NEUROPSYCHOLOGICAL ASSESSMENT AS A MEANS TOWARD GREATER EMPATHY AND COMMUNICATION WITH BRAIN-DAMAGED CLIENTS

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ABSTRACT. Two case examples demonstrate how formal assessment of cognitive functioning can enhance and clarify empathizing with the emotions and verbal expressions of brain-injured clients. Neuropsychological Assessment, broadly defined to include information gathered from others, behavioral and systematic observation, careful listening to the patient and standardized tests, can explain how brain-injured people think. This can enhance our ability to know and reflect on what it is like to be them (empathy).

INTRODUCTION

As a Geropsychologist I have encountered many obstacles to empathy with my patients. Barriers to empathy include having a vastly different perspective on life, having lived for a much shorter time than my clients, clients' sensory deficits which interfere with direct communication, and cultural differences which blind me to many subtleties of experience and communication. Some of my patients have suffered brain damage, and I have found that brain damage can present a barrier to understanding which is more profound than any of the above.

Ward (1994) has presented a thoughtful review of difficulties in using testing in Person-centered therapy. Testing can undermine the client's authority when the therapist does not actively seek or respect the client's opinion regarding their validity (Bozarth, 1991). Testing can also undermine the client's appreciation of the therapist as a fellow human eager to understand and willing to accept the client (Raskin & Rogers, 1946; Rogers, 1989). Instead, the test-giver may be perceived as an expert preparing to discover secrets about which the client is unaware, or is unwilling to reveal. Furthermore, test findings and diagnostic labels can be misused, resulting in stereotyping of the client (McWilliams, 1994).

This paper presents my use of neuropsychological assessment as a tool for empathizing with clients whose thought processes have been altered by neurological damage. When used properly, I believe formal testing can be done without diminishing respect for the client, or the client's role as treatment collaborator and expert about herself. Sensitive discussion of assessment findings, and openness to client feedback are essential to this process. Formal
assessments can serve as a bridge between the therapist and experiences which the client cannot put into language but that the therapist can understand.

**EMPATHY**

Empathy “means temporarily living in the other’s life...” (Rogers, 1980, p. 142). Empathy “means that the therapist senses accurately the feelings and personal meanings that are being experienced by the client and communicates this acceptant understanding to the client.” (Rogers, C., date unknown, p. 2-3).

**BRAIN INJURY**

Over 2.6 million Americans (over one percent) experience brain damage from trauma or stroke each year (Forkosch, Kaye & LaPlante, 1996; Curb, Abbott, MacLean, C. J., Rodriguez, B. L., Burchfiel, C. M., Sharp, D. S., Ross, G. W. & Yano, K., 1996). Others experience brain damage from cancer, dementias, anoxia, poisoning and other causes. Even “a little” brain damage can seriously impair a person's ability to form and maintain relationships; work and enjoy life. (The Brain Injury Association of Connecticut, 1997.)

Three factors make it particularly difficult to understand the inner experience of brain-injured clients. First and foremost are language disorders caused by brain damage. (For a description of various types of aphasias and dysphasias see Goodglass & Kaplan, 1983.) These disorders make it difficult for those affected to organize and express their thoughts. Language comprehension can also be affected, depriving the brain-injured person of helpful feedback about how their speech is heard by others. Secondly, brain damage can alter perception and the regulation of emotions in ways that are rarely experienced by people without neurological damage. These latter effects can challenge the neurological patient's sense of self and identity, but can be very difficult to describe to a counselor. The brain-injured client is also often unable to compare their current and past experiences, and is therefore unaware that their experience is abnormal. Thirdly, brain injury can impair a person's ability to act independently, purposefully, and in their own self-interest. A person's ability to monitor their own behavior, and to utilize feedback from others or the environment may also be impaired (Baddeley, 1986; Gagné, 1984; Lezak, 1995). Just as empathy for someone from a different country can be enhanced by understanding their culture and language, empathy for someone with brain damage can be enhanced by understanding how the damage influences their perception, behavior and language.

