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The development of Character Adaptation SysTem (CAST) intervention

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Abstract

The primary objective of this dissertation was to explore the feasibility and utility of an individualized intervention derived from a group therapy manual grounded in Henriques' (2011) Unified Theory of Psychology. This framework serves to translate terminology from different theoretical perspectives and map their overlap and distinctive qualities onto human functioning. This project provides a more directive educational approach to explore whether and how clients can be directed to understand these systems and benefit from them. The second goal was to explore the appropriateness and impact of this manual on a client presentation typically seen in college outpatient treatment. These individuals can be described as having a sense of social inferiority, and they often develop submissive, dependent relational styles to protect themselves from rejection. This presentation has been widely researched and thus allowed for integration between personality theory, psychopathology, and treatment implementation. To address these aims, two undergraduate students (James, age 21; Sarah, age 20) participated in an intervention designed to provide education of this integrative view of human functioning and explore each participant's functioning within ten individual sessions over the course of five weeks during the spring of 2014. Results were examined within a concurrent embedded multiple case study research design to address outcome measures related to implementation and appropriateness. In comparison of these two cases, both clients reported an increased capacity for emotional regulation and ability to deal with stressors in a resilient way; however, there was variability in their overall reactions to treatment. Findings are discussed with regards to individual client characteristics, mode of treatment implementation, and assessment procedures. Future directions include increased use of assessment procedures and increased flexibility of treatment protocol.

Chapter 1

Introduction and Overview

The primary purpose of this dissertation was to refine an initial treatment manual derived from Henriques' (2011) model for unifying psychology into and individualized format. This study was the second in series of attempts to develop intervention approaches based on this unified framework. Kleinman, Asselin and Henriques (2012) demonstrated that the unified framework could be used to organize an undergraduate course experience such that students in the course experienced an increase in their well-being relative to undergraduates in a control class. Glover (2013) examined the feasibility and utility of a group therapy intervention based on this framework for an in-patient population with severe mental illness and found that the framework afforded many positives, both for the participants and for how groups at such a facility might be organized. The current study extended these findings by implementing aspects of this manual within individual treatment sessions intended for a presentation commonly seen in college outpatient mental health. The current intervention was designed to educate clients on a map of human adaptation systems and explicitly apply this framework through repeated assessment and discussion within a therapeutic framework. The intervention utilized Glover's (2013) manual as a guide; however, the main objective was to further develop how to enhance client's understanding of the theoretical framework and their own functioning.

The presentation of focus for this project was individuals with clinically significant levels of negative affect (i.e., individuals who meet criteria for a depressive disorder, anxiety disorder or both) and with identity and relationship problems

characterized by cognitive theorists as “sociotropic” (Beck, 1983) and by psychodynamic theorists as “anaclitic” (Blatt, 1974). Descriptively, these individuals have identity and relational problems in that they tend to have low self-esteem, low coping self-efficacy, and a sense of social inferiority. They also have deep concerns about being liked and accepted, and often develop a submissive, passive, and dependent relational style to protect themselves from rejection. This population was chosen for several reasons. First, it represents and important intersection between issues of personality (i.e., identity and relationships), psychopathology (symptoms of anxiety and depression), and treatment. Second, although often described with different terminology (e.g., sociotropic, dependent, or anaclitic), it is a population that has been examined and discussed by many different theoretical perspectives. Third, it is a relatively common presentation in outpatient college sample populations. As such, it serves a useful population on which to develop the current treatment protocol.

Two individuals participated in a structured intervention designed to enhance adaptive living through a well-specified framework for understanding their psychological functioning. These therapy sessions were conducted through a community mental health center associated with a public university by a doctoral student in clinical and school psychology (Lauren Mays, MA) and supervised by a licensed clinical psychologist (Gregg Henriques, Ph.D.). Participants were two college students (James, age 21; Sarah, age 20) who meet eligibility criteria and were recruited through a screening process done with a sample of potentially eligible undergraduate students. When the necessary screening was done and consent was obtained, the individuals were entered into the intervention. The therapy manual was based on a psychoeducational curriculum (Glover,

2013; Kleinman, 2012) that was created from Henriques and Stout's (2012) framework for a unified approach to psychotherapy. The development of this manual evolved throughout the course of treatment as a result of the continuous evaluations between consistencies and variations between theoretical assumptions and actual presentations. The outcomes of the intervention were developed according to case study methodology, and feasibility and utility of treatment were examined using a concurrent embedded mixed-methods approach. Specifically, quantitative pre-treatment and post-treatment measures and weekly rating scales were utilized to supplement the qualitative case study methodology.

Central Research Questions

The primary goal of the present research project was to illustrate the iterative process of creating and refining the treatment manual for a common presentation. The criteria for developing the manual was based on both the participants' and clinician's experiences of feasibility and utility in developing a unified psychotherapy for these individuals. Feasibility and utility were determined by the ability of the clinician to implement the intervention, by the ability of clients to tolerate the treatment as measured by attrition and participation, by the clients' level of satisfaction on weekly rating scales reflecting therapeutic process outcome variables, by therapist clinical judgment, and by pre-treatment and post-treatment outcomes.

Concerning the emphasis on methodological rigor, it would be considered "unsystematic" to begin an investigation of the feasibility and utility of the current psychotherapy program without a clear understanding of key concepts (Boote & Beile, 2005, p. 11). Therefore, relevant literature will be discussed in the next section regarding

the factors contributing to the fragmentation of the field of psychology and to emphasize the importance for therapies to stem from comprehensive view of human nature. To demonstrate the process by which various perspectives can be potentially incorporated into the unified framework (Henriques & Stout, 2012), the last section of this review focuses on the theoretical and empirical support provided for a common presentation from various schools of thought.

Chapter 2

Literature Review

The goal of the current project is to create a structured outline of a general approach to psychotherapy by integrating a previous curriculum developed to teach college-aged students about well-being and a manual designed to educate an inpatient population on a map of human functioning to generate a recovery narrative. These previous treatments and the current manual are based on the new integrative meta-theoretical framework proposed by Henriques (2011), who argued his Unified Theory (UT) provides a general paradigm for psychological intervention. By "general paradigm," he meant a comprehensive, integrative, internally consistent, and ecologically valid approach to understanding human personality and psychopathology in biological, developmental, and social contexts that allow professional psychologists a concrete but flexible model from which to operate. To date there has been no macro-level theory that allows the major perspectives in psychology in general and psychotherapy in particular to be assimilated and integrated into a more unified paradigm. The current treatment is the next step in actualizing this vision that psychotherapy will, in the future, move from its current state of fragmented pluralism to a state of integrated pluralism.

Fragmented pluralism, as defined by Henriques (2011), is a pre-paradigmatic state of inquiry whereby the major perspectives in the field are anchored to fundamentally different, unrelated, or incompatible conceptions of human psychology. Without a shared foundational understanding, modern psychotherapies are based largely on traditions that are not integrated nor based a similar read of the empirical and theoretical literature in the science of psychology. Functionally, then, the major systems often talk past one another

and thus tend not to not allow for the science of human psychology to effectively result in a cumulative growth of knowledge pertaining to psychotherapy. Henriques (2011) argued that the fields of human psychology and professional psychology could move from the current state of fragmented pluralism to an integrative pluralism. An integrative pluralism embraces the inevitable diversity of psychological inquiry and practice, but emphasizes the need and continued search for broad, comprehensive and coherent frameworks that enable the key insights from various perspectives to be combined and integrated into a coherent whole. Without these integrative frameworks, the different paradigms will continue to be seen by practitioners and the general public as competing against one another for attention, rather than parts of a whole that provides insights into the human condition.

The tension between these perspectives highlights a central underlying problem for this fragmented field. Henriques (2011) argued, however, that empirically derived approaches based on alleviation of discrete symptoms (e.g., CBT), perspectives that have a more holistic view of emotional functioning and emphasize humanistic values (e.g., EFT), and treatments that focus on relationships and internal conflicts (e.g., psychodynamic) can be integrated to increase the field's ability to understand, investigate, and improve human nature. Consider, for example, the concept of defense. This is a basic and central concept in psychodynamic theory. Yet, it is almost nonexistent in traditional cognitive and behavioral paradigms. More recently, however, newer "third wave" CBT practitioners have focused a fair amount of attention on what is labeled "experiential avoidance" (see below). Despite the fact that experiential avoidance is similar to some of the most common defenses identified by psychodynamic therapists

(e.g., repression or suppression), the connection or similarity between the two is rarely identified. In the current state of fragmented pluralism, similar concepts and insights can be used and promoted with virtually no explicit recognition or acknowledgement of their overlap. If professional psychologists had unified frame that allowed for an integrative pluralism, they could move beyond the factional disputes between specific paradigms (e.g., CBT versus psychodynamic) and more toward a holistic conceptualization and integrative system of intervention that leads to cumulative knowledge.

