

## TOWARD A WORKING DEFINITION OF TRANSPERSONAL ASSESSMENT

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In mainstream clinical psychology, there is a strong emphasis on psychological assessment and its effective use in the description of client functioning (e.g., determination of diagnosis and prognosis), the selection of appropriate treatment modalities, and the demonstration of treatment effectiveness. In fact, given the current climate of economic cutbacks to psychological services, e.g., the increasing accountability to third-party payers, and the increasing likelihood of malpractice litigation against psychological providers, conventional clinicians are relying more than ever before on psychological assessment to substantiate their formulations and treatment decisions. Furthermore, there are currently major political efforts to standardize psychological care to very restricted models of acceptability. For example, the American Psychological Association, as well as other professional organizations and governmental regulating agencies, appears committed to creating templates for acceptable standards of psychological intervention using conventional psychological measurement methodologies to determine treatment efficacy. Referring to the potential impact of this on a number of alternative approaches to psychotherapy which have resisted the development of measurement methodologies and resultant efficacy studies, specifically including transpersonal approaches, Stern (1996-1997) concluded, "If this in fact occurs, then there are two likely outcomes: 1) they will be excluded by third-party payers, and 2) they may be proscribed under prevailing standard laws" (p. 3). Clearly there is a pressing need for the further development of scientifically solid transpersonal assessment strategies in order for transpersonal psychological practitioners to continue to function in this climate.

In the transpersonal area, though a good deal of attention has been given to transpersonally oriented psychotherapies, there has been far less effort directed at

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developing and utilizing assessment methodologies and procedures grounded in transpersonal theory in applied transpersonal practice. This is reflected in the paucity of literature not only on transpersonal assessment in general but also on the verification of the validity and effectiveness of transpersonal theories and practices in professional work. This is not to argue that no work has been done. Some literature exists which centers on the relationship of apparent spiritual pathologies to conventional diagnostic taxonomies (e.g., Greyson, 1993; Hughes, 1992; Ossoff, 1993), the development of spiritual or psychoreligious diagnostic categories and protocols proper (APA, 1994; Barnhouse, 1986; Grof & Grof, 1989, 1990; Lukoff, 1985; Lukoff, Lu & Turner, 1992; Pruyser, 1984), and on the impact of transpersonal therapies on professional practice and client functioning (Hutton, 1994). Unfortunately, few of these efforts directly address the nature of assessment, and all but one (i.e., Grof & Grof, 1990) do not offer a theoretical or pragmatic orientation for how a clinician could engage in the assessment process from a perspective which includes and embraces transpersonal theory. Moreover, the available research on psychotherapy has been largely exploratory in nature. Most investigations, for example, involve case studies which are useful in demonstrating the principles and potential utility of transpersonally oriented psychotherapy as they unfold in the context of clinical work (e.g., Miller, 1993) but, at best, provide only anecdotal evidence to support the general validity and effectiveness of such interventions.

Of course, the marginal status of psychological assessment in the transpersonal area does not come as a surprise; it has already been established that, within the transpersonal movement, formal assessment, and in particular, psychological testing, has typically been viewed as an ineffective means of understanding people (MacDonald et al, 1995). However, in showing reluctance to embrace assessment, a commonly accepted professional and research activity which is widely perceived as crucial by significant aspects of our social system (such as insurance companies and the legal system), transpersonal practitioners appear to be putting themselves at unnecessary risk by virtually ignoring assessment issues. Without significant energy being directed at demonstrating the validity and usefulness of transpersonal theory and associated clinical practices, transpersonal psychological practice can be seen as being in an increasingly defenseless position relative to the larger psychological and scientific community, since transpersonal practitioners are not making satisfactory attempts at being accountable for the quality and effectiveness of their work to their clients, their profession and their science. As Hutton (1994, p. 166-67) aptly stated, "it can be speculated that transpersonal therapists therefore might do well to apply carefully the same rigorous criteria to their utilization of techniques as do other professional groups, if transpersonally oriented techniques are to gain credibility."

Clearly, there is a need for transpersonally oriented practitioners to develop an approach to assessment which addresses the ethical and social needs for accountability as well as the scientific needs for validity and effectiveness. However, with current mainstream models and methods of assessment proving to be unsatisfactory in large part to the transpersonal community, it becomes apparent that efforts to redefine assessment with the intent of adequately incorporating the spiritual dimension are required.

The purpose of this paper is to discuss the relationship of transpersonal theory to psychological assessment. In so doing, we critique conventional assessment practices and propose an alternate conception of assessment which addresses and incorporates the transpersonal orientation.

