents gives a brief introduction to the assessment process and sets up the initial appointments (Finn, 2007). Written information is sent out and consists of a brief introduction for the parents and adolescents as well as informed consent forms. The adolescent introduction and consent forms are composed in client friendly language and addresses questions that might arise for the adolescent such as, "Why am I being brought to see you", "Will you really tell me what you figure out", and " Who else will get results from the assessment".

Table 2.0 Steps of TA-A

Step 1	**Initial Phone Contact with Parents; Written Information Sent**
Step 2	Initial Session with Parents and Adolescent
Step 3	Individual Session with Adolescent
Step 4	Individual Session with Parents
Step 5	Standardized Testing with Adolescent (Possible Testing with Parents)
Step 6	Assessment Intervention Session with Adolescent
Step 7	Sessions with the Parents
Step 8	Family Session
Step 9	Discussion/Summary Session with Adolescent
Step 10	Discussion/Summary Session with Parents (and adolescent if he or she wants to attend)
Step 11	Written Feedback Sent to Parents and Adolescent
Step 12	Follow-up Sessions (if needed)

Initial Sessions. The initial sessions include a meeting with the parents and adolescent, a meeting with just the adolescent, and a meeting with the parents. The first meeting with both the parents and adolescent provides a more in depth explanation of the TA process and answer any questions that may arise. The assessor works hard to establish trust both with the adolescent and the parent. This includes negotiating the appropriate amount of autonomy and confidentiality for

the adolescent with the parents regarding the assessment and asking the adolescent for their consent to participate in the assessment (Finn, 2007). Beyond establishing guidelines, educating, rapport building, the most important concrete goal of these initial sessions is to develop assessment questions both for the parent and adolescent. This is done in a similar manner to the adult TA except that the parents create their assessment questions during the meeting with both the adolescent and the parents, but the adolescent creates their questions during their private session with the assessor. This allows the adolescent to feel like a collaborator in the process and that nothing is being hidden from them. This increases their engagement and cooperation in the process as well as their perceived importance (Finn). Finally, with the adolescent's consent, the assessor meets with the parents alone to collect background information or concerns that would not be appropriate or necessary to discuss in front of the adolescent (Finn).

Standardized Testing and Assessment Intervention Sessions. The standardized testing sessions and assessment intervention sessions in TA-A are conducted in the same manner as the TA with adults but with the client's developmental level in mind. For example, the adolescent may be given the MMPI-A instead of the MMPI-2, and the assessment intervention session might involve activities appropriate for adolescents. Although optional, in TA-A, the parents are invited to participate by taking their own set of standardized tests, usually personality measures such as the MMPI-2 (Finn, 2007). As the assessor works with the family system, it is important to understand the psychological functioning of the main members of that system. This is presented to the parents as a means to better answer the original assessment questions. After these sessions, the assessor has a session with the parents to introduce pieces of feedback. This session gives the opportunity to begin introducing possibly difficult feedback and allows

observation of the parents' responses to this feedback. From this, the assessor starts to plan the family session and the final summary/discussion session.

Family Session. The family sessions is designed to give the family a chance to recognize assessment findings on their own (Tharinger, et al, 2007). These findings might be difficult for the parents and/or the adolescent to absorb, so the session creates a living example of the results for the family to experience and relate to. It is an important opportunity for the assessor to observe the family system as well as to provide the family with support when problems arise.

An example of a specific family session might include a mom and son that are extremely close but a father who appears distant and uncaring. Through previous session and test results, the assessor might have the hypothesis that the father actually desires a relationship with his son but does not know how to relate to him. In turn, the son, feeling rejected by the father, acts out and becomes very disrespectful towards the dad. The family session might include an activity where the father and son must work together to fill out a sentence completion exercise. The goal of this would be for the father and son to start interacting in a positive and cooperative manner. Presumably, this would demonstrate that they are able to appreciate each other's company and actually can relate to one another. This realization can be a powerful changing point in their relationship; whereas simply telling them the findings might be dismissed. It also allows them to experience success working together in a safe environment.

Summary/Discussion Sessions and Written Feedback. The summary/discussion sessions occur in two parts: one with the adolescent alone and one with the parents where the adolescent also is invited to attend. These sessions occur in a similar manner to that of adult TA. When meeting with the adolescent, the assessor encourages opinions and feedback regarding the results, discusses information, and possibly integrates client opinions into the final report. The

adolescent is also given feedback in response to both his or her own questions and the parents' questions (Finn, 2007). The assessor then goes over what information will be presented to the parents and invites the adolescent to attend the parent feedback session. The adolescent is also given the choice to either keep their questions and answers private or to share them with their parents.

The meeting with the parent is also conducted in a similar fashion as that of adult TA. They are given answers to their questions according to the levels of difficulty. Parents are also invited to discuss, question, and even disagree with the results given. Written feedback is later sent separately to the adolescent and the parents, and it is the adolescent's decision whether or not to share the letter with the parents. However, like every step in the assessment process, the adolescent is privy to the information conveyed to the parents through a copy of the letter the parents receive. These letters are formatted in a similar fashion as the adult TA written feedback although modified to fit the developmental level of the adolescent.

Outcomes of TA with Adolescents

Due to the beginning nature of the research literature, there are many hypothesized outcomes that could be examined. From the developmental literature, the outcomes chosen, self-knowledge, feeling understood, positive feeling towards the examiner, symptom reduction, and feelings about the assessment experience, all have heighten importance due to the developmental tasks or nature of adolescents.

