Psychological assessment as a psychotherapy phase: a cognitive behavioural example between idiographic (clinical) approach and nomothetic (psychometric) approach

by Riccardo Sartori*

Introduction

The term *assessment*[1] refers to a set of operations carried out in order to deliver a judgment or make an evaluation. A situation of assessment arises when candidates are evaluated in a personnel selection to decide whether to hire them or not, students are examined at school or university to test their learning, patients are visited to make a diagnosis of them.
A typical situation of assessment includes different methods, such as individual or group interviews, simulations (role-plays, in-baskets, etc.), questionnaires, tests, inventories, etc. The aim is to gather information about people to be assessed (clients, patients, candidates, etc.) in order to draw an integrated picture of them, which should be useful to answer the questions that started the operations of assessment and make consequent decisions (hiring, promotion, diagnosis, therapy, etc.).

The expression *Assessment Center*, for example, refers to a method used in professional, business and organizational contexts to assess employees' potential according to career development. It may last some days and administers people assessed with a series of tasks (interviews, simulations, self-monitoring questionnaires, psychological tests and so on and so forth).
Also psychological assessment use different methods (clinical interviews and psychological tests above all). But, as Nassim Nicholas Taleb (2008, p. 160) reports, "In 1965 Stuart Oskamp provided a group of clinical psychologists with a series of cards containing further and further information about patients. Psychologists' diagnostic abilities did not increase with the increase of data in their possession. They only became more secure about their initial diagnoses".
Before a situation that may well be defined discouraging, since even the so-called experts (in this case clinical psychologists) are subject to common evaluation biases (in this regard, you can see the classic text by Rumiati and Bonini *Le decisioni degli esperti*), such as *anchoring* (to remain anchored to first judgements or evaluations in spite of the information added to complicate or even change the picture), Taleb concludes (2008, p. 160): "Agree, we could not expect much from psychologists in 1965"; but then he adds (2008, p. 160): "these discoveries seem to be valid for all the disciplines".

The use of different methods to gather information about people to assess is open to discussion. Taleb asserts the thesis, surely not so typical and maybe provocative, that the greater the information, the smaller both the accuracy of our predictions and the efficacy of our decisions. As Di Blas writes (2008, p. 18): "The choice of a method or another to measure a psychological variable is not irrelevant […] since there is not a necessary accordance between conclusions drawn by using such different methods as self-monitoring questionnaires and direct observation".
In 2003, in a year which is closer to us than 1965, Hunsley and Meyer, in a paper about the incremental validity of psychological testing and assessment, evidenced once again that adding information derived from different tests cannot involve any advantages for the judgments, the

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[1] The term *assessment* seems to derive from the Latin verb *assidere* (*sit as a judge*) and the medieval *assise* (italian *court session*). The verb *to assess* can be translated simply as consider, evaluate and judge, or, more specifically, as to value something, to take stock of something.

diagnoses and the decisions made by clinicians. Nevertheless, as Taleb points out throughout his book, if people keep an *open mind*, that is to say, they do not make judgments, evaluations and diagnoses before the whole assessment process can be considered to be finished, and they do not become too fond of their positions, collecting different information can be seen as an operation not only appropriate but also sensible.

The real problem does not lie in collecting different information by different methods, especially when the aim is to assess, but in the tendency to confirm our first judgments (*confirmation bias*) and make information converge towards a sometimes really forced coherence.
The way to contrast with all this, as authors from different tendencies (cognitivists, psychoanalysts, economists, etc.) have pointed out, is to *suspend the judgment* until the information gathering can be considered achieved, certainly NOT to avoid collecting all the necessary data by using different methods. And even in this case, it is necessary to pay attention to what Taleb calls *narrative fallacy* (also called *illusory correlation*), that is to say the tendency to construct stories around facts in order to get a coherent picture from them, even if some of them are discordant. And then: pay attention to the tendency to establish cause-effect relations between independent information, according to another logical fallacy known as *post hoc ergo propter hoc* (since a fact B happens after a fact A, then B *must* be necessarily caused by A). Basically, to keep an open mind.

