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Evaluating the Effectiveness of Therapeutic Assessment with Depressed Adult Clients Using Case-Based Time-Series Design

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Nicole J.Wolf
December 2010

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Abstract

Therapeutic Assessment (TA) is a collaborative model of psychological assessment developed by Finn and colleagues (Finn & Tonsager 1992, 1997; Finn 2007) that is guided by the client's questions and concerns. Although promising evidence is accumulating for the effectiveness of TA, the available empirical research does not rise to the bar set by the American Psychological Association Division 12 Task Force on Promotion and Dissemination of Psychological Procedure (APA, Chambless & Ollendick, 2001). The current investigation uses case-based time-series design, a method endorsed by the Division 12 task force (Borchardt, Nash, Murphy, Moore, Shaw & O'Neil, 2008), to evaluate whether Therapeutic Assessment is an effective, stand-alone treatment for depression. Daily, periodic, and pre/post measurement of hopefulness/wellbeing and symptom status were collected from three adult clients with depression; the data collection spanned three phases: 2-week baseline, 5-8 week intervention, and 4-week follow-up. Descriptive case material is presented for each individual, alongside quantitative findings. The quantitative data is as follows: one participant showed a statistically significant improvement in the daily hopefulness/wellbeing measure. Two of the three participants showed a statistically significant reduction in the daily measure of symptom status. All three of the participants showed a meaningful improvement in the periodic measures of wellbeing and depression. Only one participant showed an improvement in one of three pre/post measures of symptom status. The findings support the therapeutic values of TA as psychological treatment for depression. The results underscore the importance of the Assessment Intervention and Summary/Discussion sessions in the observed therapeutic gains.

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Chapter One: Introduction

Therapeutic Assessment (TA) is a collaborative model of psychological assessment developed by Finn and colleagues (Finn & Tonsager 1992, 1997; Finn, 2007) that is guided by the client's questions and concerns. The TA model differs from the traditional assessment approach, which is entirely in service of diagnosis and treatment planning. In TA, the process of assessment itself is fashioned as a therapeutic intervention. According to Finn and Tonsager (1997), assessors who work within the Therapeutic Assessment framework are committed to "developing and maintaining empathic connections with clients, working collaboratively with clients to define individualized assessment goals, and sharing and exploring assessment results with clients" (p. 378).

As the Therapeutic Assessment model has matured (Finn, 2007), clinicians have begun to test whether there are in fact benefits of working collaboratively and therapeutically with assessment clients (Finn & Butcher, 1991; Finn & Tonsager, 1992; Newman & Greenway, 1997; Ackerman, Hilsenroth, Baity & Blagys, 2000; Hilsenroth, Peters, & Ackerman, 2004). Although promising evidence is accumulating, the available empirical research does not rise to the bar set by the American Psychological Association Division 12 Task Force on Promotion and Dissemination of Psychological Procedure (APA, Chambless & Ollendick, 2001). In the current investigation, I use case-based time-series designs, a method endorsed by the Division 12 task force (Borchardt, Nash, Murphy, Moore, Shaw & O'Neil, 2008), to evaluate whether Therapeutic Assessment is in fact therapeutic and, if so, how improvement unfolds across time.

Theoretical Underpinnings of TA:

TA can be conceptualized as a short-term clinical intervention that fuses assessment and psychotherapeutic technical elements into a brief, focused therapeutic protocol. Finn (2007) contends that when we administer a psychological test, "it is an interpersonal event that has the potential to impact that person" (p. 21).

According to Finn (Finn et al., 1992; Finn et al., 1997), the Therapeutic Assessment method is informed by psychoanalytic Self-Psychology, a theory developed by Heinz Kohut (Kohut, 1977, 1984). TA provides clients with an experience of "intense, positive, accurate mirroring." Assessment feedback, Finn et al. (1992) postulate, may actually have the potential to stabilize and strengthen clients' self-structures and reduce anxiety. Building upon and reinforcing clients' self-structure can lead to greater ego strength in the wake of stress or conflicting information and, thus, to greater psychological wellbeing.

Therapeutic assessment shares much in common with Harry Stack Sullivan's approach to treatment (Sullivan 1953a, 1953b). As Finn (2007) notes, TA is similar to Sullivan's work in several ways. Specifically, TA stresses meeting the personalized goals of the client, respecting the client's privacy, conceptualizing the assessor as a participant-observer, focusing carefully on what the client is communicating through word and action, and speaking with the client in vivid, first-person accounts rather than in psychiatric jargon.

Fundamentally, Sullivan (1953) believed that a close and trusting relationship developed between a client and clinician could facilitate a change in the client's "self-system." Sullivan conceptualized a "self-system" as the thoughts and conceptions that define one's identity and protect one's self-esteem. Individuals inherently attempt to maintain self-systems to avoid the

experience of anxiety. However, such a pursuit can be the source of various problems in the wake of changing life circumstances. Sullivan (1953) believed that “closeness” and “good will” between the therapist and client could facilitate a change in the client’s self-system, whereby the therapist “spreads a larger context before the client” and in spite of anxiety “the self-system can be modified.”

Finn (2007) writes that Sullivan’s concept of “self-system” is integral to his thinking about “why assessment can produce lasting and far-reaching change in clients” (p. 30). Finn (2007) believes that the methods of TA (e.g. enlisting the client’s efforts in the assessment, working collaboratively to discuss the findings) can lead to a refinement in the client’s “story they tell themselves about themselves” (p. 30). During TA, the clinician strives to support the client and create an environment of safety and security so that the necessary change in the client’s “story” can transpire.

Plausibly, then, TA is a time limited intervention through which a client’s “story” about his/her problems is ‘put into words,’ collaboratively examined, and refined. Theoretically, this process strengthens the client’s self-structure and ability to tolerate distress (Kohut 1977, 1984). Additionally, this process can pave the way for higher-order self-definition, greater self-organization, and better predictions about how behavior will need to change for problems to be resolved. This process should reduce a client’s distress, and increase their overall psychological wellbeing and hopefulness for the future. Moving from this theory-based proposition, I test whether therapeutic change is realized in TA, and whether the timing and sustainability of improvement conforms to Finn’s model.

The TA model:

Finn's TA model is rooted in the belief that assessment can in itself be a therapeutic experience. He places significant value in the client's contribution during the assessment and the interpersonal relationship between the client and clinician. For several decades, astute clinicians have observed and reported the positive impact of therapeutic assessment (Berg, 1985; Craddick 1975; Dana, 1982; Dana & Leech, 1974; Fischer, 1986). Craddick (1975), for example, suggested that when emphasis is placed on establishing trust and openness in the testing environment, the client experiences a sense of worthiness and is more able to give his or her best to the assessment. Several clinicians have written about their collaborative work with assessment clients and have recognized the possibility that assessment can lead to positive outcome and change (Fischer, 1994; Handler, 1998). Finn (2007) formalized these concepts by developing of a semi-structured, systemized method for using assessment in a collaborative, therapeutic fashion. This model of Therapeutic Assessment is a six-step process as described below:

Step One- Initial Sessions: The initial session sets the collaborative tone for the assessment, with the focus centered on the client's presenting concerns. Clients are asked what they would like to learn about themselves from the assessment; they work with the clinician to formulate concrete questions that will be the focus of the following meetings. Clients are encouraged to be curious about the nature of their problems. Additional objectives are outlined in Finn's framework for the initial session; specifically, the clinician gathers information about the client's current understanding of him/herself and the parts of the client's narrative that are more and less open to change.

Step Two – Standardized Testing Session(s): There is no predetermined battery of tests that is recommended by the TA model. However, Finn (2007) outlines several guidelines for

selecting and administering tests. Tests that are closely related to the client's questions are administered first. These are followed by tests that are less obviously tied to the client's presenting concerns. Second, each test should be introduced before administration, with reference to their relevance to the client's identified questions. Finally, after the tests have been administered, Finn recommends that the clinician talk with the client about their experience of taking the tests, with specific focus on events that seem clinically relevant to the client's concerns. The inquiry following the assessment is an opportunity for the clinician and client to work together gradually, over time, to edit the client's working understanding of him/herself and their world.

Step Three – Assessment Intervention Session: The assessment intervention session(s) is an attempt to bring into the therapy room the client's presenting problems and concerns for the purpose of observing, exploring, and for possibly navigating an appropriate intervention with the client. This can be achieved by use of a variety of techniques (Finn, 2007; Fischer, 1994). Finn (2007) believes that it is more "therapeutic" to "midwife" changes to an individual's story throughout the course of the assessment rather than to present it all at once in step four. The assessment intervention helps this process to occur.

Step Four – Summary/Discussion Session(s): Finn (2007) has subjectively observed that discussing assessment results with clients can produce "moving and powerful experiences" (p. 8). Finn uses the term "summary and discussion session" to describe this step because it is done in a collaborative manner. This is an opportunity for the clinician and client to discuss the tentative findings of the assessment and to allow for the client's contribution to confirm or revise the clinician's thoughts.

Finn organizes feedback according to the degree to which it is discrepant from the client's ways of thinking about himself/herself. The session begins by sharing the information that maps onto the way the client thinks about himself/herself. The next level of findings is intended to reframe the client's self-view. These findings may provide enhanced clarification and greater organization of the client's difficulties. Finally, information may be provided, depending upon the client's readiness, which is in major conflict with the way that he/she sees oneself in the world. These findings may lay the groundwork for changes in a client's self-system that can lead to a more adaptive resolution of the client's presenting concerns. When such information is introduced, Finn has observed that clients may take some time to assimilate and accommodate it, and the positive impact of such feedback may occur after the assessment is completed (Finn, 2007).

Step Five – Follow-up Session(s): The TA method includes a follow-up meeting a few months after the discussion/summary session. The purpose is to address and discuss questions that may come up after the assessment. Although several clients follow up with psychotherapy, some do not. This session can be used to discuss a client's progress and to clarify the next steps. Finn postulates that clients will continue to think about the assessment long after the assessment is over. He views the follow-up session as an opportunity to continue to work with the thoughts that the client continues to process (Finn, 2007).

TA with Adult Clients:

Over the past decade, several clinician/researchers have documented the positive outcome of providing assessment feedback to their clients in a collaborative manner (Finn, 1996; Finn, 2003; Finn & Martin, 1997; Finn & Kamphuis, 2006a, 2006b). These are anecdotal

accounts of Therapeutic Assessment with a range of adult clients and concerns. To date, three studies have examined TA. I describe them below.

Finn & Tonsager (1992) examined the benefit of using the MMPI-2 in tandem with a TA approach when assessing students at a university-based counseling center prior to treatment. Clients were provided with feedback prior to beginning psychological treatment in accordance with several questions that they developed through a collaborative conversation with the assessor. The study examined differences between two treatment groups. One group completed the MMPI-2 and received feedback on their test using a collaborative approach similar to that of Finn (1990), Fischer (1986), and Butcher (1990). The control group met with an assessor for a similar amount of time and did not complete the MMPI-2. Rather, the assessor talked with them about their presenting concerns and their reactions to taking the test and participating in the study. As compared to the control group, the collaborative feedback group showed a reduction in symptomatic distress and an increase in self-esteem and hopefulness. They expressed positive impressions about their experience. Repeated-measures ANOVA analysis of self-esteem (measured before and after the procedure, prior to treatment) showed a significant effect for Group X Time $F(2,56) = 9.02$, $p<.001$, which was unrelated to subjects' level of distress on the MMPI-2, prior attitudes toward mental health professionals and mental health services, and the length of time between testing, feedback and follow-up.

Newman & Greenway (1997) replicated Finn & Tonsager's study (1992), making only one major technical modification. They administered the MMPI-2 to *both* the control and the TA subjects, thereby correcting the confound in Finn & Tonsager's original design. The TA procedure was conducted according to guidelines outlined by Finn (1995) for using the MMPI-2 as a therapeutic intervention and consisted of two meetings. During the initial 30-minute

meeting, both the intervention and control group met with an assessor, discussed the nature of the problems they were experiencing, and formulated questions that they had about themselves. Two weeks following this, the intervention group received feedback (according to the questions each individual identified), while the control group met briefly with the assessor to clarify the questions they initially identified and to add additional questions they may have had. Follow-up dependent measures were mailed to the intervention participants two weeks after the feedback was provided. At this time-point, the control group participants met with the assessor, completed the dependent measures, and were then provided with assessment feedback. Repeated-measures ANOVA analysis showed a significant Group X Time effect for overall distress (as measured by the GSI index of the SCL-90) $F(2,116) = 7.59$, $p<.01$ and for self-esteem $F(2,116) = 12.43$, $p<.001$, indicating that the collaborative-style MMPI-2 assessment feedback was therapeutic with lowering of distress and improvement in self-esteem.

Ackerman, Hilsenroth, Baity, and Blagys (2000) extended these findings a step further by comparing a therapeutic assessment approach with the traditional information gathering approach (IG). This study was conducted at an outpatient clinic affiliated with an APA-approved clinical psychology doctoral program. Participants came to the clinic seeking psychotherapy; the assessment was conducted prior to treatment, and the investigation followed clients through their third session of psychotherapy. There was a significant difference between the groups in the percentage of individuals who terminated treatment against medical advice. Five of 38 (13%) subjects from the therapeutic assessment group and 30 of 90 (33%) subjects from the IG group terminated before the first psychotherapy session. Within the therapeutic assessment group, the overall good/bad rating on the Session Evaluation Questionnaire (SEQ) was most related to the "depth" and "positivity" of a session and least related to the "smoothness" and "arousal" of the

session. Additionally, the clients' rating of their alliance with their therapist at the third session of psychotherapy (as measured by the Combined Alliance Short Form and the Penn Helping Alliance Questionnaire-Revised) correlated strongly with their ratings of the alliance with the TA clinician following the assessment feedback session. Ackerman et al. (2000) concluded that a comprehensive, collaborative assessment aids in the development of a stable therapeutic alliance and may reduce premature treatment termination. Hilsenroth, Peters, and Ackerman (2004) replicated these effects and demonstrated that the therapeutic alliance between therapist and client is stronger by the third session of psychotherapy when a therapeutic method of assessment is utilized, as compared with the traditional information gathering approach.

Limitations of the available research on therapeutic assessment:

Taken together, the above studies, which investigate the use of collaborative, therapeutic assessment prior to psychological treatment, show promising results. The studies indicate that assessment prior to treatment can be immediately beneficial and can help clients make better use of therapy. However, this work does not test the more radical claim that "Therapeutic Assessment" by itself is an empirically valid short-term psychological treatment.

Since the publication of these early studies, therapeutic assessment has developed into a several-session *stand-alone* intervention that is procedurally articulated and fully described. Finn differentiates his model from other forms of collaborative, therapeutic assessment by referring to his model as Therapeutic Assessment with the capital "T," capital "A." The studies by Finn & Tonsager (1992) and Newman & Greenway (1997) utilize a model for therapeutic assessment that is only a fraction of the current TA model described in Finn (2007). The approach used in these early studies can be regarded as the therapeutic assessment with a lowercase "t," lowercase

"a" because they include therapeutic elements but do not constitute a treatment in itself; nor have they been investigated as such.

The two studies by Ackerman, et al., (2000) and Hilsenroth, et al., (2004) utilize a model of therapeutic assessment that is more consistent with Finn's "TA"; however, these investigations focus exclusively upon the variables of therapeutic alliance and client attribution. This research does not assess whether their clients experienced a reduction in symptomatology during the assessment phase, a necessary component of treatment outcome research.

None of the three studies tracks the change in symptom status after the therapeutic assessment or during subsequent treatment.

Most importantly, the available research on therapeutic assessment does not adhere to the methodological guidelines outlined by the American Psychological Association Division 12 Task Force on Promotion and Dissemination of Psychological Procedure (Chambless & Ollendick, 2001) for identifying and validating empirically supported psychological interventions. First and foremost, the available research has been conducted with no specificity to psychological disorder.

Significance of Current Investigation:

In 1998, the Psychological Assessment Work Group of the American Psychological Association concluded that the majority of research conducted within the field of assessment focused almost exclusively on test validity (Meyer, Finn, Eyde, Kay, Kubiszyn, Moreland, Eisman & Dies, 1998). The committee expressed alarm over the dearth of studies on whether assessment either directly or indirectly imparts therapeutic benefit. As a result, the APA made an urgent call for research to be conducted within this area.

In recent years, knowledge about the therapeutic use of assessment tools with adults and children has grown (Handler, 1998, 2007; Handler & Hilsenroth, 1994). With respect to the use of collaborative, therapeutic assessment techniques with adult clients, Finn (1995, 2007) has been at the forefront of the field, refining a semi-structured model of Therapeutic Assessment for researchers and practitioners. The model identifies several components that are deemed critical to producing positive outcomes.

In sum, though there have been a handful of studies examining whether TA imparts benefit, none has tested whether TA has an effect as a short-term stand-alone intervention, as Finn claims it does. Neither has there been an empirical test of Finn's recently developed comprehensive TA procedure, which fully articulates procedure and makes specific predictions as to when impairment ought to occur in the process. Finally, because a time-series design is well suited to test Finn's claims, and because these same designs have been vested by the Division 12 Task Force as empirically valid, I undertake a case-based time-series study of TA's efficacy as a treatment.

Time-series as a method to study TA:

Case-based time-series analysis is a recognized methodological approach to empirically examine the clinical value of psychological interventions. This approach has been endorsed by researchers as a viable research method for studying how, when, under what conditions, and (in some cases) why psychological interventions work across time (Borchardt, Nash, Murphy, Moore, Shaw & O'Neil, 2008; Peterson, 2004; Bergin & Strupp, 1970; Kazdin, 1892; Kazdin, 1992).

The American Psychological Association Division 12 Task Force on Promotion and Dissemination of Psychological Procedure approves the use of case-based time-series design as a methodological approach to examine the effectiveness and/or efficacy of psychological interventions (Chambless & Ollendick, 2001). Specifically, a small series of single-case design experiments meeting "well-established-treatment" criteria is sufficient to classify an intervention as a "Probably efficacious treatment."

Case-based time-series analysis can build upon the available literature by providing a complementary tool for descriptive and scientific investigation of Therapeutic Assessment that meets the standards set forth by the APA. Time-series designs provide a means to continuously and quantitatively observe change in symptomatology across a baseline phase, intervention phase, and a follow-up phase of Therapeutic Assessment. Time-series design can provide a rich source of information concerning the process by which change occurs in TA.

The Phase Model of Psychotherapy Outcome:

In conjunction with Finn's documented clinical observations, I utilize the Phase Model of Psychotherapy Outcome (Howard, Leuger, Maling & Martinovich, 1993; Howard, Moras, Brill, Martinovich, & Lutz, 1996) to guide my hypotheses about how the therapeutic change will unfold in TA. The Phase Model of Psychotherapy Outcome is a three-phase paradigm that describes how a client benefits from psychotherapy. It contends that a client shows initial improvement in subjective wellbeing (phase one), followed by a reduction in symptomatology (phase two), and gradually by an enhancement in life functioning (phase three).

Phase one is called "Remoralization," and is the reverse process of the clinical phenomenon of "demoralization" (Howard and colleagues 1993, 1996). Demoralization, initially

described by Frank & Frank (1991), commonly occurs prior to seeking psychological treatment, when a client feels that he/she has failed to meet his/her own expectations or is unable to cope with some pressing problem; the client feels powerless to change his/her predicament (Frank & Frank, 1991). Treatment, however, can help the client to clarify his/her symptoms and problems, inspire hope, and provide an experience of mastery. Howard, Leuger, Maling & Martinovich (1993) contend that an improvement in hopefulness and wellbeing ensues when a client clarifies symptoms and problems and realizes that they are not powerless to change their predicament. I expect that remoralization will occur as a result of TA, and anticipate that it will occur early in the TA process (see Figure 1).

Phase two is called "Remediation." During this phase, a client typically uses treatment to mobilize his/her coping skills, realize more effective coping skills, or both, and resolution of symptoms begins, as the client is better able to cope. Finn (2007) contends that TA can pave the way for higher-order self-definition, greater self-organization, and better predictions about how behavior will need to change for problems to be resolved. Because these potential outcomes are closely connected with Howard and colleagues' (1993, 1996) concept of Remediation, I anticipate that the client's symptomatology will improve as an outcome of TA. However, I expect that it will occur toward the end of the intervention because Finn (2007) cites the Assessment Intervention and Summary/Discussion sessions as integral in the process of change (see Figure 1).

Phase three is called "Rehabilitation." It is characterized by a change in long-standing, maladaptive patterns and is the result of long-term psychotherapy (Howard, Leuger, Maling & Martinovich, 1993). Because TA is a short-term intervention, this phase will not be examined by this investigation.

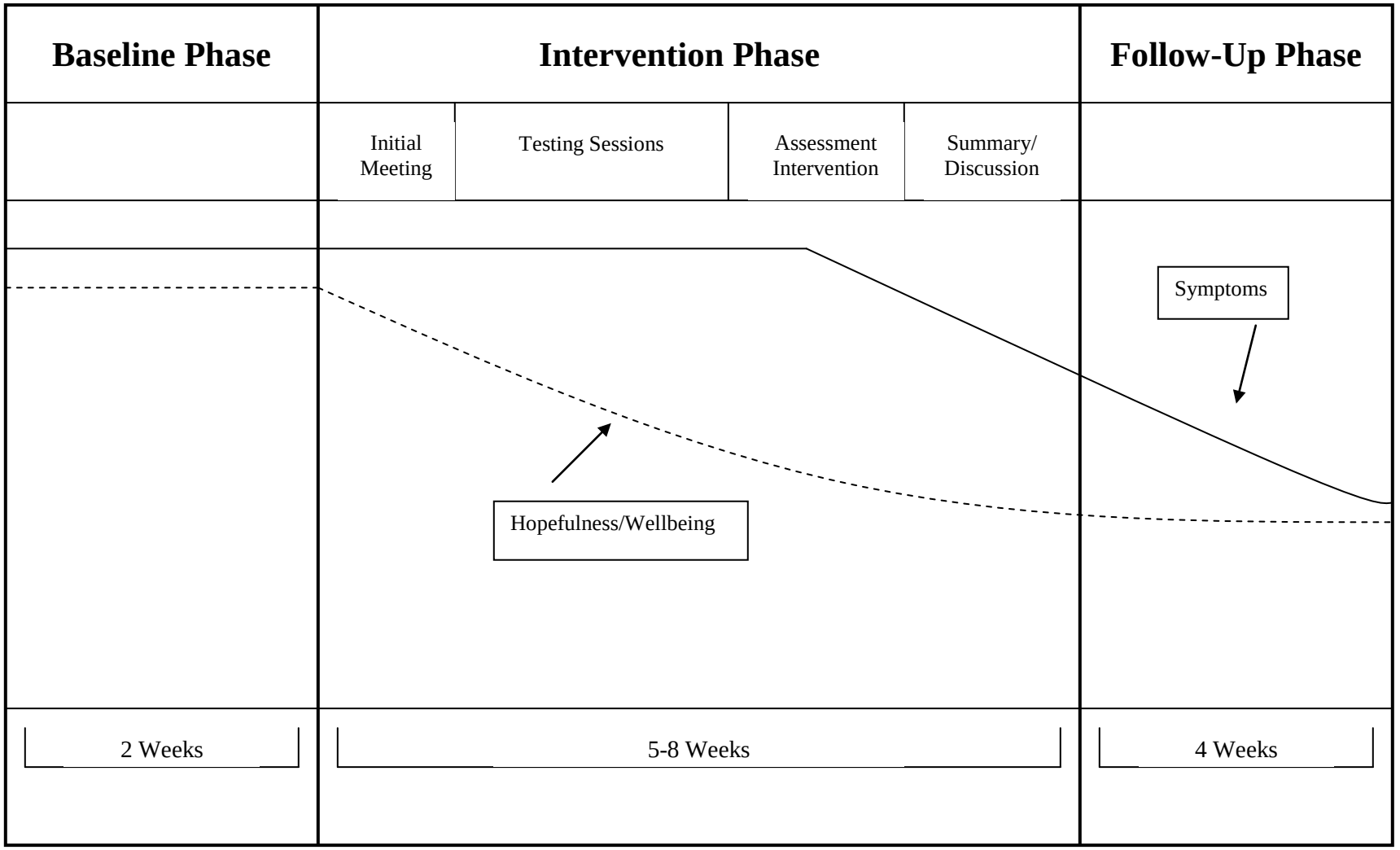


Figure 1: Schematic of Phase Model of Psychotherapy Outcome with TA
(Howard, Leuger, Maling & Martinovich,1993)

Chapter Two: Methods

Subjects:

Three consecutive subjects are recruited for the study, through an outpatient clinic affiliated with the University of Tennessee graduate program in Clinical Psychology. All adult clients (ages 18-65) who come to the clinic seeking psychological/educational assessment, personality assessment, and psychotherapy were considered for the study. The intake clinicians referred *all* clients that meet the selection criteria (see Methods Section II, items 1-4) for further evaluation with the study clinician. All clients who are diagnosed with a Depressive Disorder, who do not have schizophrenia or a psychotic, substance use, or eating disorder (see Methods Section II, item 5), and who consent to participate in the study are included. Recruitment ended when three subjects when enrolled through this process.

Individuals seeking psycho/educational evaluations are considered for the study, which is an unconventional group to work with. In fact, Ackerman, et al. (2000) and Hilsenroth, et al. (2004) consider psycho/educational evaluations an exclusionary criterion. However, in a sample of 15 learning-disabled adolescents, Cohen (1985) identified two major emotional concerns predominant in this population: distress and anxiety and chronic depression. Sadness, loss, confusion, helplessness, anxiety about failure and humiliation, incompetence, and inadequacy were discussed as typical experiences in the emotional lives of learning-disabled individuals. Arthur (2003) contends that the emotional functioning of individuals with learning difficulties has been largely neglected, and he stresses the need for “further research and therapeutic initiatives regarding the emotional development and disturbance of people with learning disabilities” (p. 28). By including psycho/educational assessment clients, this investigation

begins to address a disparity in the literature and, at the same time, will better generalize to the assessment and treatment population of an outpatient psychological clinic.

Selection Criteria:

Consistent with the UT clinic protocol, potential clients undergo a standardized intake procedure. They complete Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1977), the MMPI-2, and meet with an intake clinician for one hour to discuss their presenting concerns. Clients were considered for the TA study if they met *all* of the following criteria:

1. Scoring 'High' (t-score>65) for at least two of the nine MMPI-2 clinical scales, including Scale 2 (Depression) or meeting DSM-IV criteria for a depressive disorder.
2. Expressing interest in "psychological testing" prior to treatment. Or, in the case of psycho/educational assessment, expressing "additional emotional testing" to explore whether and how emotional issues may be contributing to learning problems.
3. Interest in participating in Therapeutic Assessment.
4. Willingness to complete paperwork associated with the study.

The first three clients who met the first five criteria were further evaluated for the study according to item 5. All three participants met the criteria in item five and began the study.

5. Participants are interviewed with the Structured Clinical Interview for the DSM-IV Axis I Disorders, Clinician Version (SCID-CV; First, Spitzer, Gibbon, Williams, 2000).
    a. Inclusion Criteria:
        i. Meeting diagnostic criteria for a Depressive Disorder: This includes Dysthymic Disorder, Major Depressive Disorder, and Depressive Disorder, Not Otherwise Specified.

b. Exclusion Criteria:

   i. Co-morbid Schizophrenia and other Psychotic Disorders

   ii. Co-morbid Substance Use Disorders

   iii. Co-morbid Eating Disorders

Assessment Procedures:

TA is conducted in accord with the guidelines outlined in the section above entitled "TA Model." A timeline for the study is provided in Figure 2:

1. Subjects are recruited through the University of Tennessee Psychological Clinic. All adult clients seeking psychological treatment and psychological/educational assessment are considered for the study. Prospective participants are screened for the study during the one-hour intake appointment, which is conducted according to the policies and procedures of the UT clinic. Following this meeting, all individuals meeting the initial criteria (items 1-4 in the "subjects" section above) are scheduled for an additional meeting with the study's assessment clinician.
2. Prior to beginning the study, the assessment clinician meets with each prospective participant. No Therapeutic Assessment techniques are used during this meeting. The purpose of this session is to provide information (to the client) about the study, to gather additional background/history (not covered during the intake), to complete the SCID-CV. If the client meets the additional criteria (item 5 in the "subjects" section above) for the study and agrees to participate, he or she is asked to complete baseline measures: Outcome Questionnaire (OQ-45; Lambert et al., 1996), Schwartz Outcome Scale (SOS-10; Blais et al., 1999), and the Beck Depression Inventory-II (BDI-II; Beck et al. 1996).