Self-Knowledge

Adolescence is a time when youths gain the ability to think abstractly (Dusek, 1977; Muuss, 1988). Through this they are able to form ideas about their thinking and the world around them. According to Piaget, this is the time period in which the primary task is identity formation

(Beauchaine & Hinshaw; Muuss). In order to do so, it is crucial that adolescents be able to understand themselves and different aspects of themselves in order to evaluate which are salient to their identity. Self-understanding is distinguishing oneself from others and the world around them which facilitates identity formation (Damon & Hart, 1982).

While developing the ability to hear and process information, even negative, about themselves, adolescents are often not taught how to understand themselves (Jersild, 1951). This is important because it is often difficult to accurately self-evaluate in an objective way compared to others, proving the need for adolescents to be aided in how they gain an understanding of themselves. The difference between the self and others also affects how feedback is interpreted (Damon & Hart). People are emotionally invested in their own identity and are more sensitive about how they process feedback about themselves than others.

Despite the difficulty in learning how to process information about themselves, adolescents want to gain more self-understanding (Damon & Hart, 1982). Their developmental task requires that they start to form their identity, which requires learning about and examining the self. According to self-efficacy theory, humans need to increase their knowledge about themselves (Freud, 1936; Hartmann, 1958; Hartmann, Kris, & Lowenstein, 1946; & Bandura, 1994), which serves as a motivation for assessment. Therefore, the assessment process will be more satisfactory if they gain new information about themselves during the process.

Feeling Understood

As adolescents reach formal operations, they tend to be somewhat hypervigilant in terms of sensing how others perceive them, making it important that the adolescent feels understood by the assessor and the assessment process. They develop “reflected appraisals,” which are aspects of their identity based on these perceptions (Muuss, 1988). This tends to lead to “selective

inattention" where the adolescent ignores information what contradicts their self-system (Muuss). Selective inattention relates to Swann's self-verification theory (Swann, 1997), discussed earlier in relation to TA. Just as Swann (1997) described, people do not listen to information that contradicts the view they have created about themselves. Adolescents especially seek self-consistency (Meleddu & Guicciardi 1998). In addition, according to self-enhancement theory, it is crucial that adolescents leave the assessment feeling positive about themselves (Fairbairn, 1952; Winnicott, 1957, 1975). Therefore, it is important that adolescents feel that the assessment verifies their self-view and leaves them feeling secure and proud of their self-concept. Without feeling this, the adolescent will be inclined to dismiss the findings and rate the whole process as unsatisfactory.

Positive Therapeutic Alliance

Therapeutic alliance has been shown to be clinically significant in treatment outcomes (Fitzpatrick, & Irannejad, 2008; Karver, Shirk, Handelsman, Fields, Crisp, Gudmundsen, et al. 2008). The term working alliance or therapeutic alliance encompasses different aspects of therapy such as trust, positive feelings with the therapist, and even collaboration. For the purpose of this study, the therapeutic relationship will consist of feelings of trust, respect, connection, and collaboration. While most of the literature on alliance has focus on adults, researchers are showing that alliance also has a profound impact on adolescents (Fitzpatrick, & Irannejad, 2008; Karver, et al. 2008). The therapeutic alliance can be a predictor of client involvement, particularly in nondirective therapy (Karver et al., 2008). In addition, outcomes were higher for adolescents, when both they and their therapist ranked each other positively (Hendren, 1993). Unfortunately, adolescents are often brought to complete treatment with little or no choice, which makes developing a therapeutic relationship with an "unwilling participant" more difficult

(Fitzpatrick, & Irannejad, 2008; Keating & Cosgrave, 2006). Besides being forced into treatment there are also numerous other reasons why an adolescent may be hesitant to engage in any mental health service, including psychological assessment (Keating & Cosgrave, 2006). Therefore, the therapeutic relationship typically begins in a very fragile state. The therapist must be very attentive in order to promote that they are interested and caring. For brief therapies and assessments, establishing a relationship quickly is crucial for success (Clair & Predergast, 1994).

If an assessor is able to form a healthy working relationship with the client, then it will encourage openness and trust from the adolescent (Braski, 1999). The therapeutic relationship then serves as an important aspect of the process in order to alleviate some of the youth's concerns and help them become more invested in the testing. In addition, when the adolescent is treated as an equal and given more freedom, they are more satisfied with the relationship and engaged in the process (Church, 1994). When adolescents feel respected, they begin to break down their walls and become invested in the process (Young, Anderson, & Steinbrecher, 1995).

In therapy, outcomes were higher for adolescents, when both they and their therapist ranked each other positively (Hendren, 1993). Considering adolescent's concern with how others view them, they often reject those that they do not feel a mutual connection with. This translates not just in social situations with peers but also to interactions with adults. Adolescents simply respond better when they feel liked by their clinician. Therefore, the therapeutic relationship is an important avenue to develop and communicate that connection with the youth. It is important to realize that the therapist can never be fully objective and always has an impact on the client. As such, the client needs to feel understood and accepted from the psychologist, in order for goals to be achieved (Engleman & Frankel, 2002).

As discussed in previous sections about the principles of collaborative assessment and TA, collaboration is a vital part of the assessment process; this can, in part, be categorized as a component of the therapeutic relationship. Collaboration aids in discovering a truer understanding of the therapy process (Engleman & Frankel, 2002; Young, Anderson, & Steinbrecher, 1995), which relates to the TA process, as well. As the adolescent feels more empowered, often through collaboration, they begin to open up and take charge of the sessions more (Church, 1994; Young, Anderson, & Steinbrecher, 1995).