#### WHAT IS ASSESSMENT?

##### A BRIEF CLARIFICATION OF THE CONVENTIONAL PERSPECTIVE

Though it may seem to any individual who engages in applied psychological work that assessment is a straight-forward activity which does not require any explanation, when one scans some of the available literature for a sound description of it, a wide range of definitions and perspectives can be readily found. For example, Woody (1981, p. xxxi) states that assessment is "inherent to all professional functions, be it the reaction in the initial contact with a prospective patient, the decision to accept or reject a patient, the services to be offered and the techniques to be used, the decision to terminate treatment, or the impression of the treatment's efficiency and relevance to treating other patients." Maloney and Ward (1976) define psychological assessment as "a process of solving problems (answering questions)" (p.5). Sundberg (1977) defines personality assessment as "the set of processes used by a person or persons for developing impressions and images, making decisions and checking hypotheses about another person's pattern of characteristics which determine his or her behaviour in interaction with the environment" (p.21-22). Shea (1985) takes a more pragmatic view of assessment as a process "which consists of evaluating a referral question, selecting appropriate procedures and tests, administering and scoring tests, interpreting and synthesizing findings, and communicating these effectively to the appropriate persons" (p. 2). Finally, Maxmen and Ward (1995), define assessment as "a time-limited, formal process that collects clinical information from many sources in order to reach a diagnosis, to make a prognosis, to render a biopsychosocial formulation, and to determine treatment" (p.19).

A clear understanding of assessment seems to be further obscured by the existence of a number of controversies about the nature and goals of assessment practices (e.g., use of clinical versus actuarial prediction, Meehl, 1954; emphasis on psychological versus situational causes of behavior, Mischel, 1968; value of objective versus projective tests, Megaree, 1966) including, most notably, the debate as to whether assessment should center upon the development of a comprehensive formulation of a client's overall functioning or, instead, simply focus upon specific problems (Schafer, 1967; Sweeney, Clarkin & Fitzgibbon, 1987).

Notwithstanding the confusion and debate about the finer elements of assessment found in the literature, we can understand assessment as being a professional/applied activity which consists of collecting information on clients through systematic means for the purposes of arriving at as accurate and unbiased an understanding of their functioning as is possible within the resources available. The information and formulations developed through an assessment can be used to identify areas of weakness/strength in the client's functioning (i.e., it can be problem-oriented or person-

oriented), identify the most appropriate treatment modality for a client given her/his difficulties or dispositions, and to determine treatment effectiveness for a client. Assessment data may also be used for research purposes (e.g., to examine the effectiveness of a given treatment for clients with a specified problem or treatment goal).

The “means” through which a conventional psychological/psychiatric assessment is completed are varied but can be summarized as four clusters of information gathering strategies. These approaches are the interview (which can be structured or unstructured and can involve interviews with significant others as well as the client), standardized testing (which can be objective or projective), behavioral observation (which can occur in natural or controlled settings), and physiological testing. The last approach is not typically part of an assessment completed by a non-medically trained professional, and there is a range of opinion regarding the degree of acceptance of physiological testing performed by non-medically trained professionals. However, physiological testing may be recommended in order to rule out any organic or biological factors contributing to the client’s state of functioning (e.g., thyroid testing may be recommended for a client demonstrating manic or hypomanic behaviors).

Utilization of these strategies is contingent primarily on the clinical judgment of the practitioner who must take into consideration such factors as the nature of the assessment referral, the amount of resources, including time availability, the professional’s competence in properly employing a given assessment procedure, and the type of standardized measures to be used. Generally, in order to minimize any bias which may arise from an over utilization of any one information source, at least two modalities of information gathering are employed; in the case of conventional psychological assessments, this typically involves the use of the clinical interview and psychometric tests.

#### AN ASIDE ON ASSESSMENT AND STANDARDIZED TESTING

For many practitioners, assessment and testing are virtually synonymous activities. However, most psychologists make a distinction between testing and assessment with testing being viewed as only part of the assessment process (e.g., Cohen, Swerdlik & Smith, 1992; Matarazzo, 1990; Roberts & Magrab, 1991; Shea, 1985). Further in this vein, Maloney and Ward (1976), present three differences between psychometric testing and clinical assessment. First, standardized testing tends to be measurement oriented while psychological assessment is typically problem-focused. Second, psychometric testing is usually concerned with describing and studying groups of people, while assessment is aimed at describing and analyzing a particular individual. Third, psychometric testing can be completed by persons without any applied clinical training who are knowledgeable about test construction and validation. In other words, satisfactory completion of testing demands little to no clinical acumen. Conversely, “the role of the clinician or expert is crucial and integral to the process of psychological assessment” (Maloney & Ward, 1976, p. 38).

The development, validation, and use of psychometric assessment instruments, both objective and projective, is a major part of conventional psychological practice. The

reasons for the strong emphasis on tests are multifold but the main justifications lie in their ease of use (e.g., they are easy and quick to administer and interpret) and in their ability to operationalize a wide range of theoretical and clinical constructs, and thus be useful for research and evaluative purposes. On a more specific level, Barlow, Hayes and Nelson (1984) state that the inclusion of quantified measures in clinical assessment has three notable benefits: a) they allow for the improvement of treatment by providing an avenue to assess not only client functioning before and after treatment but also by assessing elements of the treatment itself; b) they strengthen the practitioner's ability to be accountable to the consumers of professional services (e.g., clients, third-party payers), by demonstrating the validity and usefulness of assessment as well as treatment effectiveness and; c) they contribute to clinical science by expanding "our armamentarium of effective techniques and our knowledge of therapeutic processes" (Barlow et al, 1984, p. 76).