The assessment operations carried out in order to make a diagnosis, for example, can be studded with traps, biases and difficulties. Nevertheless, it is not appropriate to give up carrying out any assessment operation or to attribute to methods and only to methods the responsibility for evaluations badly made, judgments hastily and untimely expressed or decisions made without considering data. A bottom-up approach (that is to say, from data to theory) is in this sense more appropriate than the corresponding top-down approach (that is to say, from theory to data).

In this paper we are going to talk about psychological and clinical assessment as a psychotherapy phase, especially cognitive-behavioural psychotherapy, by reporting an example of idiographic (clinical) use of a nomothetic (psychometric) test.

Psychological assessment as a psychotherapy phase: definitions and aims

As you can read in Sica e Cilia (2004, p. 117), “The expression psychological assessment generally means the wide evaluation that clinical psychologists make about patients and their personal problems (Turkat, 1985). It is a matter of understanding and interpreting the behavioural phenomena in the perspective of the historical reconstruction of the phases that have led to their stabilization and their present expression” (cfr. Cilia & Sica, 1998).
The term assessment is different from the term diagnosis. As Lauriola writes (2007, pp. 71-72), “The term diagnosis indicates the whole of methods and techniques by which a complex phenomenon (such as the set of symptoms described by a patient) is traced back to a classification system which is known and allows people to make a decision related to the phenomenon itself (for example, which therapy choose to treat or heal the patient). The widespread classification system used at present to label different forms of psychopathologies is the *Diagnostic and Statistical Manual of Mental Disorders*, *Fourth Edition*, *Text Revision*”.
Assessment and diagnosis are not the same thing, but in clinical contexts a form of assessment is usually carried out in order to establish how patients function (from a psychological and relational point of view) and make a diagnosis of them.
Assessment can be conceptualized as a process that implies the integration of information coming from different sources. Examples of sources and information are: test scores and answers to projective techniques, life and clinical stories of patients, the description both of their psychological and somatic symptoms and their family, relational and work problems. Information can be gathered by interviewing patients themselves and the so-called *informants* (relations, cohabitants, friends, colleagues, etc.) (Kamphuis, Emmelkamp, & de Vries, 2003; Kolanowski, Hoffman, & Hofer, 2007).

Psychological testing – which can be defined, with Anastasi, as the process to obtain an objective and standardized measure of a sample of behaviour – is *one* part of assessment – which can be conceptualized as a more articulated process of *problem-solving* – the one usually called psycho-diagnosis. Normally, in fact, professional psychological assessment is achieved by carrying out:
- *Interviews with patients* – to gather information related to speech, relational style, posture and, generally, to observe verbal and non verbal communication;
- *Interviews with others* – to get different points of view referring to facts already described by patients;
- *Self-report tools*, such as repertory grids (Kelly, 1955, 1963) and standardized questionnaires;
- *Psychological tests*, such as projective techniques and psychometric instruments.