Negative Feelings about the Assessment

Adolescents are often difficult to work with because they are brought to the assessment against their will (Fitzpatrick, & Irannejad, 2008; Keating & Cosgrave, 2006; Young, Anderson, & Steinbrecher, 1995). As a result, they are already inclined to view the procedure negatively. Therefore, an assessment must work harder with adolescents to decrease negative feelings towards the process. Negative feelings not only include their view of the assessment process but also of how they feel they are being treated. Young, Anderson, and Steinbrecher (1995 p. 37) stated, "as the adolescent feels listened to—not judged—and respected, they begin to unmask their own disguise (i.e., explain their symptomatology), and they often feel an increased sense of competence and a personal investment in making changes and assuming responsibility." This lends to reason that the more negative an adolescent feels towards the assessment and how they are being treated during the assessment the more likely they are to withhold information and not engage in the process. In addition, it may have a negative impact on their sense of self-competency. Adolescents are often self-conscious and are more sensitive to feeling unaccepted (Gumbiner, 2003). Therefore, they are more likely to be affected by feeling that they are being hurt, judged, or exposed by the assessment.

Proposed Research Study

Statement of Purpose

Developmentally, adolescence is a period marked with transitions in multiple dimensions of the teenager's life. Biologically, emotionally, socially, and cognitively the adolescent evolves rapidly. From this standpoint, adolescence is a time where youth can discover their own sense of self and explore different adult roles (Dusek, 1977). Adolescents are gaining the ability to engage in abstract thinking and reasoning (Beauchaine & Hinshaw, 2008; Dusek, 1977; Muuss, 1988). This allows them to begin to think in more relative terms and envision possibilities rather than only the observable and concrete. In addition, adolescents are grappling with the task of forming an identity separate from that of their parents (Holmbeck & Updegrove, 1995; Muus, 1988). During this process, adolescents actively seek to increase their own autonomy while shifting from the role of the child to the role of adult. However, they are resistant to people and situations that contrast with their developing self-concept to maintain self-consistency (Meleddu & Guicciardi 1998; Muus, 1988). Thus, they are sensitive to situations in which they feel they are being treated as a child or do not feel respected. This creates problems within the family system as the parent attempt to adjust to their child's new role. The attachment relationship between parents and adolescents shift from one of authority to one of cooperation and mutual respect (Holmbeck & Updegrove, 1995). New responsibilities and freedoms must be given, and appropriate and consistent limits should be set in order to foster a mature self-concept development (Dusek, 1997).

The balance between giving the adolescent the privacy and autonomy they are seeking while still providing needed support and limits also proves difficult in psychological assessment with adolescents. Many adolescents cannot describe or accept their feelings and often respond by

acting out or blaming others (Rubenstein, 2003). Therefore, they often enter into the assessment unwillingly (Fitzpatrick, & Irannejad, 2008; Keating & Cosgrave, 2006) and may feel as if seeking help or admitting a problem may conflict with their striving for autonomy (Oetzel & Scherer, 2003). Thus, the assessor must not act as the objective observer or clinician but must establish the therapeutic relationship as a partnership, unique of that with an adult or child. The goal is to build self-confidence, resiliency, and ownership while providing support (Rubenstein, 2003). Traditional assessments primarily focus on obtaining clinical data in order to diagnose and make decisions (Finn & Tonsager, 1997; Gumbiner, 2003), and while a therapeutic relationship is viewed as important (Gumbiner, 2003), it is seen as secondary to ensuring standardized procedures are following and test data is collected quickly. Unfortunately, without a close working alliance, the adolescent will likely remain closed and disengaged in the process potentially affecting the accuracy of results.

However, TA provides a model for assessment that attempts to engage the adolescent as a collaborator in the process (Finn, 2007). Built on the principles of collaborative assessment, TA-A gives a semi-structured method to working with adolescents. By inviting the clients to actively participate in their own assessment as equals with parents and assessor, adolescents feel they are respected and important to their own assessment. TA-A not only strives to obtain accurate test data but to create positive change within the adolescent and even the family system. When adolescents feel listened to and accurately understood, they begin to hear themselves and are able to not only engage in more self-exploration but also gain more self-knowledge (Braski, 1999). By creating a collaborative atmosphere and taking into account the unique developmental characteristics of adolescence, TA-A has been found clinically to be not only a high-quality assessment method, but also a potentially powerful psychological intervention (Finn).

Empirical studies examining the effectiveness of TA-A are needed, but the complex nature of TA-A makes it difficult to conduct studies with large sample sizes. The amount of time, training, and clinicians needed to implement TA-A on a large scale would require large funding resources. TA-A, being somewhat of a blend of assessment and psychotherapy, poses a problem when trying to control for confounding variables and finding an adequate control group. As a consequence, existing studies examining TA with adults have used a brief TA model and have studied the utility of particular aspects of TA. These studies have found that even a brief TA model can create symptom reduction, greater client satisfaction, enhanced self-knowledge, and positive feelings about the therapeutic relationship (El-Shaieb, 2005; Finn & Tonsager, 1992; Hanson, Clairborn, & Kerr, 1977; Newman & Greenway, 1997; Rogers, 1954). The use of a brief model coupled with the difficulty of sample sizes and controls creates a large gap in the literature in terms of examining the power of TA, especially looking specifically at adolescents. The proposed study aims to help fill this gap by conducting a study contrasting the brief TA-A model with assessment as usual (AU).

While the full TA-A model provides an eloquent and potentially powerful assessment model, it is important to exhume specific aspects to examine their unique contributions. Due to the importance of allowing the adolescent to have some autonomy and privacy, the proposed study looks at the impact of individual and private assessment questions and subsequent private feedback related to those questions when compared with assessment as usual (see Table 3.0). By engaging adolescents in such a collaborative manner, it is hypothesized that they should feel a more positive relationship with the assessor as contrasted with those in the AU group.