It is important to again emphasize that psychometric testing has helped practitioners gain credibility with not only the scientific community, but also insurance companies and the legal system. In these times of economic cutbacks, health care reform, and increased involvement in legal processes, conventional psychologists are relying more than ever on psychometric test data as objective information to substantiate assessment formulations, and perceptions of treatment appropriateness and effectiveness.

#### THE CENTRALITY OF CLINICAL JUDGMENT

The entire assessment process (i.e., why and how it is done; what formulations arise and how the information is used) is grounded in and directed by the clinical judgment of the practitioner. By clinical judgment, we are referring to the practitioner's "ability, given limited information about a target person (patient), to judge correctly other pertinent characteristics about that person and to identify behavioral exemplars as part of a pattern of behavioral consistencies" (Reed & Jackson, 1975, p. 475). Stated differently, clinical judgment refers to the degree of accuracy that a practitioner demonstrates in devising a conception of a client's functioning based upon inferences made from limited data obtained from the client.

Generally, clinical judgment can be viewed as being comprised of two main elements, namely the clinician's perception of, and response to, the pragmatic demands of the assessment situation and the theoretical orientation of the practitioner. In conjunction, these factors determine the type of assessment strategies used and the types of interpretations generated from the information obtained which are considered valid and useful. Incidentally, because each assessment is different (e.g., due to the uniqueness of each individual client) and has different pragmatic demands (e.g., due to different referral questions), clinical judgment may be best viewed as representing the use of "scientific knowledge and methods artistically" (Woody, 1981, p. xxxii), in order to arrive at the most valid and useful product.

Finally, even if a clinician abstains from explicit formal assessment of clients based on a belief that assessment is irrelevant, or perhaps harmful in some way, to clients, implicit assessment is unavoidable. It is our contention that assessment, including in

the transpersonal area, needs to be embraced explicitly so that it can be critically evaluated rather than performed implicitly without the benefit of such examination.

In summary, assessment may be viewed as a process which is primarily defined and directed by the clinical judgment of the practitioner; formal assessment concerns the use of systematic information acquisition strategies to guide a practitioner's clinical judgment. Ultimately, with several types of client data on hand, practitioners rely upon their clinical judgment to not only arrive at an integrated and pragmatically useful conception of their clients, but to also communicate their formulations in a manner useful to the client and other service providers.

#### ASSESSMENT AND THE TRANSPERSONAL DOMAIN

For our purposes, a spiritual or transpersonal orientation can be understood generally, without allegiance to any specific theory, as involving the perception that non-ordinary states of consciousness, especially those which take the individual beyond her/himself (i.e., transpersonal experiences) are valid, available to everyone, and have potential for creating levels of health and adjustment which include but also extend beyond traditional views of health. Examples of these types of non-ordinary states are experiences which have been labelled peak, mystical, spiritual, and religious. Furthermore, the adherence to theories (e.g., Wilber, Grof, Washburn) which incorporate these experiences into the explanation of human functioning and their application to enhance the growth and development of self-awareness and increased health of both practitioner and client constitutes a transpersonal orientation.

When a close examination of conventional assessment practices is made from a transpersonal psychological perspective, one encounters at least three general points of contention which makes mainstream assessment largely incongruent with a spiritual orientation. The first point of contention concerns the fact that traditional assessment tends to follow the medical or allopathic model. That is, it assumes that the client is passively experiencing a number of symptoms which are reflective of an underlying disease or illness (Tamm, 1993). In the context of psychology, the disease can be seen as rooted in biology or in learned behavior patterns. Following from this, the purpose of assessment becomes problem-oriented, aimed at generating a diagnosis used to describe a person's functioning in terms of a disease or dysfunction. The diagnosis, in turn, tends to be associated with a treatment modality which is viewed as having effectiveness for the given disease; once a diagnosis is made, a specific form of treatment is recommended to "cure" the illness.

Though there are certain benefits to relying upon a biomedical model for assessment (e.g., this approach saves time due to assessments being structured around concrete information gathering strategies such as structured interviews, medical tests and psychological measures which are designed to organize data on the client in terms of a diagnosis), the propensity of the medical model to describe people in reductionistic terms runs somewhat antithetical to the emphasis in transpersonal theory on holism (Tamm, 1993), personal experience, psychological growth and development, and optimum health beyond that of the accepted convention.

A second related area of contention concerns the lack of emphasis on the importance of the clinician and the clinician's level of self-awareness, including biases, on the validity and effectiveness of the assessment process and formulations. Generally, the stance taken to assessment in mainstream psychology (which is reflected in conventional clinical training) is theory driven and technique-oriented, i.e., it is directed at applying specific clinical procedures such as structured interviews and methodologies such as standardized tests to generate information which is then structured within the context of the clinician's theoretical perspective. The impact of the values, beliefs, and attitudes of the clinician on their understanding of a client receives little to no attention and are largely assumed to have minimal influence on the validity and meaningfulness of the assessment process.