A Brief History of Psychotherapy Integration

There are several indicators that the cultural zeitgeist of psychology and psychotherapy may be moving towards integration with the increasing evidence for the connection between biology and social behavior discovered through social neuroscience (e.g., Cacioppo, Berntson, Sheridan, & McClintock, 2000), for the implications of attachment on social and brain development across a wide range of scientific disciplines (e.g., Siegal, 2001), and for the growing evidence that humans are influenced by both conscious and nonconscious (i.e., implicit) processes (e.g., Bargh & Morsella, 2008; Greenwald, 1992). In a similar vein, a large number of professional psychologists (36%) in APA's Division of Psychotherapy identify as integrative or eclectic (Norcross, Hedges, & Castle, 2002).

Norcross and Newman (1992) identified key factors that have contributed to the growing number of clinicians to embrace psychotherapy integration. The proliferation of therapies has led to confusion about their conflicting nature and "narcissistic fatigue", meaning that therapists find it difficult to keep up with the branding of new treatment approaches (p. 5). Moreover, this proliferation likely increased awareness that no one

theory has the predictive or explanatory power to account for the change process in psychotherapy and that no single intervention can be applied across the diversity of psychopathology encountered by clinical and counseling professions. As clinicians began to experiment with diverse treatments and gain access to other specialties, they were intrigued by the commonalities across the various approaches. The final factor to be reviewed is the development of the Society for the Exploration of Psychotherapy Integration (SEPI) in 1985, affording those interested in the psychotherapy integration movement access to a professional network.

Four main pathways to integration have been identified. The first and broadest, most general approach is called "common factors". Grounded in the observation that many bona fide treatments have been found to produce similar outcomes, a common factors approach identifies common elements from various models that have demonstrated effectiveness, such as the importance of a strong working alliance in therapy, and emphasizes those elements in treatment (see, e.g., Frank's (1973) *Persuasion and Healing*). The second approach to integration is called technical eclecticism, which operates from a pragmatic, rather than theoretical framework, by utilizing techniques that have an empirical basis on an as needed basis (Lazarus, 2005). A third approach, assimilative integration, emphasizes a solid foundation in a single theoretical framework, encourages practitioners to explore techniques from various treatments that can be understood from the primary theoretical framework to improve practice (Norcross & Newman, 1992). Finally, the most systematically integrative approach is called theoretical integration, which attempts to conceptually blend two or more paradigms together in a more holistic approach that is presumably greater than the

sum of its parts (e.g., Wachtel's (1977) cyclical psychodynamics).

Due to the field's evolution from single school approaches, to eclecticism, to integration, could the next stage of development be that of unification? The idea of unification moves beyond exploring the possibility of psychotherapy integration by creating a more comprehensive and complete framework from which practitioners can operate. As an advocate for a unified psychotherapy and clinical science, Magnavita (2008) noted that, "a comprehensive meta-theory must have an array of techniques, methods, and processes applicable to diverse clinical populations, and these must be grounded in scientific evidence" (p. 274). Henriques (2011) claimed that this is exactly what his integrative meta-theoretical approach offers the field.

Importantly, the unified approach is not just one more approach to psychotherapy. It is not an approach grounded in a specific population or a single intervention that organizes treatment or even a separate paradigm based on some presentation. Instead, what it offers is first a way to organize the science of psychology (Henriques, 2011), and it is from that organization that the perspectives of the major paradigms are then assimilated and integrated. As such, it represents a fundamentally different approach to psychotherapy integration that, if successful, would end the fragmented arrangement of the different perspectives and instead replace them with a general model of psychotherapy, grounded in a unified science of psychology. Importantly, there would be much "pluralism" stemming from this model because different scientists and practitioners would be envisioned to emphasize different areas, different techniques and take different approaches to understanding. But what would change is that such pluralism would exist in the context of a larger, shared general framework for understanding. In the following

section, a brief overview of theoretical underpinnings of this unified approach is offered to highlight the foundational elements that will be used to weave together the various approaches to psychotherapy.

A Brief Overview of the Unified Theory of Psychology

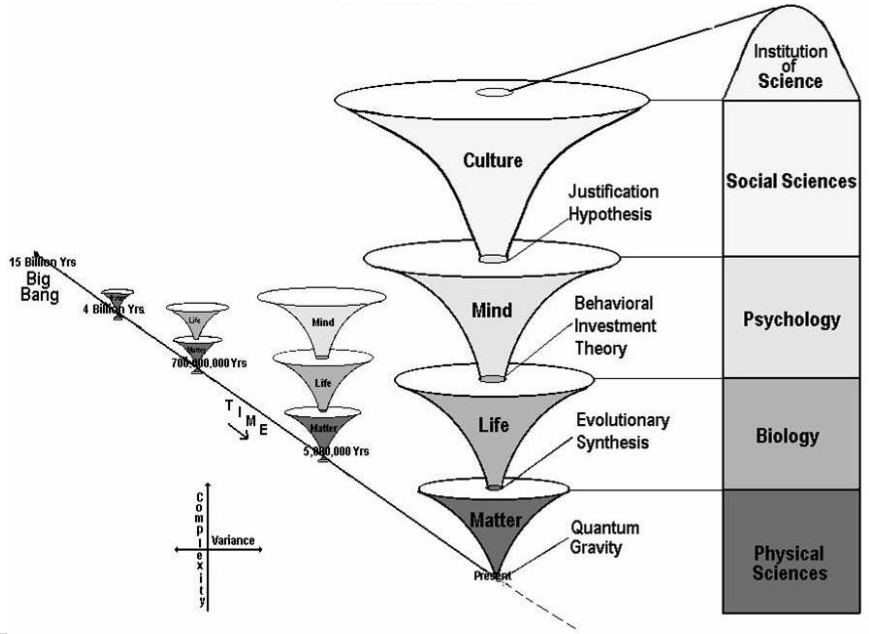
In a series of publications, Henriques (2003; 2004; 2008; 2011; 2013) outlined a new system of thought that he argued addresses psychology's problem with fragmentation. A brief overview of this frame is offered in the next section in order to weave together the various approaches that will be outlined and discussed later in this paper. The Unified Theory (UT) outlined in these publications consists of four separate but connecting theoretical ideas: The Tree of Knowledge (ToK) System, Behavioral Investment Theory, Influence Matrix (IM), and Justification Hypothesis (JH). Henriques (2011) argued these ideas provide the conceptual structure for the unification of psychological science. They will be touched on only briefly here and the reader is referred to the original work for a detailed articulation of each component.

The **Tree of Knowledge (ToK) System** is a central feature of Henriques' system for unifying psychology. It is a graphic that offers a new perspective on the evolution of complexity (see Figure 1). Whereas most perspectives, like that of E. O. Wilson's (1998) *Consilience*, depict complexity as a single dimension that ranges from atoms to cells to animals to human societies, the ToK System depicts complexity as emerging in four distinct phases, labeled Matter, Life, Mind, and Culture.

Henriques (2003; 2011) argued that this new view is central for both understanding why psychology has been fragmented in the past and how psychology can be conceptually unified in the future. One of the central implications of the ToK System

is that there are "joint points" in nature in which higher dimensions of complexity emerge out of lower dimensions. Henriques (2003) argued that the modern evolutionary synthesis provides the joint point between Matter and Life. If this conception is accurate, it follows that there are joint points between Life and Mind and Mind and Culture. Henriques (2003) proposed Behavioral Investment Theory (BIT) as the joint point between Life and Mind.