**ASSESSMENT**

Neuropsychological assessment is sometimes used in ways that are antithetical to the Person-Centered Approach. Assessment can be used as a way of judging, categorizing or labeling people. Used incorrectly, diagnostic labels can interfere with the therapist's ability to perceive the client as an individual, and to provide unconditional positive regard. Assessment is generally therapist-centered, rather than client-centered. The examiner (often in response to a third party's inquiry) determines what is to be learned about the client, and how to find out. Yet, assessment is a necessary component in all human interactions. Whenever we dialogue with another person, we ask ourselves in some way whether the other person is safe to be with, whether they understand what we say, and whether they understand
why we are interacting (oriented to purpose). Unanswered, these basic assessment questions interfere with the therapist's ability to be fully present for the client.

Neuropsychological Assessment is a method of identifying “the behavioral expression of brain dysfunction” (Lezak, 1995.) It is a way of getting beyond the therapist's limited capacity to understand someone whose thought process is different from both that of the therapist and that of the client's former self. This is not to say that assessment can capture all of the client's experience. As an articulate Alzheimer's patient once said, “I am not my brain” (People 2/27/95, p. 4). Human experience is more than biology, but the physical structure of our brains greatly influences how, but not necessarily what, we think and feel.

METHODS OF ASSESSMENT

There are two primary methods employed in neuropsychological assessment: actuarial and process. The actuarial approach relies on the statistical interpretation of standardized tests. Its advantages include being objective, relatively fast, systematic and standardized. Some disadvantages include being therapist-centered, and having limited norms available that do not reflect the full diversity of individuals who are actually assessed. (The sample a test is normed on should be similar to the client in essential demographics such as age, gender, education and ethnicity.)

The process (also known as clinical-theoretical) approach to neuropsychological assessment requires extensive knowledge of functional neuroanatomy. The structure and hypotheses of the assessment co-evolve as the evaluator forms increasingly specific questions from the client's responses to each inquiry. Advantages include being less intrusive than the actuarial method, since the tests flow more naturally from the client's demonstrated strengths and weaknesses. The examiner considers not only whether or not a test demand is met sufficiently, but also how the client goes about working on each task. The quality and method of performance is examined for clues as to how the client perceives and processes information. However, since each client receives a customized test battery, and the information gathered about the client is more difficult to quantify, this approach is more vulnerable to the therapist's blind-spots.

Like many neuropsychologists, in my own practice I combine both approaches, employing a customized battery to compare each client to a representative sample group (actuarial approach), while also paying careful attention to how each test is approached and the subtle quality of the client's productions (process approach). The process of empathy and the process approach to neuropsychological assessment both involve the continual formulation and testing of hypotheses about the client's inner experience. This common process is described in Truax's (1967) definition of the highest level of empathy:

...The therapist is sensitive to his mistakes and quickly alters or changes his responses in midstream, indicating that he more clearly knows what is being talked about and what is being sought after in the client's own exploration. The therapist reflects a togetherness with the [client] in tentative trial and error exploration. (p. 556.)
ASSESSMENT PROCESS

My assessment process varies somewhat according to whether the client is self-referred or referred by someone else (other-referrals). In the latter condition, I may have considerable information and misinformation about the client before ever meeting him or her. Following is an outline of the process:

- Obtain consent (self referrals)
- Review records, interview people who know client
- Establish rapport, obtain consent (other referrals)
- Attempt client-centered empathic understanding of problem
- Observe, form hypotheses
- Test hypotheses (actuarial and process approach)
- Provide feedback, empathy, and further observation
- Make recommendations and/or therapy

CASE STUDIES

The following two case studies demonstrate how I have applied assessment findings to further my empathic understanding of clients. The cases are real, but identifying information (e.g., names and occupations) has been changed to insure confidentiality.

