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Symposium I:  
*Using and Teaching the Written Word in Collaborative Therapeutic Assessment:  
Reports, Letters, and Stories*

**A Comma or a Period?  
An Assessment Client's Perspective  
on the Impact of the Written Word**

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“Never place a period where God has placed a comma.”  
– Gracie Allen, American entertainer

In written English, a comma marks a threshold. It represents a pause, indicating that more will follow. A period, on the other hand indicates an ending: The thought is complete. That thought may expand in a following sentence. It may grow into something more, but not necessarily. A period has no threshold quality. It simply marks an ending.

A threshold, such as a doorway, is the point where something new begins. Recent studies have shown that passing through a doorway can affect memory; you can easily forget what you intended to do simply by passing through the doorway (Radvansky, Krawietz, & Tamplin, 2011). Airports can be seen as temporary holding areas leading to a threshold. The flight becomes a doorway, of sorts, as what you are leaving behind recedes in memory and what you are approaching heightens. And life-changing events – birth, marriage, death, illness – are also thresholds.

Some of you in this audience know that I am a writer. My book on effective writing for psychological assessors was recently published. What most of you do not know is that I have also been an assessment client. Almost 20 years ago, I was diagnosed with a chronic, multi-system, medical illness. That was my threshold experience, though at the time I could not see the threshold. It did not feel like a comma, but rather, like a period. My previous life ended abruptly and no new life seemed possible.

One of the more disconcerting symptoms was cognitive dysfunction. I referred to it as “brain fog.” Word finding became very hard. I struggled to follow multi-step instructions, such as those for a recipe. My previously excellent short-term memory became nearly non-existent. I could no longer work on several tasks at the same time. I also experienced visual/perceptual shifts that I nicknamed “Alice-in-Wonderland episodes,” in which objects near me seemed to grow or shrink. Those episodes felt very much as Lewis Carroll describes Alice experiencing after she nibbles on a mushroom in Wonderland (Carroll, 1865).

Studies have shown structural brain changes with this illness. One study published in the British Journal of Radiology showed significant decrease in both grey and white matter volume in various regions, including those that affect memory and visual processing (Puri et al., 2011). My physician referred me for a neuropsychological evaluation to quantify the cognitive problems I experienced, both for his and my information and to share with my insurance company. This occurred before I began to collaborate with neuropsychologist and assessor, Diane Engelman, which means I had no idea what an assessment would or should be like. I was unfamiliar with its terminology and its requirements. I had no idea that “collaborative” or “therapeutic” assessments even existed.

My assessment was by no means either collaborative or therapeutic. Everything happened in a black box: I was not asked about my concerns or questions. No attempt was made to relate to me or to set a context for the testing. Between measures, I sat alone in a room, unsure what I was doing or why I was being asked to do it. Though I was the one who wrote the check to pay for it, I was not really the client but merely the subject of testing.

This seemingly endless process went on over three days – a total of 12 testing hours - as my energy diminished by the minute. One particular task demanded both speed and correctness. I knew that my brain fog would not permit both, so I opted to do it correctly. At the end of that measure, the assessor said to do it again, but the second time, I really must do it *both* quickly and correctly. I said, firmly, “I can do it fast or I can get it right. I cannot do both.” The assessor said nothing to me, but turned to the intern and said, “Oh, she’s getting feisty!”

By not addressing me directly, I felt firmly placed back in the seat labeled “subject.” “Butterfly pinned to a board” or “frog being dissected” are other possible descriptions of my experience. Not long after that exchange, testing ended abruptly when the assessor said we had done enough and I need not return the following day.

Even after this non-collaborative experience, I expected some level of insight into what caused the cognitive issues and what I might do to improve them. I also counted on the assessor using words that were accurate, sensitive, and easy to understand. I was wrong on all counts. I received no verbal feedback session, and the report ... oh, the report... Let me share some of it with you.

Those of you who know my colleague and presenting partner, Diane Engelman, know that she has not one non-collaborative or non-therapeutic cell in her body. However, she has graciously agreed to speak the words of the non-collaborative assessor, using the assessor’s sentences from the report. My comments are those I might have made *if* a dialogue had taken place.

**JB Allyn:** So... what did you find?

**Diane Engelman:** *(She speaks to the audience with little expression, very business-like. She does not acknowledge JB throughout this exchange.)*

Her IQ has deteriorated from premorbid functioning, as shown by inter-test and intra-test scatter. The range of scaled scores shows a difference of almost four standard deviations.

**JA:** That sounds like a big deviation...

**DE:** Her motor speed and persistence is bilaterally impaired. These motor abnormalities are typical in patients with this illness.

**JA:** (*Nods and murmurs.*) “Typical...”

**DE:** On a test of verbal learning, her score is very poor, with a T-score of 14 placing her in the severe range. She could not work in any occupation with this kind of memory impairment. She cannot initially store information, and the small amount she does store cannot be retrieved efficiently after time passes.

**JA:** (*Smiles, attempting to joke.*) Yes, I had noticed that!

**DE:** Her visual perception is definitely impaired. Her drawings are concrete and simplified and score in the organic range. They are not unlike drawings I have seen with other patients who have this illness. There is a serious problem with her verbal fluency. Her raw score is below the cutoff for brain damage. Given her educational and employment background, this inability to generate words suggests brain dysfunction.