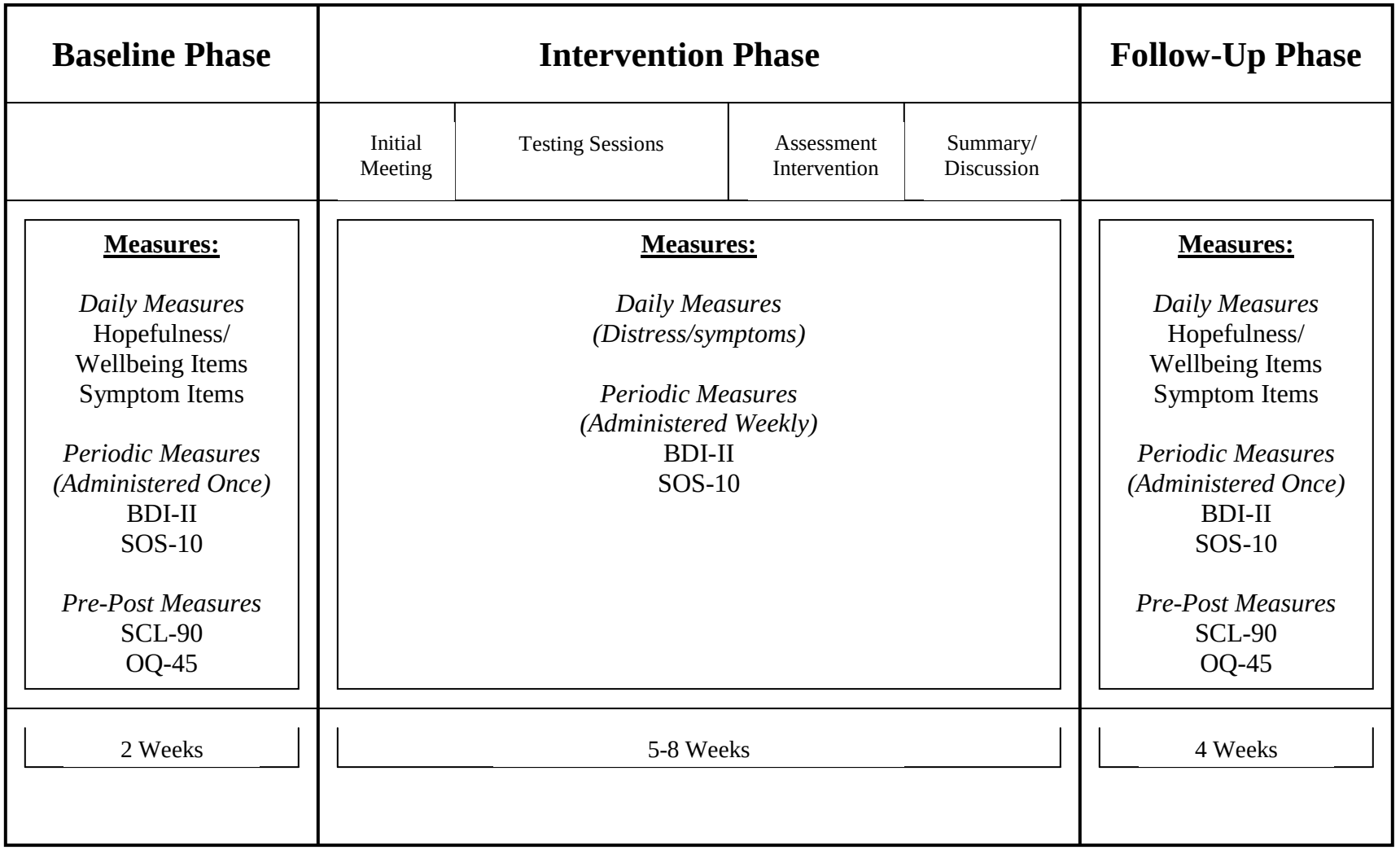


Figure 2: Study Timeline

3. The first three eligible participants were scheduled to begin the Therapeutic Assessment. Prior to beginning the TA, the participants complete the daily measures for a two-week baseline period. The daily measures will be constructed according to the following criteria:
    a. The six outcome measures are as follows:
        i. “Hopefulness about the future.”
        ii. “Overall Psychological Wellbeing.”
        iii. “Feeling Depressed.”
        iv. “Overall Distress.”
        v. Symptom specific to each client’s presenting concern (emotional, interpersonal, or behavioral).
        vi. “Self-Esteem.”
4. If possible, the initial session, testing sessions, assessment intervention session, and summary/discussion session are scheduled at one-week increments to allow for consistent collection of data. Each meeting will be 1.5-2 hours in length.
5. At the end of each meeting, the client is asked to complete the following measures: SOS-10, and BDI-II.
6. Following the summary/discussion session, the follow-up session is scheduled for one month following this meeting.
7. During the one-month lapse between the summary/discussion and the follow-up sessions, the participants continue to complete the time-series forms on a daily basis.
8. The follow-up session occurs one month after the completion of summary and discussion session. Following this session, the client is asked to complete the OQ-45, SCL-90, BDI-

II, Open-Ended Questions (OEQ), Client Satisfaction Questionnaire-Revised (CSQ-R; Larsen, Attkisson, Hargreaves & Nguyen, 1979), and Assessment Questions Rating Form (AQRF).

Measures:

Daily Measures:

Daily Measures: Participants will be asked to monitor and rate six items on a daily basis. This will include five standard items: overall distress, overall psychological wellbeing, hopefulness about the future, feeling depressed, and self-esteem. One item will be tailored to presenting symptoms and concerns of each client, and will be directly related to the assessment questions that they generate. Clients will rate each items on a nine-point Likert scale.

Periodic Measures:

Beck Depression Inventory-II (BDI-II; Beck et al. 1996) consists of 21 items, each of which is rated on a 4-point Likert scale. The instrument is developed to assess depression and has been demonstrated to have excellent reliability and validity with depressed younger and older adults (Beck et al., 1996; Dozois, Dobson, & Ahnberg, 1998).

Schwartz Outcome Scale (SOS-10; Blais et al., 1999): The SOS-10 is a 10-item scale designed to measure a broad domain of psychological health and wellbeing. Items are rated on 6-point Likert scale, from 0 (indicating “never”) to 6 (indicating “all of the time or nearly all of the time”). The SOS-10 has been shown to have strong internal consistency (Cronbach’s alpha = .96) as well as convergent and divergent validity with measures of hopelessness, self-esteem, positive

and negative affect, mental health, fatigue, life-satisfaction, psychiatric symptoms, and desire to live (Blais et al., 1999). Further studies by Young, Waehler, Laux, McDaniel & Hilsenroth (2003) have extended the support for the use of the SOS-10 across a range of settings, indicating that it is sensitive to a wide range of responses, sensitive to changes that occur during psychotherapy, with no apparent ceiling effects.

Pre-Post Measures:

The Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1977). The SCL-90-R is a self-report instrument for assessing symptoms of emotional distress in adults. Internal consistency (coefficient alpha) and test-retest reliability of the SCL-90-R scales range from .77 to .90 (Derogatis, 1983). This measure consists of 90 items, each of which presents a problem or complaint. Participants rate the level of distress caused by that problem over the last seven days, including that day. The rating scale ranges from zero ("not at all") to four ("extremely"). There are nine symptom dimensions on the SCL-90-R: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. There are also three global indices: Global Severity Index (GSI), Positive Symptom Distress Index (PSDI), and Positive Symptom Total (PST).

Outcome Questionnaire-45.2 (OQ-45.2; Lambert et al., 1996): The OQ-45.2 is a 45-item self-report measure through which clients rate their psychological functioning on a five-item Likert scale from '0' equivalent to "never" to '4' being equivalent to "always." It was designed to assess a wide array of clinical symptoms and mental health disorders. The OQ-45 has three subscales, including symptoms involving distress, interpersonal relations, and social

roles. It has been used in naturalistic settings and should work well with this outpatient population. This measure provides criteria for determining clinically significant change. The OQ-45 has demonstrated good psychometric properties (Lambert et al., 1996).

Follow-up, Client Satisfaction Measures***:***

Open-Ended Questions (OEQ): Participants will be asked to respond in writing to the following questions:

1. What part(s) of the assessment did you find most valuable?
2. What changes do you think have occurred as a result of the assessment?

Client Satisfaction Questionnaire-Revised (CSQ-R; Larsen, Attkisson, Hargreaves & Nguyen, 1979). The CSQ-R is an 8-item self-report questionnaire that measures satisfaction with health care services. It uses a 4-point Likert scale, with "4" indicating the highest level of satisfaction. The measure results in two subscales: Service Satisfaction and Help Received. Psychometric properties are acceptable (Larsen, et al., 1979).

Assessment Questions Rating Form (AQRF). The AQRF is a self-report measure designed by Tharinger, Finn, Gentry, Hamilton, Fowler, Matson, Krumholz, and Walkowiak (in press) to study TA with children and families. This measure is comprised of the assessment questions that the assessor and client develop at the beginning of the assessment. Clients are asked to rate how well they thought each question was addressed, using a four-point Likert scale ranging from "not at all" to "completely." As outlined by Tharinger, et al., the resulting score is

the sum divided by the total number of questions that were generated. Higher scores indicate that the questions for the assessment were well addressed by the TA process.

Chapter Three: Questions, Hypotheses, and Proposed Analyses

Hypotheses concerning the improvement in hopefulness/wellbeing indices:

1. Does the client improve on daily measures of hopefulness/wellbeing?

    a. Rational: Finn posits that sharing assessment findings, when conducted according to the principles of collaborative and therapeutic assessment, increases clients' hope about the future (Finn & Tonsager, 1992). The Phase Model of Psychotherapy Outcome (Howard, Leuger, Maling & Martinovich, 1993) predicts hopefulness/wellbeing improvement to occur very early in the therapy. Along the same lines, Finn (2007) contends that many clients report that they experience relief after the initial session simply from the process of putting their concerns and inner turmoil into concrete questions. Hence, I anticipate that if there is a change in *hopefulness/wellbeing*, it will occur early in the TA and be maintained through follow-up phase. In this regard, I anticipate a significant difference between the baseline and intervention phase, with little change from the intervention phase to the follow-up phase.

    b. Statistical Analysis: A composite *hopefulness/wellbeing* measure will be calculated for each client: each client's daily data for *hopefulness* and *wellbeing* will be transformed into z-scores and these data will be added together to form the *hopefulness/wellbeing* composite measure. Simulation Modeling Analysis (SMA) will test for a *hopefulness/wellbeing* effect comparing the baseline phase with the intervention phase plus follow-up phase. If there is a statistically significant effect, the components of the *hopefulness/wellbeing* measure will be

examined individually (i.e. baseline to intervention, baseline to follow-up, intervention to baseline). An alpha of 0.05 is applied. I expect a significant phase effect from the baseline phase to the intervention phase. I anticipate no phase effect from intervention phase to the follow-up phase.

2. Does the client meet criteria for meaningful improvement in the periodic measure of wellbeing?

    a. Rational: See section I.A.1. I anticipate that the client will show a meaningful improvement in the periodic measure of *wellbeing*: the Schwartz Outcome Scale (SOS-10).
    b. Statistical Analysis: The composite scores are calculated for each periodic SOS-10 measure, and graphed across time. Meaningful improvement will be evaluated using Reliable Change Index (RCI; Jacobson & Truax, 1991; Ogles, Lambert, & Masters, 1996): RCI = (posttest - pretest)/ (Standard Error of Measurement). The Standard Error of Measurement is calculated as 2.18, using a standard deviation of 10.9 and coefficient alpha of 0.96 (Young, Waehler, Laux, McDaniel & Hilsenroth, 2003; Blais, Lenderking, Baer, deLorell, Peets, Leahy, et al., 1999). An RCI greater than 1.96 constitutes a reliable and meaningful change. An RCI will be conducted using the first and last SOS-10 measure (the first measure is collected at baseline, the last measure is collected at follow-up). This is done independently for each client.

Hypotheses concerning the improvement in symptoms:

1. Does the client improve on daily measures of symptoms?

    a. Rational: Finn posits that sharing assessment feedback, when conducted according to the principles of collaborative and therapeutic assessment, results in a decrease in distress and symptomatology (Finn & Tonsager, 1992). The Phase Model of Psychotherapy Outcome contends that a reduction in symptoms follows an improvement in subjective wellbeing (Howard, Leuger, Maling & Martinovich, 1993). I anticipate an improvement in the client's daily symptom measures. However, given the Phase Model, I anticipate symptom change to occur relatively late in the TA process, with non-significant change from the baseline phase to the intervention phase, but a significant change from baseline phase plus intervention phase to follow-up phase.

    b. Statistical Analysis: A composite symptom measure will be calculated for each client: each client's daily data for distress, depression, and client specific symptom will be transformed into z-scores and this data will be added together to form the composite measure. Simulation Modeling Analysis (SMA) will test for a symptom effect comparing the baseline phase with the intervention phase plus follow-up phase. An alpha of 0.05 is applied. If there is a significant effect or the Pearson's-r is > +0.10, an additional analysis will be conducted that will test for a symptom effect comparing the combined baseline phase plus intervention phase

with the follow-up phase. If there is a statistically significant effect in either of the two analyses, the phase components of the symptom measure will be examined individually (i.e. baseline to intervention, baseline to follow-up, intervention to baseline).

2. When compared to baseline, at follow-up does the client meet criteria for symptom improvement on the periodic measure of symptom status: Beck Depression Inventory (BDI-II)?

    a. Rational: See section II.A.1. I anticipate that the client will show a meaningful improvement in the periodic measure of *symptoms*: the Beck Depression Inventory (BDI-II).

    b. Statistical Analysis: The composite scores are calculated for each periodic BDI-II, and graphed across time. Symptom improvement is considered a change in the classification of depression from the baseline measurement to the follow-up measurement (Steer, Cavalieri, Leonard & Beck, 1998). The criteria are as follows: minimal depression, 0-13; mild depression, 14-19; moderate depression, 20-28; severe depression, 29-63.

3. When compared to baseline, at follow-up does the client meet criteria for meaningful improvement on the pre/post measures of symptoms: the OQ-45 Symptomatic Distress

Index, the SCL-90 Global Severity Index (GSI), and the SCL-90 Positive Symptom Distress Index (PSDI)?

a. Rational: See section II.A.1. I anticipate that the client will show a meaningful improvement in the pre/post measures of *symptoms*: OQ-45 Symptomatic Distress Index, the GSI, and the PSDI?

b. Statistical Analysis: The composite scores are calculated for the pre- and post-measurement of the OQ-45 Symptomatic Distress Index, the GSI, and the PSDI. Symptom improvement on the OQ-45 symptom distress score will constitute a reduction of 10 points or more; This is the standard for reliable change, outlined by the OQ-45 Administration and Scoring Manual (Lambert, Hansen, Umphress, Lunnen, Okiishi, Burlingame, et al., 1996). Improvement on the SCL-90 subscales will constitute no longer meeting the clinical threshold (t-score>65). This is done independently for each client.

Chapter Four: Case One - Melanie

Referral:

Melanie is a 31-year-old woman who came to the psychological clinic requesting an evaluation for Attention Deficit Disorder. She was struggling to keep pace, working full-time and taking part-time graduate classes through an extension-learning graduate program. She reported being extremely "disorganized" at work, having trouble meeting deadlines and expectations without a lot of structure, and simply taking much longer than others to complete work. Additionally, she reported having difficulty with communicating her ideas to her colleagues, classmates, and professors, and accurately understanding what is expected of her at work and in school.

Melanie reported taking medication for anxiety and depression. She talked about the anxiety and depression as an isolated medical condition, something that she was afflicted by, unrelated to the problems that she was experiencing in her daily life. She was open to the idea of investigating, together, the ways in which her emotional problems might be connected with the problems she was experiencing.

During this meeting, Melanie was dressed professionally and interacted to me in a very businesslike manner. She appeared guarded, anxious, and sad. I was struck by the way our conversation did not follow a connected, sequential pattern. Melanie's thought process was markedly tangential, expansive, and loosely connected. While talking with her, I got the sense that she had the experience of floating in space and was desperately attempting to be grounded. She talked about several methods she uses to try to experience "better in control" of her life (i.e.

herbal supplements, self-help books, moving apartments, changing jobs), and expressed exasperation with the lack of results she obtained. She seemed to be searching for the right "fix."

Initial Meeting:

Melanie arrived on time for the initial TA meeting (see Figure 2 for study timeline), again professionally dressed. She greeted me with a smile, yet her body language communicated that she remained very guarded, despite our previous meeting. Melanie was focused upon getting to the bottom of her functional problems, so we began by talking in greater detail about the troubles she was experiencing at work and at school. We then discussed her depression and anxiety.

During our discussion, we constructed the following questions that we would explore during the assessment:

1. How is my ADHD related to my depression?
2. Why, when everything is going OK, do I feel depressed and hopeless?
3. Why does depression seem to hit me out of the blue? Why do my moods seem either good or bad? Why are they at such extremes?
4. Why do I feel like a crazy person? Why does it seem that no one gets what it feels like to be depressed?

Regarding the first question, I asked Melanie about her ADHD, specifically, how it interferes with her life. Melanie said that she was working as a branch manager for the sales department of a small company and was required to make several phone and in-person sales contacts per week. She experienced this as overwhelming and simply too much work. Additionally, she was required to complete paperwork documenting these contacts as well as the overall sales for the department. She reported that she "puts things off a lot" and can become

bombarded with all that she has to do. This often prevents her from finishing her work and meeting deadlines. When she does settle into the work, she has a difficult time keeping focus on it.

Melanie said she was also having problems with ADHD in her part-time graduate program. She was taking extension-learning courses online, working toward her Master's degree. She was encouraged by her supervisors at work to pursue this, and she appeared pleased that her company was subsidizing this education. However, this was an ongoing source of anxiety for Melanie because she needed to attain at least a 'B' in her coursework to be fully reimbursed and she was currently in a statistics course. She pinpointed the tests on which she was required to write several essays as the primary problem. She had enormous difficulty understanding what each question was asking and organizing her ideas to respond. This process was very time consuming; she told me that she would often get "stuck" on a particular problem and would often not complete the test in the allotted time.

She stated that she has experienced ADHD-like problems for as long as she could remember. In kindergarten, she recalls that she would frequently "daydream," stare off into space, and could not sit and focus. She told me she was predominately "left-brained," whereas most of the world was predominately "right-brained." She felt she thought very differently from most people, and that this was a real problem when she was faced with conventional tasks. Melanie stated that she simply "learns things different" from others and has a hard time trying to figure out what is being asked of her. She felt much more comfortable with and competent on tasks with fewer guidelines and limitations.

Regarding the second and third questions, Melanie informed me that she was profoundly confused about the origins of her symptoms. She described her depression and anxiety as an

intrusive experience, “hitting me like a ton of bricks.” She reported periods of time when she feels intensely “all alone,” “hopeless,” and “out of control.” These experiences seemed to flood her when she came into contact with what she considers “small problems,” such as when she discovered a flat tire on her car. Melanie recalled that she also felt this way when she reached the end of weekend visits with her out-of-town boyfriend and with her out-of-town family.

Melanie reported sporadic, symptomatic patterns when she feels “out of it, fuzzy, and dizzy.” She stated that this typically occurs when she is driving to work, and she has to pull over to the side of the road to reorient herself. She described this experience as isolated, intense, and debilitating. She could not connect these experiences with her deeper ongoing internal experience, emotional life, or even (most of the time) problems in her daily life but, rather, felt as though they appear out of the blue. As a result, she would either feel very good or very bad. However, she expressed feeling generally very consumed by thoughts of “what could go wrong,” and actively constructed her life around trying to establish a sense of security and eliminate the painful emotional experiences that she talked about.

With regard to the fourth question, Melanie stated that she prefers to be alone when she is upset. She reported that she has often tried to talk with her parents about her struggles but feels that they “don’t understand.” Instead, she experienced them as trying to talk her out of being depressed. As a result, she feels “like a crazy person.” Given this experience, I understood why she was apprehensive to talk with me about her emotional concerns.

The problems that Melanie described seemed to be long-standing. Although she experienced them as “out of the blue,” they seemed to me to be very connected with her life. She lived an unsettled lifestyle, having voluntarily moved several times in recent years with her job. Although she expressed the desire to stay in one place, she had happily relocated at each juncture

because she believed that by moving she would feel better. This never seemed to happen. She recalled being “a loner” as a child and adolescent, and does not have well-established friendships or a solid social support network, with the exception of a long-distance relationship with a man. She met this man while working at a previous job, and travels to visit him on the weekends. She reported with sadness that he was very preoccupied by his own life. It seemed that Melanie was very alone even in the presence of other people.

Standardized Testing Sessions:

See Figure 2 for study timeline. Melanie arrived on time for each session, dressed professionally. She always appeared upbeat, cheery, friendly, and cooperative.

WAIS-III: The WAIS-III testing took two hours to complete. Melanie appeared to have difficulty concentrating, which intensified as the testing progressed. It was apparent to me that she struggled, but was extremely persistent. Given enough time, however, she was able to arrive at the correct answer. Periodically, she would get off-track and her performance was inconsistent. As the test progressed, this pattern became more pronounced.

After the test, Melanie informed me that the test had been challenging for her. She was very frustrated by tasks that were confusing, and noticed her mind wandering. She also stated that on some tasks, arithmetic in particular, she experienced the questions as foreign, and could not immediately respond. She had to “translate” them into something that she could understand, adding an additional challenge.

Despite her struggles, Melanie performed in the High Average Range of Intellectual Functioning (Full Scale IQ = 113), indicating that she has a high aptitude. Notably, Melanie’s Performance IQ (107) was lower than her Verbal IQ (116). This is likely connected with the

additional time that Melanie exhausted to overcome the challenges that she described. For example, although Melanie produced the correct response for most of the items on the Picture Completion test, she lost credit on several items because she did not respond within the allotted time.

Additional ADHD assessment: To fully address Melanie's question of whether she has ADHD, I asked her to complete a self-report measure and a behavioral task. On the Brown Attention-Deficit Disorder Scale for Adults, Melody scored extremely high. Her T-score was 96 for Cluster 1, "Organizing and Activating to Work," 91 for Cluster 2, "Sustaining Attention and Concentration," and 103 for "Total Raw Score." A Cluster T Score that is above 65 represents a clinically significant level of impairment, and a Total Raw Score T-score that is above 55 indicates that it is highly probable that diagnostic criteria for AD/HD will be met. However, on the TOVA Visual Continuous Performance Test, Melanie scored -1.08, which is below the clinically relevant threshold of -1.80.

MMPI-2: Melanie produced a valid 2,3,7 MMPI-2 profile. Consistent with her self-report, people with this profile experience debilitating anxiety and have frequent worry, agitation, and sadness. According to her symptomatic pattern, Melanie appeared inhibited and over-controlled, relying on denial and repression to deal with anxiety and conflict. The MMPI-2 test data indicate that she feels hopeless, condemned, regretful and unhappy about life. Her pattern of responding suggests that she views the world in a negativistic manner, develops worst-case scenarios, and interprets events as problematic. Although she denied suicidal ideation, and does not report this directly on the MMPI-2, she endorsed several items that loaded on the Koss-Butcher Critical Items scale for Depressed Suicidal Ideation.

She scored high on the Psychoticism scale, indicating that she feels isolated from others and might experience unusual symptoms, such as circumstantial and tangential thinking and loosening of associations. She also reports some unusual beliefs, which indicate that she can become disconnected from reality at times. She endorsed several items that suggest problems with memory, concentration, and making decisions.

Consistent with her clinical presentation, Melanie's MMPI-2 profile indicates that she tends to approach interpersonal relationships with caution and skepticism. She tends to be passive-dependent and is easily hurt by others. Overall, the MMPI-2 results indicate that she tends to be nonassertive, avoids confrontation for fear of being rejected, and instead keeps anger bottled up.

Rorschach: The Rorschach was administered and scored using the Exner Comprehensive System (Exner, 2003) (See Figure 3&4). Melanie reported that she enjoyed this test much more than the WAIS-III and TOVA, felt more comfortable with it, and appreciated that there was not a right or wrong answer.

Although she felt more comfortable, Melanie did not do well with less structure. Over half of her responses were atypical and arbitrary (X-% = 0.52, Norm = 0.07$\pm$ 0.05), indicating that her perception of reality is more than "unconventional," and, rather, seriously and pervasively distorted or inaccurate. Contributing to this problem, Melanie's profile indicates that she tends to put things together that do not belong together and that her thought process is disorganized, inconsistent, and marked by flawed judgments (FAB2 = 2, Norm = 0.03$\pm$ 0.16; WSum6 = 27, Norm = 4.48$\pm$ 4.08). Consistent with these variables, Melanie met four of the five criteria on the Perceptual-Thinking Index (PTI), signifying that she has considerable mediational/ideational problems.

