Chapter 3
A Collaborative Therapeutic Neuropsychological Assessment Model

The Collaborative Therapeutic Neuropsychological Assessment (CTNA) model represents a hybrid clinical intervention that draws from the NAFI of Gorske and the CNA of Smith. Given their similar goals of increasing the clinical impact of neuropsychological assessment on patient well-being, feelings of responsibility and control, and life narrative, it seemed logical to combine the two into one comprehensive assessment intervention. Specifically, CTNA borrows its initial interview and general clinical approach from Smith's CNA, but the feedback and report are derived from Gorske's NAFI. The resultant product is both *collaborative* (in that the patient and the therapist work together to understand a particular set of life problems) and *therapeutic*, given that the ultimate goal is to reduce patient suffering or to help bring about a transformative experience.

Throughout this chapter, we generally refer to experiences, expectations, needs, and wishes of the patient. However, we acknowledge that in many neuropsychological cases, the patient may not be the *consumer* of the CTNA approach. When patients have experienced significant cognitive decline or injury, when the patient is a child, or when the patient is psychiatrically compromised, it is the patient's family who will be most directly involved. This does not mean that the CTNA approach is inappropriate or ineffectual, however. In all cases involving families, a collaborative approach that brings about a change in the way that a family views, understands, or treats a loved one can be extremely powerful and life changing. We will make such examples explicit in the following sections, but when we simply refer to *patients*, we have done so primarily for the sake of simplicity, not because we only think that patients are the only consumers of this intervention.

Last, there are some situations and settings in which the complete CTNA approach may not be appropriate or possible. In inpatient settings or in a consultation model in which testing is circumscribed and rapid or in which patients may be suffering from severe dementia, medical problems, or psychiatric involvement, the full model of CTNA, as we describe it, may not be practical. Furthermore, we know of some clinical settings where neuropsychologists are prohibited from providing test feedback directly to patients. However, a general collaborative approach with the patient is still relevant and important.

T.T. Gorske, S.R. Smith, *Collaborative Therapeutic Neuropsychological Assessment*,
DOI: 10.1007/978-0-387-75426-0_3, © Springer Science+Business Media, LLC 2009

Furthermore, given the importance of feedback in clinical practice (Allen et al., 1986; Gass & Brown, 1992; Lewak & Hogan, 2003), clinical neuropsychologists should look for ways that they can increase their impact and make their services relevant to patients they serve (Ruff, 2003).

Basic Assumptions of CTNA

This section will provide a set of basic assumptions that guide CTNA.

Assumption 1: *The patient/caregiver/referral source has noticed a change in the patient's cognitive and/or behavioral functioning and would like a professional to tell if there is a true change, to what degree, how severe, its potential causes, and outlook for the future*. CTNA operates under the assumption that patients or supportive others are looking for information that can explain changes they are experiencing in their daily lives. And even if there has not been a change in the patient's behavior, there might now be a mismatch between a patient's functioning and the demands of their environment (e.g., a child begins to show signs of a learning disability in school). Historically, neuropsychological information was hidden from patients and caregivers, and it was often left to the referring provider to interpret the results and use them for the benefit of the patient. However, this places the patient and supportive others in a passive situation where they have little to no input into how the information is used and therefore do not have a voice in their care. CTNA follows patient-centered methods of care, where patients and supportive others are active collaborators and empowered to be involved in the testing and use of results. CTNA works to meet this need for knowledge and empowerment through an open sharing of neuropsychological test results.

Assumption 2: The patient/family members are distressed because of the change in the patient's cognitive/behavioral functioning. Part of the reason they are coming in for the evaluation is to receive help, direction, and guidance in order to feel less distressed. Changes in cognitive functioning and the confusion created by the change can lead to emotional distress and fear in patients. Essentially, it is the fear of the unknown. Not knowing what's "going on inside your own head" can be frightening, because patients often catastrophize by thinking more is wrong with them than there really is. For example, patients who are depressed and experience information processing slowing, attention, working memory, and general memory difficulties, may fear that they have a tumor, Alzheimer's disease, or some other horrible illness. CTNA seeks to alleviate patient distress by providing concrete information in a way that is understandable. The provision of knowledge can provide guidance and direction and begin alleviating fears of the unknown while clarifying misconceptions that feed these fears.

Assumption 3: *So that they might feel better about themselves, patients would like to know of potential ameliorative strategies so that they are able to perform*

better in school, work, and social spheres. Patients who are confused, scared, and distressed want to feel better. In general, patients who have knowledge, guidance, and direction begin to feel less distressed and more in control of their lives. One of the goals of CTNA is to provide recommendations for treatment or rehabilitation that are individualized. Patients are more likely to follow through with recommendations if they have been active collaborators in the decision-making process and have a voice in what type of treatment they feel would be most helpful. In CTNA, recommendations are individualized, and one of the first questions asked is "How would you like to use this information?" When standard, prescribed rehabilitation recommendations are given (e.g., a cholinesterase inhibitor for an elderly patient with mild cognitive impairment; cognitive therapy for a patient who is depressed, academic tutoring for a child with dyslexia, or cognitive rehabilitation for a TBI patient), patients are more likely to consider such recommendations if they have been actively involved in the decision-making process and they feel the recommendations have been individualized to fit their needs.