Figure 1. The Tree of Knowledge System

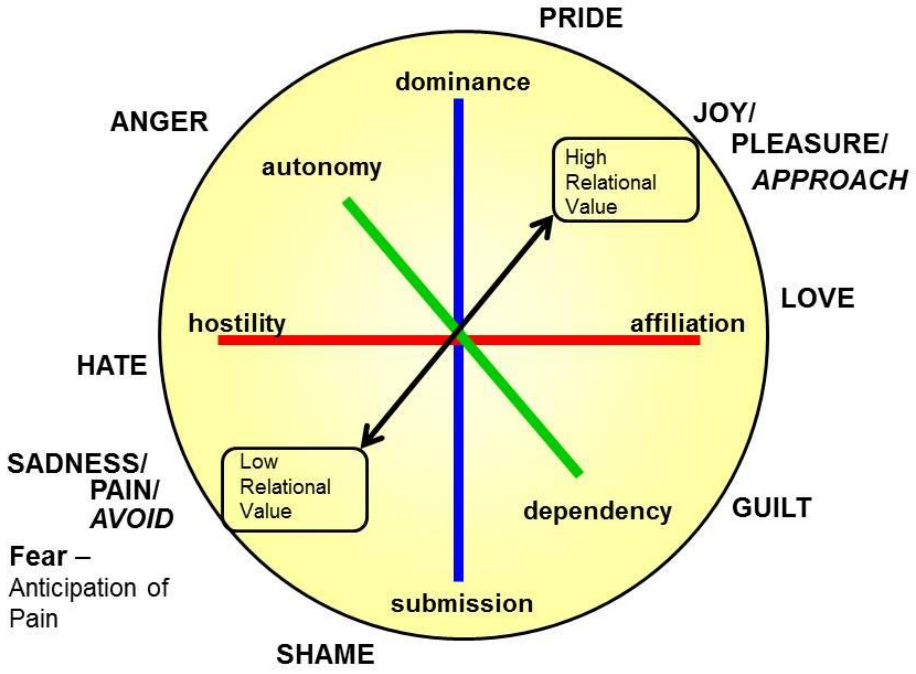


Behavioral Investment Theory provides a framework for understanding the foundational architecture of the nervous system that combines evolutionary, learning and cognitive science perspectives. From this perspective, the nervous system is an investment value system that has evolved to compute energy expenditure of increasingly complex behaviors. Consistent with behavioral and affective neuroscience, the BIT holds that behavior is selected for that increases an individual's positive feeling states (i.e.,

individuals will increase behavior that yields positive outcomes and will decrease behavior that yields aversive consequences). This system is rooted in emotional experience and serves as the foundation for an individual's motivation to maintain, pursue, and/or avoid relationships.

The human relationship system is grounded in behavioral investment principles and is represented by the **Influence Matrix**, a three-dimensional map of how humans process social information, develop social goals, and are guided by emotions in navigating the social environment (see Figure 2).

Figure 2. The Influence Matrix

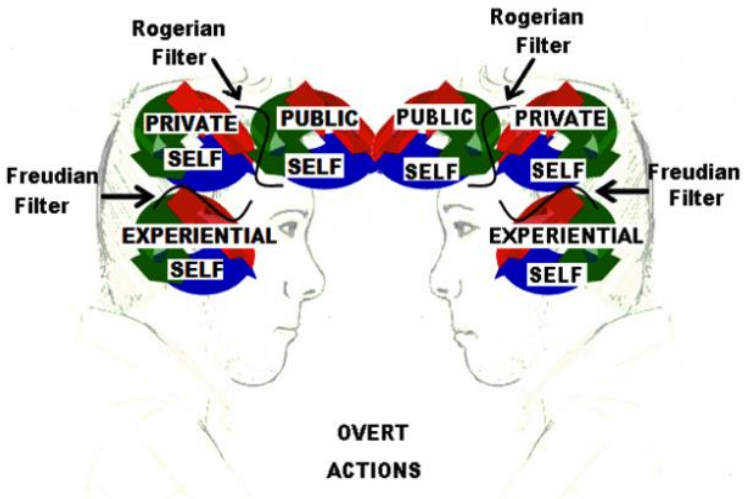


According to the IM, relational value is the fundamental dimension and guiding barometer underlying social exchange. The IM is considered an extension of the Interpersonal Circumplex (Leary, 1957), which posits that human social motivation and interpersonal processes exist on two dimensions of dominance (**power**) and nurturance

(**love**). The IM expands on these dimensions by adding another relational process dimension of autonomy-dependency (**freedom**) and includes the capacity to influence others in accordance with one's interest as another dimension (**relational value**). In sum, the relational process dimensions of power, love, and freedom are secondary to navigating this fundamental need for relational value. The IM serves as the basis for the relational system that will be discussed in reference to conceptualizing human nature.

The fourth piece of the unified framework is called the **Justification Hypothesis** (JH), which provides the conceptual "joint point" between animal behavior (Mind) and human self-consciousness and knowledge systems (Culture). This connection also provides the link between and individual's mind and the minds of others through the ability to process and communicate symbolic information. Relevant for the current discussion is that the JH ultimately yields a map of human consciousness that has much integrative potential. The map divides human consciousness into three domains that are connected by two distinct filters (Figure 3).

Figure 3. The Context of Justification



The first domain is called the **experiential self** and refers to sensations, perceptions, feelings, and desires (e.g., anger, hunger, smell) and is primarily organized through emotion. The second domain or, the **private self**, refers to an individual's the internal dialogue that is made up of language-based beliefs and used to make sense of his or her experiences. The **Freudian Filter** mediates between these domains by allowing the individual to internally justify his or her own feelings and actions in more socially appropriate way than true unconscious motives. The last domain is called the **public self**, which consists of the communication between individuals that allows each person to justify his or her beliefs to others. It is through the **Rogerian Filter** that individuals learn how to communication these justifications in a way that is socially acceptable and facilitates or maintains relational value. In sum, Freudian and Rogerian filters provide the basic structure of justification within an individual and form the foundation for culture as large-scale justification systems (Henriques 2003, 2011).

According to Henriques (2011) these four pieces that together make up the UT, create a new opportunity to see afresh the field of psychology and psychotherapy. Metaphorically, he argued that it enabled psychologists to shift from seeing specific trees (i.e., parts of the whole) to seeing the forest (i,e, the whole field of human psychology). An analysis of how the technical elements of these ideas accomplish this is beyond the scope of this review, and the reader is encouraged to consult Henriques (2011) for a detailed review of these components. What is relevant for this review is how they set the stage for a new approach to conceptualizing people and integrating various perspectives in psychotherapy. In the next section, the various perspectives that will be integrated to create a unified approach to psychotherapy are reviewed. A case study will be examined

through each of these unique lenses in order to demonstrate both their similarities and relative emphases.

Mapping the Fragmented Pluralism: Insights and Interventions of Major Approaches

The objective of this section is to provide a brief overview of the major approaches with the ultimate goal of demonstrating ways in which these major approaches in psychotherapy provide unique, complementary and/or overlapping insights in their conceptualization and treatment. The major approaches will be discussed as follows: (1) Traditional Behavioral Therapy; (2) Traditional Cognitive Therapy (CT), Third-wave Cognitive-Behavioral Therapies (CBT) (e.g., Dialectical Behavior Therapy, Acceptance and Commitment Therapy) and more integrated CT (Young's Schema Focused Therapy); (3) Neo-humanistic approaches, specifically Emotion-Focused Therapy (EFT); (4) Interpersonal Psychotherapy; (5) And modern psychodynamic therapy as represented by McCullough's (2003) Short-Term Dynamic Psychotherapy for Affect Phobia and Fosha's (2002) Accelerated-Experiential Dynamic Psychotherapy (AEDP).

Each approach will be discussed separately with specific treatment modalities to demonstrate their main components, basic assumptions, and approach to treatment. In addition, to help clarify each perspective, a case example, that of Caroline, will be introduced and then analyzed briefly. The goal of this analysis is to set the stage for a crucial claim of the unified approach, which that it provides a way to integrate and assimilate the key insights from the major perspectives into a more coherent, holistic map.

The case of Caroline. Caroline is a 19-year-old single, Caucasian, female, currently in her sophomore year of college. When Caroline first entered the clinic, she avoided eye contact and kept her head low as she struggled to find the words to express her presenting concerns. She was apologetic throughout the session and spoke vaguely of her problems with inattention, confused thoughts, low self-esteem, anxiety, and depression. She spoke about her overall sense of inferiority that frequently resulted in harsh self-criticism when she perceives herself to have failed in some way. Her affect was generally mildly negative, and she reported certain times when her thoughts and feelings become overwhelmingly negative. When this happens Caroline cannot interrupt her negative thought patterns and has experienced passive death ideation thinking, "It would be easier if I wasn't here." Her main way of coping with these feelings is to seek contact with other people and trying to tell herself that everything is fine.