Sequence of Scores

Card	Resp. No	Location and DQ	Loc. No.	Determinant(s) and Form Quality	(2)	Content(s)	Pop	ZScore	Special Scores
I	1	D+	2	Ma-	2	H		6.0	INC, COP, PHR
	2	W+	1	Mao	2	H		4.0	AG, PHR
II	3	WSo	1	Ma.FC.FY-		Hd		4.5	MOR, PHR
	4	Do	4	FD.Ma-		Hd,Cg			PHR
	5	Do	3	FCo		A			
	6	DSo	5	FY-		Cg			
III	7	D+	1	Ma.FVo	2	H,Ls,Cg	P	4.0	GHR
IV	8	D+		FY.FMp-	2	Ad		4.0	
	9	Do		ma.FYu		Ad,Art			
	10	Do	6	FDu	2	Cg			
V	11	Wo	1	FMpo		A	P	1.0	
VI	12	Wo	1	FVo		A	P	2.5	
VII	13	D+	2	Ma+	2	Hd,Art	P	3.0	GHR
	14	Do	4	FY-		Cg			
	15	Do	3	FV.Mau	2	Hd			AG, PHR
VIII	16	W+	1	FMa.FD.FC-	2	A,Bt		4.5	AG, FAB2, PHR
IX	17	Do	2	FMa.FD-	2	A			MOR, FAB
	18	Do	6	FC-	2	An			
	19	D+		FC.mp+		An		4.5	
X	20	Do	1	F-	2	Bt			INC
	21	Do	1	FC-	2	Ex			ALOG
	22	D+	11	FMau	2	A,Bt		4.5	
	23	D+		FMa.FC-	2	A,Art,Fi		4.0	FAB2
	24	Do	2	FCo	2	A			
	25	Do	1	FD-		A			

Summary of Approach

I : D.W	**VI :** W
II : WS.D.D.DS	**VII :** D.D.D
III : D	**VIII :** W
IV : D.D.D	**IX :** D.D.D
V : W	**X :** D.D.D.D.D.D

Figure 3: Melanie's Rorschach Sequence of Scores Report

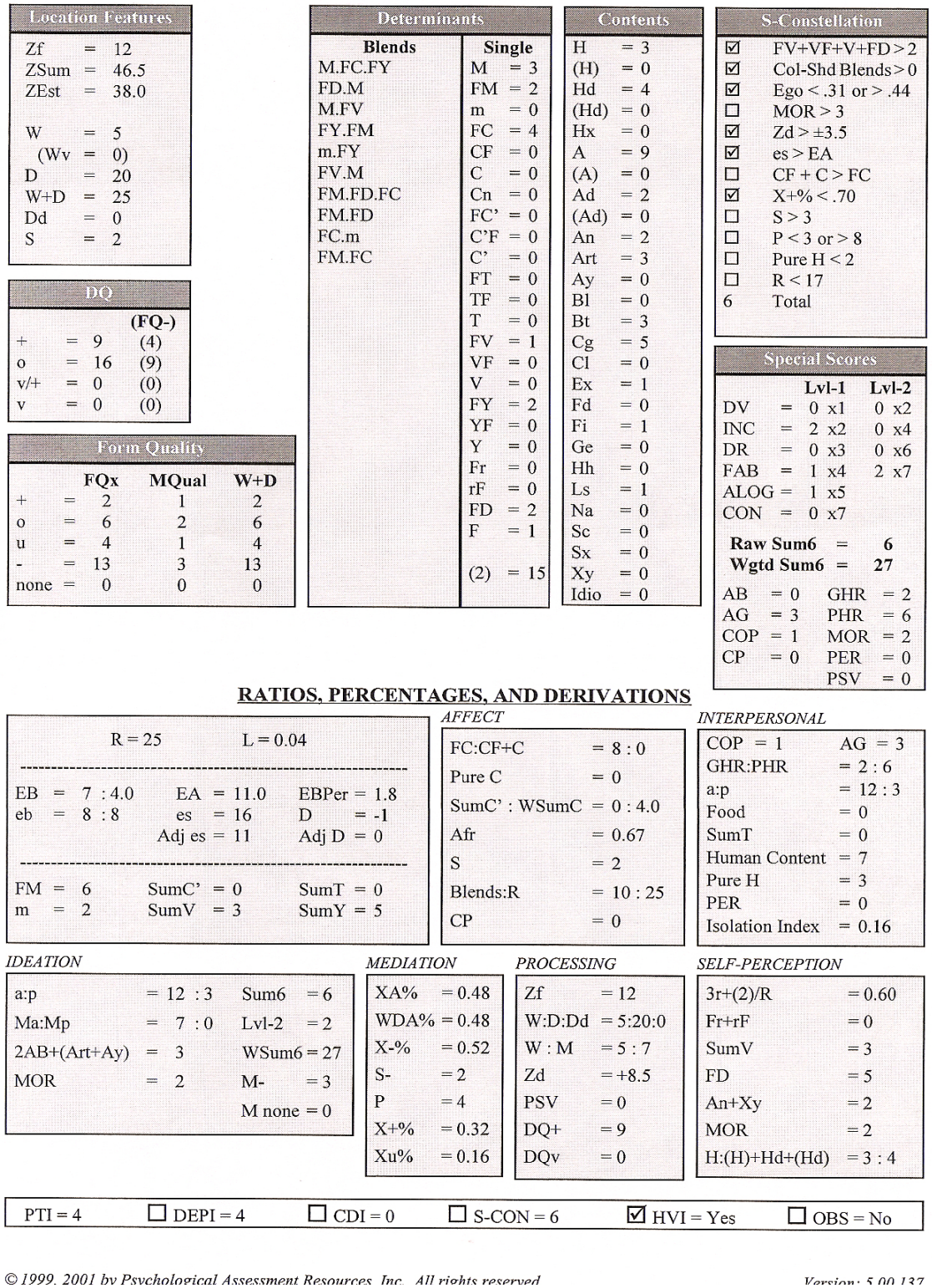


Figure 4: Melanie's Rorschach Structural Summary

I began to think that this finding might be the central key to Melanie's difficulties communicating with, understanding, and being understood by others. These variables may contribute to why she struggles at school and work, experiences herself as "thinking differently" than others, and spends additional time on concrete tasks. I hypothesized that this finding might be why she becomes frustrated and experiences difficulty persisting with a task.

After the standardized administration, Melanie said that she liked the cards with brighter, warmer colors, but also struggled to understand how everything fit together. When I suggested that everything that she fit together did not actually fit together well, she appeared taken aback and reminded me that she approached tasks and thought about things differently than most people. I agreed with this and did not push it any further, sensing that this was a very delicate matter.

In addition to these concerns, Melanie's profile shows a low *Lamda* (L = 0.04, Norm = 0.60± .31), indicating that she may experience difficulty distancing herself from her emotional experience, despite her concerted attempts to do so. Given Melanie's elevated Zd score (Zd = +8.5, Norm = 0.64± 2.69), her low *Lamda* score may also indicate that she tends to over-incorporate information from her surroundings. When coupled with a high X-% and high WSum6, the picture suggests that when Melanie experiences emotional conflict and turmoil, her efforts to distance herself from her emotions are not successful, and her attempts to accurately make sense of her emotional experience and external reality fail.

Melanie has an introversive style, suggesting that she relies heavily on thought and reasoning when processing information and making decisions. This quality seems to appear in her mechanistic attempts to exert some control over her emotional experience and careful

planning. When looked at in the context of other Rorschach variables discussed above, it is not working well for her at this time and probably has not in the past.

Finally, Melanie met threshold criteria for the Hypervigilance Index (HVI), suggesting that she has some long-standing emotional problems. According to Exner (2003), the HVI identifies individuals who use "considerable energy to maintain a relatively continuous state of preparedness" (p. 407). The HVI is thought to represent a trait-like feature that evolves early in development through repeated experiences in which a child finds it difficult to predict the response of significant others. These experiences may connect with Melanie's difficulty interpreting reality accurately.

Interpersonally, HVI positive individuals tend to have a mistrusting attitude, feel quite vulnerable, experience preoccupation with personal space, and stay very guarded in their relationships. Additionally, these individuals can be suspicious and confused by the gestures of closeness by others. These attributes are suggested to interfere with conceptual thought and can provoke patterns of illogical thought (Exner, 2003), which is consistent with Melanie meeting the threshold criteria for the Perceptual-Thinking Index (PTI). In my understanding, this description fit with Melanie's excessive focus on 'what could go wrong,' her guarded presentation, and her fundamental preoccupation with safety and security.

In the following session, I talked with Melanie about the HVI and read her Exner's (2003) description of the interpersonal characteristics that are common among this population. I asked her whether this connected in any way with her experience. She agreed with me that the description seemed to "fit" with her experience, both in terms of her concerns about interpersonal closeness and her preoccupation with physical safety. She shared with me that she does not trust anyone, and knows that if she does, she will be let down. She expressed several

fears, and acknowledged that she probably fixates on these concerns more than do others. Melanie did not open up about her experience much more than this, but my feedback did seem to resonate with her. I suggested that additional tests that might help to shed more light on what underlies these concerns. Melanie agreed to this plan.

Additional Projective Assessment: I administered the House-Tree-Person Test (Buck, 1966), the Sentence Completion test, and Thematic Apperception Test with the hope that they might provide more information about Melanie's emotional experience and/or open opportunities to talk with her about it.

We began with the House-Tree-Person test. Melanie spent considerable time drawing the house (see Figure 5). She drew a two-level beach-house on stilts; she stated that the stilts are to protect the house from the rising water. The windows and a door are closed, and secured with cross-shaped windowpanes and clasps. She drew two wrap-around porches, one on each level, and spent considerable time drawing elaborate railing around each. There is an open stairway that leads to the entryway of the house. However, a fully shaded gate, held closed by a dark clasp, barricades it.

I told her that house looked very guarded to me. She nodded in acknowledgement and said that she didn't think that she "ever really opens up to anyone." I asked her why, and she said that she "really didn't know." The open stairway leading to a barricaded entryway reminded me of my work with Melanie. In many ways she appeared open; she showed up for her appointments and appeared effortful. However, frequently my inquiry and attempts at discussion did not help me get to know her better.



Figure 5: Melanie's H-T-P 'House'

Next I asked Melanie to draw a person. She drew a woman with an open posture, wearing a long coat that covered her body (see Figure 6). She told the following story: “She’s cold because it is winter. She put her coat on before she went outside.” When I asked her about why she drew the woman with a coat on, she stated that she didn’t want to draw a chest or the waistline, so she decided to draw a coat to cover it. I understood this to reflect her guardedness, her desire to cover-up or hide, and her experience of the world outside (herself) as “cold.” The woman’s face is striking; her eyes are drawn without pupils, eyebrows pronounced; they appear to communicate suspiciousness, distrust, and anger. The woman’s hands look sharp and pointed, almost like claws, which might indicate fear, defensiveness, and anger.

Melanie’s ongoing conflict and attempts to regulate psychological distress also appear in several of her responses to the Sentence Completion Test. The sentence responses reflect her experience of depression, hopelessness, and loneliness. They resonate with her description of her emotional experience as isolated, intense, and flooding, and her response to these emotions as dangerous, overwhelming, and needing to be extinguished.

25. *Worse than being lonely is* being hopeless and lonely and feeling like no one cares.

30. *If people only knew how much* I have on my mind, they might be able to grasp my feelings.

45. *A naked man* ran down the street and scared the women.

60. *Nothing is harder to stop* than worrying.

9. *Depression comes* suddenly and takes me on an emotional rollercoaster.

10. *When a fire starts* make sure it is controlled.



Figure 6: Melanie's H-T-P 'Person'

Assessment Intervention Session:

The testing indicates that Melanie has substantial difficulties in developing and sustaining trusting, connected relationships. In addition, she has some significant problems with her thinking. Melanie had been very guarded with me up to this point, and I felt that it was important to be respectful of this. Therefore, my primary focus of the Assessment Intervention was to provide a good experience for Melanie, during which we could begin to talk together about aspects of her internal experience.

I decided to focus on Melanie's experience of "thinking differently" from others. This appeared to be central to her problems at school, work, and to contribute to her experience of isolation. The Assessment Intervention was designed to bring this experience into the room and to discuss with her what may be going on for her.

The Rorschach demonstrated Melanie's experience of "thinking differently" most clearly. She seemed to have especial difficulty on color cards and on cards in which she saw humans, suggesting the possibility that emotional flooding and human interaction intensify her problems. On Card X, a color card, for example, Melanie had spent several minutes examining it. She appeared to be 'stuck,' consistent with her experience in school. She produced six responses, four were minus responses, and three had special scores (INCOM, ALOG, & FABCOM2). I chose to try to talk with her about this card because her behavior and responses on it seemed to be very connected with her problems: She took a long time to respond, and when she did, she did not make appropriate use of the contours of the blot and put things together that did not belong together.

In addition to trying to talk with her, I wanted to test my hypothesis that she might have done better if Card X was not a color card. I photocopied the card so that I had both a color version and an achromatic version.

I began by telling Melanie that I wanted to try to better understand what the experience of "thinking differently" was like for her. I said that the inkblot test suggested that she thought very differently at times, as she had told me. I asked her if she was willing to work with me to try to define and to understand this problem better. She agreed. I then asked her if I could read one of her responses. She agreed. I read the fourth response on Card X:

"I see two red seahorses playing a horn; Separate horns but facing each other. Some creature on their back, walking around with flaming heads and they are swinging some sort of orange tapestry. In between the seahorses, there are two caterpillars coming together."

I asked her what she thought of it. She said, "That's what I saw" and shrugged as though she didn't know what I was getting at. I told her that this was an unusual response because she had put things together that do not go together. Again she looked at me suspiciously and said, "I don't like to go the way that everything else goes." I said that she seemed to get 'stuck' on this card while taking the test, and I wondered whether this was similar to the experience she had described of being 'stuck' on her schoolwork. She said that she had struggled with the card because of all of the different colors; there was a lot going on in the card and she didn't know how to pull it all together. She stated, "If it was all the same color, it would not have been so complicated." I told her that I had also had this thought and had prepared by making the card black and white to replace all the colors. I asked her to give it another try, and see if we were correct. She was initially hesitant but spontaneously produced three responses with 'ordinary' form-quality and no special scores. I told her that according to the Rorschach scoring criteria she had done much better than before.

She told me that "when you have to come to a common answer, that's when I have problems." I agreed with her, and pointed out that when the card was achromatic, she did better. She said that she could see everything as separate, and she didn't feel "like there was as much going on." I asked her if the experience of 'much going on' felt overwhelming to her. She agreed. I also mentioned that I noticed she took much less time to respond when the card was less overwhelming. I asked her if there were ways she knew of or could think of that helped her to feel less overwhelmed and to break things down in a way that she could more easily come to a common answer. She told me that she had tried to get help from several tutors in her life and that "none had helped." I asked her why and it led into a discussion about some of Melanie's other concerns that she brought to the TA: Her experience of hopelessness and her trouble sharing experience with others. The conversation went as follows:

Melanie: When I was having someone help me, it was like a foreign language.
Nicole: So it is hard to get help from other people?
Melanie: It's just too much work. I just let them finish trying to help me and figure things out for myself later.
Nicole: What is the experience like for you?
Melanie: It's frustrating. I get to a point where I get really upset, because I feel like I don't understand anything.
Nicole: Because you cannot speak the same language, you are left to feel as though you don't understand anything and have to figure everything out on your own?
Melanie: Yeah, I become like, 'fine, lost cause.'
Nicole: It must feel hopeless. Maybe this is why you feel hopeless a lot of the time.
Melanie: Yes (nods).
Nicole: Is there *anything* that helps?
Melanie: Nothing. If someone could explain it in a way that I need it to be explained to me, or if they could understand my question, because sometimes they don't even understand my questions. There's no one that explains things the way I can understand it.
Nicole: No one? It must feel like you are really alone in the world.
Melanie: My second grade teacher seemed to get me. If someone takes enough time to understand me, I think that they could. I did have a helpful tutor in eight-grade. There were nights that we would just get though 2-3 problems, but she would take the time to really understand me and help me understand.

Nicole: I wonder if this connects with why you feel like no one understands your depression? There is not a way to talk about what you are feeling with another person and feel understood.

Melanie: Yeah, but I think that most people around me don't understand. If I say, I am really feeling bad to my boyfriend, he'll say, "I understand," but I don't think that he does.

Nicole: Therapists can sometimes be like the tutor who was able to help you. Typically, they are very invested in trying to understand where another person is coming from. I think that therapy might be able to help you develop a language that can be shared with other people – that way you wouldn't have to feel as though you are speaking in a foreign language and like no one gets what it feels like to be depressed.

Melanie: That would be nice. I will think more about it.

Summary/Discussion:

Melanie arrived for the summary/discussion session markedly more relaxed than I had experienced her to be in previous sessions. The session progressed according to Finn's recommended guidelines (2007). In addition to what we discussed during the Assessment Intervention, we talked more about Melanie's concerns about 1) Why, when everything is going OK, does she feel depressed and hopeless? 2) Why this seems to hit her out of the blue?

I talked with Melanie about her efforts to ward off the experience of depression and hopelessness. I suggested that maybe she felt depressed and hopeless a lot of the time but didn't allow herself to experience it because it felt dangerous or overwhelming to her. I told her that I also thought that these feelings didn't really go away, despite her efforts to make them do so; her efforts to ward them off functioned like a dam in that dams can hold back water, but when there is a lot of pressure, it can cause a flood. She seemed to really connect with this metaphor. I told her that therapy could help her to experience her emotions more fully in her daily life so that they would not flood her. She decided to begin therapy after the follow-up period.

Follow-up:

Melanie and I met one month following the Summary/Discussion session. She appeared excited to share a story with me about a recent interaction that she had had with her mother. She had told her mother about the assessment and what she had learned about herself in the process. Her mother, in response, told Melanie about her own personal struggle with depression, her attempts to overcome it, and her wish that her daughter would not have to struggle with similar problems. According to Melanie, her mother said that this was why she felt so exasperated when Melanie would try to express painful experiences, which previously Melanie understood as her mother trying to talk her out of being depressed. Melanie happily reported that she felt much better after this conversation, and was surprised and pleased by it.

Melanie also informed me that she was "feeling better" and more "in control of her emotions." For Melanie, that was very important. It seemed to me that the Therapeutic Assessment had helped her to begin to come in contact with painful, turbulent and confusing emotions in her daily life and with another person. Previously, she appeared to be trying to ward off her emotional experience through compulsive behaviors, striving for subjugation of troubling affect. At best, this approach temporarily helped her to feel better. While her defensive style was maintained throughout the assessment and follow-up, she appeared more effective at using it. She also appeared to experience her affect as less threatening.

Results:

Hypotheses:

Hypothesis IA: Does the client improve on daily measures of hopefulness/wellbeing? Contrary to what is predicted, Melanie did not show a statistically effect for *hopefulness/wellbeing*

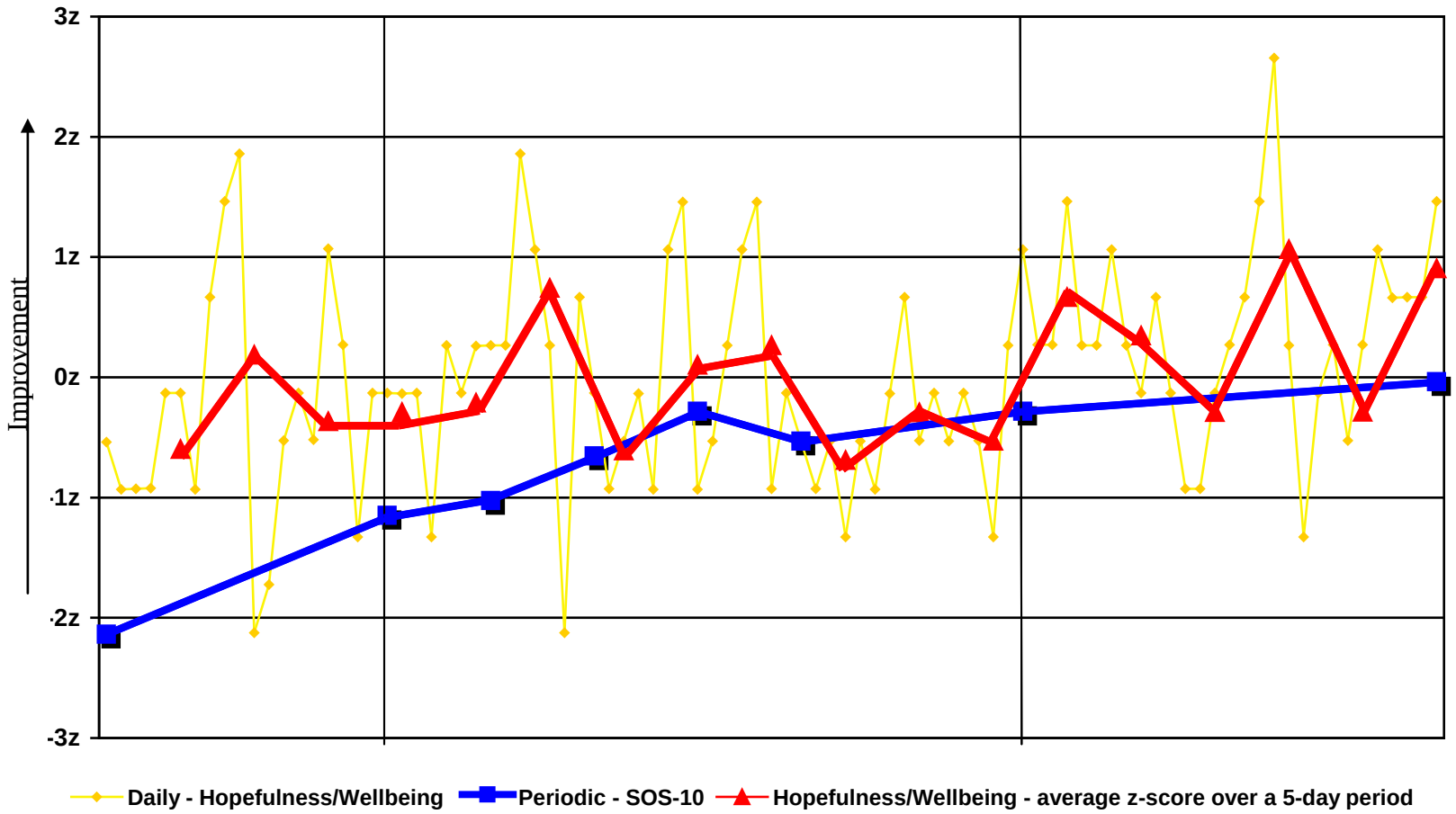
comparing the baseline phase with the intervention phase plus follow-up phase (R=+0.169, p=0.226) (see Figure 7).

Hypothesis IB: Does the client meet criteria for meaningful improvement in the periodic measure of wellbeing? As predicted, Melanie showed a steady improvement in wellbeing across treatment (see Figure 7). Her SOS-10 increased from 30 at the beginning of the baseline phase to 47 at the end of the follow-up phase. According to the Reliable Change Index, this magnitude of improvement is reliable.

Hypothesis IIA: Does the client improve on daily measures of symptoms: Melanie did not show a statistically significant effect for *symptoms* comparing the baseline phase with the intervention phase plus follow-up phase (R=+0.093, p=0.546) (see Figure 8). Because the Pearson's-r is < +0.1, the additional analysis comparing the baseline phase + intervention phase to the follow-up phase was not conducted.

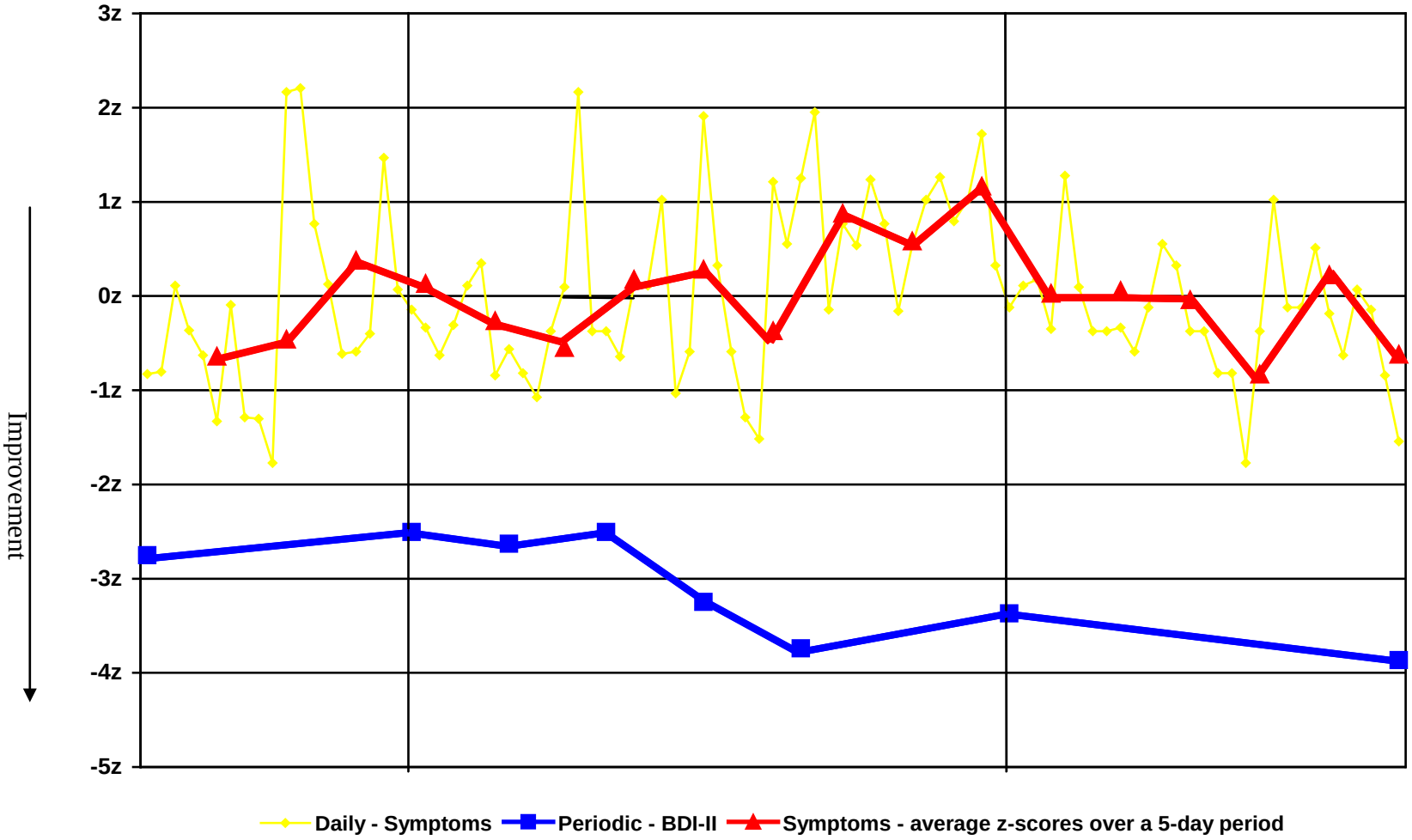
Hypothesis IIB: When compared to baseline, at follow-up does the client meet criteria for symptom improvement on the periodic measure of symptom status: the Beck depression Inventory (BDI-II): As predicted, Melanie showed a clinically significant reduction in the Beck Depression Inventory at the end of the follow-up phase, when compared with the beginning of the baseline phase (see Figure 8). According to the BDI-II classification system, Melanie scored in the "Moderate Depression" range at baseline, and in the "Mild Depression range at follow-up.

Hypothesis IIC: When compared to baseline, at follow-up does the client meet criteria for meaningful improvement on the pre/post measures of symptoms: the OQ-45 Symptomatic Distress Index, the SCL-90 Global Severity Index (GSI), and the SCL-90 Positive Symptom Distress Index (PSDI): Contrary to what is predicted Melanie did not show a meaningful improvement in the three pre/post measures of symptoms. Specifically, Melanie showed a



For Daily Hopefulness/Wellbeing, the values on the vertical axis are the average of the z-scores for the two variables that comprise the composite measure. The Periodic Schwartz Outcome Scale (SOS-10) values are normed z-scores, based on SOS-10 norming data (Young, Waechler, Laux, McDaniel & Hilsenroth, 2003).

Figure 7: Hopefulness/Wellbeing across Phases for Melanie's Daily and Periodic Measures.



For the Daily Symptoms, the values on the vertical axis are the average of the z-scores for the three symptoms that comprise the composite measure. The Periodic Beck Depression Inventory (BDI-II) values are normed z-scores, based on BDI-II norming data (Steer, Ball, Ranieri, & Beck 1999).

Figure 8: Symptoms across Phases for Melanie's Daily and Periodic Measures.

reduction in symptomatic distress on the OQ-45, from 36 to 28. This does not meet the threshold for reliable change that is a reduction in 10 or greater points. Likewise, Melanie showed a reduction in the SCL-90 Global Severity Index (t-score at baseline=59; t-score at follow-up=52) and the SCL-90 Positive Symptom Distress Index (t-score at baseline=53; t-score at follow-up=49). Because neither the pre- nor the post- scores on these indices meets clinical threshold, meaningful improvement cannot be assessed.

Follow-up, Client Satisfaction Measures:

On the Client Satisfaction Questionnaire, Melanie scored a 30 out of a total of 32, reflecting high satisfaction with the services she received.

On the Assessment Questions Rating Form (AQRF), she reported that she was "completely" satisfied with the degree to which three of her four questions were answered. She reported "3" ("4" is equal to "completely") on the question "How is my ADHD related to my depression."

Melanie completed two open-ended questions about her experience of the therapeutic Assessment. In response to the question "*What part(s) of the assessment did you find most valuable,"* she wrote, "The explanations on why I feel the way I do sometimes (I build up a wall for my protection, but the feelings of loneliness and lack of security build up and knock them down). It has helped me understand more how my mind operates so I can better predict when the sad, lonely or panicky feelings are going to come."