Assumption 4: *Although patients seek guidance and direction from the psychologist, they also want to be respected and to be empowered as active and autonomous participants in treatment and decision-making processes*. This assumption best describes the core foundation as to why CTNA is important. Adherence to treatment regimens is a problematic issue in health care. Despite advances in scientific, and more specifically neuropsychological, knowledge, patients often do not follow through with recommendations from health-care professionals. One reason is that patients do not believe they have been empowered to be active participants in their own health-care decisions. A basic philosophy of CTNA is that an informed, educated, and empowered patient will be actively involved in their health care and are more likely to trust and respect professional recommendations. Consequently, they may be more likely to adhere to suggested treatment regimens.

Assumption 5: *Neuropsychological tests provide objective, concrete information about patients' cognitive and behavioral functioning that applies to their daily life and problems they may be experiencing*. There is evidence from both research and experience that neuropsychological tests are valid measures of individuals' functional abilities (Lezak, Howieson, & Loring, 2004; Meyer et al., 2001). Neuropsychological tests measure skills most people use on a daily basis, but take them for granted. Often, patients will report feeling disorganized, unable to focus and pay attention, unable to remember things, or having trouble making decisions. Difficulties with these cognitive skills have a reciprocal relationship between patients' moods and consequent life stressors.

For example, consider a patient who is depressed because she believes that she is worthless. Her depression leads to difficulties with focusing and concentrating, which affect her work performance. Her impaired work performance reinforces her belief that she is worthless, which further exacerbates her depression and ability to focus. Her poor concentration worsens to the point where she believes she is flawed and defective and may have brain damage. The negative

beliefs and depression are now so deep that she only feels relief from drinking alcohol and being drunk.

In this case, the patient could benefit from hearing that she is not flawed, defective, or brain damaged but that her attention and focusing problems are likely due to depression, and some antidepressants and psychotherapy may begin to help her feel better by challenging her negative beliefs. This example illustrates the generalizability of neuropsychological tests to everyday life and the reciprocal nature of cognitive and emotional problems.

Assumption 6: *Feedback to patients from neuropsychological tests can help answer questions regarding changes in cognitive and behavioral functioning, provide hypotheses as to the causes of these changes, and give direction for treatment planning or rehabilitation*. This assumption speaks of the benefit of feedback, specifically neuropsychological feedback, in enhancing patient care. The exact mechanisms that make feedback effective are not well understood. Experience and research suggest that feedback may be effective because the information provided can change patient's attitudes and beliefs about their health and may motivate them to make changes that are perceived as necessary. Furthermore, feedback allows patients to change their cognitive narratives in a way that helps them have a more complex understanding of their strengths and weaknesses, the origins or their deficits, and their ability to care for themselves and plan for the future. In addition, the comparison to social norms may facilitate motivation to make changes (DiClemente, Marinilli, Singh, & Bellino, 2001). However, the provision of information is not sufficient in and of itself, which leads to the final assumption.

Assumption 7: Feedback presented in a patient-centered manner can elicit the patient as an active collaborator, empower them in the treatment and decision-making process, and lower resistance to hearing difficult or discrepant information. This will motivate them to work closely with professionals to alleviate their problems and distress. Information and feedback that are provided in the context of a supportive and helping relationship that respects patient perceptions and autonomy are more likely to be heard and used than feedback that is given in an authoritative "top-down" manner, where a patient is told what to do and offered a prescriptive treatment plan without consideration for their individual needs. CTNA individualizes neuropsychological information by applying the information to patients' lives and functioning while enlisting them as active decision-makers in the treatment-planning process. CTNA empowers patients by giving them valuable knowledge about themselves, their behavior, and their functioning. With CTNA, patients are empowered to use the knowledge for their benefit and they decide, with help and guidance from professionals, how they would like to use the information they learn.

A key component is the patient-centered interpersonal nature of the clinician. Clinicians provide feedback in a manner that conveys respect and empathy for the patient. The patient is seen as the expert on themselves, while the clinician has knowledge and expertise that may help explain aspects of the patient's cognitive and behavioral functioning. The clinician freely imparts this information to the

patients and gives the message that the patient is empowered and ultimately responsible for how they use this information. Thus, the patient and clinician contribute their individual knowledge in a collaborative effort to help the patient understand themselves and make any important changes that might be necessary. This type of collaborative, patient-centered approach has shown to lower patient's resistance to hearing information that might otherwise be difficult for them to take in (Finn, 2007). Ultimately, patients feel empowered to accept or reject the information. However, experience suggests that when patients are empowered and initiated as collaborators, they are more likely to accept information.