Given that the clinical judgment of the practitioner is the most significant element of the assessment process, the lack of attention directed to clinician-based variables and how they influence clinical judgment can be viewed as a serious shortcoming of mainstream assessment practices. Within the transpersonal area, most notably in terms of psychotherapy, it is commonly recognized that the clinician's personal "beliefs, values, and state of mind" (Vaughan, Wittine & Walsh, 1996; p. 484) have a profound influence on course and effectiveness of therapy. Consistent with this, the transpersonal movement has strongly emphasized the importance of clinicians exploring their own value and belief systems on a continual basis via a systematic and disciplined methodology (e.g., spiritual practice) in order to grow both professionally and personally. Extending this stance towards therapy to the domain of assessment, it can be argued that the beliefs and values of the clinician not only determine the context of the assessment process but also of the interpretation as well. We therefore consider it to be particularly crucial for transpersonal assessors to actively examine their biases during assessment since dealing in transpersonal areas where consensus is often lacking can easily lead to practitioners losing their professional usefulness, or causing serious harm.

The third area of difficulty concerns the lack of systematic application and integration of transpersonal theory in traditional assessment practices. The most commonly accepted and used theoretical and clinical orientations to assessment exclude, and even pathologize, the spiritual dimensions of human experience/functioning (cf., Lukoff, Turner & Lu, 1992). Moreover, examination of the existing literature on assessment as well as the predominant assessment measures (e.g., Minnesota Multiphasic Personality Inventory-2; Rorschach) will reveal a lack of transpersonal constructs. Furthermore, responses that could be viewed as transpersonal are typically viewed as psychotic indicators. In order to have a transpersonal orientation to assessment, "a mental-health professional has to accept the fact that spirituality is a legitimate dimension of existence and that its awakening and development are desirable" (Grof & Grof, 1990, p. 252).

Related to the minimal application of transpersonal theory to psychological assessment in general is the fact that there has been minimal effort to develop, validate, and utilize measures of transpersonal constructs in applied practice. Stated another way, there are no available evaluative methodologies (e.g., psychometric tests) which are grounded in transpersonal theory that have found regular use in applied psychological

work, in spite of the availability of a number of research instruments used in scientific studies. Even though testing instruments are often viewed with scepticism by transpersonal psychologists, the apparent lack of sound measures of spiritual constructs in combination with the ambiguity surrounding the possible clinical usefulness of such measures is probably among the largest deterrents contributing to the minimal use of transpersonal assessment procedures. Thus, transpersonal practitioners might be more inclined to rely on assessment procedures if they had some methodologies, particularly psychometric tests, which they had confidence in using. Similarly, conventional clinicians may also be more inclined to incorporate transpersonal theory into their practice if they felt that transpersonal theory was grounded in sound empirical research.

#### DEFINING TRANSPERSONAL ASSESSMENT

Taking the above discussion into consideration, a definition of transpersonal assessment is needed which addresses the apparent limitations of the conventional approach as well as incorporates the transpersonal perspective. Transpersonal assessment may be defined as an activity requiring professional judgment whereby the practitioner and client work collaboratively at arriving at an expanded conception of the client, including viewing non-ordinary states and both their antecedents and consequences as potentially, but not necessarily, beneficial, for the purpose of enhancing the client's growth and development of self-awareness and health. In the process of developing such an understanding of the client, the practitioner relies upon transpersonal theory in a systematic way (e.g., through the use of standardized measures of transpersonal constructs) and examines his/her potential biases as an essential aspect of the assessment. Though information obtained through an assessment is focused on increasing client self-awareness and awareness in a general sense, it may also be used for more conventional purposes (e.g., diagnosis, prognosis, treatment recommendation, treatment evaluation). Thus, the main points of difference between conventional and transpersonal approaches to assessment are that the latter utilizes transpersonal theory and methodologies to understand a client, requires that the assessor and client actively collaborate, and emphasizes the explicit role of clinician awareness of potential biases in professional judgment used in the transpersonal arena. Transpersonal assessment, on the other hand, shares the same high standards of professional rigor as is required by conventional approaches.

From a transpersonal orientation, this definition is an improvement over the conventional description of assessment on several accounts. First, the nature and focus of assessment becomes one that is compatible with the inclusion of transpersonal theory, and spirituality more generally, but which does not exclude conventional approaches or methodologies. Thus, transpersonal practitioners can engage in assessment for conventional reasons, using transpersonal theory as another avenue for generating insights into client functioning, or they can rely on the assessment process to further treatment oriented goals of increasing client self-awareness or health. Second, the definition indicates that transpersonal practitioners may rely on transpersonal theories and assessment methods of transpersonal concepts in assessment. Third, it reshapes the goals of assessment. It is not oriented primarily at describing the limitations of the

client but instead, focuses equally on how the assessment process and resulting formulation can be used to enhance the client's level of self-awareness and health from a transpersonal perspective. Consequently, assessment can be viewed not only as a means of understanding the client but also as another treatment modality. A specific example would be a client who fears that his non-ordinary experiences might be pathological could, through assessment feedback, receive positive validation that, by itself, is an effective intervention.