In addition, by having questions and opinions acknowledged, the adolescent should feel increasingly understood by the assessor and become more open to self-exploration and new self-

knowledge. As most adolescents enter into treatment with a negative mindset, the respectful and collaborative nature of TA-A should alleviate some negative and resentful feelings. Finally, the goal of TA is to promote positive change within the client. Through collaboration, engaging the adolescent, and providing interactive and personalized feedback, TA-A should also produce greater symptom reduction than the AU group.

Hypotheses

Hypothesis 1: It is hypothesized that those participants in the brief TA-A group will be more satisfied with the assessment experience than those in the AU group.

Rationale: Based on previous studies, TA has been shown to positively affect assessment satisfaction (El-Shaieb, 2005; Finn & Tonsager, 1992; Hanson, Clairborn, & Kerr, 1977; Lance & Krishnamurthy 2003; Newman & Greenway, 1997; Rogers, 1954). Specifically, overall assessment satisfaction has been shown to be higher for those who receive TA than those that receive traditional assessment (Newman & Greenway, 1997). While these empirical studies focused primarily on adults, case studies have shown high satisfaction with adolescents as well (Handler, 2006; Michel, 2002). It is hypothesized that the group receiving brief TA-A will have higher overall assessment satisfaction than the AU group largely because of the components that comprise the construct of overall satisfaction. These are discussed in subsequent hypotheses.

Hypothesis 2: It is hypothesized that those participants in the brief TA-A group will learn more about themselves when compared with the AU group.

Rationale: Self-efficacy theory states that people are driving to learn more about themselves (Freud, 1936; Hartmann, 1958; Hartmann, Kris, & Lowenstein, 1946; & Bandura, 1994). Finn and Brunner (1993) and Lance and Krishnamurthy (2003) found that TA increased client's self-knowledge. Case studies have also reported that clients say they gained new insight into themselves and their problems (Handler, 2006; Michel, 2002). While these studies focused on

adults, the developmental nature of adolescence indicates that this will also be true for that population. It is a time where adolescents are focused on discovering their own identity and new information about different aspects of themselves (Muuss, 1988; Tierney & Herman, 1973). Therefore, TA should also increase their self-knowledge as in the studies with adults.

Hypothesis 3: It is hypothesized that those participants in the brief TA-A group will feel more understood by the assessor and the assessment process itself than those in the AU group.

Rationale: According to self-enhancement theory, people strive for situations that make them feel positive about themselves (Fairbairn, 1952; Winnicott, 1957, 1975). One aspect of this is feeling proud and secure in one's self-concept (Finn, Schroeder, Tonsager, 1995). This is particularly important for adolescents when trying to solidify their own identity in order to fully achieve Erikson's stage of identity versus identity confusion (Beauchaine & Hinshaw, 2008; Muuss, 1988). The other aspect of this is feeling is if the assessment captured an accurate picture of the adolescents self-system. Swann's (1997) self-verification theory suggests that people are more likely to believe information that they feel accurately fits with their view of themselves. Adolescents especially seek this form of self-consistency (Meleddu & Guicciardi, 1998). TA is based on these principles of human behavior and studies have shown that TA increases these feelings (Finn & Brunner, 1993; Finn, 2007) with adults. By using a technique that focuses on making the client feel understood and validated, adolescents in the TA-A group should feel more understood than the AU group.

Hypothesis 4: It is hypothesized that those in the brief TA-A group will rate their relationship with the assessor as more positive than the AU group.

Rationale: Adolescent research has shown that the therapeutic relationship between the clinician and adolescent is positively related to treatment outcome both in therapy and

assessment (Fitzpatrick, & Irannejad, 2008; Karver, et al. 2008; Clair & Predergast, 1994). The collaborative relationship is paramount in TA and considered a main focus of the assessment; whereas traditional assessment focuses more on obtaining and reporting data (Finn & Tonsager, 1997; Finn, 2007). Therefore, the TA group should report feeling more positive about their relationship with the assessor than the assessment as usual group.

Hypothesis 5: It is hypothesized that the TA group will report less negative feelings about the assessment than the assessment as usual group.

Rationale: It is important that the adolescent does not feel judged or exposed during the assessment so he or she does not close themselves off during the assessment. The majority of the studies on TA have shown that clients experienced the assessment process positively (El-Shaieb, 2005; Finn & Tonsager, 1992; Lance & Krishnamurthy 2003; Newman & Greenway, 1997; Rogers, 1954; Hanson, Clairborn, & Kerr, 1977). Case studies have also found that adolescents also report feeling positive about the TA experience. Therefore, it should reason that the TA group would have less negative feelings about the assessment experience than the assessment as usual group.

Hypothesis 6: It is hypothesized that those in the TA-A group will demonstrate greater symptom reduction than the AU group.