Caroline described her childhood as "ok", but that she always felt a bit vulnerable. She reported that her parents were there for her, but that she was not sure they really knew her and that she had many thoughts and feelings she did not share with anyone. She reported a history of conflicted relationships, both with peers and romantic partners, with major themes being a fear of being rejected, a sense of being not good enough, a feeling that she was being taken advantage of, and, on occasion, periods when she "blew up" and became extremely upset. At her initial presentation, a detailed assessment revealed Caroline met criteria for both Generalized Anxiety Disorder and Major Depressive Disorder Recurrent, in Partial Remission.

This presentation was chosen because it has many features that are quite typical, especially for a college age populations. Problems with identity and relationships, specifically feelings of low self-esteem, a lack of a clear sense of self, poor relationships with little intimacy or security and other indicators that are suggestive of a less than healthy socio-emotional development, coupled with clinically significant levels of anxiety and depression represent one of the most basic constellations seen in psychology clinics. Yet the dominant intervention models orient practitioners toward quite different modes of conceptualizing and intervening with this case.

A brief review of some of the more common perspectives and the key concepts and interventions that practitioners from those perspectives would likely operate from is offered below. The goal is to help orient the reader to the landscape of individual psychotherapy for adults, which in turn will set the stage for what the unified approach has to offer. It is worth noting in setting up these descriptions, that many more approaches exist. Indeed, some have estimated that as many as 500 separate approaches to adult psychotherapy exist (Norcross & Goldfried, 2005). There has, thus, been a massive proliferation of approaches that create an ocean of information and the high potential for confusion and difficulty making cumulative progress. Nevertheless, one can reasonably assert that there are major traditions in Western individual adult psychotherapy, and that is what our focus is on here.

Behavioral. The basic assumption of the behavioral perspective is that only behavior that can be observed should be the focus of study and intervention. Learning theory is central to this perspective, and those who use this approach emphasize classical and operant conditioning, the formation of habits, consequences of a behavior, and

adaptations to the immediate environment. For example, from a classical conditioning perspective, anxiety becomes paired with certain stimuli (e.g., assertiveness, public speaking, etc.), leading the individual to engage in problematic avoidance behaviors. Since anxiety can be learned, it can be unlearned through the process of counterconditioning by pairing the anxiety-laden stimulus with relaxation (e.g., systematic desensitization) or substituting an opposing response (e.g., assertiveness training, behavioral activation). The goal of behavioral treatments is to reduce symptoms by changing environmental contingencies (e.g., reinforcement and/or punishment) or by altering the negative, automatic associations that lead problematic responses.

Caroline. For Caroline, the behavioral approach would posit that she is avoiding anxiety-provoking situations by withdrawing from interpersonal exchanges, thus creating a negative cycle of depression and anxiety. Caroline appears to have a fear of either loss, failure or criticism and, therefore, attempts to decrease conflict by being passive and submissive to others needs at the expense of her own in an effort to maintain her relationships. Her interpersonal behaviors are reinforced by the avoidance of loss, but at a great personal in the sense that she must sacrifice other needs to achieve them (McCullough Vaillant, 1997).

A behavior therapist likely would want to alter the behavioral cycles of submissiveness and resentment and promote healthy activation through counter-conditioning techniques. Through systematic desensitization Caroline would learn relaxation techniques and create a fear hierarchy that ranks anxiety provoking situations relating to assertiveness, from least to most fearful. Caroline would gradually be introduced to these situations using assertive responses while simultaneous engaging in

the relaxation techniques. Another possible method would be psychoeducation and practice regarding social and communication skills needed to assert her needs, feelings, and ideas in a respectful way that considers both self and other. Moreover, behavioral activation would help counteract Caroline's depressive symptoms that are brought on by her withdrawal, feelings of low self-worth, and negative affect by interrupting the cycle of depression through increasing her levels of engagement (Jacobson, Martell, & Dimidjian, 2001).

Cognitive. Unlike the behavioral perspective, traditional cognitive approaches assume that maladaptive and distorted beliefs produce distress and problematic behavior, rather than the environment itself. Using a traditional cognitive therapy (CT) approach to depression as an example, the underlying belief structure of these individuals includes negative appraisals about themselves, the world, and their future (Beck, 1970). These pessimistic evaluations occur automatically in certain situations and lead to activation of negative emotions; however, since these beliefs have gone unchallenged, the individual suffering from depression believes these thoughts to be unquestionably true.

A CT therapist initially collaborates with the client to help her become aware of and understand the nature of these automatic and core beliefs. Once this is achieved, then the process is designed to assist with determining the extent to which these beliefs are logical or illogical/adaptive or maladaptive. Once the maladaptive thoughts are elucidated, the client then begins to learn how to restructure these thoughts by examining the evidence, using alternative explanations, and determining realistic fears. Therefore, the goal is to identify maladaptive thoughts and restructure or eliminate the faulty belief systems from which they originate.

***Caroline*.** According to this view, Caroline's negative thoughts about herself and others make her particularly vulnerable to symptoms of depression because these schema are overly pessimistic, produce negative feelings, and tend to reduce self-efficacy in coping and relationships (Beck, 1970; Beck, 1979). The way she interprets interpersonal relationships increases her negative reactions to threats of rejection, possibly stemming from beliefs that she is incompetent or that she is unlovable. As such, when faced with real or imagined loss or abandonment, she automatically begins thinking that the loss would be unbearable and that if she is abandoned, no one will ever lover her again (Beck, 1983).

Third wave approaches. Although the effectiveness of CT and CBT has been demonstrated in reducing symptoms, there are some who believe that these techniques are too focused on changing distressing symptoms (Dimeff & Linehan, 2001). Two therapies in particular, Dialectical Behavior Therapy (DBT) and Acceptance and Commitment Therapy (ACT), incorporate the Zen Buddhist notion of *dukkha* (roughly translated as suffering or anxiety) that assumes that suffering is both an inevitable and unavoidable aspect of human existence. Moreover, this principle holds that when individuals attempt to avoid or control this suffering, they end up increasing the experience of pain and distress (Hayes, Strosahl, & Wilson, 1999). Consequently, these treatments incorporate ways to help individuals release themselves from this struggle by learning how to be more accepting and mindful of their experiences, rather than eliminating aspects of them.

DBT explicitly teaches mindfulness skills to create a holding environment for clients to maintain connection with their moment-to-moment experiences without

judgment. Mindfulness techniques are used to increase the client's ability to tolerance distress and accept her current emotional state. From this model, competence in mindfulness techniques is necessary to increase the client's ability to regulate her emotions by focusing on ways she can alter her reactions to distressing situations and let go of emotional suffering by altering painful emotions. Rather than focusing on changing the environment, DBT helps individuals tolerate these painful emotions adaptively without letting the distress overwhelm them, even in situations that cannot be changed no matter how upsetting the circumstances may be (Linehan, 1993a, Linehan, 1993b).

Also rooted in Eastern ideals of acceptance of emotional suffering, ACT's treatment model emphasizes the role of psychological flexibility in altering the relationship language-based beliefs and environmental contingencies that lead to the inability to change behavior to achieve long-term goals (Hayes, 2004). Specifically ACT focuses on improving this flexibility through six core processes: (1) Acceptance is viewed as the alternative to experiential avoidance; (2) Cognitive defusion modifies the way that individuals relate to their thoughts; (3) Being present in non-judgmental awareness of one's surroundings and subjective experience in the present moment; (4) Self as context is a way for individuals to view themselves in relation to others to help gain perspective; (5) Values provide a direction to lead a more purposeful life; and (6) Committed action are concrete goals that guide individuals toward increasing their desired behavior change (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Therefore, when an individual is unable to appropriately regulate her behavior through language, cognitive methods are insufficient and should be altered by engaging in experiential strategies by increasing the client's capacity to tolerate distress, rather than control her

experience, as taught in traditional CT.

Caroline. Returning to Caroline, many of her relationship concerns would greatly benefit from the skills emphasized by third wave CBT perspectives since her difficulties stem from avoidance, rather than acceptance, of her experience by compulsively seeking contact and trying to escape from her suffering. Moreover, during stressful situations, she has difficulty accessing feelings of compassion or warmth due to her sense of inferiority and harsh self-criticism. Rather than nonjudgmentally observing and accepting authentic thoughts, feeling, and emotions, she is actively trying to interrupt them, further increasing her distress.