Background -- Lilly

Lilly was a 72 year old widow of 12 years. She lived in a large urban nursing home with a religious affiliation. She had been in the nursing home for nine months, after being diagnosed with Alzheimer's Disease. Lilly was referred by her medical doctor and her social worker to evaluate the possibility that she had been misdiagnosed, and could live in a less restrictive environment. Lilly had been functioning extremely well in the nursing home for the first seven months, but in the two months preceding her referral she had become withdrawn.

Records revealed that she was the second of seven siblings. Three were still living, and one of them was in frequent contact with Lilly by phone. Another sister suffered dementia, lived in another nursing home, and was not able to call or write. Lilly had a poor relationship with her third sister, and they had not had contact for a few years.

A nephew and niece were Lilly's most attentive relatives. They had assumed responsibility for making decisions related to her care that she could not make for herself. They said she had often had issues of control with siblings, falling in and out of mutual favor over the years.

Lilly had a 9th grade education. She had worked as a retail clerk. She married at age 27, and currently described her deceased husband as “stingy and selfish.” She had one miscarriage, and subsequently abstained from sex, fearing she might miscarry again.

Lilly was unable to manage activities of daily living (ADL’s) or instrumental activities of daily living (IADL’s) at home for a few months prior to her nursing home admission.
These include basic tasks such as dressing, eating and bathing (ADL's) and tasks requiring an instrument, such as telephoning and washing clothes. Her slow, gradual decline was reported by a friend as beginning three years before. Eventually she became depressed, confused, and frightened; and her friend took her to see her physician. Just prior to admission, Lilly had begun to have frequent falls. A thorough medical and neurological examination found nothing remarkable except atrial fibrillation & osteoarthritis. Based upon the clinical findings, her physician diagnosed Alzheimer's disease, and recommended that she move to a nursing home.

Reports From Nursing Staff

Nursing home staff described Lilly as having been depressed for about two months. She was said to cry easily. She was described as self-centered. It was observed that she did not wait her turn for medications or the elevator. This often led to arguments with peers. For mutual convenience, the home had a system by which medications were dispensed at regular times at a central location. Patients took a number and sat in a common area until their turn. Lilly simply went up to the counter and announced that she was there for her medications. Her peers immediately responded with disparaging remarks. When told to take a number and wait, she became angry and had a tantrum or cried.

Lily had no remaining friendships in the nursing home. She did have a close friendship with a former male resident who came to visit her often.

Interview

When I introduced myself to Lilly and explained the referral, she was eager to talk, and said she wanted to know whether she did indeed have Alzheimer's disease. I found her to be attentive and socially graceful. Following each assessment session she stated that she felt "helped" by talking to me. She said that she had always been "dumb" and the tests were making her "smarter." This experience was possibly influenced by my habit of attempting to alternate tests that I predicted would demonstrate strengths and weaknesses. Thus after performing poorly on one test, she was usually able to do well on the next.

Between sessions, Lilly told her social worker that I was a handsome man who was courting her. She told me she feared rumors would be spread about meeting me alone in her room with the door closed. She also told me that she felt lonely--unloved & unlike by peers. Lilly stated that she was bewildered by rejection. She claimed to have made friends easily in the past.

Initial Empathic Understanding

Based upon our initial person-centered interviews, I formed the following understanding of what it was like to be Lilly, an understanding that was confirmed by her: Lilly was lonely, and interpersonally needy. Lilly was very aware of how others felt about her. She wanted to be close to others and felt rejected. This made her angry. She did not believe she did anything to warrant the negative comments made about her by others. She commonly believed that she was the center of everyone's attention, albeit negative attention for the most
part. She believed that I came to the nursing home only for her, though I had told her that I was in training there for 20 hours per week.