In response to the question "*What changes do you think have occurred as a result of the assessment,"* she wrote, "Because I better understand the way my mind works, I have been able to control the bad feelings somewhat. Since I understand what is taking place, I feel like I have better control. I also know, however, that I can't completely get rid of the loneliness and sadness in my current situation."

Post-hoc analyses:

Although there was not a statistically significant effect for *hopefulness/wellbeing* comparing the baseline phase with the intervention phase plus follow-up phase, the direction of difference was toward improvement (R=+0.169, p=0.226). In addition, the periodic measure of *wellbeing* indicates that Melanie showed meaningful improvement. Looking at the graph in Figure 7, it appears as though Melanie showed improvement in *hopefulness/wellbeing* from the intervention phase to the follow-up phase. Considering this information collectively, I decided to investigate whether Melanie improved substantially in *hopefulness/wellbeing* toward the end of treatment, as a result of the Assessment Intervention and Summary/Discussion session, rather than at the beginning of the intervention as I had initially hypothesized. Melanie did, in fact, show a statistically significant improvement in *hopefulness/wellbeing* when comparing the baseline phase plus intervention phase with the follow-up phase (R= +0.282, p=0.043). The change occurred later in the TA than anticipated.

Melanie did not show an improvement in the daily measure of *symptoms.* On the contrary, the direction of difference was toward a worsening of *symptoms* from the baseline phase to the intervention phase (R= -0.175, p=0.320). Looking specifically at the phase means her *symptoms* (distress, feeling depressed, and feeling awful; see Table A-2), she showed a non-significant intensification of all three symptoms from the baseline phase to the intervention phase, and a non-significant reduction in all three symptoms from the intervention phase to the follow-up phase. This unexpected finding could be accounted for by the way in which Melanie manages her emotional experience: by going to great lengths to keep it outside of her awareness. The assessment may have helped Melanie come into greater contact with her emotions, such that she could experience them more consistently, instead of erratically and overwhelmingly. If this

was the case, her increase in *symptoms* may have been an indication of improvement. To test this hypothesis, I looked at the reporting patterns in her daily measures (see Figures 9 & 10). Approximately half way through the intervention phase (identified on Figures 9 & 10 by the line separating phase one and phase two), she appeared to show a less erratic pattern of reporting: less fluctuation, and more patterned change. I looked at the autocorrelation of the data stream before and after this point as a measure of 'patterned-ness' or 'consistency of experience.' Theautocorrelation for *hopefulness/wellbeing* increased substantially from 0.228 in phase one to 0.511 in phase two. There is a similar trend in autocorrelation for *symptoms*: an increase from 0.181 in phase one to 0.411 in phase two.

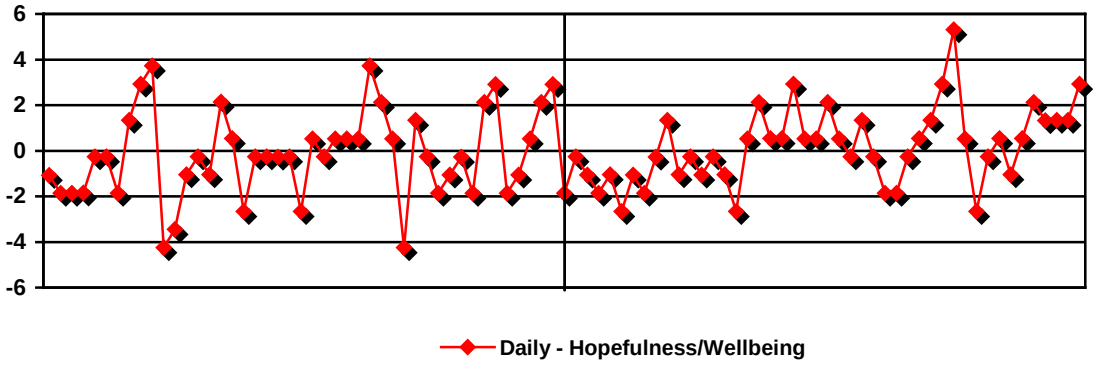


Figure 9: Autocorrelation of Melanie's Daily Hopefulness/Wellbeing

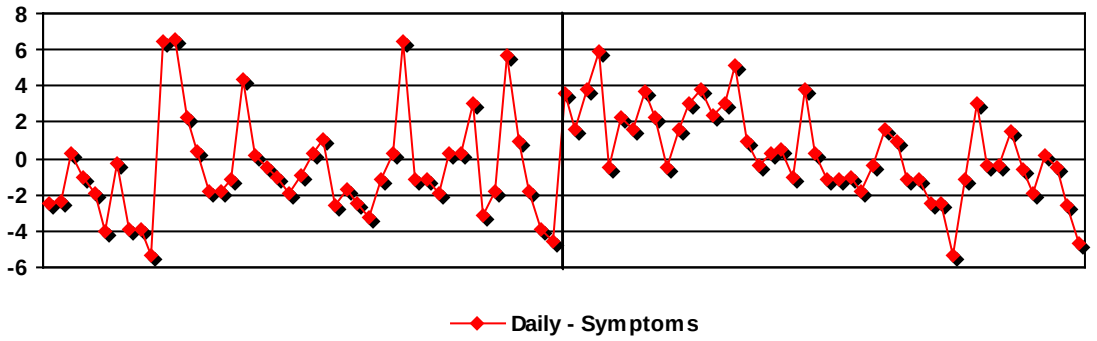


Figure 10: Autocorrelation of Melanie's Daily Symptoms

Chapter Five: Case Two - Randy

Referal:

Randy is a 43-year-old Caucasian male who came to the psychological clinic for an ADHD evaluation at the recommendation and urging of his wife. According to Randy, she was concerned with his low frustration tolerance and difficulty concentrating. He did not believe that he had ADHD, but admitted that he can "easily get off track." In addition to the presenting concern, Randy talked in great detail about his ongoing conflict with his wife and adolescent stepdaughter; he returned to this topic several times during our initial conversation, and this appeared be on the forefront of his mind. Randy had been married to his wife for a couple of years. As he explained his concerns, he appeared very uncomfortable with his stepdaughter's disorganization and irresponsible behavior, and was upset by his wife's parenting approach, which he considered too relaxed and unstructured. Randy also felt his wife and stepdaughter team up against him, and he felt alienated. He believed that he was the "scapegoat" for the family's problems.

Initial Meeting:

Randy arrived to the initial meeting on time, dressed in jeans, a polo t-shirt, and a ski jacket. He wore petite glasses, which he put on and took off frequently. He carried a large portfolio with several well-organized folders and a calendar. He referenced these frequently.

During our discussion, we constructed the following questions that we would explore during the assessment:

1. *Do I have ADHD? Why do I get off track so frequently and lose focus?*

2. *Why does it matter so much to me when I am treated as a villain?*
3. *Why do I get so angry when I am approached with false accusations? Why can't I seem to work things through?*

Regarding the first question, Randy clearly stated that it is his wife who thinks he has ADHD. However, he was open to learning techniques that might improve his overall work productivity. As Randy understood productivity, prioritization of his projects should follow a direct line. Yet for him, it did not; he would easily find himself caught up in the details. As he progressed with a task, the job seemed to get larger and more complex. As a result, Randy felt frustrated and overwhelmed because he never seemed to accomplish enough. He wondered if his behavior was normal. If it was not, he wondered whether there was something that he could do to make his projects move more smoothly.

Regarding the second question, Randy was concerned about why he was so upset "in general" by his stepdaughter's behavior and "specifically" by her attitude toward him. Randy was aware that his stepdaughter's "lack of structure" profoundly agitated him. For example, she would repeatedly forget to do her chores and was not receptive to his suggestions about how she could improve upon this. He experienced himself as "trying to be helpful." He was hurt frequently when she rejected his ideas; he was disappointed that his wife refused to impose structure and enforce discipline. Randy felt like his "sincerity" was fuel for the fire. He believed that it didn't matter what he did, his stepdaughter treated him like a "villain," without reason. This really struck a cord with him, but when he thought about it, he said that he was disappointed with himself that it mattered so much to him.

The third question was an extension of the second question, and focused on Randy's strong emotional response to the experience of being approached with what he considered "false

accusations." I asked him what he felt he was wrongly being accused of. He did not provide specific examples, but felt in general that his stepdaughter treated him like a "bad guy." He felt that his track record was good and consistent, and should not be called into question. I asked him if there was anything that he said or did that seemed to make things better or worse. He appeared genuinely unaware of how his behavior influenced the conflict. As our conversation progressed, he seemed curious about why he was unable to work things through with his wife and stepdaughter, especially when he was angry.

In addition to formulating assessment questions, I gathered some information about Randy's developmental, relational, and work history. He seemed to enjoy discussing his past, and openly provided a lot of details.

Randy described his childhood as "empty." He is the youngest of three brothers, and grew up in a small city. His father was an alcoholic who oscillated in and out of his life. Randy described him as an "adult child," who was "never able to get it together." He would surface periodically and unpredictably throughout Randy's childhood, often physically abusive toward him, his brothers, and his mother. Randy's mother worked "a lot." According to Randy, she had no choice in the matter; she did so to make ends meet. His parents divorced when he was twelve years old. Randy believes that his father "could not accept the reality of the divorce" and would surface periodically, drunk and violent.

Randy recalls that he spent most of his childhood "wandering around." He believes that he was a hyperactive child, but no one noticed. He often slept a few hours a night, but never felt tired. He became motivated by sports as an adolescent after he was encouraged by a friend to play in a summer baseball league and achieved immediate success. He remembers becoming

invested in school, work, and socializing during this time. He proudly boasts of his success, intelligence and popularity.

Randy began to experience problems when he entered college. He recalls feeling overwhelmed by how much was expected of him. He felt unprepared, lacking direction and support. He left school with the intention to return, but never did. He has since worked a range of jobs, primarily in sales and technical support. He has never been able to stay at one particular job for much time. He described a variety of reasons for terminating work, most having to do with disagreements with his superiors about how the work should be done and/or how the business should operate.

Randy's father died several years ago; Randy reported feeling indifferent about this. He continues to stay in frequent contact with his mother and brothers. He is disappointed by how his brothers live their lives. He believes that they are jealous of his accomplishments and this is a source of tension between them.

Randy has been married three times, for relatively short periods of time. He reports that his relationship with his wife has its ups and downs, but describes her as very supportive. He has a few distant friends who he contacts periodically, but does not have close friendships.

Testing Sessions:

WAIS-III: Randy appeared anxious at the onset of the IQ test. He said he considered himself to be smart, and was afraid that he the test might disprove this.

The test indicated that Randy is functioning in the Average Intelligence Range (Full Scale IQ = 109; Verbal IQ = 113; Performance IQ = 104). His Full Scale IQ falls on the border between the Average and High Average Range (High Average Range $\geq$ 110). His Verbal IQ falls

solidly within the High Average Range. His Performance IQ falls solidly in the middle of the Average Range. The Subtest Scaled Scores of the Verbal and Performance IQ shed light on this discrepancy. For the most part, Randy scored consistently well across the board. His Subtest Scaled Scores ranged between 10-13. The exception to this was Comprehension on which he scored 17. This test loads onto the Verbal IQ and contributes to why Randy's Verbal IQ is higher than his Performance IQ.

High Comprehension Subtest Scores are often closely related with Crystallized Intelligence, reasoning abilities, knowledge of conventional standards of behavior, demonstration of practical knowledge, and overtly concrete thinking (Kaufman & Lichtenberger, 1999). Consistent with this description, Randy knows rules and conventions very well. He prefers life to be concrete, and functions very well when right/wrong and good/bad can be defined and agreed upon.

A few additional WAIS-III findings are worth noting: Although Randy's Performance IQ was lower than his Verbal IQ, his highest Index Score was Working Memory (108), which is not typical of an ADHD population. His lowest Index Score was Processing Speed (99). This could be accounted for by a few variables. Despite coming to the correct response, Randy lost points on tasks like Block Design because he took a lot of time to respond. He appeared flustered and frustrated when his initial strategy did not succeed. At one point Randy commented, "I wish I wasn't making this hard." When I asked him about this after the administration, he said that he was mindful of the time, and concerned about the impact that his trial and error approach would have on the time. This made him anxious and less able to perform.

On simple response tasks, Randy lost points for impulsively responding too quickly. He appeared to answer before he finished a thought. In some cases, he would realize that the answer

was wrong when his mind caught up. In other cases, he appeared very attuned to subtle interpersonal cues (i.e. facial expressions, how I recorded each response), and used this information to gauge whether his response was correct or not.

After the administration, Randy reported that when he finished a question, he was "over it" and onto the next thing. On tasks with a follow-up inquiry component, such as vocabulary or comprehension, he was confused by questions such as "Explain what you mean," because he did not stay on task while I was recording his initial response. In response to open-ended questions about his experience, Randy appeared to be concerned about explaining why he did not do well on certain tasks (those that he identified as doing poorly on). Remarkably, he clearly remembered several of the questions that he was unable to answer. Between meetings, he researched the answers and reported them back to me. Although he was "over it" and had moved on in the moment, in the long run, he was very critical of his performance and could not seem to let go.

Additional ADHD assessment: Randy took the Test of Variables of Attention (TOVA) to more thoroughly investigate whether he has ADHD. He scored well within normal limits (ADHD Score = 1.51; A score below -1.80 fits the profile of an ADHD sample). Although not instructed to do so, he kept track of the number and type of errors he made. In addition to scoring extremely well on the test, he correctly identified his mistakes.

Randy reported that he was anxious at the start of the test. He stated that the stimuli were flashing on the screen very rapidly, and he did not know what was going to happen. He attempted to organize the flashing stimuli into a pattern; he would make mistakes when he thought he knew what the next stimulus would be (given the task, he could not possibly know).

While discussing this, Randy stated that he doesn't "adjust well to changes." He prefers his life to be predictable. He was organized around organizing.

Randy noted that he felt at ease within a few minutes of beginning the TOVA. When his anxiety diminished, he noticed that his mind started to wander. He told me that when he is not anxious, he becomes distracted. I suggested that despite this happening, he was still able to successfully persist. He told me that he was functioning on "autopilot;" he was doing the task, but his mind was reeling over his plans for later that afternoon. From his description of this experience, he was either very anxious or cognitively checked out.

Randy hypothesized that he gets bored with routine tasks; without a challenge he eventually loses focus. He related this to his trouble keeping the same job for an extended period of time. He suggested that when he is doing mundane work, he gets bored and he begins to understand better ways to do the job. He has noticed that sharing these ideas can often "rub others the wrong way," and lead to conflict with bosses and coworkers. I focused on the conflict that this creates and suggested that it might relate to the problems he experiences with his wife and stepdaughter. He agreed that he likes to do and to have things done "his way." He also agreed that others were often not very receptive to this.

Rorschach: Randy expressed hesitation at the start and demonstrated uneasiness toward the end of the Rorschach administration. He stated that when he took the IQ test, he knew when he was right and when he was wrong. He could easily reference information to confirm or disconfirm his responses and preferred this. He experienced the ambiguity of the Rorschach to be "uncomfortable." The test sheds some light on why this may be (see Figures 11 & 12).

Sequence of Scores

Card	Resp No.	Location and DQ	Loc No.	Determinant(s) and Form Quality	(2)	Content(s)	Pop	ZScore	Special Scores
I	1	Wo	1	F+		A	P	1.0	
	2	W+	1	FY.FD.Ma+		H,Cg,Ad		4.0	GHR
II	3	Ddo		FV-		Ad			
	4	DSo	5	mao		Sc		4.5	
	5	Do	6	FMao	2	A	P		
	6	Do	3	Fo		A			
III	7	D+		Ma.FC.FY.Fr-		Hd,Ad,Cg		3.0	INC2, PHR
	8	Do	2	F-	2	Sc			PER
	9	DS+		FY-		(Ad),Cg		4.5	
	10	Do	9	Ma.Fr-		Hd,Ad			PSV, INC2, AG, PHR
IV	11	Wo	1	FMa.Fr.FC'-		Ad		2.0	
	12	Wo	1	FMa+		A		2.0	DR
V	13	Do	4	FMa-	2	Ad			CONTAM
	14	Wo	1	FMp.FDu		A	P	1.0	DV
	15	Do		YF.Fr-		An			
	16	W+	1	Ma.FDo		H,Cg		2.5	GHR
VI	17	Wo	1	FC'.mp+		Ad	P	2.5	PER
VII	18	W+	1	Ma.Fru		H,Cg		2.5	PER, ALOG, PHR
VIII	19	W+	1	FMao	2	A	P	4.5	
	20	Wo	1	CFu		Sc		4.5	
	21	Wo	1	CF-		Art		4.5	
IX	22	W+	1	FC.ma-		A,Sc		5.5	FAB2
X	23	W+	1	FC.mp-		A,An		5.5	ALOG

Summary of Approach

I : W.W	**VI :** W
II : Dd.DS.D.D	**VII :** W
III : D.D.DS.D	**VIII :** W.W.W
IV : W.W	**IX :** W
V : D.W.D.W	**X :** W

Figure 11: Randy's Rorschach Sequence of Scores Report

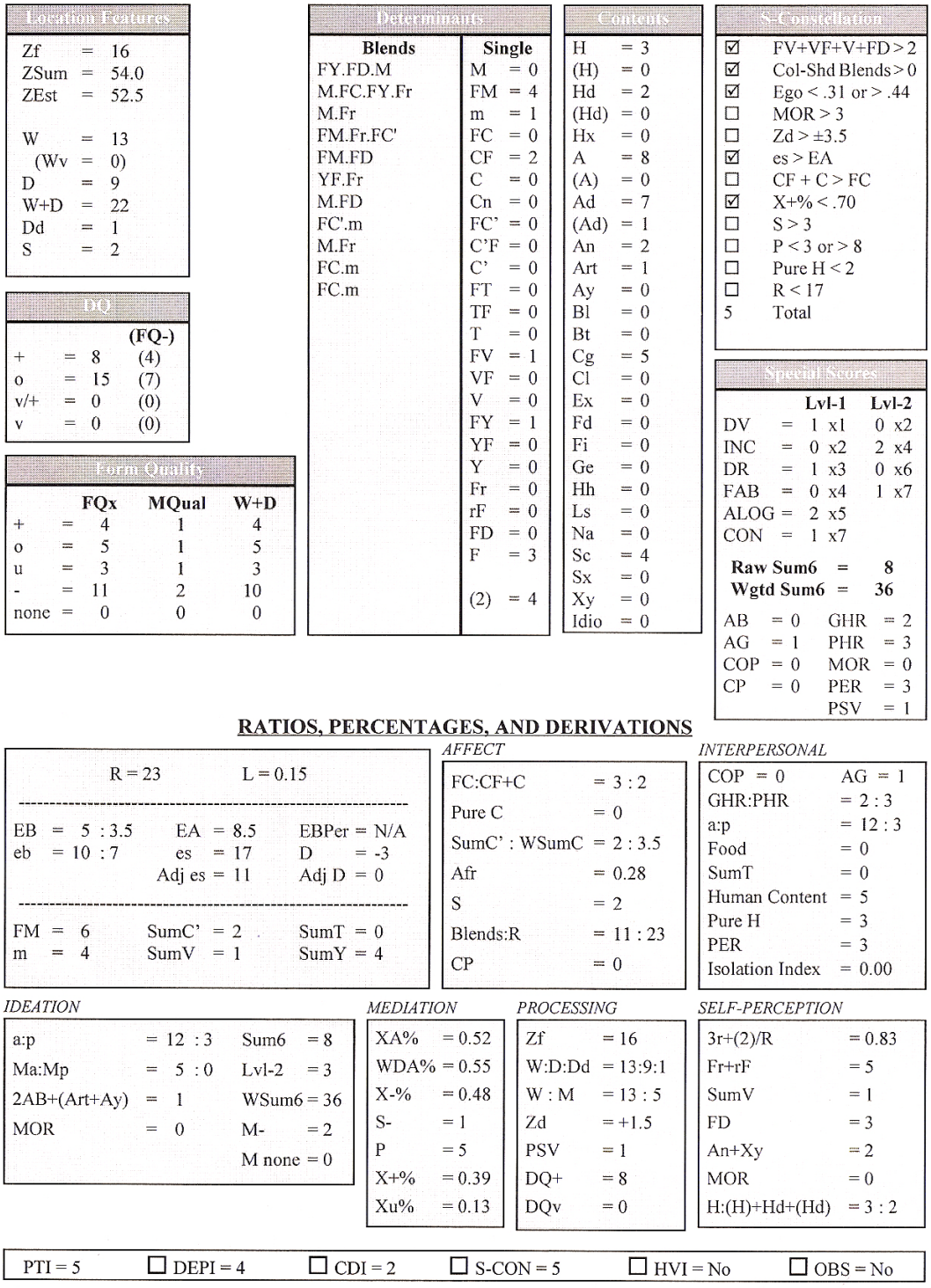


Figure 12: Randy's Rorschach Structural Summary

Randy's Structural Summary Report indicated that when he is faced with a less concrete task, he is susceptible to strained reasoning, flawed judgments, and using logic that clearly violates reality (Wsum6 = 36, Norm = 7.08± 5.35; CONTAM=1, Norm = 0.00). Randy scored positive for all five criteria of the Perceptual-Thinking Index, indicating that he experiences difficulty with thinking. His problems with thinking were pronounced when he saw aggressive content, and might contribute to why he experienced difficulty working through problems with his wife and stepdaughter when he is angry.

In addition to these problems with thinking and reasoning, Randy showed an ambitent coping style and a low Lambda (L = 0.15, Norm = 0.61±0.38). This may indicate that he has a variable and unreliable coping style. People with these features are more likely to reverse previous judgments, profit less from problem-solving errors, and often require more time to reach effective solutions. They take more time and effort to meet the demands of daily life. This finding connects with Randy's complaint that he can often be ineffective at prioritizing and accomplishing tasks at home and at work.

Randy gave several reflection responses (Fr+rF = 5, Norm = 0.26±0.81), which placed him well above the norm. Reflection responses relate to features of a narcissistic personality, including the tendency to value oneself highly, have exaggerated self-worth, and need frequent reaffirmation and reinforcement.

Randy produced a psychologically complex record, which is often the case with intelligent people (Blends = 11, Norm = 5.55±2.72; Blends/R = 0.48, Norm = 0.24±0.11). However, this can also reflect stress, unfulfilled needs and unresolved conflicts. Additionally, he met four of seven criteria of the Depression Index. This does not meet the threshold of five criteria, but suggests that Randy may struggle with underlying depressive affect.

After the test, we talked together about his discomfort with the test. As far back as he could remember, he said, he has always preferred to stick with what is known. I asked him what was so uncomfortable about ambiguity. He said that he did not know, but thought that it probably had something to do with his childhood. He shared several thoughts about this: As a child, he had little structure, was rarely supervised, and was left to figure things out for himself. His father's behavior was violent and unpredictable; he never knew when his father would be upset and how angry he would be. He recalled that when he was in diapers, he would repeatedly walk around the perimeter of his yard, mapping out the boundary. I commented that maybe when things are known and defined for him, he could experience life as more predictable and safe. He said that he had never thought about it that way, but found that talking about it was helpful.

Additional Projective Assessment***:*** We used the *Bender-Gestalt* test next because Randy's presenting concerns involved difficulty with planning, organizing, and executing tasks. The Bender cards were placed face down in a pile in front of Randy and turned over one at a time. He was instructed to copy them as best he could onto the paper that was placed in front of him.

Randy started copying each card immediately after it was presented before him (see Figure 13). He often needed to accommodate the size and shape of the figures to fit on the page with the other figures because he did not do much planning on the forefront. He paused periodically to count the number of dots, etc., and often did so more than one time. He appeared rushed even though there was no concrete evidence or cues that time was a consideration. Several of his copied items were much larger than the Bender figure itself.

After Randy completed this step, the cards were again placed in a pile in front of him and he was instructed to do this again, but to change the figures in any way he wanted to change

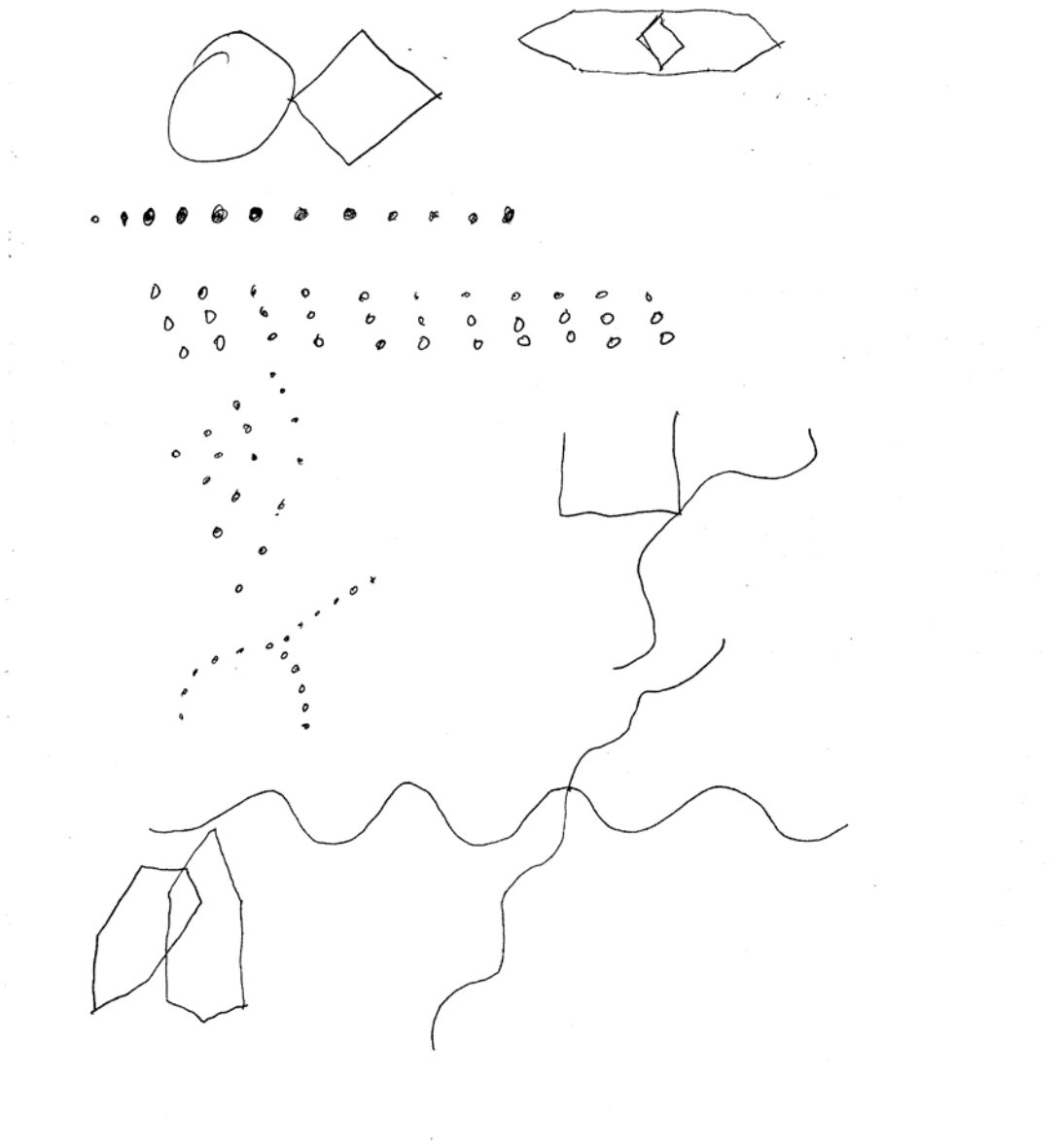


Figure 13: Randy's Bender Gestalt – Part I

them (see Figure 14). He told me that his objective in doing this was to “compartmentalize them.” After the test, he said that he had rearranged the figures the “right way.” Given the nature of the task, I suggested that there was no way to be right or wrong. He pointed to the drawings labeled ‘a’ and ‘b’ in Figure 14 and described how he arranged the wavy lines according to the mathematical concepts of ‘sine’ and ‘cosine.’ He commented that he took a slightly different approach on ‘c’ and chose to arrange the picture so that it was aesthetically pleasing. He drew ‘d,’ however, to show how a “wire” on the top of a “box” would look like in its “natural state.”