It is important to note that we are not suggesting that transpersonal assessment involves directly measuring spiritual enlightenment or any other ultimate concept. Rather, we are advocating a view of assessment which involves an integration of transpersonal theory with conventional assessment methodologies for the purposes of both expanding our ability to understand and provide interventions to clients and as a means to verify empirically the validity and effectiveness of transpersonal theory and practices. By implication this means that transpersonal assessment provides an avenue for the wider empirical examination and verification of transpersonal theory and methodologies. It is explicitly acknowledged that all empirical approaches, including psychological assessment, have inherent limitations when dealing with ultimates and absolutes. This, however, does not reduce their relative merits for important contributions to transpersonal psychology.

Though we have been advocating the use of conventional empirical methodologies, most notably psychometric assessment instruments, it is important to emphasize that our definition of transpersonal assessment also allows for the inclusion of alternative assessment methodologies such as divination techniques (e.g., Tarot cards, *I Ching*), shamanic or shamanistic practices, mediumistic practices (cf. Krippner & Welch, 1992) and, in general, the systematic use of non-ordinary states of consciousness by the clinician to generate information about a client. However, it must be stressed that the use of such strategies may be rendered suspect by conventional psychology if there is no evidence supporting their validity and clinical usefulness. These alternative assessment methodologies are amenable to scientific study, although such study may present unique challenges to investigators. Therefore, prior to their use in professional practice, the same scientific requirements for demonstrating validity and clinical usefulness should be required for both alternative and conventional assessment methodologies. Consequently, we strongly encourage practitioners who rely on such strategies to make considerable efforts at examining their scientific and professional merits as formal assessment methodologies.

In order to further explicate what is meant by transpersonally oriented assessment, the following is an extended examination which focuses on the application of one psychometric measure of transpersonal self-concept to clinical work. The purpose of this discussion is to specifically illustrate how transpersonal theory and methods can potentially guide clinical assessment through demonstrating ways in which a specific transpersonal measure may have great utility for a transpersonal practitioner. Clinical generalizations which follow in this discussion are heuristically proposed from the clinical experiences of the first author in utilizing the measure described below in applied work and have not been empirically examined in a rigorous fashion. All interpretive guidelines are offered by the first author in a tentative fashion to encour-

age further applied examination of the measure. The following discussion thus provides an opportunity to view how a specific transpersonal measure can potentially be used advantageously in an applied professional context as part of a transpersonal clinical assessment. It should be noted, however, that other extant measures also show promise in similar applications.

The Self-Expansiveness Level Form (SELF) is an objective measure of a transpersonal concept (Friedman, 1983). Self-expansiveness refers to the extension of the sense of identity, or self, from the focus of the individual in the here-and-now as a biological constituted organism toward the capacity of that organism to transcend all limitations in sense of self. The SELF is based on a space-time grid, a type of map, against which the individual self can be measured. This cartographic approach provides a potentially useful objective measure to assess individual differences in a relevant transpersonal way. Furthermore, the SELF has been developed in a rigorous fashion and has well established reliability and validity, making it scientifically acceptable as a research and clinical tool.

The SELF is also devised to be easily and quickly administered and scored and readily available to encourage further clinical and research use. It is a self-report instrument consisting only of 18 statements which require a simple rating. It has been published in its entirety in *The Journal of Transpersonal Psychology*, 15(1) 37–50 and is available from the publisher.

The SELF consists of three scales. The Personal Scale is a measure of identification with the here-and-now state of the biological organism which exclusively constitutes the person from a conventional, non-transpersonal frame of reference. Anyone who does not identify with this level of identity is considered unconventional, if not seriously disturbed. This scale taps into a dimensional continuum of presentness which on the one pole can be seen as alienation from the conventional self to the other pole as self-acceptance on a conventional level. Extremely low identification at this level could represent a schizoid or psychotic pattern of self-rejection (i.e., denying one's basic humanness), whereas moderately low identification at this level could represent a more neurotic pattern (i.e., low self-esteem). It should be noted at this time, however, that there are those individuals who disidentify consciously with the mundane present not out of pathology but out of a conscious attempt to achieve a transpersonal disidentification, such as is encouraged by certain meditative and psychosynthesis exercises. Consequently any interpretation of this scale, or the other SELF scales, should be sensitive to this potential variation of identification style that would not necessarily denote pathology, but may instead constitute an alternate response pattern of a potentially healthy transpersonally oriented individual.