From the point of view of psychotherapy theory (Galeazzi & Meazzini, 2004; Bara, 2005/2006), assessment is conceptualized as the phase that comes before the therapeutic intervention. Authors belonging to different orientations (Lanman & Grier, 2003; Petit, 2008) basically agree to maintain that, without an accurate, precise and in-depth assessment, it becomes at least improbable to make an adequate, effective and specific therapy. From this point of view, assessment should end with a diagnosis and the knowledge of how patients function. Afterwards therapy can begin.
However, as Cionini writes (2006, p. 17), "when we talk about assessment we refer […] to an evaluation activity that starts the very moment of the first contact with patients and goes on all over the therapy". Cionini continues (2006, 17): "it is appropriate to distinguish two moments in the assessment process: the initial phase of the first sessions, that can be dedicated to the collection of the data that are necessary to outline a first hypothesis about the patients' characteristics, and a second phase – that lasts over the entire therapeutic process – when therapists are always verifying their understanding and professional constructions about patients in order to orient and re-orient their strategic choices in psychotherapy".
So, even if assessment comes necessarily before therapy, given its evaluation aims, the line between assessment and therapeutic intervention is never so clear, and this for two reasons:
- When therapists ask assessment questions, tell patients to produce such documents as the self-characterization (Kelly, 1955, 1963), various kinds of diary (emotional, cognitive or behavioural), ABCs (cognitive, like in Ellis, or behavioural, like in Skinner), etc.[2], and try to outline their life-stories (Cionini, 2006, pp. 55-78), effects related to self-awareness, knowledge of thoughts, emotions and mechanisms of functioning are obtained on patients, which are therapeutic in themselves;
- Assessment can be a long and meticulous process, especially in case of patients with particular life-stories and complex diagnosis. It can take even months of sessions and alternate with "pieces" of "real" therapy. On the subject, Sica and Cilia (2004, p. 117) write: "Assessment is to be considered a never ending process, during which observations are gathered and hypotheses on observations are outlined, tested, formulated and formulated again and so on (Meyer, 1975)".
These two reasons can be accompanied by the fact that, while therapist and patient are engaged in the assessment phase, they establish, probably and hopefully, what technically is defined *therapeutic alliance*[3] (Carli, Paniccia, Bonavita, Terenzi, & Giovagnoli, 2009; Ackerman, Hilsenroth, Baity, & Blagys, 2000; Lingiardi, 2002; Hilsenroth, Peters, & Ackerman, 2004), which affects the

[2] Self-characterization is a technique invented by Kelly where patients are asked to describe themselves in third person. In the technique of diary, patients are asked to keep a daily journal about behaviours, thoughts and/or emotions relevant for psychotherapy. ABC is a technique where a situation lived by patients is analysed through its components. According to Skinner, the components are Antecedents (A), Behaviour (B) and Consequences (C). According to Ellis, the components are Antecedents (A), Believes (B) and Consequences (C).
[3] According to Bordin (1975, 1979), it is possible to define *therapeutic alliance* as an expression indicating an interactive dimension referred to the ability of patient and therapist to develop a relation based on trust, respect and collaboration and whose aim is to face patient's problems and difficulties. It is obviously a disputable definition: it is so generic that it can be refused. On the other hand, the concept is not easy to define (see for example, other than the references at the end of this article: http://www.psychomedia.it/asp/strumenti/ivat-II.htm).

probabilities of both carrying out a good assessment and giving life to a good therapeutic intervention.

Assessment is thus a multiphasic process that lasts the entire time of therapy and that, in clinical contexts, can be carried out in order to detect a disorder or a problem, conceptualize a case, plan a treatment, monitor it and evaluate it (Hunsley & Meyer, 2003). It "can be seen as a true hypothetic-deductive process that allows therapists to outline specific programmes for each patient which are sufficiently flexible to cope with all the problems and obstacles commonly met during a psychological treatment (Kanfer, 1985)" (Sica & Cilia, 2004, p. 117).
"The main function of an assessment process is represented by the attempt of understanding patients and their world of meanings. And what are the problems patients present, how they were born and how they still maintain. In other words, what assessment tries to achieve is:
- Understand the patients' problems: the values and meanings problems have for patients in everyday life and for their self-images, relations and future.
- Build up a model (in professional language) of how patients work; identify which systems of knowledge (procedural, declarative, episodic, affective-imaginative) patients use most; and catch the internal logic of the system on the whole.
- Reconstruct processes, steps and critical moments of personal development that have led to the present individual structure.
- Understand the role that symptoms play in keeping the maximum internal coherence and consistency" (Cionini, 2006, pp. 18-19).
In order to achieve their aims and objectives of assessment, therapists can count on a series of instruments and tools and refer to two models that literature indicates with the initials IG (*Information Gathering*) and TMA (*Therapeutic Model of Assessment*).