He compared his reasoning process to math, stating that “in math you come to an absolute; when you have an answer, it is because you did it right.” By using this approach, he said that he was comforted by the assurance that he would come to the same answer if he took the test at a later point in time. I told him again that the task was subjective; there was no absolute, no mathematical equation. He laughed and said, “Maybe this is why my wife thinks I am so crazy.” I asked him to tell me more about this. He gave an example of mowing his lawn: He can’t begin until he decides which pattern is best. To decide what pattern is best, he tries to calculate which pattern would use the least amount of fuel and take the least amount of time. He anxiously laughed and said, “Maybe I should just mow the lawn.” I asked him why he doesn’t just mow the lawn. He said with strong affect, “If I worked very hard on something and realized that another person did not think it was good, it would be awful.” I asked him what would be so awful. He said, “it would be too personal.” I said, “ So you do this to avoid being criticized and hurt.” He told me a story about several unique gift boxes he made out of wood, which his wife filled with potpuree that she grew in their garden. They received several complements from neighbors and friends. I commented that when he was personal, the outcome could be positive.

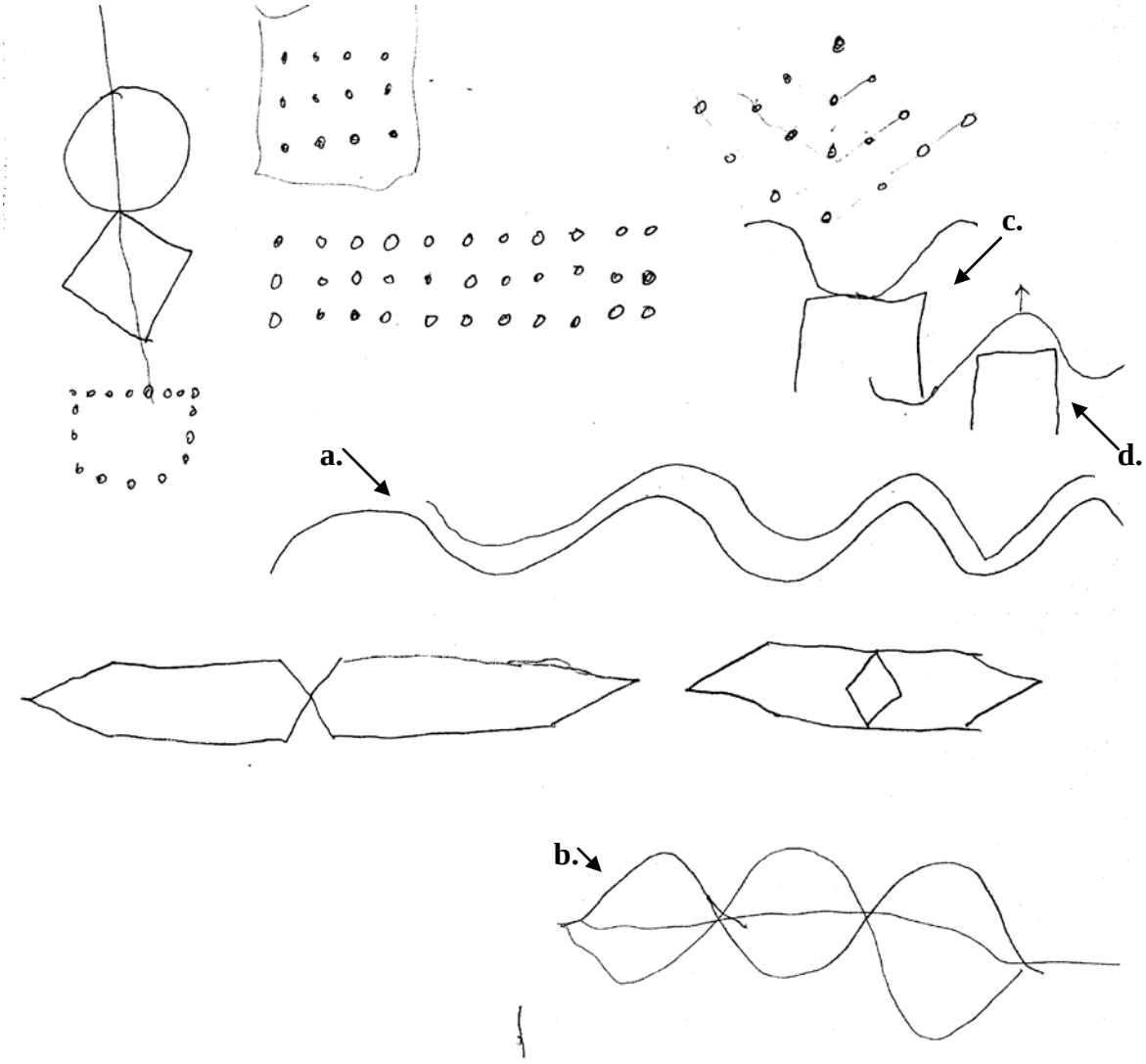


Figure 14: Randy's Bender Gestalt – Part II

I asked Randy why he rushed through the test, and pointed out that he told me it takes him a very long to complete a task, such as mowing his lawn. He said that he was worried about the time. I told him that there was no limitation on the time. He thought about this for a moment, and said that he has learned from past job experiences that he tends to take longer than others to complete his work. He said he prefers to do a job thoroughly and well, but often feels that he must compromise performance to get a job done quickly. He began to critique his drawings as an example of this, so I asked him if he wanted to try again with one card, but this time he could put as much time and effort into it as he felt was necessary. He drew the picture in Figure 15. He took less than a minute to complete it. He began to critique his drawing and compare it to the one on the card. He counted dots and made hypotheses about how and why they did not look the same. This lasted for about ten minutes. He began to explain these ideas to me, and concluded that he would need drafting tools or a special computer program to assist him. I asked him if his projects at home become increasingly complex like this. He said yes, but also indicated that if he had access to additional tools he would eventually do a very good job.

Adult Attachment Projective and Early Memories: Because Randy expressed concerns about his relationships, I asked him if he would be open to additional emotional testing that might shed more light on these concerns. I used the Adult Attachment Projective (George & West, 2001), and asked Randy to tell a story about each card that had a beginning, middle and end, and included what the character(s) was thinking and feeling. He produced several evocative stories, each with unresolved emotional/relational conflict. He told the following story about a card with a picture of a child standing in a corner with hand and arm extended outward:

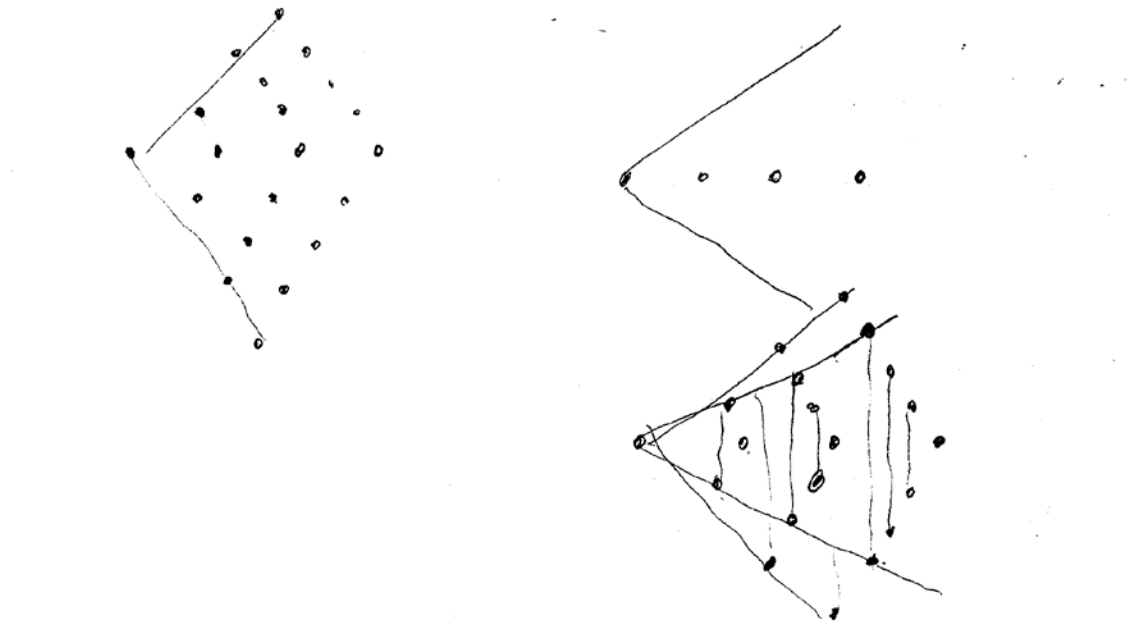


Figure 15: Randy's Bender Gestalt – Part III

> This young person is backed into a corner. He maybe is not so afraid but is so disapproving of what is in his presence that he is backing away. He has seen enough and doesn't want to see anymore. It looks like he has been confronted with it enough. He has been backed into a corner. I would imagine that he wants to escape. He has lots of rambling ideas going through his head. "Why can't this stop?" "How can I make this stop?" His parents are not getting along. He is not liking what is going on.

In response to another card with a youth sitting alone on a bench, Randy gave the following story:

> Something has gone wrong, whether a single or several incidents. It is a picture of disappointment or sadness. Closed posture – someone is sad, hiding from the world, shut down, giving up. Sitting right in the middle of the bench, you could read into that – "I am taking up the bench, don't want company now" - the look of trying to get away from a current mood. Hopefully a friend will come by and help this person out of a mood of despair. It would have to be a friend, because this person would probably take some help. They would want to stay in this mood.

In both stories, Randy comes to no resolution of the concerns he describes. In the first story, the boy is backed into a corner. He doesn't like what he is seeing, but doesn't know what to do about it. In the second story, the youth remains in a continual state of despair, and cannot move on without the aid of another person. Randy has several emotional conflicts and does not believe that there is a resolution.

Interview with Randy's Wife:

Randy and I decided to schedule a meeting his wife, Christy. She had initiated the assessment, and Randy had expressed some confusion about what she was concerned with. We thought that this was a good idea because several of Randy's difficulties, concerns, and assessment were interpersonal in nature. It was helpful to see how Randy interacts with his wife.

Christy initially stated her reasons she thought he had ADHD. She felt that he has trouble staying on track. She stated he shows an intolerance of boredom and a quickness to become bored with anything routine. He is irritable. He is intolerant of frustration and has difficulty working through frustration. Interpersonally, Christy believes that Randy reacts greatly to small things. She expressed to her husband in the meeting that she felt she could not "disagree about the smallest thing without it escalating to a big fight."

At one point in the conversation, Christy said that Randy doesn't fight fair. She shared an association between his approach to conflict and demolition. She suggested that he puts out a fire by creating a huge explosion. Randy responded obstinately by stating, "It does work, by the way." He repeatedly reiterated the point until she agreed with him that, in fact, this was a viable solution to dealing with the problem. Afterward, she expressed her concern they were not able to learn anything from their conflict. This seemed to be an accurate assessment, given their prior interaction. Randy, however, stated that he wanted to be able to have a logical and accurate dispute, which was where he felt he was coming from. Christy asked him whether he was listening or just trying to defend himself. Randy was silent, with no response.

Christy and Randy discussed how they understand the nature of their ongoing conflict with and about their daughter Abby. Christy believed that Randy was so irritated by Abby because his problems are very similar to hers. Randy said that he did not like the way Abby treated him. They both pinpointed several arguments that led up to Abby treating Randy as the "villain." Christy believed the rupture occurred when Randy became very angry with her and yelled at her in a berating and belittling manner. He appeared to treat this as an even-handed disagreement between him and Abby, even though Christy repeatedly emphasized that she was a child and he was an adult.

The meeting ended with Christy acting maternal toward Randy. She expressed sadness about the challenges that he experienced in his early life, and her hope that his life could be easier if he worked though some of his emotional difficulties. Randy responded well to this.

Assessment Intervention Session:

Based upon the information we gathered it became obvious that Randy has a great deal of difficulty tolerating ambiguity and struggles with several unresolved emotional conflicts. Together this creates a lot of difficulty for him in relation to others. Randy's cognitive resources are consumed by putting order into his life, work, and relationships. He prefers to understand things in terms of black/white, right/wrong, and good/bad so that he can be assured that he has come to the right decision. Order helps him to manage anxiety by making the world more understandable, manageable, and predictable. Believing that he is "right" prevents him from feeling criticized and hurt.

Randy's need to be "right," however, appears to be very problematic in the following ways: He often distorts reality and uses extremely strained logic to accomplish this goal. He is in frequent conflict with his family, co-workers, and friends. The Assessment Intervention was designed to bring this experience into the room, so we could talk about this further.

I began by talking with him about a Rorschach response on Card V, on which he produced a CONTAM special score: "It looks like alligator heads on a wingtip or winglet. It looks like a long mandible movement." I read him the response and asked him what he thought of it. He responded by adding some additional description and detail to his percept. As I began to point out the problems with his response, he became increasingly defensive. For example, when I suggested that he had combined two things that are separate into one, he told me that he likes to

look at the big picture and that this was “the better approach.” I asked him why he was so adamant about justifying his response. He said that he didn’t like that I was insinuating that he has a problem. I asked him what it meant to him to have a problem. He said that it would mean “there is something wrong with me.” I asked him if he felt shame. He nodded. I suggested that this might be why he became so angry when he was approached with accusations by his stepdaughter and wife; maybe he experienced them as telling him he was wrong or bad and to prevent from experiencing shame, he fought against it. He agreed.

I then showed Randy a video clip of the interview with him and his wife, during which he evaded her concern that he “doesn’t fight fair” by concretely disputing the accuracy of a metaphor that she used to describe her experience. He laughed when he saw this. I asked him what he thought was funny. He began to justify why he said what he did.

I told him that it seemed to me like he was trying to win a fight, trying to be right in anyway possible. He disagreed and said that he was trying to encourage accurate and logical communication between himself and his wife. I asked him what his wife was communicating. He was stumped and silent for several seconds. He humbly said that he did not know. I suggested that if he heard what his wife was telling him, it might be painful, like when I was telling him that he had some problems on the Rorschach. He seemed to take this in, but quickly transitioned into telling me that his wife also had some problems. I said that it might be easier to hear his wife’s concerns with him if he kept in mind that she, like all people, also has problems.

Summary/Discussion:

I began the session by asking Randy how things were going. He voluntarily talked for quite a while about the ongoing problems in his life. He seemed to be consolidating and

organizing what we had talked about during our meetings. I noticed the ways in which his story had changed since the initial meeting: Randy spoke more about himself and his emotional experience in the context of his interactions with his wife and stepdaughter. He seemed to have some insight, an intellectual understanding of how his actions can affect the responses he receives from others. This is in contrast to the experience he described of being a "scapegoat" for the problems of his family. For example, he expressed things like "the unknown isn't something that I really like" and "there are certain times that it is hard to convince me of something other than what I am thinking."

Listening to what he said, I also wondered if he was expressing anxiety about receiving feedback. I also considered that he may be trying to anticipate what the feedback might be, and tell me before I could tell him. This would be consistent with how he deals with his anxiety.

I then shared with Randy some of the ideas I had about his questions. I tried to integrate as much of what he said, in his specific words, with what I had prepared to discuss with him. I found that this seemed to ease his anxiety and allow him to be more "tuned in" to our discussion and receptive to what I had to share.

I told him that I did not think that he had ADHD, but I emphasized that I still thought he struggles substantially with organizing and executing work. I referenced our conversations about the Bender-Gestalt, and suggested that he has a lot of difficulty finishing a task because the task itself becomes increasingly more complex as he gets going. He seemed to agree with this and we talked about things that he has done successfully and can do to get back on track when he recognizes this experience. I also shared with him that the testing indicated that this happens with his thoughts as well. Randy agreed. We talked about the several things Randy has already done to stay organized, such as keeping written records and schedules.

Next, I responded to his questions, “Why does it matter so much to me when I am treated as a villain,” Why do I get so angry when I am approached with false accusations,” and “Why can’t I seem to work things through?” I referred back to our discussion during the assessment intervention, and suggested that when he encounters criticism or someone insinuates that he has a problem, it is very painful. I also referenced his comment earlier in the session that he does not like the unknown, and suggested that when he is faced with information that is in conflict with how he views himself, it introduces ambiguity. When he encounters this, I told him, I think he gets very angry and defensive; and similar to the video clip we watched with his wife, this interrupts his ability to listen and hear what another person is trying to say. I suggested that in order to work things through with his wife and stepdaughter, he would need to try to understand what they were saying. He agreed with me that when he was angry, both he and his wife were less able to communicate. He also hypothesized that he could be more receptive at times when there was less stress in his household, such as when his stepdaughter was staying with her father for a few days. He proposed talking with his wife at these times. I encouraged him to give this a try, but also suggested that long-term therapy can also help with him with this.

As we ended the meeting, Randy reflected on the TA and stated that although he had been very concerned with the time expense of our meetings, in terms of his reduced productivity with household responsibilities, he was going to miss coming.

Follow-up:

I had a difficulty getting into contact with Randy to schedule the follow-up session. When we did eventually speak, he reported that his work schedule had changed, and he was having a hard time adjusting. During the meeting, Randy reported that he was doing better. He

was getting along better with his wife, and felt that they were getting better at working through conflict. He reported that he was taking a hands-off approach from his stepdaughter, and felt that it was working better for both of them. He referenced his daily measures and said that I would notice that he had been feeling better about himself and about life in general.

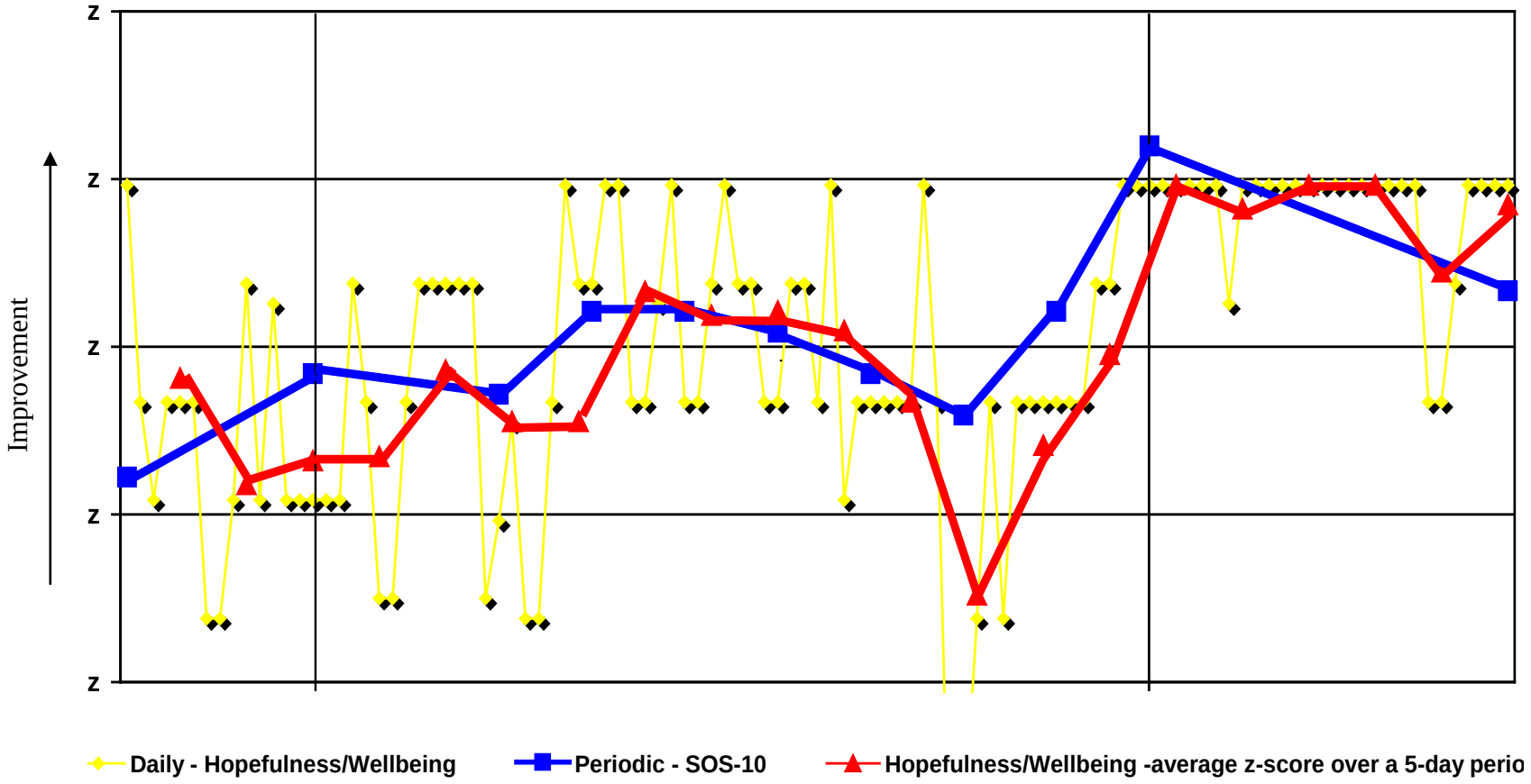
Randy talked about a few examples of times that he wanted to help Abby but refrained because he felt that she would not respond well. I commented that it is very hurtful to him when that happens. He agreed. He said that his job was going well because in customer assistance, he could troubleshoot and give helpful advice that others were appreciative of. We both agreed that this job was well suited for him. He said that his new approach with Abby was not ideal because he often felt very distant from his wife and stepdaughter. However, he said that it was the best he could do at this point in time. I suggested that longer-term therapy could be a useful tool in helping him with this. He agreed to give it a try because he had found the TA to be beneficial.

Results:

Hypotheses:

Hypothesis IA: Does the client improve on daily measures of hopefulness/wellbeing? Contrary to what is predicted, Randy did not show a statistically effect for *hopefulness/wellbeing* comparing the baseline phase with the intervention phase plus follow-up phase (R= +0.229, p=0.230) (see Figure 16).

Hypothesis IB: Does the client meet criteria for meaningful improvement in the periodic measure of wellbeing? As predicted, Randy showed an improvement in wellbeing across treatment (see Figure 16). His SOS-10 increased from 41 at the beginning of the baseline phase



For the Daily Hopefulness/Wellbeing, the values on the vertical axis are the average of the z-scores for the two variables that comprise the composite measure. The Periodic Schwartz Outcome Scale (SOS-10) values are normed z-scores, based on SOS-10 norming data (Young, Waechler, Laux, McDaniel & Hilsenroth, 2003).

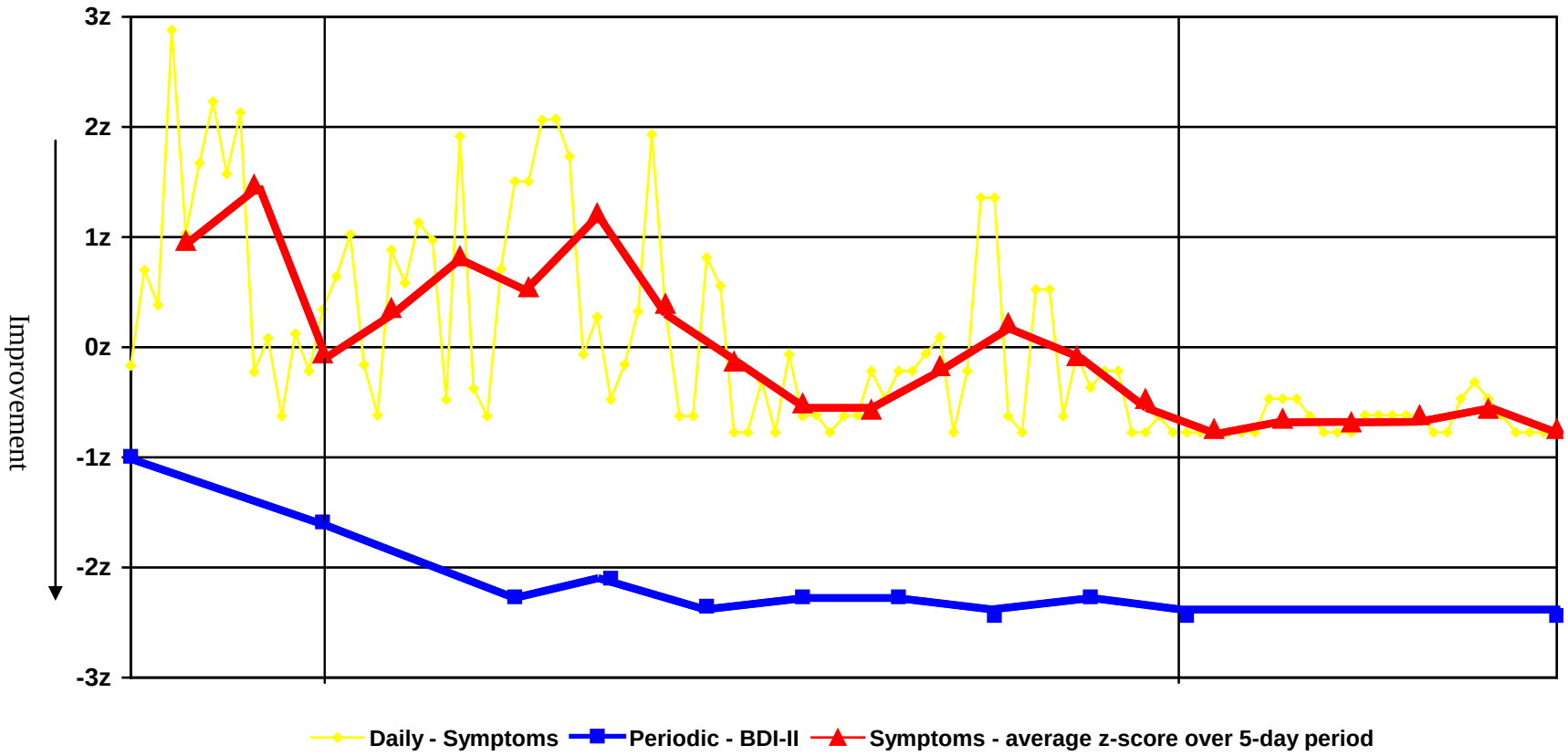
Figure 16: Hopefulness/Wellbeing across Phases for Randy's Daily and Periodic Measures

to 50 at the end of the follow-up phase. According to the Reliable Change Index, this magnitude of improvement is reliable.

Hypothesis IIA: Does the client improve on daily measures of symptoms: Randy showed a statistically significant effect for *symptoms* comparing the baseline phase with the intervention phase plus follow-up phase (R= +0.363, p=0.037) (see Figure 17). Because the Pearson's-r is > +0.1, the additional analysis comparing the baseline phase plus intervention phase to the follow-up phase was conducted. Randy showed a statistically significant effect for *symptoms* comparing the baseline phase plus intervention phase to the follow-up phase (R= +0.449, p=0.013) (see Figure 17).

Hypothesis IIB: When compared to baseline, at follow-up does the client meet criteria for symptom improvement on the periodic measure of symptom status: the Beck depression Inventory (BDI-II): As predicted, Randy showed a clinically significant reduction in the Beck Depression Inventory at the end of the follow-up phase, when compared with the beginning of the baseline phase (see Figure 17). According to the BDI-II classification system, Randy scored in the "Mild Depression" range at baseline, and in the "Minimal Depression range at follow-up.