Rationale: One goal of TA is to apply new information about themselves to problems in their lives to decrease negative symptoms; whereas traditional assessment aims at accurately describing the client and make decisions based on test results (Finn & Tonsager, 1997; Finn, 2007). Adolescent psychotherapy literature indicates that there are a variety of mechanisms that produce positive change. Different theories indicate that promoting a strong therapeutic alliance, actively engaging the adolescent, and involving family are valuable for positive outcomes

(Sommers-Flanagan & Sommers-Flannagan, 1995). Some practical techniques posited include aligning with the adolescent, working together to define a problem, using client appropriate analogies, and putting behaviors and examples into a real world context. TA-A ideals and steps, such as working collaboratively, contextualizing behaviors, meeting with the adolescent privately, having the adolescent generate their own private questions, and providing personalized feedback, parallel techniques described by adolescent psychotherapy theories. Studies have shown that TA reduces symptomology even with brief TA interventions (Finn & Tonsager, 1992; Newman & Greenway 1997). Therefore, it is hypothesized that the TA will show a greater reduction in symptoms than the AU group

Participants

Participants will include 60 adolescents, ages 15 to 18, referred for psychological assessment concerning emotional or behavioral problems. The rationale behind the restriction of age is due to the vast individual differences within the period of adolescence. Individuals develop at varying speeds during this period and can be quite different in terms of their social, cognitive, and personal development. However, researchers have stated that, primarily, adolescents have gained the ability to think abstractly by the age of 15 (Muuss, 1988). This is critical, because most of the measures require that the adolescent be able to think introspectively, which becomes possible with the development of formal operational thinking (Dusek, 1977; Muus). Participants' ages will range from 15 to 18 with an expected mean age of 16. Thirty participants will be in each group, which will be comprised of 15 males and 15 females. Participants will be randomly assigned to each treatment group to ensure that the groups will be normally distributed. Participants who are currently in any other form of psychological treatment will be excluded from the study. This exclusion is to eliminate any additional benefits from other

treatments that might confound the results. In addition, those seeking cognitive or achievement testing are also excluded from the study, as only personality testing will be conducted.

Sample size was determined using G-Power, a statistical program that computes sample size and power. The researcher set the desired power as .80 with an alpha of .05 and an anticipated medium effect size of .5. With the parameters and accounting for the different statistical methods to be used, it was determined that the sample size should be 54 in order to have an 80% chance of seeing mean differences, if these differences are present. However, 60 participants will be gathered to ensure significant power if any participants drop out of the study.

Measures

Assessment Satisfaction

The Assessment Questionnaire-2 (AQ-2; Finn, Schroeder, Tonsager, 1995) is a 48-item paper-and-pencil measure that assesses four factors of assessment satisfaction: new self-awareness/understanding, positive accurate mirroring, positive relationship with the assessor, and negative feelings about the assessment. These four subscales can be looked at individually or as a whole. The participants are asked to rate their degree of agreement with the items on a five-point Leikert scale; “1” corresponds with strongly disagree and “5” corresponds with strongly agree.

The new self-awareness/understanding subscale has a coefficient alpha of .89 and includes items such as, “I gained a new understanding of myself” and “I'm more aware of how I behave with other people.” The positive accurate mirroring subscale has a coefficient alpha of .87 and included such items as, “The assessment made me proud of who I am” and “The assessment captured the "real" me.” The positive relationship with assessor subscale has a coefficient alpha of .87 and included items such as, “The assessor was interested in what I had to say” and “I felt that the assessor respected me.” Finally, the negative feelings about the

assessment subscale had a coefficient alpha of .85 and included items such as, “The assessment made me feel that my life is nothing but problems” and “I felt judged by the assessor.” Test-retest reliability for the four scales was .78, .75, .84, and .81, respectively. Newman and Greenway (1997) also showed these four subscales to have good internal consistency.

The proposed study will examine each of the individual subscales to determine the effects of TA on gaining self-awareness, feeling understood, perceiving a positive therapeutic relationship and experiencing the assessment as positive or negative. The study will also examine the relationship between TA and overall satisfaction with the assessment process.

Symptom Reduction

The Behavioral Assessment System for Children- Second Edition, Self-Report of Personality (BASC-2 SRP; 2004) attempts to measure emotional disorders in children ages 2-21. The BASC-2 consists of self- report items with a 4-point Likert scale and true/false response styles. There are multiple primary and content scales comprising a composite score. The composites have alpha coefficients in the mid to high .80s and yield strong inter-rater and test-retest reliabilities. Evidence also supports moderate to high concurrent and construct validity.

Procedures

Prior to contacting the participants, they will be randomly assigned to one of two groups: the group receiving a brief model of TA-A (TA group) and the group receiving assessment as usual (AU group). Participants will then be called to schedule their first appointment. At the first session, a research assistant (RA) will go over the consent and assent forms, which highlight information regarding confidentiality and their rights as a participant in a research study. The RA will clarify that all identifying information will be kept separate from any questionnaires they fill out with respects to the study. The adolescent will then met with the RA alone and fill out the

BASC-2. After this is completed, the families will meet with the assessor for the first time. Table 3.0 provides an overview of the procedures for both groups.

Table 3.0 Procedures

Adolescent Therapeutic Assessment	Assessment as Usual with Adolescents
Initial Phone Contact with Parents	Initial Phone Contact with Parents
TA Interview with Parents and Adolescent (Parent Assessment Questions Constructed)	Clinical Interview with the Parents
TA Interview with Adolescent (Adolescent Assessment Questions Constructed)	Clinical Interview with the Adolescent
Testing Session (MMPI-A Administered)	Testing Session (MMPI-A Administered)
Discussion/Summary Session for Adolescent	Feedback Session for Parents and Adolescent
Discussion/Summary Session for Parents	
Written Feedback Sent Separately to Parents and Adolescent	Written Feedback sent to Parents

Therapeutic Assessment Group (TA)

There are additional limits to confidentiality when working with minors. When the family meets with the assessor, an agreement will be made that the assessor will let the parents know if the adolescent mentions anything that indicates the youth is a danger to self or others. Outside of that, all information is kept in confidence unless the adolescent gives permission for something to be shared. The adolescent will then be asked if they would like to participate in the study; if the adolescent is unwilling, the process will not proceed. With consent, the assessor explains the assessment procedure and purpose in detail to the family, and the parents begin by developing assessment questions they would like answered by the assessment. Afterward, the parents are

asked to leave the room so the assessor can meet alone with the adolescent. The assessor begins to work to establish rapport with the adolescent and gain background information, and the youth is then asked to develop questions to be answered. It is explained that these questions will only be shared with the parents with the adolescent's permission. When done, the assessor asks the adolescent's permission to meet alone with the parents to obtain background information. With permission, the parents meet with the assessor alone to discuss in-depth history of the adolescent and the referring problem.