Instruments and models of clinical assessment: information gathering (ig) versus therapeutic model of assessment (tma)

Although assessment can be defined as "the evaluation of people's psychological characteristics by using such different methods and tools as observations, interviews, scales, check-lists, tests, personality inventories, etc." (Pedrabissi & Santinello, 1997, Glossary); and although the expression *multimethod assessment* refers to the fact that assessment can or even must be carried out by using different methods and tools (Lang, 2008), the most popular instrument in psychotherapy is still the interview (Lis, Venuti, & De Zordo, 1995; Morrison, 1995; Quadrio, 1997; Fine & Glasser, 1999; Sartori, 2007, 2011) or, better, the clinical interview (Othmer & Othmer, 2004). Nevertheless, it is also possible to use observation (in natural or artificial contexts) and various pen-and-paper instruments, usually defined *self-report* or *self-monitoring*. They can also have the shape of *homework* (Baldini, 2004). This with two aims:
- To get information *by* patients and *on* patients;
- Let patients *work* (= reflect on themselves) also at home and not only during the sessions.

As mentioned, some of the self-report instruments used in cognitive-behavioural contexts, are self-characterization, diaries and ABCs. In this paper, however, we want to focus on the use of such psychometric instruments as questionnaires and personality tests.

In an article published in 2000, Camara, Nathan and Puente report that the use of questionnaires and tests in assessment carried out by clinical psychologists and psychotherapists in USA is still quite rare (while it is not in case of assessment carried out by neuropsychologists), even if the authors also show that this use has increased over the twentieth century (Louttit & Brown, 1947; Sundberg, 1961; Lubin, Wallis, & Paine, 1971; Brown & McGuire, 1976; Lubin, Larsen, & Matarazzo, 1984; O'Roark & Exner, 1989; Ball, Archer, & Imhof, 1994). They finally suggest that clinical psychologists should use questionnaires and tests for personality inquiries (Camara, Nathan, & Puente, 2000).
When it comes specifically to cognitive-behavioural psychotherapy, questionnaires and tests, although not typical, "are not incompatible if: *a*) they are considered as *one* of the sources of

information on patients; *b*) users know advantages and disadvantages of tests and questionnaires they use; *c*) information is considered critically and confronted with other sources, perhaps more reliable. Clinical experience teaches that with this premise even the use of traditional questionnaires can be extremely helpful, especially to measure some personal characteristics of patients that can orient in different ways the choice of objectives and the general structure of psychotherapy" (Sica & Cilia, 2004, p. 133).

As for assessment models it is possible to find in literature, they are of two kinds (Hilsenroth & Cromer, 2007):
- *Information Gathering* (IG): more traditional, widespread and spontaneous, it is simply based on data collection (*information gathering*), which is not necessarily accompanied by hypotheses, at least at the beginning, nor by instruments, but relies on a number of interviews and does not provide for specific moments of feedback to patients. It does not specifically consider aspects of interaction which deal with verbal and non verbal communication either. It rather concentrates on the task of information gathering.
- *Therapeutic Model of Assessment* (TMA): more structured, but less traditional and widespread, it provides for an integrated use of clinical interviews and psycho-diagnostic instruments in a fixed time (for example: the first five sessions) and includes feedback to patients. It also considers and suggest that therapists should control their behaviour in order to keep the appropriate attitude towards patients in terms of verbal and non verbal communication.