Hypothesis IIC: When compared to baseline, at follow-up does the client meet criteria for meaningful improvement on the pre/post measures of symptoms: the OQ-45 Symptomatic Distress Index, the SCL-90 Global Severity Index (GSI), and the SCL-90 Positive Symptom Distress Index (PSDI): Contrary to what is predicted, Randy did not show a meaningful improvement in the three pre/post measures of symptoms. Specifically, Randy showed a slight reduction in symptomatic distress on the OQ-45, from 26 to 24. This does not meet the threshold for reliable change that is a reduction in 10 or greater points. Likewise, Randy showed a reduction in the SCL-90 Global Severity Index (t-score at baseline=54; t-score at follow-up=42)



For the Daily Symptoms, the values on the vertical axis are the average of the z-scores for the three symptoms that comprise the composite measure. The Periodic Beck Depression Inventory (BDI-II) values are normed z-scores, based on BDI-II norming data (Steer, Ball, Ranieri, & Beck 1999).

Figure 17: Symptoms across Phases for Randy's Daily and Periodic Measures

and the SCL-90 Positive Symptom Distress Index (t-score at baseline=49; t-score at follow-up=42). But because neither the pre- nor the post- scores on these indices meets clinical threshold, meaningful improvement cannot be assessed.

Client Satisfaction Measures:

On the Client Satisfaction Questionnaire, Randy scored a 31 out of a total of 32, reflecting high satisfaction with the services he received.

On the Assessment Questions Rating Form (AQRF), he reported that he was "completely" satisfied with the degree that all his of three questions were answered.

Randy completed two open-ended questions about his experience of the Therapeutic Assessment. In response to the question "*What part(s) of the assessment did you find most valuable,"* he wrote, "I think that at times I diverged into a stream of conversation that brought out issues that were troubling; that I was not aware of the impact that it had on me." In response to the question, "*What changes do you think have occurred as a result of the assessment,"* he wrote, "I feel that I am now more able to assess things that are troubling me and deal more easily and positively in response."

Post-hoc analyses:

Although there was not a statistically significant effect for *hopefulness/wellbeing* comparing the baseline phase with the intervention phase plus follow-up phase, the difference was in the direction of improvement (R= +0.229, p=0.230). In addition, the periodic measure of *wellbeing* indicates that Randy showed meaningful improvement. Looking at the graph in Figure 17, it appears as though Randy showed considerable improvement in *hopefulness/wellbeing* from the intervention phase to the follow-up phase. Specifically, during the follow-up phase his rating of *hopefulness/wellbeing* is much more consistently positive than during the baseline and

intervention phases. Considering this information collectively, I decided to investigate whether Randy improved substantially in *hopefulness/wellbeing* toward the end of treatment, as a result of the Assessment Intervention and Summary/Discussion session, rather than at the beginning of the intervention as I had initially hypothesized. Randy did, in fact, show a statistically significant improvement in *hopefulness/wellbeing* when comparing the baseline phase plus intervention phase with the follow-up phase (R= +0.539, p=0.002). Like Melanie, the change occurred later in the TA than anticipated.

Chapter Six: Case Three - Mark

Referral:

Mark is a 46-year-old man, who was referred for a psychological assessment and treatment. He had been seeing a counselor for several months, and was referred to our clinic to continue with his treatment. He reported ongoing problems with anger and depression. Mark requested an assessment to better understand the nature of his problems and how to go about working with them. He appeared very enthusiastic to participate in the study because it fit well with what he was looking for.

Initial Meeting:

Mark appeared anxious during the initial meeting, but was open and descriptive about what had brought him for treatment. He oscillated between talking about his problems on an intellectual/reasoning level and expressing intense resentment about the circumstances of his life and relationships. These two experiences seemed disconnected.

During our discussion, we constructed the following questions that we would explore during the assessment:

1. Why can’t I seem to catch an even break?
2. Why do things seem to get to me so much?
3. Is there something wrong with the way that I am coping with things/thinking about things that is contributing to my symptoms? How do I go about changing this if there is a problem?
4. What interferes with my ability to have solid/stable relationships?

5. What the heck do I want to do with my life? What am I well suited for? Why is it so hard to find what I am well suited for?

Regarding the first question, Mark stated that he wants to have a full life, but that he felt in limbo and not able to attain this. He expressed the desire to have a stable job, to be married, and to have children. He was upset that he had not achieved this at this point in his life. Instead he was living with his parents, unhappy with his job, and in a long-term relationship that was "on hold." He focused heavily on the situational circumstances that contribute to why this is so.

Regarding the second question, Mark reported that he is sad most of the time, and feels things very deeply. He experiences depression, and commonly feels helpless, out of control, and as though he has "no say in anything." He reported excessive anger control problems and severe OCD-like symptoms. However, these problems and symptoms appear to have more to do with his internal experience of anger and anxiety than his actual behavior. He reported being angry driving a car or at work and that "incompetent people" upset him. He expresses anger through road-rage, snideness, and sarcasm. Mark defined his OCD-like symptoms as checking his alarm clock several times to make certain that it is set correctly.

Regarding the third and fourth question, Mark was very concerned about an ongoing romantic relationship. He had dated a woman for several years, and generally felt that "she did not meet his needs." She had asked him for a several month hiatus with limited contact so that she could decide how she felt about their relationship. Mark had agreed to this but was very frustrated and resentful.

For the most part, he discussed the relationship in a very evaluative and intellectual way. Using specific instances of behavior, he asked me directly whether she was "healthy." He appeared frustrated when I told him that I could only help him to understand himself better.

Although his third and fourth question seemed self-reflective, he appeared to understand his problems as originating outside of himself and wanted me to help him figure out what was going on with this woman and decide what to do next.

He described a series of long-term relationships (each lasting several years), which ended in disappointment. He stated that when he meets someone in whom he is romantically interested in, “he doesn’t dangle his feet, he jumps in the pool.” His romantic relationships end “out of the blue,” and he feels rejected. He attributes this to “choosing the wrong people to be with,” and thinks that he does not realize this until the relationships are over. He believes that he “idealizes” the women he dates, and attributes this to really wanting a stable, healthy relationship.

With regard to the last question, Mark reported that he was working as an attendant at a gas station and had worked 4-5 odd jobs in the last couple of years. He felt unable to find work that was satisfying. Mark has his bachelor’s degree in English, and previously worked for several years in this profession. He was pleased with this, but quit to move closer to his family a few years ago, when his great aunt was ill. He seemed convinced that there were no opportunities for him; he was not actively seeking jobs in this field.

I asked Mark about his developmental history. He grew up in a small city, the younger of two sons. He described his family environment as “wholesome,” “uneventful,” and “normal.” He reported that family members on his mother’s side struggled with depression. Mark believes that his father resents the attention he receives from his mother. He had a close relationship with his great aunt, and felt that she was the only person he could talk to. He was very upset when she died a few years ago.

Mark said there was a part of him that did not want to know the answers to these questions. I took a mental note of this as we progressed with the TA, and realized that it may

not be indicated to give Mark Level-3 information. I wondered whether this was why he had spent so much time talking about other people and seemed to experience his problems as being outside himself. Based on the report of the problems he was experiencing in his daily life, this approach did not seem to be working well for him.

Standardized Testing Sessions:

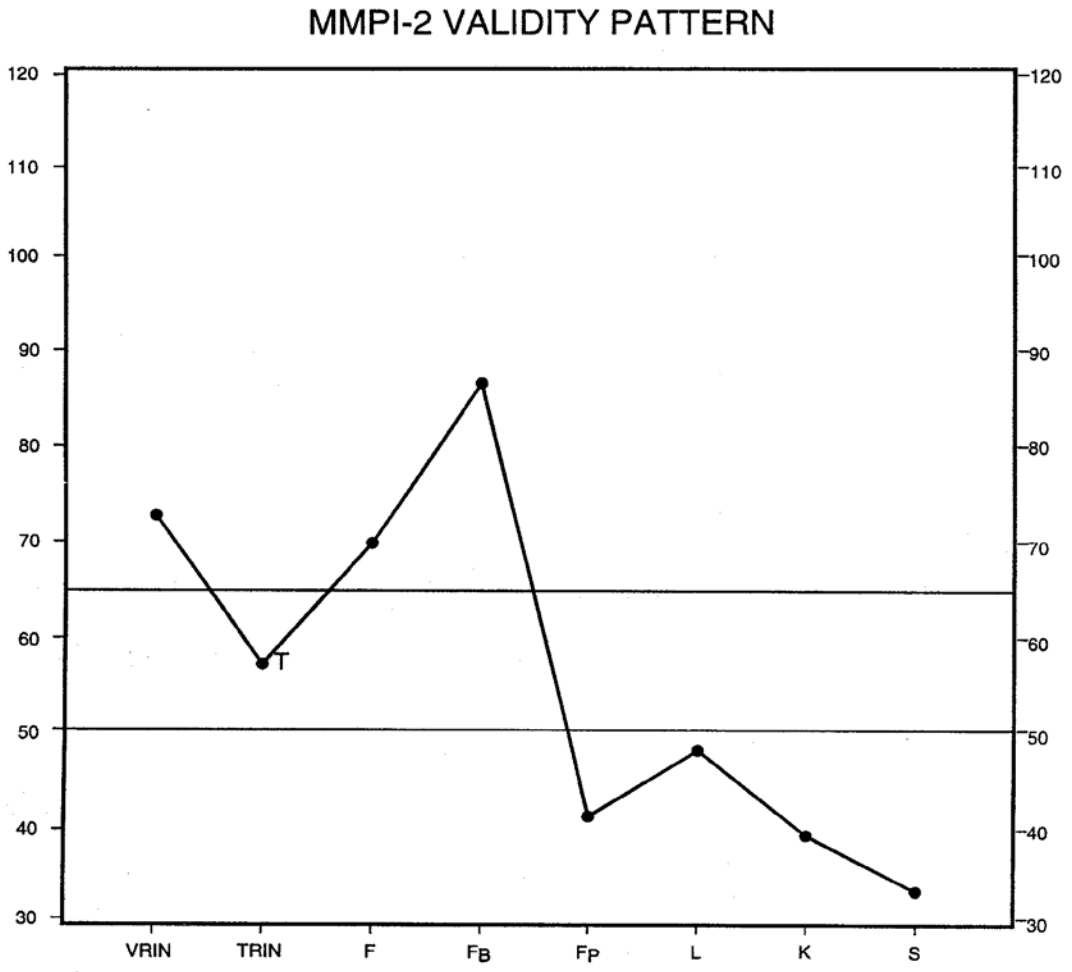
Mark appeared particularly anxious at the beginning of our meetings and would commonly make a joke, an attempt to establish familiarity, or ask several questions about what we would be doing and why. He was very aware of my presence and sensitive to my responses/reactions to what he said and did. He seemed to want to assure a connection, but was very sensitive to any perceived form of rejection.

MMPI-2: Mark's MMPI-2 clinical profile was probably valid, although he answered several of the items inconsistently, which may reflect some degree of carelessness or inattention. I asked him about this and he said that he found the test "tedious," and was frustrated by having to take the time to do it. His profile is shown in Figure 18.

Relative to his other scores, he was high on Hy (T-score = 86), D (T-score = 85), Hs (T-score = 77) and Pd (T-score = 77). This type of MMPI-2 profile often reflects a chronic pattern of psychological maladjustment, involving several physical, emotional, and relational concerns.

He reported many vague physical complaints, including tension, insomnia, and stomach distress.

On the test, his self-report indicated the following: He experiences depressive symptoms along with a preoccupation with feeling guilty and unworthy. At times, he feels hopeless and condemned, deserving of punishment. Similar to his presenting concerns about the future, he



	VRIN	TRIN	F	F_B	F_P	L	K	S
Raw Score:	11	10	11	11	0	3	10	10
T Score:	73	57T	70	87	41	48	39	33
Response %:	100	100	100	100	100	100	100	100

Cannot Say (Raw):	0
Percent True:	47
Percent False:	53

	Raw Score	T Score	Resp. %
S_1 - Beliefs in Human Goodness	4	41	100
S_2 - Serenity	1	31	100
S_3 - Contentment with Life	1	35	100
S_4 - Patience/Denial of Irritability	2	40	100
S_5 - Denial of Moral Flaws	2	43	100

Figure 18: Mark's MMPI-2 Results

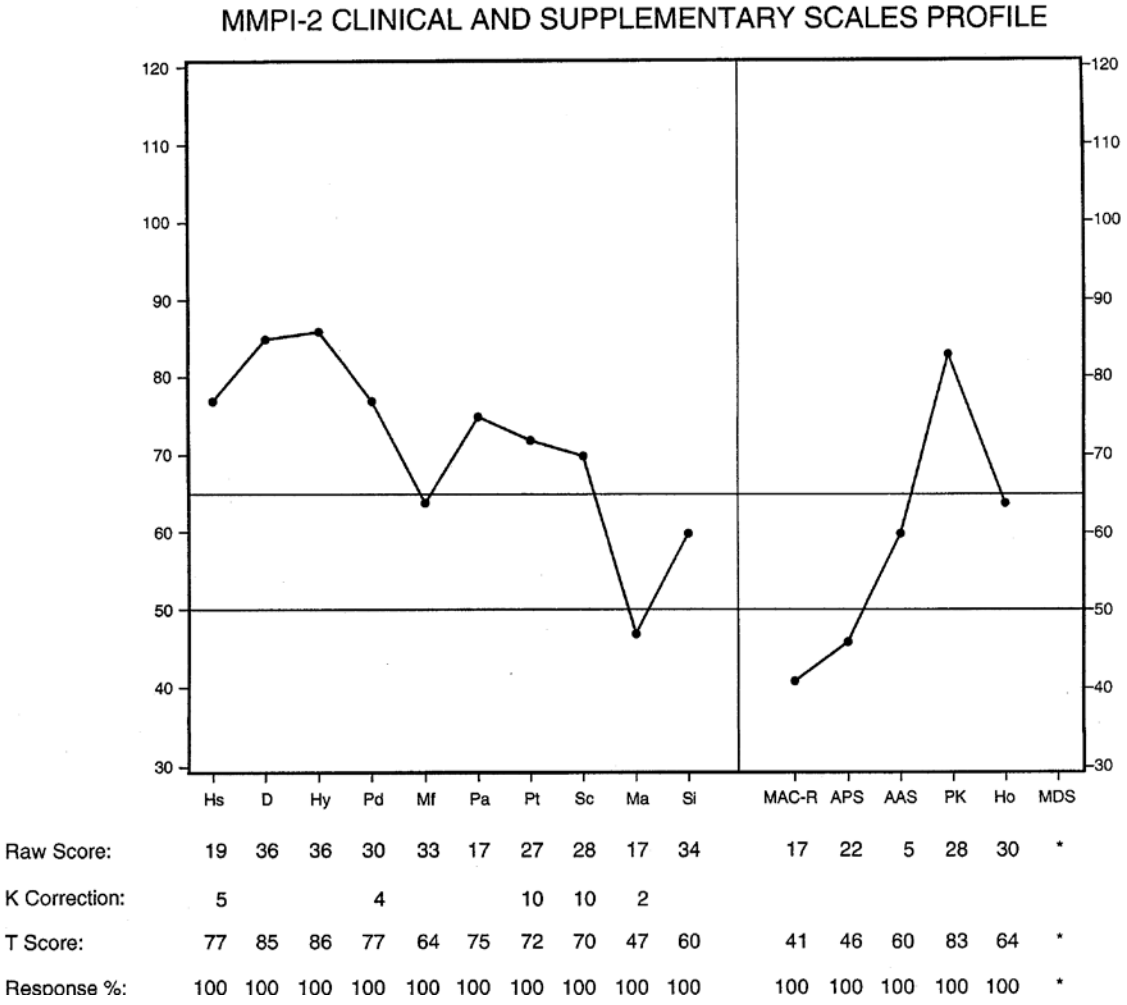
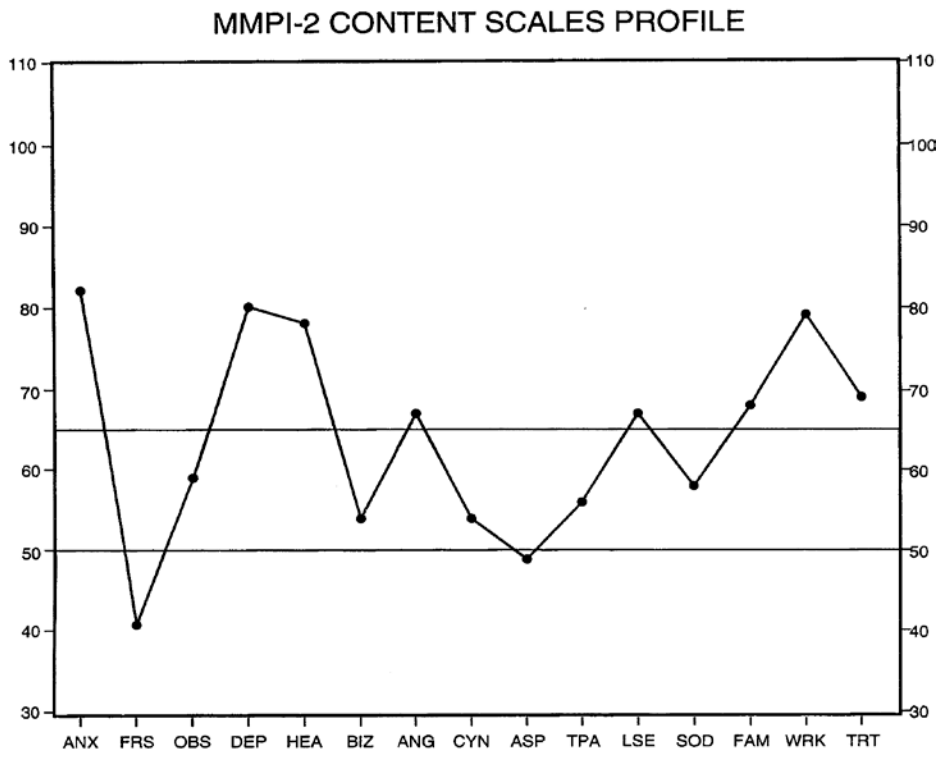


Figure 18, continued.



Raw Score:	19	1	8	21	18	3	11	13	8	11	11	12	12	23	12
T Score:	82	41	59	80	78	54	67	54	49	56	67	58	68	79	69
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Figure 18, continued.

feels regretful and unhappy about his life, and anxious and worried about the future. He has a high degree of anger, is high-strung, and experiences his emotions more intensely than others do.

His PSY-5 scores indicate that stable personality characteristics may contribute to his maladjustment. On the surface, the MMPI-2 suggests that he is somewhat shy, and can be hypersensitive about what others think of him. Additionally it indicates that he is inhibited and may experience some difficulty expressing his thoughts and feelings with others. His profile also suggests the following: He is emotionally immature and is very dependent, demanding, and manipulative. His perception of others is very negative, and he can often interpret neutral events as problematic. He can become very irritable, angry, or even hostile when his demands are frustrated by others.

WAIS-III: I administered the WAIS-III to better understand Mark's cognitive style, capabilities, and limitations because he had expressed the desire to know better what work he was well-suited for. Mark is functioning in the Average Range of Intellectual Functioning (Full Scale IQ = 108, Performance IQ = 89, Verbal IQ = 123). Notably, Mark's Verbal IQ is within the Superior Range, placing him at the 94th percentile, while his Performance IQ is within the Low Average Range, placing him at the 23rd percentile. The discrepancy between these scores is extremely uncommon, occurring in only 0.4% of individuals tested.

Mark did especially poorly on Subtests that had an imposed time limit, which I believed contributed to his much lower score on the Performance IQ. After the test, I asked Mark what he thought about it. He said that he struggled when he felt "pressed for time," as though he should respond "promptly" and this ultimately slowed him down. Additionally, he stated that he was careful not to make mistakes. He checked over his responses cautiously, also limiting the speed at which he performed, causing him to lose points.

I decided to test the limits by asking Mark to complete some of the items that he missed points on because he ran out of time. I was curious about this because many people miss these items because they increase in difficulty (and not because of time), such as on the Picture Completion subtest. Mark was able to provide the correct responses to each of the items that I inquired. His problems with performance do not appear to be accounted for by a lack of ability. I told him this and he seemed to be upset with himself that he did not do better. He talked about some of the things that were going on in his life at the time, which might have slowed him down. I asked him if this translated into his life in any way, the experience of feeling pressed for time and concerned with having the right answer. He said that it slowed him down at work. He reported that his managers would get irritated with him when he took too long to get a small job done. He also stated that he had some problems with this when he was a journalist. He was concerned with his final product and never felt like it was good enough. I told him that I imagined journalists often work on a tight time frame. He agreed and said that this was challenging for him. I pointed out that he answered most of the answers correctly, even though he was anxious about having done poorly.

There was one notable exception: he had real difficulty with two of the Picture Arrangement items. I gave him a second opportunity to arrange them, and asked him to tell a story about what was going on in the cards. With enough time, he was able to recognize his error, but this seemed to take a great deal of energy. On the item "SAMUEL," he told me that he was embarrassed by this sequence and had trouble concentrating. He told the following story about it: "A man purchased a female bust at an auction and hailed a taxi to take him home. He feared it getting damaged, but then he realized how it must look to other eyes behind the taxi and decided to put it on the opposite side of the cab." On the item LUNCH, Mark told the following

story about it, “One man came up to the other and the second offered the first an apple. The first pulled a gun and demanded the man’s money. The man was afraid and gave him his money, but the first man gave him his apple, took the money and left.” Mark spent considerable time studying the picture before and after telling the story. Eventually, he stated that he did not notice the exchange of money, and without this detail, had not understood the sequence of events. The items involve human activities that contain either sexual (which Mark experienced some embarrassment and shame about and had trouble concentrating on) or aggressive content (which seemed to prevent Mark from taking in all the details of the scene); this may have been why he struggled with them and was not able to effectively problem-solve.

Rorschach: Because several of Mark’s assessment questions pertained to his emotional experience and interpersonal relationships, I thought that the Rorschach would be a helpful test. I also selected the Rorschach because the WAIS-III picture arrangement indicated that Mark might have some problems with thinking clearly in certain circumstances. However, for the most part, Mark’s overall Exner Comprehensive System profile looked relatively good. He showed no evidence of a thought disorder. He did not meet the full criteria for any of the clinical constellations. He produced several good human responses.

More specifically, Mark produced seven human content responses (Norm = 5.49, SD = 1.75), which suggests that he has considerable interest in people. His Good Human Response to Bad Human Response ratio was good. However, looking more closely, his H:(H)+Hd+(Hd) was 3:4. He produced three (Hd) responses, suggesting that his impression of others is not always based in reality and that he may not understand others well. Although this is common in children, who often identify more with fictitious characters, it is uncommon in adults. He also produced one Hd response, which in combination with the three (Hd) responses might indicate that he can

focus solely on certain aspects of others, and not take into account the whole person. Taken together, this may reflect that Mark has a strong interest in others, yet a poor understanding of others. This can lead to unrealistic expectations of relationships and/or problems that can alienate a person. This is consistent with his story.

In addition, Mark produced two pure Color responses, and had an FC:CF+C of 3:3. This indicates that he may have problems modulating strong emotions. People with this quality often have intense displays of emotions and appear very impulsive.

Brian has an ambitent ideational style, suggesting that his decision-making style is unpredictable. People with this style fluctuate in making their decisions between a more thinking approach and a more intuitive, feeling approach. This finding suggests that Mark takes greater time to reach a solution, is more vulnerable to errors in judgment, and profits less from problem-solving errors than most people. This finding might be related to Mark's difficulties with making decisions about his career and relationships.

When we talked after the test, Mark said that he liked the cards that had a "personal connection." Also, on Card VII he saw an island and reflected that this was not appealing to him because it reminded him of being alone. He made several references to fictitious characters beyond what he produced during the protocol. For example, he said that Card I reminded him of "El Zorro," a fictional character who "fights for justice." This information is consistent with his H:(H)+Hd+(Hd) ratio and suggests that he is somewhat immature, childlike in his understanding of others. He yearns for human connection, but his way of connecting with others is plagued with problems.

Additional Projective Assessment: To further address the questions that Mark posed about his emotional experience, we used the House-Tree-Person (H-T-P) technique (Hammer,

1991). He drew Figures 19 and 20. Taken together, the pictures are underdeveloped. He described the house in Figure 19(a) as “a California house that survived an earthquake,” which could reflect a traumatic episode(s) that is experienced as detrimental (Hammer, 1991). The tree in Figure 19(b) is completely enclosed, suggestive of strong hostile impulses, some which may be internalized (Hammer, 1991). When prompted to draw a person, he drew a man (see Figure 20(a)). His man is exceptionally small. His small body in relation to his arms and to the size of the woman figure may reflect feelings of inadequacy and inferiority. When prompted, he created a story about the man that reflects an ongoing conflict in his life, which is structured like a fairy tale: “Once there was a man who was extremely lonely. He was looking for someone to spend his life with. He searched high and low until one day he met a woman who he liked, so he tried to win her heart. She wasn’t interested at first, so he put more effort into the relationship. Finally, she realized what a good guy he was and they lived happily ever after.”

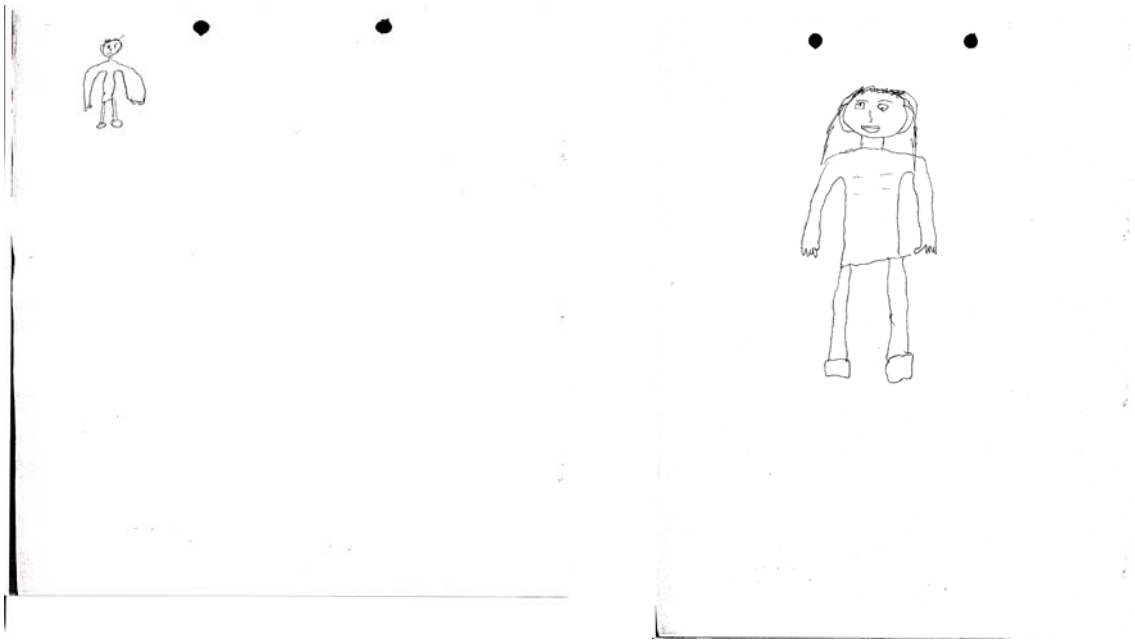
Assessment Intervention Session:

Based upon the information we had gathered, I hypothesized that several of Mark’s concerns arose from his immature understanding of others and expectations in relationships. He expressed several times that he was waiting for his life to begin, to catch an even break that would set him headed in the right direction toward the life that he desired. He is angry and resentful that this has not happened. In reality, it seemed that Mark was living his life; he was just not encountering life as he desired it to be, and this seemed to prevent him from finding work that he enjoyed and was well suited for, and developing stable relationships with others. Although he experienced a strong sense of urgency to get what he wants out of life, he is stuck in place because his methods of trying to attain this have not worked.