**JA:** Brain dysfunction?

**DE:** The concentration SPECT scan on the brain that she had performed at the time of this evaluation is consistent with brain abnormalities seen during testing.

**JA:** Sounds pretty hopeless. Isn't there *anything* I'm capable of doing?

**DE:** She has compromised executive functioning and lacks the stamina or cognitive capacity for any job in the national economy at this time or for the foreseeable future.

**JB Allyn:** The assessor made no suggestions for rehabilitation or help with these problems.

Up to a point, I can make allowances for this assessor's approach. One of the challenges of any report is the issue of multiple audiences. The report was to be shared with my insurance company, and the assessor may have suspected that the company would respond only to a worst-case scenario. But my physician, a thorough, optimistic, and supportive person, could have used concrete suggestions for remediation. And I needed a bit of hope. As psychologist Irving Weiner said, in a personal communication that I quote in my writing book, “Psychologists doing these evaluations are well advised to keep in mind that their written report, although not addressed to the client, may be shown to him or her” (Allyn, 2012, p. 69).

A novel that I enjoy says the same thing in different words: It says that what is written continues *every time it is read* (Shaffer & Barrows, 2009). My assessor apparently had given little, if any, thought to the impact on me, the client, were I to read or re-read the report.

With nothing of a therapeutic nature coming from the assessment and my physician doing all he could to manage the physical part of the illness, I knew I was responsible for the rest of my healing. I found a caring and effective therapist to help me deal with the emotional impact of life change as I struggled with grief over the loss of my former life. I also became my own therapeutic agent: I learned to deal with cognitive problems by practical approaches – sticky notes, calendars, and timers helped manage memory issues. I realized that I could no longer multi-task, though I would still try - and fail. I completed a computer-aided memory program to help imprint new brain circuits and ways of using memory. Thank goodness for the brain's neuroplasticity!

My memory did improve a bit over time – though it is still unreliable when I try again to multi-task or when I am under stress. Recently, my only sibling had his third heart attack in 10 years and the worst by far. The stress took a major toll on my ability to retrieve words or recall tasks or information in short-term memory. But I know that when the stress mitigates, those abilities will once again be more reliable.

My other form of “therapy” was the written word, both my own and that of others. Initially, my health permitted only reading. I sought solace and understanding in the writing and characters of two English authors – one dead for many years and the other, for over two centuries. Their stories had nothing in common except wit, irony, precision, and the creation of magical worlds different from my own. I reached for the words of Jane Austen and A. A. Milne.

Somehow, I had earned an undergraduate degree in English without ever reading Austen. At first it was tough going with her. Language shifts and changes over time. Austen's sentences are long and dense, and the punctuation of that era varies somewhat from ours today. She also used old-fashioned words and phrases like “thither” or “tomorrow fortnight.” Many times, her long, dense sentences would collide with my brain fog, and I would have to read the sentence aloud or write a paraphrase before I could understand it. I read and re-read her six completed novels and her partial works. Slowly, her word choice and rhythm began to make sense. She was a sort of “writing tutor,” helping me learn to choose words precisely and to build characters whose behavior and words reflected who they were internally.

I had also lived a life devoid of A.A. Milne's Winnie-the-Pooh characters, though I had read endlessly starting in childhood. Milne based those characters on his son's stuffed animals and set his stories in the fictional “Hundred Aker Wood.” Milne's books were simpler than Austen's, of course, but I marveled at the levels of plot, humor, and character built into these so-called *children's* books. Milne's stories coached me on metaphor and building connections among characters. I also began to appreciate the archetypal qualities in each of the inhabitants of the Hundred Aker Wood and used them in managing my life and the illness. I relied on Rabbit's efficiency when I needed to set up doctor's appointments and on Piglet's emotion when dealing with those I love. I was careful to recognize Eeyore's sadness when it crept over me and tried to manage Tigger's excitable energy since I knew it would exhaust me. And I treasured Pooh's creativity when I thought of my own writing.

When health finally permitted, I got back to that writing. I was inspired by the work of Laura Hillenbrand, who had written the best-selling nonfiction book *Seabiscuit* while dealing with the

same illness that I wrestled with. I began writing a long planned novel, set in Southeast Asia in the 1960s. It was a long, long process, kept on track by love of words and their precision and by enthusiasm for my topic. A few years ago, I began collaborating with Diane Engelman in writing metaphorical, therapeutic stories for her adult assessment clients, and we started giving presentations that incorporated them. My book on effective writing grew out of those presentations.

I do not know that my experience would have been different had my assessment been collaborative and therapeutic, but I suspect it would have. At the very least, I would not have felt like a “butterfly pinned to a board.”

Anyone who successfully navigates a comma in his or her life and crosses that threshold is a survivor of sorts. Imagine how much harder to see even the *possibility* of survival – of recognizing that it *is* a comma and not a period – when the written report uses words that paint it as a period, as an unqualified ending with no hope of survival.

As French writer Jean Paul Sartre expressed it, “Words are loaded pistols” (1947/1988, as cited in Allyn, 2012, p. 27).

Use them carefully.

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