An Integrative Cognitive approach. Several individuals have attempted to blend the cognitive emphasis on belief and information processing views with more relational approaches to conceptualizing and treating psychopathology. Young's Schema Focused Therapy is an example as it attempts to assimilate elements of attachment, psychodynamic and experiential therapies to treat problems relating to self and other schema. Finding that cognitive-behavioral therapy was too narrow for individuals with chronic personality problems, Young posited that early maladaptive schemas of self-other relationships develop in childhood or adolescence and are maintained through the assimilation of negative experiences throughout the lifespan. As a result, individuals develop maladaptive coping styles to adapt to threats in their relational environment. Although schemas are fixed, schema modes are moment-to-moment emotional and cognitive reactions dependent on the context. These modes are associated with various emotional reactions that occur as a result of encountered people and situations. The goal of ST is to gradually work toward the *Healthy Adult* mode to increase emotional stability

and integration and balance between the various modes (Young, Klosko, & Weishaar, 2003).

***Caroline*.** According to Schema Therapy, Caroline would have an early maladaptive schema of *other-directedness*. That is, Caroline is focused on meeting the demands of others while neglecting her own needs in order to gain approval from others, stay connected, and avoid conflict. It would be hypothesized that she was raised in a family system where love was conditional (Young et al, 2003; Young & Klosko, 2005). In an attempt to satisfying these unmet emotional needs, Caroline tends to seek out relationships that intensify her schema and generally accepts that she must take care of others. She employs this style of coping to decrease the anxiety around her schema, but it has unwanted consequences (Martin & Young, 2010; Young et al., 2003). Lastly, Caroline exhibits various schema modes, two of which will be discussed in this section. Caroline frequently operates in the *Compliant Surrender* mode by tolerating maltreatment and being unable to express her own needs. Therefore she utilizes passive, submissive, and ingratiating relational strategies to avoid conflict and abandonment. There are also instances when Caroline is in the *Vulnerable Child* when she feels lonely, hopeless, worthless, unsupported, and unlovable. According to ST, being in this vulnerable mode is integral to Caroline's ability to tolerate these emotions in an adaptive way, while simultaneously being able to maintain a healthy adult perspective on them (Young et al., 2003).

Neo-humanistic. Humanistic/Experiential approaches emphasizes that "emotions are inherently connected to feelings of closeness and trust and are intimately involved in the ability to deal successfully with relationships" (Greenberg, 2002, p. 8). Such

approaches also focus on the relationship between client and therapist as an integral component of therapeutic change. Therefore, in contrast with CT's language-based approach and view that automatic thoughts lead to psychopathology (Beck, 1976), humanistic approaches dissuade individuals from suppressing healthy emotion and posit that growth occurs from exploration of these direct experiences of these feelings. Moreover humanistic ideals seem to parallel the third wave CBT approaches that people need to learn to accept, rather than control, their emotions (Greenberg, 2002; Rogers, 1959).

Greenberg's Emotion-Focused Therapy (EFT) is a prominent example of a neo-humanist approach due to its foundations in humanistic ideals and its concurrent contrasting and complementary nature to CT. According to EFT, individuals are constantly navigating emotional experiences and attempting to make meaning from them, and that there is enormous adaptive potential for those who can both effectively regulate and fully experience their emotions. According to this view, psychopathology would stem from the disintegration of head and heart, and therefore, optimal health would allow the client to have a consistent sense of self, while feeling the full range of her experiences. To do this, therapists take the role as an "emotion coach" to help the client cope with her experiences though awareness, acceptance and, finally, integrating their complex feelings into the self-narrative. This coaching occurs by helping the client arrive at her emotional experience to understand it, and once it is understood and integrated; the coach helps her leave the experience (Greenberg, 2002; 2004).

EFT categorizes the differences between emotions (i.e., primary, secondary, and instrumental) and uses this understanding to help therapist's coach their clients. Primary

emotions are initial reactions to the environment, but they can be *adaptive* (i.e., the emotion aligns with the situation relative to an individual's values and future goals) or they can be *maladaptive* (i.e., the emotion is dysfunctional can lead to serious -term consequences). Secondary emotions are the reactions activated by the individual in response to an unwanted or intolerable primary emotion. For example, when a man's romantic partner ended their relationship, Tom initially felt hurt (primary emotion); however, without realizing it, his sadness was quickly replaced by anger (secondary emotion) because the sadness (primary) was intolerable. EFT also defines another maladaptive use of emotions, instrumental emotions, when individuals habitually utilize certain feeling states to manipulate others into fulfilling their needs. Continuing with Tom's response to his heartache, his anger would be considered an instrumental emotion if he used this emotion to intimidate and control his partner's behavior to keep her from ending the relationship. During the course of EFT, the entirety of the client's emotional experience is activated and explored to determine the type of emotion(s) being felt and their adaptive quality. The goal of EFT is to help the client fully experience their emotional experience emotions to identify the environmental signals that activate primary emotions, to build upon his or her tolerance of adaptive emotions, and to explore painful historical dynamics that influence maladaptive emotions. The client also explores secondary emotions to explore their function and learn more effective ways of coping (Greenberg, 2002).

***Caroline*.** EFT would posit that Caroline's inability to express emotions has prevented her from processing thoughts and feelings (Greenberg, 2002; Greenberg & Watson, 2006). Caroline's feelings of low self-esteem, anxiety, and depression have

organized her behavior in the clinic (e.g., bowed head, avoiding eye contact) and in other areas of her life. Moreover, Caroline's emotionality is hypersensitive to perceived threats of rejection and distance, leading her to desperately seek support. Her "overwhelmingly negative" emotions are likely communicated to others in Caroline's life through verbal and nonverbal communication, and her intense reactions to criticism may keep others from communicating their authentic experience to her for fear they may hurt her.

From this perspective, EFT might intervene by coaching Caroline to assess, rather than ignore, her emotional experience. Her drive to seek contact when she feels that a relationship is threatened helps her to quickly decrease the negative emotionality without allowing herself to fully process the complex feelings that make up her anxiety. Through treatment, Caroline might be able to understand her anxiety and depression as secondary emotions that signal her to possible feelings of loss, fear, despair, anger, and so on. Caroline may also begin to understand her negative emotionality originates from seemingly core, yet unhealthy aspects of her identity. These maladaptive feelings of shame and inferiority keep her trapped and confused in her maladaptive patterns. An emotion coach would assist Caroline's access these feelings and help her understand their origins and ways in which Caroline is reacting to them that is not serving her goals (Greenberg, 2002).

Interpersonal. Interpersonal psychotherapy (IPT) focuses on interpersonal functioning to enhance the patient's current social support network and reduce symptomatic distress (Weissman, Markowitz, Klerman, 2000). IPT utilizes some techniques common in modern psychodynamic psychotherapy (e.g., managing anxiety of painful affects, exploration of themes, etc.), but the focus of these interventions are to

alleviate depressive symptoms rather than change fundamental attachment patterns or increase client insight. It operates under the assumption that distress originates from interpersonal problems and does not warrant processing of unconscious conflicts or direct attention to the therapeutic relationship (Stuart, 2006). The role of the therapist is to be an active, supportive, and "benign and helpful ally" who guides the client to understand and communicate his or her needs within *current* relationships (Weissman et al., 2000, p. 13).

The initial connection between the client's distress and problematic interpersonal functioning is determined through an inventory of relational dynamics factoring into the onset and maintenance of symptoms. IPT posits that there are four fundamental relational problem areas that can be addressed: (1) Grief - IPT operates under the assumption that inadequate or abnormal grieving can lead to depression due to their inability to return to their everyday lives; (2) Interpersonal role disputes - the client and a significant other in the client's life have unshared and contrasting view about the other person's role in their relationship; (3) Role transitions - the client is having difficulty maintaining a stable sense of self while adapting to a change in life circumstances (e.g., divorce, birth of a child, retirement); (4) Interpersonal deficits - these deficits can range from a poverty of attachment relationships, social isolation, feeling unfulfilled in current relationships, difficulty maintaining relationships. From this inventory, the therapist and client determine the problem area(s) contributing to the client's distress, and they embark on a mutually agreed upon goal that is attainable within the time-limited framework (Weissman et al., 2000).

***Caroline*.** From an IPT perspective, Caroline's current depressive symptoms are a result of her interpersonal deficits as evidenced by her history of conflicted relationships.

By gathering a detailed account of these relationships, and IPT therapist would look for patterns and possible problem areas for Caroline. The therapist would help Caroline recognize these patterns of harsh self-criticism and her clinginess as poor reactions and help her avoid falling into those patterns in future relationships.