(a) **(b)**

Figure 19: (a) Mark's House and (b) Mark's Tree.



(a) **(b)**

Figure 20: (a) Mark's Person #1 and (b) Mark's Person #2.

I designed the Assessment Intervention to bring into the room Mark's tendency to focus solely on certain aspects of others and experiences, and not take into account the whole person or circumstance. I prepared by selecting a few Thematic Apperception Test (TAT) cards, which have particularly evocative material. The first card that I showed Mark was Card 3BM, which shows a boy on the floor, huddled against a couch. His head is bowed and there is a revolver on the floor beside him. Mark told a story about a young woman who was deep in thought. According to Mark, "she was dreaming about what her future would bring. She sat for a while and thought and thought, until she worked it out, and went on to be happy and successful." I pointed out to Mark that the person looked upset. He said that he could imagine how someone could see it that way. I pointed to the revolver, and asked him whether he had noticed it. He said that he didn't. I told him that the assessment findings indicated that he tended to overlook important details, and as a result, he often understood people or situations in an inaccurate way. He said that one of his previous therapists had told him that he tends to idealize others. I said that I recalled he told me that he idealized his girlfriends because he really wanted to have a solid, stable relationship; I also suggested that this may, instead, prevent him from having one.

I asked Mark if he wanted to try this exercise again with another card. I encouraged him to pay attention to the character's facial expressions, to what was going on in the picture, and to details that might help him understand more accurately what is taking place. I showed him Card 8BM, which is of an adolescent boy looking straight ahead. There is the barrel of a rifle on one side, and a dim scene of a surgical operation in the background. Mark created a story with a more accurate depiction of the events. I asked him what his experience of it was like. He said that it was upsetting to pay attention to the details because the scene was very sad. I agreed and

suggested that maybe this was why he preferred to look at things, sometimes, in an overly optimistic way.

Summary/Discussion:

Mark arrived for the Summary/Discussion session reporting that he was not doing well because of a dental concern. He said that he would need to have tooth extracted, but did not like the idea of having to lose something to feel better. I emphasized that loss is always hard to deal with. I asked about his experience of the previous session. He stated that he had come into the TA wanting to learn more about himself, and he felt that he had got that.

I began by responding to Mark's question of "What interferes with my ability to have solid/stable relationships" because we had addressed it directly during the Assessment Intervention (AI). I began by telling Mark that the testing affirmed that he has strong interest in others; I could understand why being in a solid/stable relationship was important to him. I then referred to our discussion during the AI, and said that I thought he often sees others in an overly optimistic or unrealistic light because it is often painful to see things as they really are. I also suggested that he could have unrealistic expectations of relationships that can interfere with working things through. I emphasized, however, that he could see things as they really are, as he did with the "sad" TAT card of the boy and the surgical scene.

Next I addressed his question of "Why do things seem to get to me so much?" I asked him what he thought was going on, and he said, "I don't have anything that I can put into words." I told him that the testing confirmed that he can experience things very strongly, and when he is faced with this, the testing indicated that when he doesn't have words for or an understanding of the experience, it can be overwhelming. I told him that the testing also showed

that when this happens he feels a sense of urgency to do something about it. I suggested that long-term therapy could help him to put words to his experience, and that this process might make it feel more manageable.

We moved on to talk about Mark's question "Why can't I seem to catch an even break?" I told him from what I had gathered he had experienced a lot of challenges in his life. I referenced his description of his H-T-P house drawing, and said that it must feel like he had been through and survived an earthquake. I suggested that these experiences have influenced his outlook on life, and told him that when a person experiences substantial adversity, when hopeful expectations have repeatedly been met with frustrations, the person begins to anticipate rejection and failure. I also suggested that he can often set the bar really high, and his expectations of "an even break" may be hard to meet.

Finally, we talked about Mark's questions "What the heck do I want to do with my life? What am I well suited for? Why is it so hard to find what I am well suited for?" I recalled that he had told me about his profession in English, which he reported enjoying. He agreed, but felt disillusioned after being rejected from several job positions for which he had applied. I suggested the solution to the problem might be less about finding what will be exactly right for him but instead figuring out how to develop a niche in something that he can reasonably take pleasure in and stick with. We talked some about this, but he seemed to be very focused on the obstacles that might stand in the way.

Follow-up:

Mark began the session by talking about a recent conflict he had encountered with his girlfriend and said that he did not know how to feel about it. He asked several concrete questions

and expressed wanting concrete details, stating that since I knew him, I should be able to give him a good idea of what he should do. I asked him if he had hoped to get more concrete answers from the assessment. He agreed.

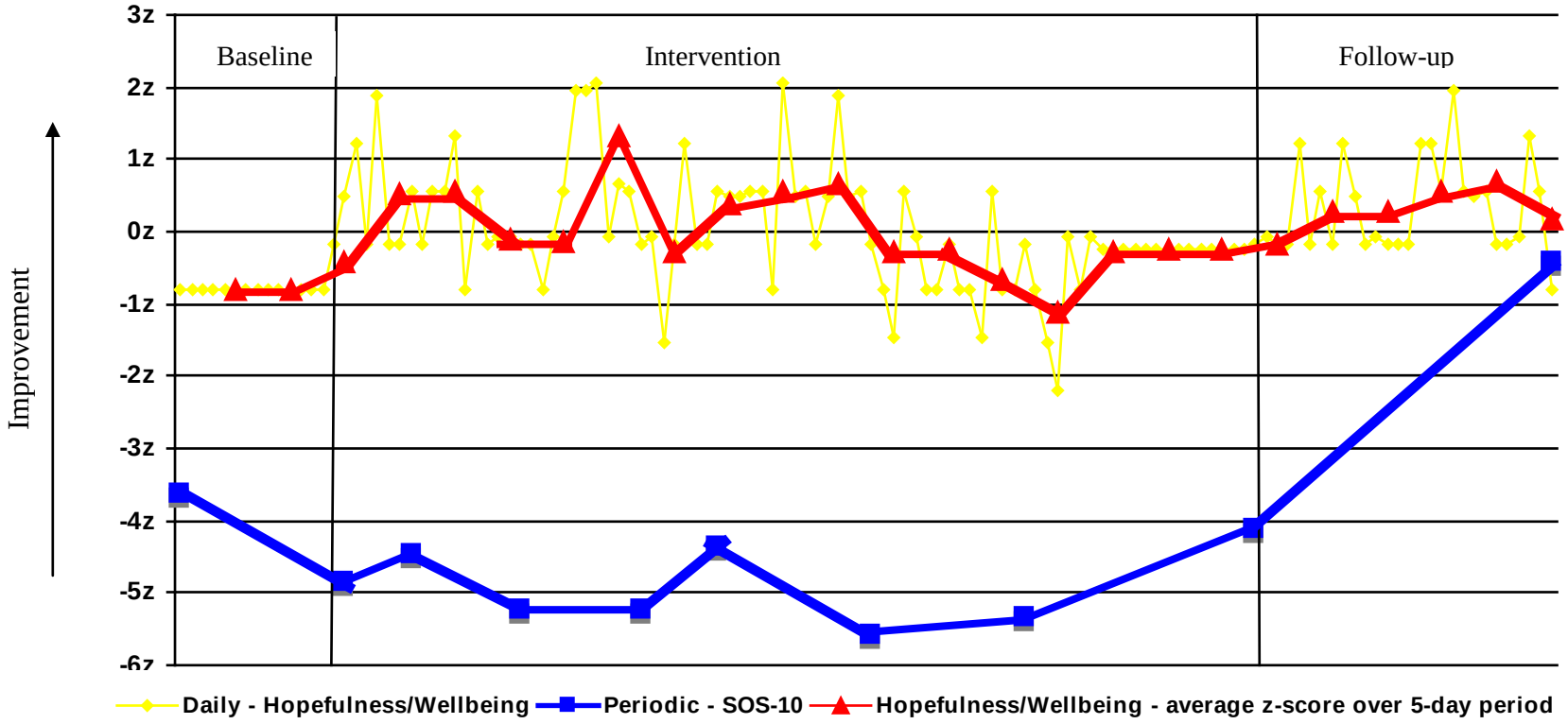
I asked Mark if he had any thoughts about the TA, the summary/discussion session, or the feedback letter that I had sent to him, summarizing what we had discussed. He said that he appreciated what he had learned about himself, and we talked some about this. He said that a lot of it had been new to him, but that he was trying to use it in his daily life. He jokingly stated that it would be great if I could give him a diagram of what he was supposed to do next. I laughed with him, and said that it can be hard to integrate new information. We went over some of the findings again together.

Results:

Data:

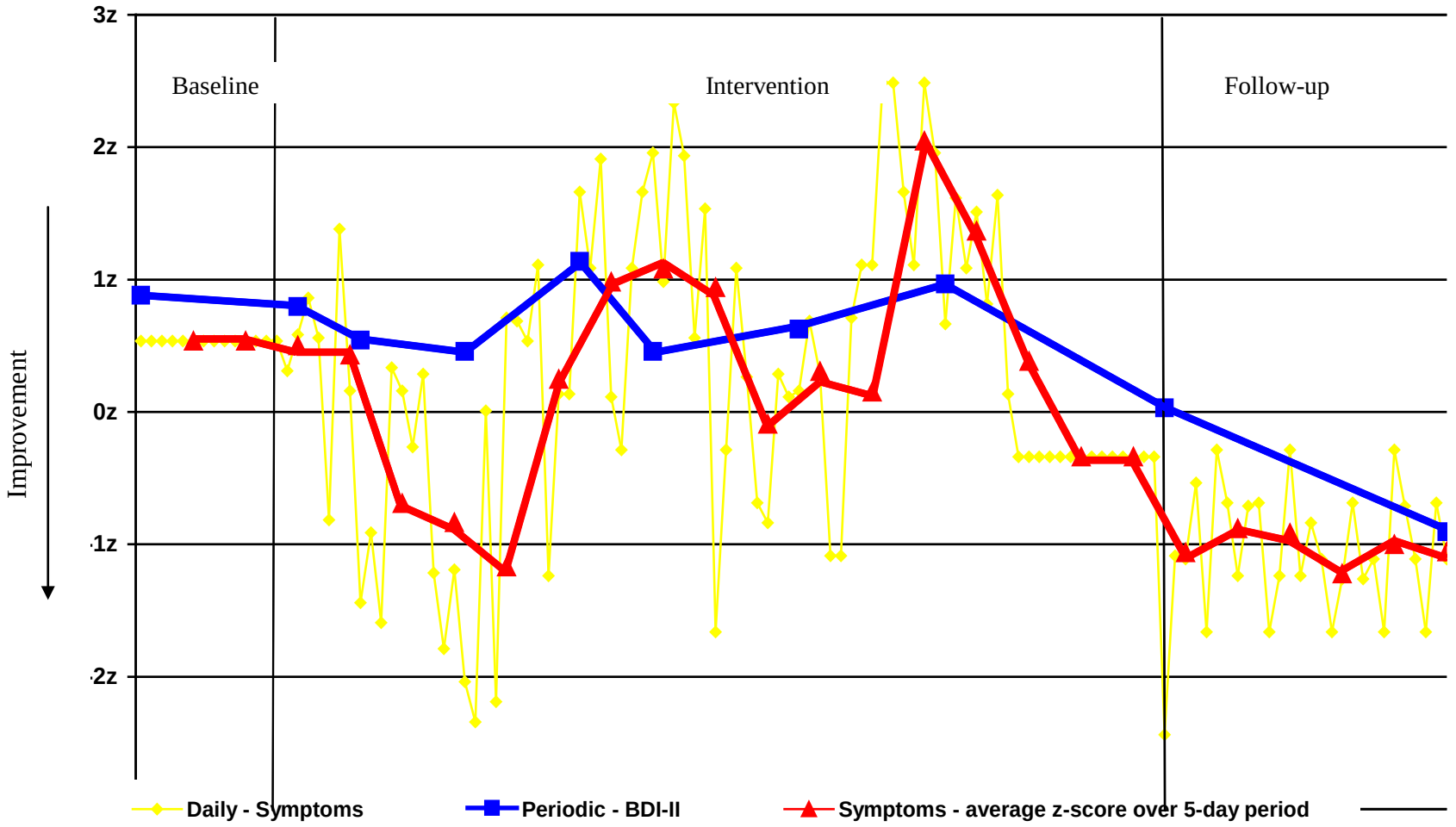
Each variable of Mark's baseline has a standard deviation of zero. This is inconsistent with his daily measure ratings for the intervention and follow-up phases, on which there is fluctuation from day to day. I do not believe that this pattern is clinically relevant. Likely, Mark was not completing the measure on a daily basis, and filled it out prior to the initial meeting. Even though this is not ideal, I consider his ratings to accurately reflect the average of the two-week time period.

Mark did not complete data for a two-week period during the intervention phase (Time points 85-99 in Figures 21 and 22). I used the SPSS Missing Values Analysis to calculate values for the two-week period of time, by using the average of the three numbers proceeding and the three numbers following the missing data.



For Daily Hopefulness/Wellbeing, the values on the vertical axis are the average of the z-scores for the two variables that comprise the composite measure. The Periodic Schwartz Outcome Scale (SOS-10) values are normed z-scores, based on SOS-10 norming data (Young, Waechler, Laux, McDaniel & Hilsenroth, 2003).

Figure 21: Hopefulness/Wellbeing Across Phases for Marks's Daily and Periodic Measures



For the Daily Symptoms, the values on the vertical axis are the average of the z-scores for the three symptoms that comprise the composite measure. The Periodic Beck Depression Inventory (BDI-II) values are normed z-scores, based on BDI-II norming data (Steer, Ball, Ranieri, & Beck 1999).

Figure 22: Symptoms across Phases for Marks's Daily and Periodic Measures

Hypotheses:

Hypothesis IA: Does the client improve on daily measures of hopefulness/wellbeing? As predicted, Mark showed a statistically effect for *hopefulness/wellbeing* comparing the baseline phase with the intervention phase plus follow-up phase (R= +0.353, p=0.007) (see Figure 21). Also as predicted, this change occurred early in the treatment. There was a statistically significant effect when comparing the baseline phase with the intervention phase (R=+0.351, p=0.020), and a much smaller, non-significant effect when comparing the intervention phase with the follow-up phase (R=+0.164, p=0.228).

Hypothesis IB: Does the client meet criteria for meaningful improvement in the periodic measure of wellbeing? As predicted, Mark showed an improvement in wellbeing across treatment (see Figure 21). His SOS-10 increased from 18 at the beginning of the baseline phase to 44 at the end of the follow-up phase. According to the Reliable Change Index, this magnitude of improvement is reliable.

Hypothesis IIA: Does the client improve on daily measures of symptoms: Mark did not show a statistically significant effect for *symptoms* comparing the baseline phase with the intervention phase plus follow-up phase (R= +0.173, p=0.339) (see Figure 22). Because the Pearson's-r is > +0.1, the additional analysis comparing the baseline phase plus intervention phase to the follow-up phase was conducted. Mark showed a statistically significant effect for *symptoms* comparing the baseline phase plus intervention phase to the follow-up phase (R= +0.517, p=0.002) (see Figure 22).

Hypothesis IIB: When compared to baseline, at follow-up does the client meet criteria for symptom improvement on the periodic measure of symptom status: the Beck depression Inventory (BDI-II): As predicted, Mark showed a clinically significant reduction in the Beck

Depression Inventory at the end of the follow-up phase, when compared with the beginning of the baseline phase (see Figure 22). According to the BDI-II classification system, Mark scored in the "Severe Depression" range at baseline, and in the "Minimal Depression range at follow-up.

Hypothesis IIC: When compared to baseline, at follow-up does the client meet criteria for meaningful improvement on the pre/post measures of symptoms: the OQ-45 Symptomatic Distress Index, the SCL-90 Global Severity Index (GSI), and the SCL-90 Positive Symptom Distress Index (PSDI): Contrary to what is predicted Mark did not show a meaningful improvement in the three pre/post measures of symptoms. Specifically, Mark showed a reduction in symptomatic distress on the OQ-45, from 63 to 53. This meets the threshold for reliable change that is a reduction in 10 or greater points. However, Mark did not show a reduction in the SCL-90 Global Severity Index (t-score at baseline=63; t-score at follow-up=65) or the SCL-90 Positive Symptom Distress Index (t-score at baseline=62; t-score at follow-up=60). But because neither the pre- nor the post- scores on these indices meets clinical threshold, meaningful improvement cannot be assessed.

<u>Follow-up, Client Satisfaction Measures:</u>

On the Client Satisfaction Questionnaire, Mark scored a 24 out of a total of 32, reflecting relative satisfaction with the services he received.

On the Assessment Questions Rating Form (AQRF), he reported a '3' out of '4' on all his of five questions that were answered ("4" is equal to completely).

Mark completed two open-ended questions about his experience of the therapeutic Assessment. In response to the question "*What part(s) of the assessment did you find most valuable,*" he wrote, "The IQ test and learning what questions to ask." In response to the

question, "*What changes do you think have occurred as a result of the assessment,"* he wrote, "None as of right now."

Chapter Seven: Discussion

Consistent with Finn's contention that TA provides a therapeutic expeirence (2007), all three of the study participants showed some degree of improvement throughout the course of the TA. The summary of the findings is presented in Table A-1.

With regard to the question of whether the clients will improve on *hopefulness/wellbeing*, only one of the three participants, Mark, reported a statistically significant improvement when the baseline phase was compared with the intervention phase plus follow-up phase. Consistent with the Phase Model of Psychotherapy Outcome, this improvement in *hopefulness/wellbeing* occurred early in the treatment. All participants showed meaningful improvement on the periodic measure of wellbeing. Post-hoc analyses revealed that all three participants showed statistically significant improvement during the follow-up phase, when compared with the baseline plus intervention phase.

With regard to the question of whether the clients will show a reduction in symptoms, two of the three participants reported a statistically significant improvement on the daily measure of symptoms. As predicted, Randy and Mark reported a reduction in symptoms during the follow-up phase, in comparison with the baseline plus intervention phase; Melanie did not. However, all three participants showed a meaningful reduction in depression, as measured by the periodic measure of depression (BDI-II).

Contrary to my expectations, I did not observe meaningful changes in the pre/post measures of symptoms for any of the participants. The one exception to this was Mark, who showed a meaningful improvement on OQ-45 Symptomatic Distress; however, he did not show consistent improvement in the SCL-90 subscales for symptom improvement. In all cases, there was a change in the pre/post measures in the direction of improvement; but the change did not

meet the criteria or threshold for clinical significance, and in several cases was quite small. One substantial problem was that none of the participants met the clinically significant threshold of SCL-90 Global Severity Index and Positive Symptom Distress Index pre-intervention. Because of this, meaningful improvement simply could not be evaluated. This finding by itself is surprising because all three participants met full criteria for a DSM-IV depressive disorder so one would expect that their SCL-90 subscales would be within the clinical range. They were not, however. Another reason why there was not a meaningful change might be that a change in the composite scores reflects more substantial changes that do not occur within the scope of a short-term psychotherapy, such as TA.

Finn writes that the process of change is different for every client (2007). Consistent with this notion, the pattern of change varied for each of the three participants. I will discuss the data for each participant independently as it relates to his or her presenting concerns and the change(s) that occurred during the TA. Additionally, I will discuss data collectively and what it indicates about the effectiveness of Therapeutic Assessment as a stand-alone psychological intervention for depression.

Melanie - Melanie did not show an early, statistically significant improvement in the daily measure of *hopefulness/wellbeing*, as Finn (2007), the Phase Model of Psychotherapy Outcome, and this investigation predicted (Howard et. al., 1993, 1996). However, Melanie did show a gradual improvement on the periodic measure of wellbeing (SOS-10) across the intervention and follow-up phases. This improvement was greater than two standard deviations and meets the criteria for meaningful change (see Figure 18).

Although the collective daily and periodic findings are inconsistent with the study's hypotheses, Melanie did show a non-significant trend in the direction of improvement on the

daily measure of *hopefulness/wellbeing*. Post-hoc analyses also revealed a statistically significant improvement in daily *hopefulness/wellbeing* during the follow-up, when compared with the combined baseline and intervention phases. It seems as though Melanie experienced the hypothesized improvement in *hopefulness/wellbeing* but it simply occurred later in the treatment than expected.

An improvement in *hopefulness/wellbeing* is related to the process of "remoralization," as described by the Phase Model of Psychotherapy Outcome (Howard and colleagues 1993, 1996). Remoralization is a process through which a person begins to experience that he or she is not powerless over the circumstances in their life. Typically this happens early in a therapeutic intervention when a client clarifies their problems/symptoms and is frequently connected with an experience of mastery.

I believe that remoralization is central to Melanie's treatment gains. TA helped her identify, organize, and come into greater contact with her emotional life. Prior to the TA, she reported feeling hopeless in response to strong, erratic, and overwhelming emotional experiences that seemed to occur "out of the blue." From her self-report of the TA experience, she gained a better understanding of and mastery over her emotional life. Clinically, this change appeared to begin mid-intervention, reflected in Figures 9 & 10, which illustrate an improvement in the consistency of Melanie's rating of her daily measures. The periodic measure of *hopefulness/wellbeing* suggests that this treatment gain occurred toward the end of the TA intervention and may underscore the importance of the Assessment Intervention and Summary/Discussion sessions, the sessions Finn believes are integral to the TA's therapeutic value (2007).

Although not statistically significant, it is important to note that Melanie's daily rating of symptom severity increased early in the intervention phase, rather than decreased in accordance with the hypotheses. Toward the end of the intervention phase and into the follow-up phase, her symptom severity rating decreased to what it had been at baseline, but overall, she showed no improvement. I attribute this finding to Melanie's increasing subjective awareness of her emotional turmoil, which was therapeutic. Despite an increase in subjective symptomatic distress, she showed a clinically significant reduction in depression, as measured by the BDI-II. Her depression improved from "Moderate Depression" at baseline to "Mild Depression" at follow-up. This improvement appears to occur mid-intervention and stabilize into the follow-up.

Therapeutic Assessment seemed well suited for Melanie and the concerns she brought to the assessment. She sought out an assessment because she was concerned that ADHD was interfering with her work and school. Although she reported several frequent, distressing emotional experiences, she did not connect them with the problems she was having in her daily life. The TA seemed to provide her with a positive, therapeutic experience, above and beyond what could be gained from an objective determination of a diagnosis.

Randy – Randy's *hopefulness/wellbeing* profile was similar to Melanie's profile. He did not show a statistically significant improvement in *hopefulness/wellbeing* as hypothesized. He showed meaningful improvement on the periodic measure of wellbeing (SOS-10) and a non-significant trend on the daily *hopefulness/wellbeing* measure in the direction of improvement (see Figure 20). Finally, post-hoc analyses revealed a statistically significant improvement in the daily *hopefulness/wellbeing* measure during the follow-up phase, when compared with the combined baseline and intervention phases.

An important difference from Melanie's profile, though, was that Randy's rating of *hopefulness/wellbeing* was initially high and remained relatively high throughout the study. I think that to some degree, Randy over-reported his *hopefulness/wellbeing* because he was uncomfortable with accurately reflecting on the emotional distress and concerns that he was experiencing when he came to treatment. Despite this, I don't believe that Randy came to treatment in a demoralized state, as described by Frank and Frank (1991) and the Phase Model of Psychotherapy Outcome. I do not think that his improvement in the *hopefulness/wellbeing* index constitutes "remoralization."

This idea maps onto another unexpected finding. Beginning early in the treatment process, Randy reported a statistically significant improvement in his daily *symptoms*, which preceded a change in *hopefulness/wellbeing*. Contrary to what was predicted, Randy's daily *symptoms* readily improved during the intervention phase, and stabilized throughout the follow-up phase. Randy's BDI-II scores improved from "Mild Depression" to "Minimal Depression" almost immediately after the initial session.

When Randy came for treatment, I believe he was experiencing acute, severe emotional concerns and relationship problems that were the source of his *symptoms*. I gathered that these problems and concerns were of greater intensity than he typically experiences or is comfortable with. Yet I also gathered that they were attributable to long-standing maladaptive patterns of relating with others. Given the nature of the presenting problems, I imagine that empathic listening and mirroring of his emotional experience helped to alleviate some of his initial distress. However, I also believe that the TA, in particular, may have begun to prepare Randy to begin moving in the direction of a more adaptive understanding of himself, relationships, and the

world around him. Regardless, I believe that his reduction in symptoms is more likely accounted for by the therapeutic contact than by the specific therapeutic components of the TA.

Mark - Mark showed clinically and statistically significant improvement in the daily and periodic measures of *hopefulness/wellbeing* and *symptoms*. The improvement took a form that was completely consistent with each of the study's hypotheses. While this is important in its own right, I have a less clear understanding of what changed for him that contributed to this outcome. Primarily, I am unclear because Mark did not appear to take away much helpful insight from the TA. He showed several fluctuations in his data, and did not provide descriptive feedback on the follow-up, client satisfaction measures, which might indicate what he gained from the TA.

I can feasibly hypothesize that Mark, like Melanie, benefited from the TA through the process of remoralization. He most definitely put his concerns and inner turmoil into words, and seemed to experience some relief and renewed hope by doing this.

However, the Open Ended Questions (shown in the Follow-Up, Client Satisfaction Measures section of Mark's Results section) are not specific about what he gained from the assessment, and generally indicate that he did not get much from it. During the follow-up session, Mark appeared very frustrated that he had not come to more concrete solutions to his problems and very frustrated that I could not provide more concrete direction for him. He reported that he had not been feeling well, even though his measures suggested otherwise. The possibility occurred to me at this time (prior to looking at the data) that because of the nature of his long-standing character problems, TA was not the most suitable approach for treatment for him, or that another approach to the Assessment Intervention and Summary/Discussion might have been more helpful to him.

On several occasions, Mark seemed agitated and resentful about having to complete the study measures. This might have, to some degree, influenced his responding. He complied with the study requirements, but he may have expressed resentment through his responses on the client satisfaction measures. Also possible is that Mark, in compliance, responded to the measures with what he believed to be the desirable response and did not accurately represent his real experience. However, it is also equally possible that Mark did experience real and important treatment gains, but it is simply not as clear to me what the gains might be, as it was with Melanie and Randy.

Collectively, the findings do not conclusively fit with the hypotheses of the study. However, I believe that this investigation provides support for the effectiveness of Therapeutic Assessment as a short-term psychological treatment for depression, given that all three participants showed some degree of meaningful, clinically significant improvement. Consistent with previous studies that have examined the therapeutic impact of sharing assessment findings (Finn & Tonsager, 1992; Newman & Greenway, 1997), the current investigation indicates that TA, as a stand-alone intervention, can increase clients' hopefulness/wellbeing and reduce symptoms of distress.

To the best of my knowledge, this is the first empirical investigation to evaluate TA as a stand-alone intervention in an adult population and to do so in accordance with the guidelines set by the American Psychological Association Division 12 Task Force on Promotion and Dissemination of Psychological Procedure (APA, Chambless & Ollendick, 2001). Although case-based time-series analysis is not a replacement for group experimental designs, the integrated qualitative and quantitative data from this investigation provide rich, descriptive, in-depth accounts of the process of change for each individual, which is not possible with larger-n

designs. This method of study is shown to also assist in examining specific hypotheses about the process of change. For example, the following information was gathered from this investigation:

Based upon Melanie's time-series data, the therapeutic impact of the intervention can occur later in the TA intervention process than I hypothesized. Finn writes that the process of change is different for every client, but indicates that the initial session may be therapeutic for many people (2007). Consistent with this, I anticipated that an increase in *hopefulness/wellbeing* would occur early in the TA intervention process. However, for Melanie, meaningful improvement in *hopefulness/wellbeing* occurred later in the intervention process, when we began to organize what we discovered during the testing sessions, and assemble this information into something that Melanie could use to make changes in her story and in her life. Finn contends that the Assessment Intervention and Summary/Discussion are very important to the therapeutic process of TA (2007) for this reason. Melanie's findings support this notion.