At the second meeting, the adolescent meets with the RA to complete the MMPI-A. This is done in the same manner as the AU group, including that the directions and purpose of the test are explained to the adolescent. The RA scores the test and gives the results to the assessor. The assessor will begin to construct feedback based on the interviews and test results in light of the assessment questions, and it is structured according to the three levels of feedback (Finn, 2007). Written feedback will be in the form of letters to the parents and to the adolescent, separately. This feedback will be discussed in the final session, revised, and sent to the family after the study is complete. Oral feedback will focus on the original assessment questions and governed by appropriate use of the three levels.

During the final session, the adolescent will meet with the assessor alone first. The assessor will address the test results with the adolescent focusing on the adolescent's original questions. Next, the adolescent will have a chance to ask questions and provide their own interpretations. These will be discussed, and the report will be modified if needed. The assessor will then explain what will be said to the parents and ask for the adolescent's input. After this, the assessor will meet alone with the parents to discuss the feedback in a similar fashion as discussed with the adolescent. During this, the adolescent meets with the RA to complete the

AQ-2 and the BASC. Finally, revised versions of the written feedback are mailed to the parents and to the adolescent.

Assessment as Usual Group (AU)

In terms of confidentiality, the adolescent will be told that efforts will be made to maintain the adolescent's confidence; however, the purpose of the testing is to gain information about the adolescent and their behavior and/or emotional difficulties. As such, information shared with the assessor is subject to being used in the development of the final report and may be shared with the parents. Then, a brief explanation of the testing procedures will be explained to the parents and adolescent. At this point, the parents are asked to leave, and the assessor meets alone with the adolescent to conducts a clinical interview. For all participants, physical, developmental, educational and social history information will be gathered (Gumbiner, 2003). Then the assessor will meet with the parent to gather similar information concerning the adolescent. This will conclude the initial session.

During the second session, the adolescent will meet with a research assistant (RA) alone to take the MMPI-A. The RA will explain the directions of the test and that this test will help the assessor learn more about the adolescents functioning. After the adolescent leaves, the RA will then score the test and give the results to the assessor. The assessor gathers all information from the interviews with the adolescent and the parent, as well as test results, to begin to synthesize the data (Gumbiner, 2003). The clinician will revise hypotheses and start to prepare feedback, both written and oral. The written feedback should include background information, reason for the referral, behavioral observations, description of the test and results, clinical impressions, compilation of all data, and recommendations (Gumbiner, 2003). This is covered in the feedback

session and sent to the family after testing is complete. The oral feedback should be organized in a manner that will be clearly understood by the family.

During the final session, the adolescent and parents will meet with the assessor to receive feedback about the results. According to the APA Ethics Code, reasonable effort should be made to explain the results to the individual or representative (APA, 2002). The oral feedback will include a description of the test, conclusions made, strengths and weaknesses of the adolescent, and clear specific recommendations (Gumbiner, 2003). At this point, the parents and adolescent will have a chance to ask any questions they may have regarding the assessment and the results to ensure understanding. Then, the RA asks the adolescent to fill out the AQ-2 and the BASC. This is conducted without the assessor's or the parents' presence.

Results

Hypothesis 1 Analysis: A MANOVA with one between-subjects factor (condition) will be conducted to investigate the differences between the TA group and the AU group in terms of overall assessment satisfaction based on the four subscales. It is expected that the TA group will demonstrate significantly higher assessment satisfaction than the AU group. As a result, the statistical analysis will continue to test the effect of the individual subtests.

Hypothesis 2 Analysis: A univariate F-test will be conducted to determine the whether the groups differed specifically on the New Self-Awareness/Understanding. It is expected that those in the TA-A group will report learning more about themselves than those in the AU group reported.

Hypothesis 3 Analysis: A univariate F-test will be conducted to compare the TA and AU groups on Positive Accurate Mirroring subscale. It is expected that the TA group will score higher on this subscale than the AU group.

Hypothesis 4 Analysis: A univariate F-test will be conducted to determine the effect of the Positive Relationship on the TA and AU groups. It is anticipated that the results for the TA will be slightly, but significantly, higher than the results of the AU group.

Hypothesis 5 Analysis: A univariate F-test will be conducted to determine the whether the results of the Negative Feelings about the Assessment subscale differs for each group. It is expected that the TA group will score significantly lower on this subscale than the AU group, indicating that the TA group felt less negative feelings than the AU group.

Hypothesis 6 Analysis: A Repeated Measures ANOVA will be conducted to test for an interaction effect between time and group memberships on symptom reduction. It is anticipated that there will be a significant interaction such that the TA group will show greater symptom reduction over time than those in the AU group. Therefore, simple main effects will be analyzed to determine within group differences. It is expected that both groups will show an increase in symptom reduction; however, the AU group's increase will not meet statistical significance.