Modern psychodynamic. Psychodynamic approaches operate on basic assumptions that inner conflicts emerge as a result of diverging thoughts, behaviors, and motives, rather than from external to the individual (e.g., behaviorism). Moreover, there is a great deal of emphasis placed on an individual's attachment history and other developmental experiences have impacted her current level of functioning. Similar to the humanistic perspective, they also view therapeutic relationship as an essential tool for growth; however, there is an added element of exploring the relationship as a vehicle for exploring past and current relationships. Specifically, they draw parallels between past and present interpersonal patterns both within the therapeutic relationship and current relationships in the client's life, intra and interpersonal experiences. McCullough's Short-term dynamic psychotherapy for affect phobia (STDP-AP;McCullough Vaillant, 1997; McCullough, 2003) and Fosha's (2002) Accelerated-Experiential Dynamic Psychotherapy (AEDP) are two well-established approaches that address the intersection between adaptive relational representations, defenses, and emotional expression.

STDP-AP integrates psychodynamic and behavioral theories by translating core psychodynamic conflicts into behavioral language (McCullough Vaillant, 1997; McCullough, 2003). From this model, Affect Phobias, or "a fear of feelings," are central to an individual's intrapsychic and interpersonal conflicts because they lead to avoidance of the feared object in an attempt to reduce anxiety. As a result, behavioral interventions

designed to treat phobias have been adapted and applied to treatment of psychodynamic conflicts (McCullough, 2003, p. 2).

According to McCullough (2003), Affect Phobias are learned through life events and can therefore be unlearned through systematic desensitization. Much like Wachtel's (1977, 1997) cyclical psychodynamics, Affect Phobias are theorized to originate from early relationships with significant others and are repeated in current relationships. In STDP-AP, the therapist takes an active and collaborate role in helping the client identify past relationships with significant others that have contributed to their Affect Phobia and how those relational patterns are maintained in current relationships, thus incorporating the relational system and developmental context. The interactions between the therapist and client are used to highlight these relational patterns as they occur in therapy. Once defensive patterns are recognized, the therapist can begin to expose the client to the feared emotion. Through a delicate balance of confrontation and supporting techniques, the patient is systematically desensitized to the Affect Phobia. The therapist guides the client through imagery techniques so the client can move from a more cognitive understanding of the phobia to somatically experiencing it. Avoiding the emotion are restricted during the exposure; however, the therapist is actively monitoring the client's anxiety to increase optimal exposure to access. As clients experience the feared affect, they begin to learn how to improve interpersonal skills of communication and expression.

Borne out of the STDP model, Diana Fosha (2000) created Accelerated Experiential Dynamic Psychotherapy (AEDP) to operationalize the relationship between attachment and affective neuroscience in a therapeutic setting. The aim of this model is to change the way individuals connect with their core affective experiences. These

experiences are defined as "the absence of defense and aversive signal affects, and by its capacity to engender state transformations" (p. 7). Specifically, treatment alleviates pathology by allowing patients to feel the intensity of their experiences without anxiety or fear that was previously associated with these emotions. Through various relational, restructuring, and experiential-affective strategies, AEDP is designed to unleash naturally occurring resilience within the individual that is motivated toward healing (Fosha, 2000).

Similar to McCullough's (2003) Affect Phobia, AEDP utilizes a psychodynamic defensive framework to keep the therapist focused on the affective experience of the client. Fosha divides emotions into red and green signal affects. Red-signal affects are similar to MCullough's inhibitory affects, as they increase defensiveness and self-protection. Unique to AEDP, green-signal affects enable the patient to experience core affects without anxiety and replace defensiveness with expressive responses. By experiencing these core affects, patients may have a variety of healing responses (e.g., a sense of agency, feelings of closeness, being authentic). To facilitate emotional change through these core experiences, the therapists track the moment-to-moment interactions between defensiveness and openness using this framework (Fosha, 2000).

Focusing on attachment, the role of the therapist is to actively create a secure base from which the client can be understood as "existing in the heart and mind of a loving, caring, attuned and self-possessed other, an other with a heart and mind of her own" (Fosha, 2003, p. 228). The therapist encourages growth by mirroring the client's emotions, validating experiences, or deepening them through other means. In addition to processing core states internally, patients need to be able to process them with the therapist who represents an empathic, loving other. Transformative experiences are

possible within the security of the therapeutic relationship by allowing patients to experience intense emotions in a way that helps them feel more connected rather than alone (Fosha, 2000, 2005).

***Caroline*.** From a psychodynamic perspective, Caroline's current depressive symptoms and dependent interpersonal style are largely due to her internal working models of early parent-child interactions. Specifically, she would likely have an insecure anxious-ambivalent attachment history with her caregiver(s) and become activated when facing loss or abandonment (Blatt & Homann, 1992). Caroline cannot adequately cope with distress, and as a result, her intense emotionality may be seen as core affect, but in actuality is the anxiety associated with this feeling state (Fosha, 2000). Since she is defended against her authentic emotions, she would need to be systematically exposed to them. In this case, Caroline's Affect Phobia of healthy assertion is preventing her from forming meaningful relationships (McCullough, 2003).

The connection between Caroline's drive to meet social demands and her representation of others can be expressed in AEDP's emphasis on attachment. According to Fosha (2000), Caroline's previous caregiver did not have the affective competence to attend to her emotional needs. Affective competence is the ability for a caregiver to stay present with his or her own emotions while maintaining a sense of equilibrium within the self and within the parent-child relationship. Caroline's anxious attachment style is theorized to have lead her to experiences a tremendous amount of anxiety associated with her emotional experience. Thus, as an infant, she created defenses to protect herself from a potentially invalidating or frightening environment. This may be a reason for her utilization of defenses that do not threaten current attachment relationships (e.g.

regression, repression of anger, denial, displacement, and defensive exclusion of freedom: Fosha, 2000; Lipton & Fosha, 2011).

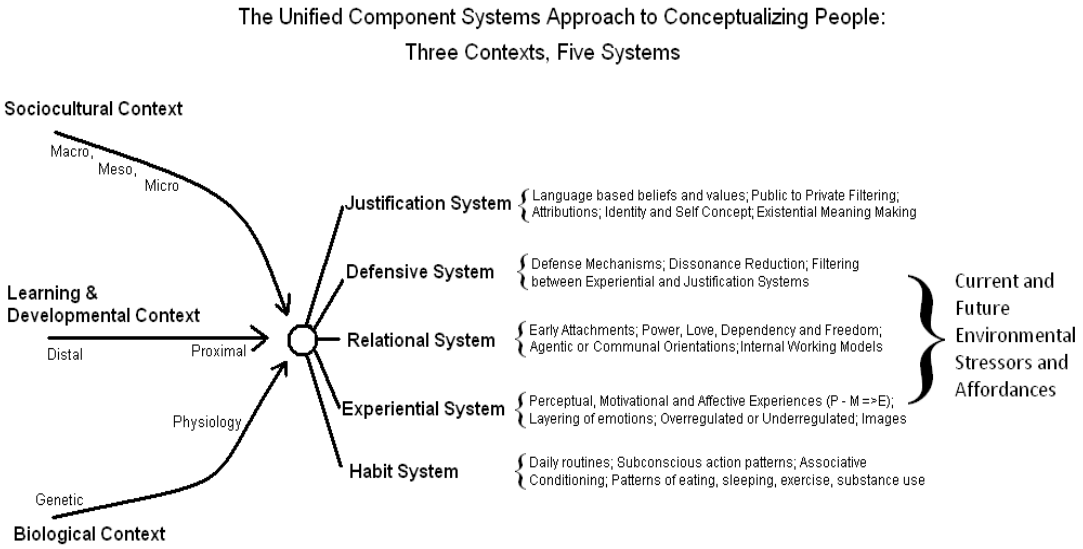
The Character Adaptation Systems Approach

Earlier, major approaches to psychotherapy were reviewed and it was pointed out that some approaches emphasized key processes like classical and operant conditioning in the formation and maintenance of behavior patterns, whereas others emphasized beliefs, and others emphasized internal working models of self and other, and others emphasized the current interpersonal sphere. From the vantage point of the unified approach, the competition between emphases is unhelpful and perspectives are unnecessarily defined against one another, and the unified approach offers a way to obtain a "birds eye" view on the field and connect the key insights together into a more coherent whole.