Although the two models can be seen as complementary (Finn & Tonsager, 1997), research shows that TMA is more effective than IG in establishing therapeutic alliance (Ackerman, Hilsenroth, Baity, & Blagys, 2000; Hilsenroth, Ackerman, Clemence, Strassle, & Handler, 2002; Hilsenroth, Peters, & Ackerman, 2004).
In particular, studies suggest that to involve patients during assessment; to adopt, in posture and verbalization, a collaborative attitude (Ackerman, Hilsenroth, Baity, & Blagys, 2000; Hilsenroth, Peters, & Ackerman, 2004; Rumpold, Doering, Smrekar, Schubert, Koza, & Schatz, 2005); and to explore patients' vision about their disorders (Rumpold, Doering, Smrekar, Schubert, Koza, & Schatz, 2005), in order to help, during sessions, involvement and depth (Ackerman, Hilsenroth, Baity, & Blagys, 2000; Hilsenroth, Peters, & Ackerman, 2004), first accelerates and then keeps the stability of therapeutic alliance.
Besides, interventions linked to the exploration of negative emotions, which allow patients to open on crucial events, point out recurrent relational topics (Ackerman, Hilsenroth, Baity, & Blagys, 2000; Hilsenroth, Peters, & Ackerman, 2004), clarify sources of sorrow and keep alive the attention on matters of treatment (Bachelor, 1995; Ackerman, Hilsenroth, Baity, & Blagys, 2000; Hilsenroth, Peters, & Ackerman, 2004), have shown their utility in helping to establish first and keep positive work relations then.
Finally, to actively explore emotions raised during sessions (Bachelor, 1995; Ackerman, Hilsenroth, Baity, & Blagys, 2000; Hilsenroth, Peters, & Ackerman, 2004; Rumpold, Doering, Smrekar, Schubert, Koza, & Schatz, 2005), to develop tasks and therapeutic objectives in a cooperative way, giving patients new abilities of understanding and new insights (Bachelor, 1995; Ackerman, Hilsenroth, Baity, & Blagys, 2000; Hilsenroth, Peters, & Ackerman, 2004), and make psycho-educational interventions about patients symptoms and about the entire therapeutic process (Rumpold, Doering, Smrekar, Schubert, Koza, & Schatz, 2005) can significantly make therapeutic alliance and relation better.
The use of questionnaires and psychological tests is put in relation to the greater effectiveness shown by TMA in establishing therapeutic alliance (Hilsenroth & Cromer, 2007; Berant & Zim, 2008). This kind of use should be justified according to therapeutic objectives, wants an adequate attitude in both the administration of instruments and feedback about results, and is based on an idiographic approach rather than a nomothetic approach (cfr. Sartori & Bortolani, 2006; Sartori, 2010). Besides, particularly in cognitive-behavioural assessment, the use of questionnaires and psychometric instruments made of semantic items can be a way to access to patients' thoughts and to work together on a collaborative level, according to *collaborative assessment* (Finn, 2007; http://www.somewareinvt.com/vcca/coassessment.htm).

Example of idiographic use of nomothetic tests with two instruments for cognitive-behavioural assessment of assertiveness

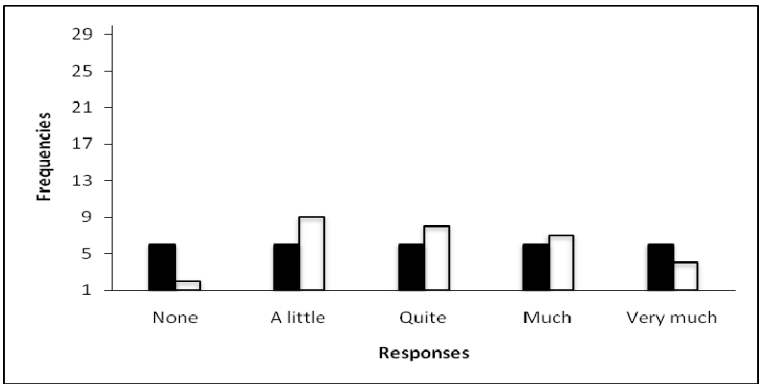
We report now a case of application of two instruments specifically made for cognitive-behavioural assessment of assertiveness to an Italian patient, as an example of idiographic use of nomothetic tests. The instruments are: the *Rathus Assertiveness Scale* (last Italian standardization and adaptation, Galeazzi, 1990) and the *Assertion Inventory* (last Italian standardization and adaptation, Nisi, Ceccarani, & Pagliaro, 1986).
The Rathus Assertiveness Scale (RAS), made in 1973 (Rathus, 1973), consists of 30 items that reflect some aspects referring to interpersonal relations. It supplies a measure of the subjective estimation of the probability of behaving or reacting in the way described by every single item. Some items are based on situations proposed by Wolpe (1969) and Wolpe and Lazarus (1966); others derive by Allport (1928) and Guilford and Zimmerman (1956); others have been drawn from diaries written by students in an American college: Rathus asked students to describe the behaviours they wish they could show and they perceived as inhibited because they were afraid they could provoke negative social consequences. Rating scale proceeds in this way: Not at all, A little, Quite, Much, Very much (with scores from 0 to 4).
Gambrill and Richey's scale (1975; Rolandi & Bauer, 1981) consists of 40 items. Each of them describes a social situation potentially difficult to manage and a behaviour considered appropriate to face it. People taking the test are asked to assess, separately:
- The degree of uneasiness or anxiety felt in each situation (rating scale from 1 to 5, where: 1 = None; 2 = A little; 3 = Quite; 4 = Much; 5 = Very much);
- The probability of behaving in the assertive way described by the item (rating scale from 1 to 5, where: 1 = I behave like that every time it is appropriate; 2 = I behave like that almost every time it is appropriate; 3 = I behave like that about 50% of the times it is appropriate; 4 = I rarely behave like that; 5 = I never behave like that).
Next sessions of the article report the results of the application of the instruments to a real patient, according to both a nomothetic (psychometric) approach and a idiographic (clinical) approach.