Discussion

Summary and Implications

Adolescence is a developmental period categorized by numerous biological, social, cognitive, and psychological changes. Adolescents are engaging is self-exploration in order to create their own identity (Dusek, 1977; Holmbeck & Updegrove, 1995; Muuss, 1988). Psychological assessment could provide an excellent opportunity to aid the adolescent in their developmental tasks. In addition, they are beginning to transition into adulthood and, as a result, are looking to increase their independence. However, this desire for more autonomy can create problematic relationships with authority figures that are not ready for this developmental shift (Holmbeck & Updegrove). Mental health professionals, including assessors, often fall into this category, especially since most adolescents are brought into treatment without their consent (Fitzpatrick, & Irannejad, 2008; Keating & Cosgrave, 2006). With this attitude, adolescents remain closed off and disengaged during assessment. Thus, important information could be lost or results may not be completely accurate. In addition, adolescents lose the opportunity for personal growth.

The results of the proposed study, if the hypotheses are confirmed, would demonstrate that a brief TA-A model could be used as a both effective assessment technique and therapeutic intervention. By including the adolescent into the process, the brief TA, when compared with assessment as usual, will gain accurate information and promote greater positive change for the client. The outcomes, based on TA and developmental literatures are expected to demonstrate the benefits of a brief TA-A model by showing the TA-A group has greater symptom reduction and feels more satisfied overall with process than the AU group. The TA-A group experiences an

increased self-knowledge, feelings of being understood, a positive relationship with the assessor, and decreased negative feelings about the assessment process.

Adolescents are actively seeking situations to learn more about themselves as they try to find their identity. Both methods of assessment could give the adolescent more information about him or herself; therefore, both groups should see an increase on this subscale. However, the TA-A group specifically addresses their desire for better self-understanding by allowing the adolescents to actively participate through the creation of assessment question and personalized feedback. A primary goal of TA-A is to ensure that the client understands the test results. As such, techniques of TA-A, such as the leveled feedback and providing contextualized examples, give the adolescents an opportunity to process feedback and gain more knowledge from the results. In addition, the results are presented in a manner that answers their initial assessment questions.

TA-A seeks to engage the adolescents as a collaborator in the process by validating their concerns and enlisting their opinions. In addition, the results are presented in a manner that answers their initial assessment questions and according to the three levels Finn (2007) discusses. By answering the assessment questions, the client feels the results are relevant to them and that the assessor understood their needs. Also, the levels of feedback give the results so that the client hears information that they agree with first. This way, they have their self-concept affirmed, which opens them up to hear results that may be more difficult to believe, and it makes them feel that the test results captured an accurate picture of who they are. Therefore, they feel understood by both the assessor and the assessment results. Assessment as usual presents all the results to the client in a more clinical than collaborative manner. This method does not actively

attempt to ensure the adolescent feels understood but rather aims at simply providing accurate results.

The therapeutic relationship is very important in engaging adolescents, as they are often resistant clients. Both methods do attempt to create a therapeutic relationship, and both groups should increase on this subscale. However, unlike assessment as usual, TA-A makes a concerted effort to ensure a close working relationship before beginning testing. At this point in their development, adolescents are striving to be seen more as adults and respect those that treat them as such. By working collaboratively with the adolescent and treating him or her with respect and equality, the therapeutic relationship should be enhanced.

Adolescents are hypervigilant to how others perceive them. Therefore, by treating the adolescent positively and with a non-judgmental attitude, they will be more inclined to view the whole process more positively. This takes effort by the assessor not only in how they treat the client but also how they present the results. Adolescents are more sensitive to negative information or feedback that contradicts their self-concept. Therefore, information presented clinically and without an intentional effort to soften difficult results, as in assessment as usual, will likely leave the adolescent feeling judged or exposed. TA-A strives to present the results in a manner that the adolescent feels emotionally safe. As a result, those in the TA-A group should report less negative feelings about the assessment than the AU group.

Finally, those in the TA-A group should demonstrate greater symptom reduction than the AU group. This is likely, because TA-A is closely linked to a brief therapeutic intervention in it is goals and methods. TA-A strives to provide opportunities for the client to work with the assessor to gain a better understanding of him or herself and develop effective recommendations to implement after the assessment. In contrast, in assessments as usual, the assessor alone creates

a conceptualization and the recommendations, which they then present to the client. By engaging the client in the process, from developing questions to helping create recommendations, the client is more invested in his or her potential success. In addition, TA-A creates a therapeutic environment to give the adolescent an opportunity to process how they are feeling and have someone listen rather than trying to gain background information, as in traditional assessment. Even the brief TA-A model used in this study provides an opportunity to process information and collaborates with the adolescent to develop an accurate conceptualization and realistic recommendations.

The positive results could provide powerful implications for assessment practices with adolescents. One implication is that the test results may be more accurate due to techniques that promote more honesty from the adolescent. However, there are greater implications for the personal growth of the adolescents. Often an assessment is the first time that adolescents are exposed to the mental health profession, and as discussed, they are initially hesitant or even resistant to treatment. By experiencing a technique that promotes a positive mindset towards psychological interventions, adolescents will be more inclined to actively participate in subsequent therapy. In addition, it provides a therapeutic intervention that will help guide the adolescent as they attempt to discover their identity and navigate this developmental period. The hope is that with increased knowledge and satisfaction with the assessment process, the adolescent will be more inclined to translate these results into their lived world.