Toward that end, Henriques and Stout (2012) delineated a Unified Component Systems Approach to Conceptualizing People in Psychotherapy. They argued that the key insights from the various approaches could be assimilated and integrated to creating a deeper understanding of human functioning. The approach is offered in (see Figure 4). On the left side of the diagram, human functioning is put into three broad contexts: Biological, Learning and Developmental, and Sociocultural. These contexts correspond to the levels of complexity represented in the ToK System and the biological, psychological, and social levels of human behavior. Because this model is grounded in a unified model of science, Henriques and Stout (2012) provide a theoretical grounding for a biopsychosocial perspective that is widely accepted as a comprehensive approach to understanding factors affecting human functioning. This framework is outlined below

within the context of contemporary personality theories and will be used to provide a much needed, macro-level from which to create an integrated intervention.

Figure 4. Unified Component Systems Approach to Conceptualizing People in Psychotherapy.



The Five Systems of Character Adaptation

As Henriques (2011) notes, contemporary personality theorists have developed a more integrated and holistic view of human functioning that expands upon the *Big Five* trait theory and together may provide a solution for the proliferation of treatments (e.g., McAdams & Pals, 2006; Singer, 2005). McAdams and Pals (2006) developed one such model in their article titled, *A New Big Five*. They offer that personality is "(a) an individual's unique variation on the general evolutionary design for human nature, expressed as a developing pattern of (b) dispositional traits, (c) characteristic adaptations, (d) self-defining life narratives, complexly and differentially situated (e) in culture and social context" (p. 204).

The third component to McAdams and Pals (2006) framework, characteristic adaptations, are central aspects of functioning and include a person's every day behavior, goals, motivation, self-regulation, effort, adjustment, and defensive structure. McAdams and Pals noted, "no definitive, Big-Five-like list exists" (2006, p. 208); however, Henriques and Stout's (2012) Unified Component Systems Approach to Conceptualizing People provides this framework. In this model, they describe the five essential systems of adaptations within a biopsychosocial framework, located on the right side of the diagram. These adaptations are: (a) the habit system, (b) the experiential system, (c) the relational system, (d) the defensive system, and (e) the justification system. Each system is reviewed briefly below.

The habit system. The habit system is the most basic and foundational system of adaptation. This system represents the automatic, non-conscious associations made by the nervous system and includes every day patterns of behavior that occur without effortful processing. This system includes conditioned responses as well as more skills-based procedural learning that can become automatized through repetition. These may include sleeping and eating patterns, exercise routines, substance use, level of engagement, and conditioned responses

The experiential system. The experiential system refers to all first-person experiences processes through the senses and corresponds to what Baars (1997) refers to as the *theater of consciousness*. This system is synonymous with the **experiential self** that was described in the section describing the JH. This system is guided by behavioral investment principles and organized by emotional states. Specifically, the basic flow of the experiential system is that perceptions are referenced against intuitive goal states and

then “result in action orienting affective response tendencies (see Henriques 2011, p. 235 for more detail). This system also includes mental images, imagined scenarios, and memories of visual information.

The relational system. The relational system is an extension of the experiential system, but it is organized by self-in-relation-to-other representations. As was previously discussed, **The Influence Matrix (IM)** serves as a three dimensional map of the relational system (Figure 2). As reviewed previously, the IM posits that human social motivation and interpersonal processes exist on the core dimension of relational value and on three process dimensions of power, love, and freedom. These processes guide individuals utilize strategies to attain relational value and social influence, defined as the capacity to influence others in accordance with one’s interest.

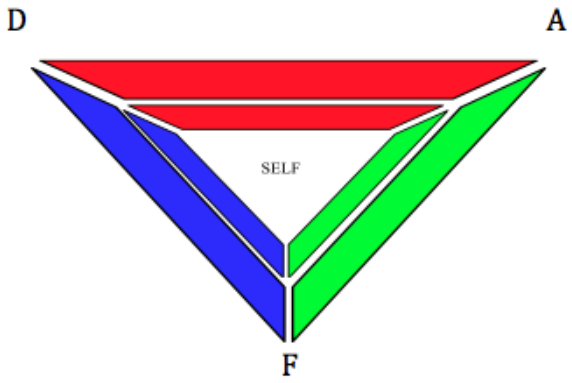
From this perspective, everyone is motivated to attain relational value and use strategies related to power, love, and freedom in this pursuit; however, in psychopathology, the mechanisms that one uses to attain relational value are disrupted and maladaptive. The IM posits that individuals high in power and affiliation and balanced between autonomy and dependency in their relationships would be ideal strategies for attaining relational value. However, the individuals who participated in this study and those who generally seek psychotherapy often engage in problematic approaches to meet this need. For example, an individual who generally believes he or she does not have social influence (i.e., believes others ignore, criticize, and neglect them) may utilize submissive, affiliative, and dependent strategies in an attempt to avoid pain and rejection. As a result, they tend to experience attachment and relationship fears

related to anxious, preoccupied attachment (Zuroff & Fitzpatrick, 1995; Reis & Grenyer, 2002).

The defensive system. The defensive system is the least clearly defined system, but it can be explained using the context of justification describe in the JH. The defensive system functions to maintain balance between the various mental systems; that is, when there are conflicting drives or activations or needs, the defensive system is activated. The **Freudian Filter** discussed in the JH, most directly represents the dynamics of this system through the tension and the filtering that takes place between the experiential self and the private self-consciousness system. It also overlaps with the **Rogerian Filter,** which refers to the consciousness mechanisms people utilize to shape their overt behavior in an effort to maintain good social impressions.

Malan's (1976, 1979) Triangle of Conflict is a pictorial representation of psychodynamic conflict. Specifically, it demonstrates the process of how humans maintain psychic equilibrium through utilization of defenses to regulate the anxiety elicited by certain images, feelings, or impulses (see Figure 5). There are three main components to the Triangle of Conflict represented on each pole of the triangle: Defenses

Figure 5. The Malan Triangle of Conflict



[D], Feelings [F], and Anxiety [A]. Defenses can be any thought, feeling, or behavior that serves to minimize anxiety and protect the psyche. Feelings refer to the naturally occurring, primary affects that motivate individuals towards healthy expression and communication. The third component is the Anxiety pole, which represents inhibitory affects that obstruct healthy expression represented by the Feelings pole.

This interaction between defenses, anxiety, and feelings is intimately tied to the conceptual framework of the **Freudian Filter.** Specifically, when individuals encounter information that does not fit their private self-narrative, an anxiety response will alert the defensive system to filter out the perceived threat from conscious awareness. These defenses could be psychodynamic defense mechanisms and/or defense mechanisms highlighted in the DSM-IV TR.

The justification system. The justification system refers to our language-based beliefs and values, and they are uniquely human phenomena. This system is explicitly tied to Henriques' (2003) conception of the Justification Hypothesis (JH), and it comprises self-narratives as justifications that legitimize our claims and behavior, and is tied to our semantic memory system. Our individual self-narratives are embedded within larger systems of justification (e.g., culture) that guide how we should act, our expectations of others' behaviors, and ways we accommodate and/or assimilate conflicting aspects of our experiences. Existential perspectives emphasize these larger belief systems and focus on how human functioning is a function of meaning and values. Justifications are understood as "the ongoing attempt to convince self and/or others that one's beliefs and values, which is to say one's 'version of reality' or VOR, is correct, defensible, and good" (Shealy, 2005, p. 81). Henriques posits that there are two contexts

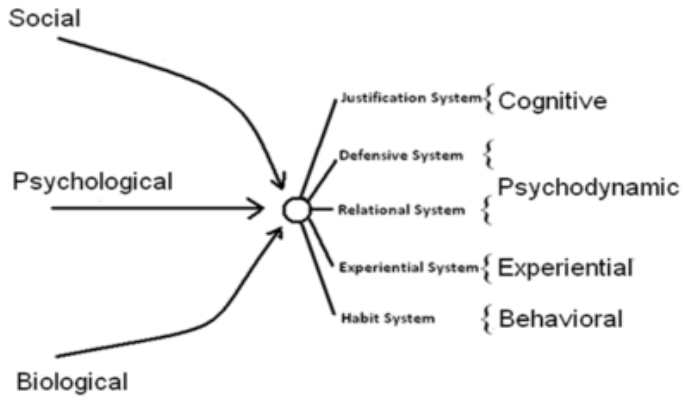
of justifications: our private narrative and the justifications we share publically.