As a clinician, the first author tends to work in a more humanistic way with individuals scoring low on the Personal Scale, grounding them into a greater acceptance of their here-and-now human feelings and thoughts, and the first author avoids transpersonal work until there is significant progress at the personal level. This could be contrary to client expectation since individuals with this type of pathological pattern may not only reject their personal level but also may over-identify with the transpersonal level in an unhealthy way. Such individuals may seek out trans-

personally oriented psychotherapists who, in turn, might exacerbate clients' adjustment difficulties to the present by emphasizing further transpersonal development. Being able to steer a client into a direction they need for wholeness, such as back to their personal level, when they seek out transpersonal work may require great wisdom and restraint from those who love transpersonal work and recognize this type of imbalance in a client. Thus, use of the SELF in assessment may allow for greater discrimination between clients who disregard the personal level while developing a transpersonal identity as compared to those who accept the present and are transpersonally identified.

The SELF also contains a Middle Scale. The utility of this scale has not been well researched. During the construction of the SELF, this scale was actually created as a filler, a set of rather neutral extensions beyond the personal level but not quite reaching what was seen as a transpersonal level. This was seen as giving face validity to the instrument, diminishing some of the negative impact of transpersonal items for those who would find them strange and intimidating by placing them into a more culturally acceptable context. It was also recognized during construction of the instrument that there was potential utility to this scale. Currently the scale is seen as providing information that is clinically valuable, not just as a filler but in terms of the importance of identification with aspects of an extended self which go beyond the personal level but not as far as the transpersonal level. As examples, identification with one's body, relationships, personal past and future are tapped by the Middle Scale. Responses to this scale can provide clues as to both over and under identifications to this level that can be translated into viable clinical interventions. If, for example, one were to barely identify with one's personal past, and it was known that there was a history of post-traumatic stress disorder, this would be a salient topic on which to focus. Likewise, if one were to identify highly with one's social relationships, this could denote a possible co-dependency to be addressed in clinical work.

The Transpersonal Scale provides information most clearly relevant to the transpersonally oriented clinician. Not only is there an overall number obtained to measure degree of transpersonal identification, but this is broken down in the cartographic dimensions of space-time to provide important information as to how one's transpersonal identification is structured. This can allow for an avenue to deepen the transpersonal identification by focusing on areas where the identification is less strong. Thus, an individual who holds a high degree of transpersonal identification with their inner bodily experience and the distant past, but who rejects the future from a transpersonal perspective, may have a significant transpersonal gap that could be addressed in a transpersonal psychotherapy.

Thus each scale of the SELF can provide meaningful clinical information about a client from a transpersonal perspective. A simple profile, for example, contrasting the Personal, Middle and Transpersonal Scales can provide meaningful clues as to where an individual's identification resides on a space-time grid.

One example of a valuable way to utilize the SELF in clinical practice is as a quick screening in a clinical setting. In a situation where there are transpersonally oriented and nontranspersonally oriented clinicians, determining which clients could best

work with which clinicians may be important. The SELF could be used to address this by selecting clients who demonstrate a high level of self-expansiveness on the SELF Transpersonal Scale and who may be more appropriately referred to the transpersonally oriented clinicians who could relate better to these types of clients. Conversely, clinicians not interested in dealing with transpersonal issues could refer these clients to their transpersonally oriented colleagues. Similarly, a clinician who is interested in quickly assessing whether a potential client would be amenable to transpersonal interventions could utilize the instrument as a screening device to increase the likelihood that transpersonal approaches would not violate client expectations.

Beyond mere screening, however, the SELF could be used to confirm the clinician's judgment as to the level of transpersonal self-expansiveness of a client. Based on the clinician's judgment that an individual would be suited for a transpersonal approach to treatment, the SELF could be administered to confirm this. Perhaps in this age of litigious clinical practice, before treading off the beaten path into the exotic realm of transpersonal interventions (that some attorneys could construe as malpractice and that managed care would most likely not reimburse), an objective justification for such a strategy would be prudent. Regardless of this prudence, all clinicians could benefit from a second opinion in assessment, and the SELF could provide that type of objective second opinion to confirm (or disconfirm) the clinician's judgment. Clearly if a clinician perceives a client to be amenable for transpersonal interventions but the client scores low on the transpersonal scale of the SELF, that would give pause for consideration. If such a difference were to occur, an alternative hypothesis, such as that countertransference on the part of the clinician created a misperception, may be considered to possibly account for the difference between the measure and the clinician's perception. Likewise, it may be that the test might be inaccurate for that particular client for any number of reasons that could be ascertained.

The greatest applicability of the SELF to clinical practice could come, however, through its use in increasing the understanding of a client, including monitoring the growth of the client over time, from a powerful transpersonal perspective. For a transpersonally oriented clinician, several successive administrations of the SELF could provide good data over time to monitor progress in treatment if the stated goal would be to increase the client's level of transpersonal growth. This could also be used to guide the selection of more or less effective treatment interventions in a broader research paradigm.