Behavioral Observation

Additionally, I formed some hypotheses based upon behavioral observations, that I did not share with Lilly. Lilly appeared to have an uncanny perception of what others needed. For example, following our first session, she saw me at the nurses station and correctly asked if I was looking for her chart, and told me where to find it. On another occasion, she commented that a peer was frequently complaining about staff due to inner turmoil. Lilly could use her empathic ability as a weapon. Following a disparaging remark made about her by a peer, she reduced the other woman to tears with a few pointed words about the woman’s self-consciousness about her appearance.

Watching Lilly walk, I noticed that she gradually shifted to her left while walking, requiring frequent re-direction. She became unsteady if talking or thinking while walking. She tired easily (probably due to her heart condition). As reported by others, she bypassed lines (elevator, meals, etc.) and did not take a number for medication. It appeared to me that Lilly felt angry about being rejected, so she trampled over others when she could.

As commonly occurs in patients with a memory disorder, Lilly accused others of stealing items she had misplaced in her room. She remained adamant about her accusations until the missing item was found.

Test Data

I administered the following tests: Wide Range Achievement Test (WRAT); Reitan-Indiana Aphasia Screening Test (RAST); Controlled Oral Word Association Test (COWAT); Thematic Apperception Test; Face-Hand Test; Finger Agnosia and Finger-Tip Writing Tests; Weschler Adult Intelligence Test-Revised (WAIS-R); Weschler Memory Scale-Revised (WMS-R); California Verbal Learning Test (CVLT); Draw-a-Clock.

Strengths Identified

Lilly’s attention and concentration were in the low normal range compared to women of similar age and education. Reading level and her fund of general knowledge were also at the low end of normal. Based upon the theory of crystallized and fluid intelligence (Horn & Donaldson, 1976), Lilly had probably had a low normal IQ all of her life. Testing indicated that Lilly valued relationships and positive regard. Results also indicated that she was sensitive to subtleties in interpersonal relationships and body language.

Weaknesses

Lilly’s verbal memory was very impaired, especially if she was distracted. Unfortunately, she was easily distracted. She had great difficulty finding specific words, and difficulty naming familiar objects.
Lilly was unable to solve novel problems, and displayed poor ability to propose solutions for more familiar problems. She relied heavily on denial to cope with frustration. Testing indicated that she tended to blame others when problems could not be denied.

Tests indicated that she experienced severe visual-spatial confusion. Her ability to copy simple designs (e.g., a triangle) was severely impaired, though she could draw the same figures from memory. Similarly, delayed visual reproduction was far superior to immediate reproduction.

Lilly had poor body awareness, displaying difficulty identifying which part of her hands and face were touched, or where her limbs were in space (while blindfolded). She had some left sided weakness, probably due to arthritis.

**Assessment-Guided Empathy**

Utilizing all the information I had collected from the interview, the chart, informants, observation and the test data, I formed an understanding of Lilly which was somewhat different than my initial empathic understanding. Lilly wanted to be liked and sought the approval of others. She tried to follow rules. New situations, for instance being the subject of a neuropsychological examination, were very difficult for her to understand. Rather than struggle to understand the new situations, she identified aspects that resembled more familiar ones, such as school and courtship, and tried to behave accordingly.

Lilly needed to concentrate so hard to get anywhere that it was difficult to recall why she'd gone there when she arrived. Thus her exclamation of "I'm here for my medicine!" could be understood as a discovery, rather than a demand. While she easily picked up on interpersonal cues that told her others were displeased with her behavior, her impaired visual perception kept her from utilizing the number dispenser as a cue for what she was supposed to do. Similarly, she did not perceive a number of people standing before the elevator to be a "line."

Lilly was comforted by structure that alleviated the need for her to remember or solve problems, even when the structure was demanding. Thus, having a designated place to keep each of her belongings (a difficult routine to adapt to at first for most people) was likely to be an acceptable solution for the problem of forgetting where she'd put things. Similarly, when she announced (to herself as much as to anyone else) that she'd arrived for her medications, having the nurse reply "It's so nice to see you. Have you remembered to take a number?" would be comforting, whereas "You didn't take a number" would be embarrassing.