Limitations

If results do not demonstrate the positive outcomes expected as a result of TA-A, a variety of reasons could explain the lack of significant findings. The intervention used is a brief model of TA-A, which may be insufficient to alter the global constructs studied, such as self-

knowledge and symptom reduction. It could also be that other aspects of TA-A, like family interventions, have a significant impact on the outcomes examined. The measures chosen also have limitations. While the AQ-2 has shown high reliability, the reliability study was conducted with college students not a teenage population. Although, it is often argued that adolescence extends into the early 20s, it may be that college students differ from high school students on the chosen constructs. The AQ-2 does possess content validity but lacks studies demonstrating other forms of validity, such as criterion and construct validity. The BASC-2 is a well-researched and highly accepted measure; however, using only the Emotional Symptoms Index may not be sensitive enough to slight changes to produce significant results. In addition to the construction of the study, social desirability might negatively impact the results. The participants might feel pressure to respond in a positive manner, which would skew the results. If the TA group did demonstrate the positive results hypothesized in comparison with the AU group, it would further suggest that TA could be a powerful therapeutic intervention when doing assessment with adolescents.

Also, there could be other variables outside of the brief TA-A intervention that could account for the positive results. The TA group receives approximately an hour to two hours more time with the assessor than the AU group, which could produce a therapeutic effect. In addition, in the TA group, the adolescent does not go to the summary/ discussion sessions and will not hear all of the results of the assessment, only the results that pertain to their questions. Therefore, they would have less information to disagree with or feel negative about; however, the adolescents in the AU group hear all of the assessment findings. As a result, it may be the amount of information presented and not the manner of the presentation that would produce the difference between the two groups. Finally, the nature of the experiment does not allow for the

assessor to be blind, which may influence how they interact with the groups. Despite these limitations, the expected results would promote a brief TA-A model as an effective assessment and intervention technique. While a full TA-A model still appears the most impactful, the brief TA-A model presented in the proposed study is hopefully something that could easily be implemented in assessment practices.

Appendix A: Assessment Questionnaire

Assessment Questionnaire

Name _____ Date _____

Assessor's Name: _____

Instructions

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

Use the following scale to rate each statement:

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

		Strongly Disagree				Strongly Agree
1.	The assessment did not teach me anything new about myself.	1	2	3	4	5
2.	The assessment made me proud of who I am.	1	2	3	4	5
3.	The assessor earned my respect.	1	2	3	4	5
4.	I felt I was under a microscope.	1	2	3	4	5
5.	The assessor introduced me to new aspects of myself.	1	2	3	4	5

6.	The assessment made me feel good about myself.	1	2	3	4	5
7.	It was easy to trust the assessor.	1	2	3	4	5
8.	The assessment hurt me.	1	2	3	4	5
9.	I gained a new understanding of myself.	1	2	3	4	5
10.	The assessment captured the “real” me.	1	2	3	4	5
11.	The assessor seemed to like me.	1	2	3	4	5
12.	The assessment was unsettling to me.	1	2	3	4	5
13.	The assessment confirmed parts of me that I had only suspected.	1	2	3	4	5
14.	The assessor said nice things about me.	1	2	3	4	5
15.	I felt very close to the assessor.	1	2	3	4	5
16.	The assessment was a humiliating and degrading experience.	1	2	3	4	5
17.	The assessment made me think of myself.	1	2	3	4	5
		Strongly Disagree			Strongly Agree	
18.	The assessment made me feel important.	1	2	3	4	5
19.	The assessor treated me warmly.	1	2	3	4	5
20.	The assessment was emotionally draining.	1	2	3	4	5
21.	I am more aware of how I behave with other people.	1	2	3	4	5
22.	I felt special.	1	2	3	4	5
23.	I really connected with the assessor.	1	2	3	4	5
24.	At times during the assessment, I felt like I did when I was a child.	1	2	3	4	5
25.	The assessment helped me organize my thoughts about myself.	1	2	3	4	5
26.	The assessment confirmed how I see myself.	1	2	3	4	5
27.	I liked the assessor.	1	2	3	4	5
28.	The assessment made me feel that my life is nothing but problems.	1	2	3	4	5
29.	I have changed the way I think about my problems.	1	2	3	4	5
30.	I feel more sure of who I am.	1	2	3	4	5
31.	The assessor was interested in what I had to say.	1	2	3	4	5
32.	I felt judged by the assessor.	1	2	3	4	5
33.	I am more aware of how I am feeling.	1	2	3	4	5
34.	I felt my strengths were recognized.	1	2	3	4	5
35.	The assessor treated me as an equal,	1	2	3	4	5
36.	The assessor made me feel inadequate.	1	2	3	4	5

37.	The assessment will make a difference in my upcoming decisions.	1	2	3	4	5
38.	The assessment made me think about where I am headed in my life.	1	2	3	4	5
39.	I felt that the assessor respected me.	1	2	3	4	5
40.	The assessor insulted me.	1	2	3	4	5
41.	I am more aware of why people react to me the way they do.	1	2	3	4	5
42.	I know that how I see myself is really true.	1	2	3	4	5
43.	The assessor and I worked as a team to learn more about me.	1	2	3	4	5
44.	I felt exposed.	1	2	3	4	5
45.	I can think of myself as I never had before.	1	2	3	4	5
46.	The assessment described thoughts and feelings I have about myself.	1	2	3	4	5
47.	The assessor was on my side.	1	2	3	4	5
48.	The assessment made me rethink the way I already viewed myself.	1	2	3	4	5

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VITA

Jamie Thomas Kuhlman was born in Baton Rouge, Louisiana and grew up in Memphis, Tennessee. After completing her high school work at Evangelical Christian School in Memphis, Tennessee, she entered the University of Tennessee at Knoxville in 2002. There she obtained a Bachelor of Arts in Psychology with honors and a Bachelor of Arts in English with honors in May, 2006. After completing her undergraduate degree, she entered the Doctoral Program in the Counseling Psychology Program at the University of Texas at Austin.

Permanent Address: 12410 Blossomwood Dr.

Austin, Texas 78727

This report was typed by the author.