When viewing the SELF from a more complex vantage, the three scales, compared and contrasted with each other rather than viewed only as individual scales, provide a clinically interesting opportunity for more sophisticated comparisons and conclusions. Specifically, the absolute value obtained on each scale becomes more meaningful when interpreted in relationship to the values obtained on the other scales. For example, moderate identification with the personal level is very different in meaning when compared to a low identification versus a high identification on the transpersonal level. The first instance, moderate personal with low transpersonal identification, suggests an individual who is fairly conventional in their pattern of self-identification with an average level of personal acceptance and little transpersonal

acceptance. The second instance reflects a pattern where transpersonal identification exceeds personal such that the meaning of the moderate personal identification becomes suspect. Is this individual, for example, actually showing some degree of alienation from the self at the personal level in comparison to their high score on the transpersonal level? Thus, although both of these individuals have the same degree of identification on the personal level, their responses to the transpersonal level leads to a different perspective on the meaning of their personal level scores. This is a good example of where clinician judgment becomes the crucial factor in assessment, and blindly interpreting a test without such professional judgment falls short of desirable.

An interesting way to conceptualize possible relationships between personal and transpersonal levels of identification is presented in Table 1. This approach was developed more fully in a previous paper (Friedman, 1984). Low personal with low transpersonal identification can be seen as a neurotic pattern with overall low acceptance of both major dimensions and consequent unhappiness and lack of meaning. This would not apply, of course, to those who disidentify as their transpersonal style, and they would be more similar to those who are high on both dimensions. Those high on both personal and transpersonal identification can be seen as those most healthy or self-actualizing. Those high on personal but low on transpersonal identification can be seen as possessing a more conventional mode of healthy functioning, but one that has not yet opened up to a transpersonal realization and, thus, is inherently limited. Those high on transpersonal but low on personal present an interesting pattern that, to an extreme, is considered as a psychotic tendency. Thus to over-identify with the transpersonal and reject the personal level is seen as potentially a type of severe transpersonal pathology.

TABLE 1  
CONCEPTUALIZATION OF THE RELATIONSHIPS BETWEEN THE PERSONAL AND TRANSPERSONAL LEVELS OF IDENTIFICATION USING THE SELF

		TRANSPERSONAL LEVEL	
		LOW	HIGH
PERSONAL LEVEL	LOW	Neurotic	Psychotic
	HIGH	Conventional Health	Transpersonal Health

The following are two brief clinical vignettes which exemplify the clinical use of the SELF:

1. Sue is an attractive and bright school teacher in her late 20's who has been in and out of psychological treatment for depression over the last five years. She scored very low on both the Personal and Transpersonal Scales of the SELF. She grew up with a particularly rejecting, and possibly schizophrenic, mother and describes never having a feeling of high self-worth. As a teen, she became active with drug experimentation and promiscuity, which further eroded her sense of self-worth. Later, she suffered a

number of emotional problems, including suicide attempts and several brief crisis psychiatric hospitalizations. Since being in psychotherapy, she returned to college, completed her degree, and began teaching. She has not been able, however, to develop a lasting relationship with a man. She describes herself as feeling powerless in all areas of life, particularly in male-female relationships, and describes feeling often like an "ant." She has a hard time feeling any positive feelings, and though her thoughts are well-organized, they have a robot-like mechanical quality to them. This psychological pattern is well measured through her low scores on the Personal Scale of the SELF. She also is very negative toward any spiritual ideas, dismissing thoughts of spirituality in any form as a mere opinion not amenable to discourse, and feels no sense of any connectedness with higher powers. She is, however, very socially and environmentally conscious, a position which she has taken through use of her logical abilities, not feelings. Her spiritual emptiness appears to further her depression, but is not an acceptable topic for discussion with her in therapy. This is well measured by her low scores on the Transpersonal Scale of the SELF. Focus in psychotherapy with her has been on developing her sense of self in the present without any major attempt to introduce transpersonal issues up to this point. It should be noted that it could have been easy to confuse her social and environmental activism with a transpersonal orientation from her verbalizations, which the first author nearly did in his treatment of her, but her responses on the SELF clarified this well. Finally, as her Personal Scale responses strengthen, as hopefully they will with further treatment, psychotherapy could well move to address issues from a transpersonal orientation so that her transpersonal potential could be less constricted.

2. Millie is a commercial artist in her early 40s who also works as a minister in a New Age church where she does psychic readings. She scored very low on the Personal Scale of the SELF and very high on the Transpersonal Scale of the SELF. She sought psychological treatment after having a number of dissociative episodes that involved time loss and possible danger to her self, when she ended up in compromising situations. She sought a neurological explanation, but after extensive medical workups, was referred for a psychological evaluation. The fact that she regularly dissociates when doing her psychic readings in a controlled fashion was not seen by her as related to the episodes that she finds frightening. Her language is full of references to Spirit guiding her and she lives her life in accord with her visions and dreams. She gives short shrift, however, to her own personal needs and, in particular, has a difficult time conceptualizing that it is good for a person to find ways to meet their own personal needs; appropriate assertiveness, in particular, occurs rarely. She does get angry on occasion, however, including inappropriate violent outbursts with her boyfriend, but these make no sense to her, and embarrass her, in terms of her commitment to "Spirit" which she interprets as without anger. In psychotherapy, she is extremely resistant to being directed toward her body feelings or toward rational plans of action to get her personal needs met. The SELF was used to give her feedback regarding her style of rejection of the personal level in an objective and non-judgmental way that she could accept. She still adheres to her position as psychotherapy struggles on, but the SELF provided a way of reducing resistance to communicating with her about her alienation from her own human nature. For example, this has enabled her to work in psychotherapy in addressing issues such as the appropriate expression of anger whereas previously "Spirit" would never have allowed her to express anger except in a dissociated state.