**Feedback**

Similar to the way each perceived message is reflected empathically to the client by the therapist for confirmation, I shared each of the above conclusions from the assessment data with Lilly to determine whether they indeed reflected her own inner experience. This was done over the course of an hour feedback session. Due to her poor memory, testing feedback had to be repeated over the course of therapy, so that Lilly could profit from it. For example, the following interchange occurred after I arrived and found her crying in her room:
The above interchange includes some directives by the therapist, in rescuing Lilly from her fear that she had been robbed and helping her find the comb. However, assessment had informed me that she was not capable of finding the comb on her own, and that she would feel comforted by structure which helped her gain control. My comment "It's easy for you to lose things" was a way of empathizing with her unspoken current experience of having no memory for using or misplacing her comb, and the implied suggestion in "if you have a place for everything..." offered direction congruent with this empathic understanding.

Lilly felt understood, and as a result, she was highly receptive to efforts by staff to provide a more structured and supporting environment. She began person-centered therapy with me that was modified to keep the purpose of my visits clear. Due to her poor memory, I decided to remind her frequently when I would have to end her therapy (due to the end of my training). This helped her to prepare for the loss, and perhaps provided further encouragement to make new friends. She began to attend activities, and began to socialize with her peers.

Background -- Lucia

Lucia was a 59 year old European immigrant who was referred to me for treatment of depression after acute rehabilitation from brain surgery.

Lucia’s father died before she was born. Her mother died when Lucia was eight. Lucia’s oldest brother moved to the USA, leaving Lucia to be raised by other siblings. She was sexually abused by two older brothers. At age 28 she immigrated to the USA to care for her oldest brother who had become very ill. After he died, she married a European she had known for a few weeks, and had one child.

Lucia’s husband divorced her when she was 47. Five brain tumors were discovered and removed when she was 50. She was unable to manage her affairs, and her doctor arranged court appointment of a conservator. When she returned home, her 20 year old son was emotionally abusive, and he was removed from the home by Lucia’s conservator.
Lucia received two years of outpatient brain injury rehabilitation, and has been in person-centered therapy with me for five years since. In that time she has made many accomplishments. She began part-time employment, though she still lacks the stamina for full-time work. She restored a normal relationship with her son. She renegotiated her divorce settlement, which had first been made while she was unaware that her then irrational behavior and poor judgment were due to brain tumors. She discussed her abuse with her sisters (her brothers have all died). She also began dating for the first time in her life.

Recent Complaints

Lucia’s depression has never fully remitted. She believes that she is inadequate due to the changes in her abilities since her surgery. Recently her work location changed, and she began to arrive late for work. She awakens several hours before she needs to leave, and has breakfast. She feeds her cat, and before she knows it, she no longer has enough time to shower, dress and commute. She can’t account for time passed. She also just began to complain of forgetting events that have recently occurred, and forgetting when she has arranged to meet people. Her health is stable, and there is no indication of further brain damage.

Client-Centered Empathy

Lucia was clear about her emotions and self-appraisal. She stated that she is depressed. She felt sad and frightened. She had low-energy and fatigued easily. She was preoccupied with thoughts about whether people who were important to her were honest and reliable, and whether her behavior has been acceptable and “normal.” She believed that she was late to work due to the above. She describes herself as "abnormal" and "retarded."

7 Years Prior Assessment

A neuropsychological assessment had been performed following her surgery seven years earlier. It had been useful in guiding her rehabilitation, and also in guiding my initial treatment with Lucia, so it seemed worthwhile to examine whether this old assessment might shed some light on her current difficulty of losing track of events and being late to work. The following tests had been performed in addition to a clinical interview, review of records, and interview with family members: WAIS-R; Rey AVLT; Wisconsin Card Sort; Trail-Making Test; Bender; Woodcock-Johnson (Achievement); BDI.