Although Randy and Mark's data reflect greater therapeutic impact than Melanie, neither client seemed to take in the assessment findings or to make significant changes in their stories, as Finn indicates in his writings (2007). Their improvement is believed to be more connected with the therapeutic contact than with the therapeutic ingredients of the TA. This finding underscores the importance of the therapeutic contact in therapeutic gain. Also, this finding might shed light on whom TA is be best suited for. The nature of both Randy's and Mark's presenting problems seemed to interfere with their capacity to work collaboratively and to take in new information, which is discrepant from how they understood themselves and the world around them. Both of these qualities are necessary for TA. It may be that TA works better with individuals who have less severe Axis II pathology. It may also have been that case that a different approach to the Assessment Intervention might have worked better.

It is important to note that the follow-up sessions were scheduled much closer to the end of the intervention phase than is recommended in Finn's writings (2007). Finn will typically schedule the follow-up session several months after the Summary/Discussion session. Because of the time constraints of the study, the follow-up session was instead scheduled one month out. Finn writes that some clients decide to work independently with the insights they have gained about themselves during the TA, while others decide to utilize a longer-term psychotherapy (2007). Regardless, he believes that clients often continue to show improvement after the TA, assimilating new information from the TA to develop more adaptive 'stories' and methods of functioning. In practice, Finn will sometimes arrange multiple follow-up sessions, to touch base with clients periodically during this process. Consistent with Finn's contention that improvement often continues after the TA formally terminates, Melanie, Randy and Mark showed gains during the follow-up phase. Melanie's improvement is believed to be consistent with Finn's writings about TA (2007), and attributed to the process of integrating new, helpful information. However, because Randy and Mark did not appear to take in the assessment findings, I believe that their improvement during the short follow-up period is an outcome of the therapeutic contact. I would not expect to observe continued gains across a longer follow-up period, which would be more consistent with Finn's writings and with what I would expect to see for Melanie. At the follow-up meeting, all three individuals decided to begin a longer-term psychotherapy to continue to work with what they learned about during the intervention. Consistent with previous research, TA appears to provide a positive therapeutic experience, which can be used as a springboard for longer-term psychotherapy (Ackerman et al., 2000; Hilsenroth, Peters, and Ackerman, 2004).

Sidenote:

Additional data were collected for self-esteem because this variable was evaluated in a previous investigation with therapeutic assessment (Finn & Tonsager, 1992; Newman & Greenway, 1997). However, this variable was not examined empirically in this study because it did not fit into either of the two composite scores (*hopefulness/wellbeing* or *symptoms*) that were developed using the Phase Model of Psychotherapy Outcome (Howard, Leuger, Maling & Martinovich, 1993; Howard, Moras, Brill, Martinovich, & Lutz, 1996). As shown in Tables A2-A7, two of the three subjects reported a statistically significant improvement in self-esteem during the intervention plus follow-up phase, as compared with the baseline phase (Randy: R= 0.489, p= 0.008; Mark: R= 0.417, p= 0.017). Melanie did not show improvement in self-esteem.

List of References

Ackerman, S. J., Hilsenroth, M. J., Baity, M. R. & Blagys, M. D. (2000). Interaction of therapeutic process and alliance during psychological assessment. *Journal of Personality Assessment, 73,* 82-109.

Alexander, L.B. & Luborsky, L. (1986). The Penn Helping Alliance scales. In L.S. Greenberg & W.M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp.325-366). New York: Guilford.

American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition. Washington DC: American Psychiatric Association.

Arthur, A.R. (2003). The emotional lives of people with learning disability. *British Journal of Learning Disabilities, 31,* 25-30.

Barber, J.P. & Crits-Christoph, P. (1996). Development of a therapist adherence/competence rating scale for Supportive/Expressive Dynamic Psychotherapy: A preliminary report. *Psychotherapy Research, 6,* 79-90.

Barber, J.P., Crits-Christoph, P. & Luborsky, L. (1996). Therapist competence and treatment outcome in dynamic therapy. *Journal of Consulting and Clinical Psychology, 64,* 619-622.

Berg, M. (1985). The feedback process in diagnostic psychological testing. *Bulletin of the Menninger Clinic, 49,* 52-69.

Bergin, A. E., & Strupp, H. H. (1970). New directions in psychotherapy research. *Journal of Abnormal Psychology, 76,* 13–26.

Blais, M.A., Lenderking, W.R., Baer, L., deLorell, A., Peets, K., Leahy, L. et al. (1999). Development and initial validation of a brief mental health outcome measure. *Journal of Personality Assessment, 3,* 359-373.

Borchardt, J.J., Nash, M.R., Murphy, M.D., Moore, M., Shaw, D. & O'Neil, P. (2008). Clinical practice as a natural laboratory for psychotherapy research: A guide to case-based time-series analysis. *American Psychologist, 63,* 77-95.

Buck, J. (1966). *The House-Tree-Person technique, revised manual*. Los Angeles: Western Psychological Services.

Chambless, D.L. & Ollendick, T.H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52*, 685-716.

Cheek, J.M. & Buss, A.H. (1981). Shyness and sociability. *Journal of Personality and Social Psychology, 41,* 330-339.

Cohen, J. (1985). Learning disabilities and adolescence; developmental considerations. *Adolescent Psychiatry, 12,* 177-196.

Craddick, R. A. (1975). Sharing oneself in the assessment procedure. *Professional Psychology, 6,* 279-282.

Dana, R. H. (1982). A human science model for personality assessment with projective techniques. Springfield, IL: Thomas.

Dana, R. H., & Leech, S. (1974). Existential assessment. *Journal of Personality Assessment, 38,* 428-438

Derogatis, *L. R. (1977).* SCL 90-R (Revised Version), Manual I. *Baltimore, MD: Johns* Hopkins University School of Medicine.

Derogatis, L. R. (1983). *SCL-90-R administration, scoring, and procedures manual-II*. Towson, MD: Clinical Psychometric Research.

Exner, J.E. (2003). The Rorschach: A Comprehensive System. Hoboken, NJ: John Wiley & Sons.

Finn, S.E. (1996). *Manual for using the MMPI-2 as a therapeutic intervention.* Minneapolis, MN. University of Minnesota Press.

Finn, S.E. (2003). Therapeutic Assessment of a man with "ADD." *Journal of Personality Assessment, 80,* 115-129.

Finn, S.E. (2007). In our clients' shoes: Theories and techniques of therapeutic assessment. Mahwah, NJ: Lawrence Erlbaum Associates.

Finn, S.E. & Butcher, J.N. (1991). Clinical objective personality assessment. In M. Hersen, A.E. Kazdin & A.S. Bellack (Eds.), *The clinical psychology handbook* (2nd ed.; pp.362-373). New York: Pergamon Press.

Finn, S.E. & Kamphuis, J.H. (2006a). Therapeutic Assessment with the MMPI-2. In J.N. Butcher (Ed.), *MMPI-2: A practitioners guide (pp.165-191).* Washington, DC: APA Books.

Finn, S.E. & Kamphuis, J.H. (2006b). The MMPI-2 restructured clinical (RC) scales and restraints to innovation, or "What have they done to my song?" *Journal of Personality Assessment, 87,* 202-210.

Finn, S.E. & Martin, H. (1997). Therapeutic assessment with the MMPI-2 in managed health care. In J.N. Butcher (Ed.), *MMPI-2: A practitioners guide* (pp. 165-191). Washington, DC: APA Books.

Finn, S.E., Schroeder, D.G. & Tonsager, M.E. (1994). *The Assessment Questionnaire-2 (AQ-2): A measure of clients' experiences with psychological assessment.* Unpublished manuscript, Center for Therapeutic Assessment, Austin, TX.

Finn, S.E. & Tonsager, M.E. (1992). Therapeutic effects of providing MMPI-2 test feedback to college students awaiting therapy. *Psychological Assessment, 4,* 278-287.

Finn, S.E. & Tonsager, M.E. (1997). Information-gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment, 9,* 374-385.

First, M.B., Spitzer, R.L., Gibbon, M., Williams, J.B.W. (1997). Structured Clinical Interview for DSM-IV Axis I Disorders – Clinician Version (SCID-CV). Washington, DC, American Psychiatric Press.

Fischer, C. T. (1994). Individualizing psychological assessment. Mahwah, NJ: Lawrence Erlbaum Associates.

Gaston, L. (1991). Reliability and criterion-related validity of the California Psychotherapy Alliance Scales-Patient Version. *Psychological Assessment, 3,* 68-74.

George, C. & West, M. (2001). The Development and Preliminary Validation of a New Measure of Adult Attachment: The Adult Attachment Projective. *Attachment and Human Development*, *3*, 30-61

Handler, L. (1998). The clinical interpretation of the Wechsler Intelligence Tests as personality instruments. In L. Handler & M. Hilsenroth (Eds.), *Teaching and learning personality assessment* (pp. 245-324). Mahwah, NJ: Laurence Erlbaum Associates.

Handler, L. (2005). *A Rorschach assessment amplified, using play in Testing of the Limits*. Paper presented at the XVIII International Congress of Rorschach and Other Projective Methods.

Handler, L. (2007). The Use of Therapeutic Assessment with Children and Adolescents. In S. R. Smith & L. Handler (Eds.), *The clinical assessment of children and adolescents: A practitioner's handbook* (pp. 53-72). Mahwah, New Jersey: Erlbaum.

Handler, L., & Hilsenroth, M. J. (1994, April). *The use of fantasy animal drawing and storytelling technique in assessment and psychotherapy*. Paper presented at the Annual Meeting of the Society for Personality Assessment.

Handler, L. & Hilsenroth, M.J. (Eds.) (1998). Teaching and Learning Personality Assessment. Mahwah, NJ: Lawrence Erlbaum Associates.

Hatcher, R.L. & Barends, A.W. (1996). Patient's view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. *Journal of Consulting and Clinical Psychology, 64,* 1326-1336.

Hatcher, R.L., Barends, A., Hansell, J. & Gutfreund, M.J. (1995). Patient's and therapist's shared and unique views of the therapeutic alliance: An investigation using confirmatory factor analysis in a nested design. *Journal of Consulting and Clinical Psychology, 63,* 636-643.

Helmstadter, G.C. (1964). *Principles of psychological measurement.* Englewood Cliffs, NJ: Prentice Hall.

Hilsenroth, .J., Ackerman, S.J., Blagys, M.D. (2001). Evaluating the phase model of change during short-term psychodynamic psychotherapy. *Psychotherapy Research, 11,* 29-47.

Hilsenroth, M.J., Peters, E.J., and Ackerman, S.J. (2004). The development of therapeutic alliance during psychological assessment: Patient and therapist perspectives across treatment. *Journal of Personality Assessment, 83,* 332-344.

Howard, K.I., Leuger, R.J., Maling, M.S. & Martinovich, Z. (1993). A phase model of psychotherapy: Causal medication of outcome. *Journal of Consulting and Clinical Psychology, 61,* 678-685.

Howard, K.I., Moras, K., Brill, P., Martinovich, Z. & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist, 51,* 1059-1064.

Horowitz, L., Rosenberg, S., Baer, B., Ureno, G., & Villasenor, V. (1988). Inventory of Interpersonal Problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56,* 885-892.

Horvath, A.O. & Greenberg, L.S. (1986). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36,* 223-233.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59,* 12-19.

Jacobson, N.S., Roberts, L., Berns, S., & McGlinchey, J. (1999). Methods for defining and determining the clinical significance of treatment effects: Description, application, and alternatives. *Journal of Consulting and Clinical Psychology, 67,* 300-307.

Kazdin, A. E. (1982). *Single-case research designs: Methods for clinical and applied settings*. New York: Oxford University Press.

Kohut, H. (1977). The restoration of the self. New York: International Universities Press.

Kohut, H. (1984). How does analysis cure? Chicago: University of Chicago Press.

Lambert, M.J., Hansen, N.B., Umphress, V., Lunnen, K., Okiishi, J., Burligame, G.M., et al. (1996). *Administration and scoring manual for the OQ-45.* Stevenson, MD: Professional Credentialing Services.

Larsen, D. L., Attkisson, C. C., Hargreaves, W. A. & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning, 2,* 197-207.

Lewak, R. W., Marks, P. A., & Nelson, G. E. (1990). Therapist guide to the MMPI & MMPI-2. Muncie, IN: Accelerated Development.

Luborsky, L., et al. (1983). Two helping alliance methods for predicting outcomes of psychotherapy: A counting signs vs. a global rating method. *Journal of Nervous and Mental Disease, 171,* 480-491.

Marmar, C.R., Horowitz, M.J., Weiss, D.S. & Marziali, E. (1986) The development of the Therapeutic Alliance Rating System. In L.S. Greenberg, W.M. Pinsof (Eds.). *The psychotherapeutic process: A research handbook. (pp. 367-390).* New York, NY, US: Guilford Press.

McNulty, S. E., & Swann, W. B. Jr. (1991). Psychotherapy, self-concept change, and self-verification. In R. C. Curtis (Ed.), The relational self: Theoretical convergence of psychoanalysis and social psychology. New York: Guilford Press.

Meyer, G., Finn, S.E., Eyde, L.D., Kay, G.G., Kubiszyn, T.W., Moreland, K.L., Eisman, E.J. & Dies, R.R. (1998). *Benefits and costs of psychological assessment in healthcare delivery: Report of the Board of Professional Affairs Psychological Assessment Work Group, Part I.* Washington, DC: American Psychological Association.

Newman, M.L. & Greenway, P. (1997). Therapeutic effects of providing MMPI-2 test feedback to clients at a university counseling service: A collaborative approach. *Psychological Assessment, 9,* 122-131.

Ogles, B. M., Lambert, M. J., & Masters, K. S. (1996). *Assessing outcome in clinical practice.* Boston: Allyn and Bacon.

Peterson, D. R. (2004). Science, scientism, and professional responsibility. *Clinical Psychology: Science and Practice*, *11*, 196–210.

Rumpold, G., Doering, S., Smrekar, U., Schubert, C., Koza, R., Schatz, D.S. et al., (2005). Changes in motivation and the therapeutic alliance during a pretherapy diagnostic and motivation enhancing phase among psychotherapy outpatients. *Psychotherapy Research, 15*, 117-127.

Seligman, M. (1995). The effectiveness of psychotherapy: The *Consumers Reports* study. *American Psychologist, 50,* 965-974.

Seligman, M. (1996). Science as an ally of practice. *American Psychologist, 51,* 1072-1079.

Speilberger, C.D., Gorsuch, R.L., Lushene, R., Vogg, P.R., & Jacobs, G.A. (1983). *State-trait Anxiety Inventory.* California: Consulting Psychological Press.

Steer R.A., Ball R., Ranieri W.F., & Beck A.T. (1999). Dimensions of the Beck Depression Inventory-II in clinically depressed outpatients. *Journal of clinical psychology 55*, 117–28

Steer R.A., Cavalieri T.A., Leonard D.M., Beck A.T. (1999). Use of the Beck Depression Inventory for Primary Care to screen for major depression disorders. *General hospital psychiatry*, 21, 106–11.

Sullivan, H. S. (1953a). Conceptions of modern psychiatry. New York: Norton.

Sullivan, H. S. (1953b). The interpersonal theory of psychiatry. New York: Norton.

Swann, W. B. Jr. (1983). Self-verification: Bringing social reality into harmony with the self. In J. Suls & A. G. Greenwald (Eds.), Social psychological perspectives on the self: Vol. 2. Hillsdale, NJ: Erlbaum.

Swann, W. B. Jr., Hixon, G., Stein-Seroussi, A., & Gilbert, D. (1990). The fleeting gleam of praise: Cognitive processes underlying behavioral reactions to self-relevant feedback. *Journal of Personality and Social Psychology, 9*, 17-26.

Swann, W. B. Jr., Stein-Seroussi, & Geisler, B. (1992). Why people self-verify. *Journal of Personality and Social Psychology, 62*, 392-401.

Swann, W. B. Jr., Wenzlaff, R. M., Krull, D. S., & Pelham, B. W. (1992). The allure of negative feedback: Self-verification strivings among depressed persons. *Journal of Abnormal Psychology, 101*, 293-30

Tharinger, D. J., Finn, S. E., Wilkinson, A. D., & Schaber, P.-M. (2007). Therapeutic assessment with a child as a family intervention: A clinical and research case study. *Psychology in the Schools, 44*(3), 293-309.

Waltz, J., Addis, M.E., Koerner, K. & Jacobson, N.S. (1993). Testing the integrity of a psychotherapy protocol: Assessment of adherence and competence. *Journal of Consulting and Clinical Psychology, 64,* 1326-1336.

Young, J.L., Waechler, C.A., Laux, J.M., McDaniel, P.S. & Hilsenroth, M.J. (2003). Four studies extending the utility of the Schwartz Outcome Scale (SOS-10). *Journal of Personality Assessment, 80,* 130-138.

Appendix

Table A- 1: Summary of Finding across the Three Cases For Each of the Hypotheses

	Significance for Hypotheses concerning the improvement in *Hopefulness/Wellbeing*			Significance for Hypotheses concerning the improvement in *Symptoms*		
	Improvement in daily measure	Early improvement in daily measure	Meaningful change in SOS-10	Improvement in daily measure	Meaningful change in BDI-II	Meaningful change in OQ-45/SCL-90
Case One: Melanie	No: Non-significant trend in direction of improvement into follow-up	No	Yes	No: non-significant trend of worsening during intervention then return to baseline during follow-up	Yes	No/No
Case Two: Randy	No: Non-significant trend in direction of improvement into follow-up	No	Yes	Yes	Yes	No/No
Case Three: Mark	Yes	Yes	Yes	Yes	Yes	Yes/No

Table A- 2: Melanie-Means and Standard Deviations of Daily Symptom Measure Data

	Individual Phases			**Combined Phases**		**Total**
	Baseline (N =19)	Intervention (N = 44)	Follow-up (N = 28)	Baseline+ Intervention (N = 63)	Intervention+ Follow-up (N = 72)	Baseline+ Intervention+ Follow-up (N = 91)
Dependent Variable	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Distress	4.263 (1.617)	4.886 (1.152)	4.357 (1.172)	4.698 (1.341)	4.680 (1.188)	4.593 (1.301)
Wellbeing	4.737 (1.516)	4.614 (1.071)	5.571 (1.015)	4.651 (1.224)	4.986 (1.149)	4.934 (1.239)
Hopefulness	3.842 (1.348)	4.432 (1.195)	4.714 (1.161)	4.254 (1.272)	4.542 (1.19)	4.132 (1.257)
Feeling Depressed	4.579 (1.816)	4.841 (1.461)	4.250 (0.987)	4.762 (1.581)	4.611 (1.328)	4.604 (1.444)
Self-Esteem	4.579 (1.812)	4.500 (0.783)	4.893 (0.772)	4.651 (0.820)	4.653 (0.802)	4.725 (0.813)
Feeling Awful	4.053 (1.791)	4.773 (1.608)	4.036 (1.052)	4.556 (1.698)	4.486 (1.462)	4.396 (1.547)

Table A- 3: Melanie-Daily Symptom Measure Phase Analysis Data

	Analysis 1		**Analysis 2**		**Analysis 3**		**Analysis 4**		**Analysis 5**	
	Baseline vs. Intervention		Baseline vs. Follow-up		Intervention vs. Follow-up		Baseline vs. Intervention + Follow-up		Baseline + Intervention vs. Follow-up	
Dependent Variable	R	p-value	R	p-value	R	p-value	R	p-value	R	p-value
Distress	-0.213	p= 0.171	-0.034	P= 0.871	+0.217	p= 0.184	-0.130	p=0.349	+0.121	p=0.382
Wellbeing	-0.046	p=0.731	+0.310	p=0.122	**+0.407**	**p=0.005**	+0.082	p= 0.564	**+0.343**	**p= 0.011**
Hopefulness	+0.213	p=0.197	+0.326	p=0.144	+0.116	p=0.484	+0.226	p=0.088	+0.169	P=0.312
Depression	-0.076	p=0.653	+0.116	p=0.584	+0.217	p=0.161	-0.009	p=0.955	+0.164	p=0.220
Self-Esteem	-0.280	p=0.102	-0.116	p=0.591	+0.239	p=0.149	-0.174	p=0.249	+0.131	p=0.377
Feeling Awful	-0.195	p=0.300	+0.006	p=0.398	+0.246	p=0.145	-0.114	p=0.470	+0.151	p=0.341
Hopefulness/ Wellbeing	+0.095	p=0.564	+0.350	p=0.099	+0.282	p=0.079	+0.169	p=0.226	**+0.282**	**p=0.043**
Composite Symptoms	-0.175	p=0.320	+0.032	p=0.883	+0.250	p=0.133	-0.093	p=0.546	+0.162	p=0.303

Table A- 4: Randy-Means and Standard Deviations of Daily Symptom Measure Data

	Individual Phases			**Combined Phases**		**Total**
	Baseline (N = 14)	Intervention (N = 63)	Follow-up (N = 28)	Baseline+ Intervention (N = 77)	Intervention+ Follow-up (N = 91)	Baseline+ Intervention+ Follow-up (N = 105)
Dependent Variable	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Distress	4.928 (2.120)	3.317 (2.210)	1.286 (0.525)	3.610 (2.280)	2.692 (2.084)	2.990 (2.223)
Wellbeing	6.643 (0.717)	6.873 (0.826)	7.893 (0.309)	6.831 (0.812)	7.187 (0.850)	7.114 (0.854)
Hopefulness	7.000 (0.535)	7.222 (0.744)	7.893 (0.309)	7.182 (0.703)	7.428 (0.713)	7.371 (0.707)
Feeling Depressed	2.929 (1.624)	2.111 (1.323)	1 (0)	2.260 (1.418)	1.769 (1.214)	1.924 (1.340)
Self-Esteem	6.357 (0.610)	7.143 (0.587)	7.929 (0.258)	7 (0.664)	7.385 (0.625)	7.248 (0.714)
Agitation	4.357 (2.967)	2.651 (2.009)	1.429 (0.495)	2.961 (2.310)	2.275 (1.786)	2.552 (2.107)

Table A- 5: Randy-Daily Symptom Measure Phase Analysis Data

	Analysis 1		**Analysis 2**		**Analysis 3**		**Analysis 4**		**Analysis 5**	
	Baseline vs. Intervention		Baseline vs. Follow-up		Intervention vs. Follow-up		Baseline vs. Intervention + Follow-up		Baseline + Intervention vs. Follow-up	
Dependent Variable	R	p-value	R	p-value	R	p-value	R	p-value	R	p-value
Distress	+0.271	p= 0.137	**+0.798**	**P= 0.001**	**+0.450**	**p= 0.011**	+0.342	p=0.055	**+0.462**	**p=0.010**
Wellbeing	+0.109	p=0.473	**+0.772**	**p=0.000**	**+0.553**	**p=0.020**	+0.216	p= 0.194	**+0.550**	**p= 0.000**
Hopefulness	+0.120	p=0.586	**+0.726**	**p=0.003**	**+0.434**	**p=0.053**	+0.206	p=0.277	**+0.445**	**P=0.025**
Depression	+0.222	p=0.179	**+0.696**	**p=0.000**	**+0.422**	**p=0.026**	**+0.295**	**p=0.050**	**+0.417**	**p=0.004**
Self-Esteem	**+0.456**	**p=0.012**	**+0.875**	**p=0.000**	**+0.580**	**p=0.002**	**+0.489**	**p=0.008**	**+0.575**	**p=0.005**
Agitation	+0.285	p=0.160	+0.617	p=0.070	+0.316	p=0.077	**+0.336**	**p=0.053**	+0.322	p=0.088
Hopefulness/ Wellbeing	+0.128	p=0.490	**+0.788**	**p=0.002**	**+0.535**	**p=0.010**	+0.229	p=0.230	**+0.539**	**p=0.002**
Composite Symptoms	+0.297	p=0.107	**+0.749**	**p=0.008**	**+0.453**	**p=0.018**	**+0.363**	**p=0.037**	**+0.449**	**p=0.013**

Table A- 6: Mark-Means and Standard Deviations of Daily Symptom Measure Data

	Individual Phases			**Combined Phases**		**Total**
	Baseline (N =15)	Intervention (N = 83)	Follow-up (N = 28)	Baseline+ Intervention (N = 98)	Intervention+ Follow-up (N = 111)	Baseline+ Intervention+ Follow-up (N = 126)
Dependent Variable	Mean (SD)	Mean (SD)	Mean (SD)	Mean SD	Mean (SD)	Mean (SD)
Distress	6.8 (0.748)	5.506 (1.302)	5.107 (0.817)	5.704 (1.319)	5.405 (1.211)	5.571 (1.250)
Wellbeing	2.067 (0.249)	2.706 (0.792)	3.107 (0.618)	2.608 (0.771)	2.807 (0.772)	2.719 (0.768)
Hopefulness	2 (0)	2.518 (0.722)	2.571 (0.623)	2.439 (0.690)	2.531 (0.689)	2.468 (0.678)
Feeling Depressed	6 (0.249)	6.446 (0.976)	5.607 (0.557)	6.388 (0.913)	6.234 (0.961)	6.214 (0.907)
Self-Esteem	2.067 (0.249)	2.526 (0.691)	2.643 (0.718)	2.455 (0.664)	2.573 (0.671)	2.513 (0.657)
Agitation	3.067 (0.249)	3.197 (1.132)	3.429 (0.904)	3.177 (1.048)	2.769 (1.251)	2.804 (1.181)

Table A- 7: Mark-Daily Symptom Measure Phase Analysis Data

	Analysis 1		**Analysis 2**		**Analysis 3**		**Analysis 4**		**Analysis 5**	
	Baseline vs. Intervention		Baseline vs. Follow-up		Intervention vs. Follow-up		Baseline vs. Intervention + Follow-up		Baseline + Intervention vs. Follow-up	
Dependent Variable	R	p-value	R	p-value	R	p-value	R	p-value	R	p-value
Distress	+0.353	p= 0.087	**+0.719**	**p= 0.009**	+0.143	p= 0.456	**+0.361**	**p=0.029**	+0.199	p=0.281
Wellbeing	+0.299	p=0.084	**+0.690**	**p=0.004**	+0.226	p=0.139	**+0.312**	**p=0.030**	+0.270	p=0.076
Hopefulness	+0.270	p=0.031	**+0.477**	**p=0.010**	+0.033	p=0.794	**+0.254**	**p=0.018**	+0.081	p=0.461
Depression	-0.149	p=0.340	**+0.420**	**p=0.002**	**+0.379**	**p=0.008**	-0.060	p=0.655	**+0.358**	**p=0.009**
Self-Esteem	**+0.249**	**p=0.048**	**+0.527**	**p=0.002**	+0.122	p=0.270	**+0.417**	**p=0.017**	+0.164	p=0.140
Agitation	-0.045	p=0.816	**+0.867**	**p=0.000**	**+0.490**	**p=0.005**	+0.082	p=0.645	**+0.430**	**p=0.012**
Hopefulness/ Wellbeing	**+0.351**	**p=0.020**	**+0.703**	**p=0.002**	+0.164	p=0.228	**+0.353**	**p=0.007**	+0.219	p=0.104
Composite Symptoms	+0.087	p=0.617	**+0.885**	**p=0.000**	+0.500	p=0.004	+0.173	p=0.331	**+0.517**	**p=0.001**

Vita

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