Rathus Assertiveness Scale
Analysis of the test score and considerations of nomothetic kind

The scale provides with a total score of unassertiveness (the construct opposite to assertiveness) which is the sum of the scores from 0 to 4 in every single item. Out of 30 items, 17 are positively worded according to unassertiveness, 13 are negatively worded (their scores is thus inverted). The total score of the patient is 82, which is equally high when compared to:
- the general population (1200 people, mean = 53.25; standard deviation = 14.59, range: 38.66 – 67.84);
- the population referring to his gender (600 people, mean = 50.50; standard deviation = 14.36, range: 36.14 – 64.86);
- the population corresponding to his age (200 people, mean = 58.89; standard deviation = 13.22, range: 45.87 – 72.11);
- the population referring both to his gender and his age (100 people, mean = 52.23; standard deviation =13.53, range: 38.7 – 65.76).
In particular, the patient score is two standard deviations over the mean in all the populations considered, which denotes unassertiveness.

Analysis of the response behaviour and considerations of idiographic kind

Patient's response behaviour is shown in the following graph (baseline: 30 items for 5 categories, 30:5=6, black bars). It shows that the patient has used all the categories (white bars), even if he preferred the three in the middle, with few extreme responses:



The items that have received extreme responses are the following:

Not at all	Very much
6. When I am asked to do something, I insist on knowing the reason	5. If a shop assistant has been very busy showing me products without me finding something really adequate for my needs, I find it difficult to say "No, thank you, I do not buy it"
22. If someone is going around telling lies about me, I meet them straight away to face the thing	14. I find it embarrassing to give back unsatisfactory goods
	16. I have avoided asking questions because I was afraid to seem stupid
	23. I often find it difficult to say "NO" to someone

During enquiry, they were administered again to the patient verbally, in order to see whether he assessed them in the same way or not, give him the opportunity to make examples and because they were considered things on which it was probably more urgent to work given the maximum level of unassertiveness expressed (the patient has indicated the situation reported in item 16 as particularly problematic for himself). These items were also the occasion to write down some ABCs where A was the situation reported in each item. In this way, it was possible to access to the thoughts the patient has in the specific situations (for example: *to look or sound stupid is a tremendous, terrible and unacceptable thing, I'd rather die!*), to his emotions (for example: anxiety, fear, shame, sense of humiliation and fear of being assaulted), to the coping strategies, often maladaptive, adopted by the patient (compliance with no discrimination, total submission and renunciation) in order to cope with the feared situation and, finally, to the exploration of alternative coping strategies (for example: verbalize his state of anxiety and confusion to the speaker and ask for help in problem solving).