Strengths Identified
1. Oriented to person, place, time and purpose.
2. Good attention span.
4. Visual memory a little better than verbal.
5. Good self-monitoring and awareness.
6. Excellent social skills.

Neurologically Based Difficulties
1. Impaired concentration and sequencing.
2. Impaired alternating attention and simultaneous processing.
3. Moderately impaired verbal learning, worse if distracted.
4. Long-term recall severely impaired.
5. Verbal IQ of 88 (normal, despite speaking English as a second language). Performance IQ of 75 (almost 2 SD below the mean). Performance IQ is significantly less than verbal IQ.
6. Reading comprehension declines with length of material.
7. Perseverative (gets stuck on a thought despite changing information or context), and occasionally impulsive.
8. Severely depressed and moderately anxious.

Assessment-Guided Empathy

Assessment confirmed my client-centered empathy for Lucia's depression. However it clarified that some symptoms which she attributed to depression were actually manifestations of brain injury.
Lucia cannot process two tasks simultaneously, such as reading and tracking time. She needs structure to compensate for this. She can often recall things if cued, so she would benefit from a memory prosthesis (diary / calendar). However, using a calendar may be aversive because she feels bad about needing it. She is very aware of her deficits.

Feedback

Based on the neurological assessment, I was able to provide some concrete suggestions for Lucia in addition to providing empathy, congruence and unconditional positive regard. I advised Lucia to change her morning routine. Instead of having her leisurely coffee first thing in the morning, I suggested that she get ready for work as soon as she awakened, set her alarm for the time she needed to leave the house, and then have her coffee and relax. Although similar suggestions had been made to her years ago, person-centered therapy had helped her to realize that she wanted to do what was necessary to take more control of her life. She tried my suggestion immediately, and has not been late to work for the past three months.

While an appointment calendar would solve her problem of forgetting important events and informal appointments (she always remembers doctor appointments), she is still unwilling to use one. Assessment data allows me to empathize with her shame about being reminded that her memory is poor. Hopefully she will eventually allow herself to feel O.K. about using a minor prosthesis like an appointment book.

CONCLUSION

The goal of empathic process is to understand and reflect, in the fullest possible sense, what it is like to be another person. In person-centered therapy the route to empathy is usually through reflection of what the client's words and affect appear to mean to the client. For a variety of reasons, brain-damaged clients may have difficulty communicating their inner experience to the therapist. Reasons include clients' difficulty conceptualizing and expressing their thoughts, and therapists' difficulty conceptualizing clients' modified thought processes. For example, Lilly was unable to articulate her experience of having no recall for putting her brush on a table after discovering that it had not been stolen. Lucia was unable
to explain how time passed for her unaccountably. Her description could have easily been mistaken for a symptom of depression and internal distraction.

Formal assessment as a means toward empathy is not without pitfalls. Clients are typically not aware of what they are revealing during the assessment, and this can create distance in the therapeutic relationship. The way in which the therapist communicates assessment results may challenge the egalitarian working alliance (Boy & Pine, 1986). Assessment findings that are contrary to the client’s experience of himself (or herself) may create an empathic break, if the therapist is not sensitive to the client’s reaction to feedback. Furthermore, findings that are contrary to the client’s experience of self may encourage the therapist to pursue goals not endorsed by the client, particularly when the assessment raises concerns about the safety of the client or others. Assessment is but a tool. The therapist can control whether or not it is used to enhance an empathic way of being.

Empathy still depends upon the therapist’s ability to communicate his or her understanding in a way that matches the client’s own felt sense of self. Assessment does not ensure empathy. Neuropsychological assessment can demonstrate, in a manner understandable to the therapist, how the client thinks. This can lead to greater understanding, thus enabling the therapist to be more empathic.

REFERENCES


People (February 27, 1995). I am not my brain. pp. 4.


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