The SELF thus can be a potentially useful objective clinical instrument for a transpersonally oriented clinician, as well as a tool for researchers and theoreticians. There is, of course, still much work to do in refining the SELF as a clinical instrument. The development of norms on different populations, for example, would provide great benefit in any clinical interpretation utilizing the measure. Also further validity studies, particularly with populations seeking transpersonal clinical services, would be highly desirable. In addition, further development of items on the Middle Scale would help integrate the SELF into more of a conventional psychological approach while preserving its fundamental transpersonal orientation. Nevertheless, the SELF stands as a measurement instrument that exemplifies the wide potential for transpersonal assessment in clinical practice and research.

Since there has been a serious lack of discussion in the transpersonal literature of the direct clinical applicability of transpersonal instruments, it is emphasized that the present discussion of the SELF is given as an example to illustrate how an instrument can be used in transpersonal clinical applications. It is intended that this example will encourage the development of additional and more refined clinical applications for the SELF, as well as the similar development of applications for other transpersonal instruments.

#### CONCLUSION

In recent years, numerous authors have explicitly argued that transpersonal practitioners and researchers must develop systematic and empirical means to verify transpersonal theory and practice if the area is to gain credibility and function as a science (Hutton, 1994; MacDonald, Tsagarakis & Holland, 1994; MacDonald et al, 1995; Walsh & Vaughan, 1991). The authors of this paper share the same position and assert that transpersonal psychologists would benefit in a variety of ways from integrating transpersonal theory with conventional professional practice and research methodologies. To do so would allow transpersonal psychology to participate in and contribute to the ongoing development of mainstream clinical science. Also, it would lead to the construction of assessment technologies and measurement tools which would not only lend themselves for use in the empirical examination of the validity and utility of transpersonal theories and practices, but equally would provide additional tools for use in professional work to enhance the understanding of client functioning. Finally, it would create a means through which individual clinicians could systematically evaluate their professional effectiveness, thereby increasing their accountability to their clients.

In order for transpersonal assessment as we have proposed it to serve a useful function for applied work and research alike, however, transpersonal psychologists first need to develop, validate, and use systematic evaluative methodologies (e.g., diagnostic taxonomies; standardized tests of transpersonal constructs) on an ongoing basis in their professional activities. A recent literature survey of transpersonal instruments (MacDonald et al, 1995) uncovered over 70 different measures already available in the literature, many of which (in addition to the SELF described previously), seem to hold value for use in clinical settings (e.g., *Index of Core Spiritual Experience*, Kass, Friedman, Leserman, Zuttermeister & Benson, 1991; the *Spiritual Orientation Inven-*

tory, Elkins, Hedstrom, Hughes, Leaf & Saunders, 1988; the *Death Transcendence Scale*, Hood & Morris, 1983; the *Spiritual Well Being Scale*, Ellison, 1983; the *Peak Experiences Scale*, Mathes, Zevon, Roter & Joerger, 1982; and the *Mystical Experiences Scale*, Hood, 1975). In this regard, some of these measures have begun to receive attention toward clinical applications.

Second, research needs to be done which compares and contrasts transpersonal to mainstream theory and practice in order to establish what the transpersonal area uniquely contributes to the overall understanding of human functioning above and beyond what is already known via conventional psychology. For instance, does any particular transpersonal construct tell us anything clinically useful in addition to what conventional theory tells us? Are there any limitations or disturbances in functioning which are most suited to transpersonal interventions, compared to other forms of psychotherapy? Though there are clinical data available which suggest that the answer to these questions will be affirmative, there is a need for more rigorous validation of both transpersonal theory and practice.

Finally, it appears that there is a division between psychological practitioners who embrace the richness of the transpersonal perspective but reject mainstream scientific approaches and those professionals who adhere to mainstream approaches but marginalize transpersonal psychology. The position of this paper is that this split is reconcilable, and that the integration of mainstream and transpersonal psychologies would be highly beneficial for the transpersonal movement, most notably in terms of enhanced scientific and professional credibility and accountability. Though we are encouraged by the recent emergence of literature which attempts to comprehensively integrate religious and spiritual concerns with the professional practice of psychology (cf., Kelly, 1995; Shafranske, 1996), there is still a clear need for members of the transpersonal psychological community to not only empirically verify their theories and practices before utilizing them in clinical work, but also to actively integrate scientific methodologies into ongoing clinical practice so as to best ensure that the concepts and methodologies grounded in the transpersonal movement are used appropriately, effectively, and responsibly. We hope that our proposed definition of transpersonal assessment may serve as a basis for the further development of a systematic and widely accepted clinical science.

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