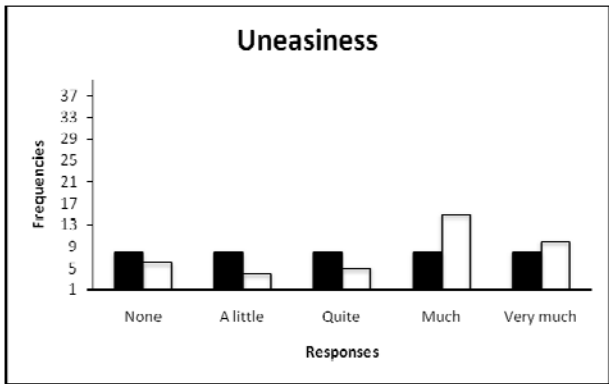
Gambrill and Richey's Scale
Analysis of the test score and considerations of nomothetic kind

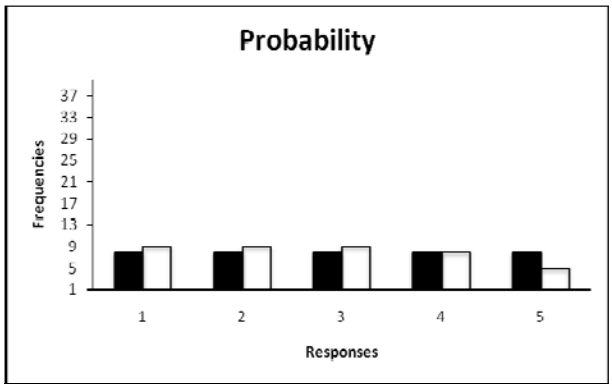
The Scale provides with two separate scores, referring one to the *degree of uneasiness or anxiety felt by the patient*, the other to the probability that the patient behaves in the assertive way described by each item. All the 40 items report assertive behaviours. So:
- the first time the patient assesses the degree of uneasiness or anxiety felt at the idea of behaving in the assertive way indicated by each item (rating scale from 1 to 5, total score is the sum of responses to each item);

- the second time the patient assesses the probability of behaving in the assertive way indicated by each item (rating scale from 1 to 5, total score is the sum of responses to each item).
The total score of uneasiness or anxiety of the patient is 139, which is high when compared to the values of the normative sample (380 people, mean = 91.99, standard deviation = 20.44, range: 71.55 – 112.43). Also in this case, patient's total score is two standard deviations over the mean, which denotes a high level of uneasiness or anxiety. The score of probability is 111 which is normal when compared to the values of the normative sample (380 people, mean = 95.21, standard deviation = 18.78, range: 76.43 – 113.99). Since 111 is in the high part of the range, and is very close to the superior limit, we could place the patient in a intermediate zone between *unassertive subjects* (which is also confirmed by the score in Rathus Assertiveness Scale) and *anxious performers* (since the patient for his job is sometimes obliged to behave according to those behaviours that make him feel anxious and not at ease).

Analysis of the response behaviour and considerations of idiographic kind

The Scale analyses two response behaviours, referring one to when the patient answers the items by assessing his level of uneasiness or anxiety, the other to when the patient answers the items by assessing the probability of behaving in the way indicated by each item (baseline for both: 40:5=8, black bars). The first graph points out that the modal answer of the patient is "Much", which is a confirmation of the high level of psycho-physiological activity in the patient at the idea of making assertive behaviours. As further confirmation, "Very much" is the second modal answer. The second graph shows that the modal answers are the first three, which indicates that the patient behaves in the way items state from "every time it is appropriate" to "about 50% of the times it is appropriate", which is in line with the hypothesis that the patient could enter the category of anxious performers.





The items that have received extreme responses are the following:

UNEASINESS (VERY MUCH)	PROBABILITY (I RARELY OR NEVER BEHAVE LIKE THAT)
	1. Say no if someone asks me to lend them my car or something I really care for
3. Ask someone for a favour	
	4. Do not give up at the insistence of a seller
	6. Say no if someone asks me out and I do not feel like doing it
8. If someone I really care for does something that	8. If someone I really care for does something that

offends me or upsets me, say it frankly	offends me or upsets me, say it frankly
19. Admit that something being discussed is not clear to me and ask for a clarification	19. Admit that something being discussed is not clear to me and ask for a clarification
20. Ask for a job	
	23. Demand to be served in an appropriate way (for examples in pubs or restaurants) when service is poor
24. Discuss openly a critical attitude someone has towards me	24. Discuss openly a critical attitude someone has towards me
25. Give back defective goods	
26. Express an opinion which is contrary to the opinion of the person you are talking to	26. Express an opinion which is contrary to the opinion of the person you are talking to
28. If it seems to me that a person has behaved incorrectly towards me, say it frankly	28. If it seems to me that a person has behaved incorrectly towards me, say it frankly
	34. Do not let pressing requests make me nervous
	37. Accept a compliment without diminishing it
39. If a friend or a colleague says or does something I do not appreciate, say it frankly	39. If a friend or a colleague says or does something I do not appreciate, say it frankly
40. If a person is annoying me in public, ask them to stop	40. If a person is annoying me in public, ask them to stop

During enquiry, as for uneasiness, given the response style, items for which the patient has expressed uneasiness at a maximum level (5 = very much) are chosen. As for probability, items for which the patient has declared he rarely (response 4) or even never (response 5) behaves in the way stated by the items are chosen.
In both cases, the items chosen have been administered again to the patient verbally. Of particular interest are those items that make the patient feel so nervous that he never behaves in the way described by the item (as for example is item 19, for which the patient has answered 5 in case of both uneasiness – *Very much* – and probability – *I never behave like that*).

Conclusions

Psychological assessment and clinical judgment is the title of a chapter written by Garb, Lilienfeld and Fowler in a book edited by Barbara Winstead in 2008 and entitled *Psychopathology: Foundations for a contemporary understanding*. Authors support the use of different instruments to conduct clinical assessment and point out the importance that these instruments are valid and reliable.
It dates back 1992 the article where Levine, Sandeen and Murphy, in the journal *Psychotherapy: Theory, Research, Practice, Training* raise the matter of the possibility of using nomothetic information to answer idiographic questions in clinical and psychotherapeutic contexts. In 2000, 8 years later, the first article explicitly referring – in the title already – to the possibility of an idiographic use of a nomothetic test comes out (it is the paper by Joshua M. Weiss: *Idiographic Use of the MMPI-2 in the Assessment of Dangerousness Among Incarcerated Felons*, published in the *International Journal of Offender Therapy and Comparative Criminology*).

In 2005 an article written by a Romanian author is published. Its title, translated in English, sounds like *Personality research between nomothetic and idiographic strategies: Conceptual methodological differences*. Finally, in 2006, an Italian article is published on the *Giornale Italiano di Psicologia*, whose title, translated in English, is: *Idioghraphic approach and nomothetic approach to the person: The case of psychological tests* (Sartori & Bortolani, 2006).
The need for an idiographic use of nomothetic instruments born for the psychometric enquiry of psychological characteristics enter every single European reality in order to try and find answers to such questions as: Is it possible to use nomothetic tests in a idiographic way? Is it a meaningful thing to do? If so, how is it possible to do it? (cfr. Sartori, 2010).
The contribution brought by this article wanted to show how it is possible to use nomothetic tests in a idiographic way in order to make a more personal use of these instruments in contexts where assessment can be considered as a psychotherapy phase.
To sum up the experience here presented, it is possible to conclude that the nomothetic interpretation of the results of the questionnaires administered indicates that we find ourselves in front of a person (the patient) who becomes very anxious and nervous at the idea of making assertive behaviours of self-determination, asking questions, expressing doubts and personal opinions. The scores of both the questionnaires support these conclusions.
Besides, the idiographic interpretation of the same results allow us to point out, in a more vivid way for the patient, his unassertiveness through his response style; and to scale items down from the one making the patient feel more anxious and nervous. In the specific case, this let us focus on the fact that asking questions and clarifications are situations particularly problematic for the patient, in whose head there is the idea that to look or sound stupid is a thing tremendous at a maximum level.
At this point, assessment of a specific and problematic aspect of the patient can be considered ended. Now a psychotherapeutic intervention on it can begin.

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