As humans, we maintain our versions of reality by engaging in a complex filtering process to preserve justifications about ourselves (i.e., private narrative) and by legitimizing our thoughts and actions to others in an effort to amass the greatest amount of social influence (i.e., public narrative). The aforementioned filtering process of the defensive system mediates between our experiential and justification systems (i.e., Freudian Filter), and our self-narratives shape and are shaped by this filtering process. This understanding of justifications is comparable to the cognitive perspective (e.g., self-talk, core beliefs) and to narrative approaches that explicit focus on deepening and reconstructing self-narratives to enhance adaptive functioning. Additionally, as was discussed with the JH (see Figure 3), there is another layer for filtering between our private and public narratives (i.e., Rogerian Filter). We motivated to communicate these justifications in a way that is socially acceptable and facilitates or maintains relational value ranging from close interpersonal relationships to a macro-level perspective. In sum, there is a basic structure of justification within an individual and collectively form the foundation for culture as large-scale justification systems (Henriques 2003, 2011).

Putting the pieces together. As these systems are reviewed, it is hopeful that a realization will dawn on the reader. The realization is that these systems of character adaptation correspond to the major perspectives in psychotherapy. For example, a behaviorist approach corresponds well to the habit system. Neo-humanistic, experiential approaches, like Emotion Focused Therapy, correspond to the experiential system. Psychodynamic theory addresses both relational and defensive systems through focusing on transference-countertransference interactions, defense mechanisms, and early

attachment relationships, among other elements. Lastly, cognitive theory focuses on the language-based justifications and should be utilized to address distortions and faulty beliefs. The overlap between The Unified Approach to Conceptualizing and major orientations is depicted below (see Figure 6). An additional key point here is that the major perspectives in psychotherapy, reviewed earlier, tend to focus largely on one or two of the five systems of adaptation. The character adaptation systems approach sets the stage for viewing the whole.

Figure 6. Overlap between The Unified Approach to Conceptualizing and Major Orientations



Toward the Development of a Unified Psychotherapy

This brief review of psychology's fragmentation and the application of different approaches to psychotherapy to a single case, not only highlight their relative emphases and commonalities, but also set the stage for the depth of understanding that could come from a unified framework for psychotherapy. The history of psychotherapeutic interventions has been that clinicians have developed insights and techniques in the therapy room and then proceeded to extrapolate about the nature of human psychology

from these interventions. Moreover, the interventions themselves, in the major perspectives, are then standardized and empirically tested to demonstrate effectiveness. While there certainly has been much knowledge gained from this approach, it has led to the problems of proliferation and fragmentation in the field. However, development of a unified approach to psychotherapy out of a unified frame might provide the necessary foundation from which treatment outcomes could be interpreted and measured.

The holistic framework articulated by Henriques and Stout (2012) provides an elegant synthesis of how these various orientation would approach Caroline's conceptualization and treatment. Although a recent study demonstrated clear feasibility of utilizing a unified approach in treating an inpatient population within a group therapy format, systematic implementation has not been attempted for individual psychotherapy. The next chapter articulates this general model of psychotherapy to demonstrate its feasibility and utility by applying it to a presentation akin to the "common cold" in general practice. Specifically, individuals presenting with dependent and avoidant personality features often experience "low grade" depression and general malaise and are frequent consumers of psychotherapy.

Chapter 3

Developing a Unified Model of Psychotherapy

The meta-perspective offered by Henriques (2011) attempts to cut across the field of psychotherapy to provide a general framework for understanding personality, psychopathology, and interventions in a physical-bio-psycho-social context. This framework serves to translate terminology from different theoretical perspectives and map their overlap and distinctive qualities onto human functioning. Although beyond the scope of the current dissertation, a unified approach to psychotherapy is the ultimate goal. To foster the development of an overarching framework, it is useful to consider what is meant by the term psychotherapy from the current perspective.

> *Psychotherapy is a formal relationship established with a professional trained in the values, knowledge base, and skills in fostering experiences and applying interventions grounded in the science of human psychology with the purpose of moving toward what the participants deem to be more valued and adaptive ways of being.*

This definition sets the stage for outlining a unified approach to psychotherapy and there are several key elements to it. First and foremost it highlights values in the psychotherapeutic process. Specifically, it posits that people enter psychotherapy to achieve more valued ways of being and that the enterprise is oriented toward that goal. In a related vein, the inclusion of values sets the stage for framing psychotherapy as ultimately being designed to enhance adaptive living. Individuals are living in an adaptive way when their capacities allow them to interact with their situation in a manner that maximizes fulfillment and effective realization of goals or valued states of being.

Individuals enter psychotherapy when they sense that their levels of distress and their functioning are unsatisfactory and they seek both understanding of what is possible and ways to move in that direction. The current intervention is considered an integral aspect of this objective of creating a unified approach to psychotherapy by exploring whether and how clients can be directed to understand these systems and benefit from them through education. Specifically, how material is presented regarding clients' understanding about developmental origins, symptoms, outcomes, and coping strategies. While this study goes beyond merely offering clients information, we are considering it a "psychoeducational" intervention to emphasize the more directive approach that explicitly addresses valued states of being. However, the goal in to help clients deeply understand themselves through educating them about the five systems of adaptation *and* applying that model to gain insight and awareness toward adaptive change

In the case of Caroline, for example, there are several aspects of her state of being that she would likely wish would change. First, she is experiencing a significant amount of distress, anxiety and depression. Second, she is also failing to experience the level and kind of relational value and connection she desires. Finally, she is disappointed in herself for her difficulty. From the vantage point of the unified approach, she is having difficulty in certain key domains of character adaptation. The current dissertation focuses on the centrality of understanding these systems of character adaptation to implementing effective treatment interventions.

It is also important to note that within the above definition of psychotherapy, there are three elements that together make up the key ingredients of the psychotherapeutic process. First there is the establishment of the professional relationship. The nature of this

relationship is crucial and research consistently demonstrates that good relationship quality is a key ingredient to successful treatment. For example, it would likely be important in the case of Caroline for the relationship to be seen as a source of security, and that she initially feel welcomed and was not criticized or judged.

The second element embedded in the general conception of psychotherapy is the formulation or conceptualization of the current situation. In order to understand the most adaptive way forward, an understanding of the individual's capacities, tendencies, symptom profiles, history, current situation, and so forth is essential. It is here that the Unified Approach to Conceptualizing (Henriques & Stout, 2012) plays a crucial role. By focusing on an individual's five systems of adaptation in a biological, learning and developmental, and social context, professional psychologists now have access to generating a holistic account of the individual's functioning.

The third element of successful therapy refers to the tasks that individuals engage in to foster change. That is, for the process to be successful, it is posited that the conceptualization needs to generate a map of the causal elements that are contributing to maladaptive patterns, which in turn gives rise to "tasks" that can be enacted to foster difference in both the way in which the current situation is perceived, experienced and responded to.

Moving From Awareness to Acceptance and Change

A review of therapeutic processes reveals three major processes that foster movement toward more adaptive and valued ways of being. The first is **awareness**. The conceptualization provides the beginning elements of awareness. Through a thorough **assessment** (e.g., intake and surveys) we help facilitate this process. We then **interpret**

the etiology and maintenance of these patterns and provide **insight** into and the degree to which they are maladaptive or adaptive according to the individual's valued goal state.

These processes then set the stage for **acceptance** and **change**. Acceptance is an "active process of self-affirmation rather than passive resignation to an unhappy fate" (Wilson, 1996, p. 417). According to the aforementioned third wave cognitive therapies, acceptance is an integral and complimentary aspect to the **change** process. The therapeutic alliance can serve increase a client's acceptance and when used with various cognitive, affective, and defensive restructuring as well as psychoeducation, clients can improve their adaptive functioning and move toward valued goal states.

Understanding Caroline Through a Unified Lens

The previous discussion of each perspective's view of Caroline's functioning demonstrated the emphasis of these various approaches. In this section, the case example of Caroline will be reexamined through a unified frame as a way to demonstrate how various aspects of functioning can be translated into a single, coherent frame. After each aspect of the conceptualization, each element of the unified component systems approach is labeled.

The case of Caroline. Caroline is currently in an important developmental stage in her life; however, there are a number of socio-emotional difficulties that are negatively affecting her ability to effectively. Most notably, Caroline has difficulty in mood and emotion regulation (Experiential System), conflicts regarding her social status and close-interpersonal relationships (Relational System), and problems with identity and self-concept (Justification System). It is crucial that Caroline understands how these domains are inter-related, so that through such

awareness she finds pathways for adaptive functioning.

Her diagnoses of Generalized Anxiety Disorder and Major Depressive Disorder Recurrent, in Partial Remission suggest that she has a chronically active and highly reactive negative affect system (Experiential System). Her negative moods are providing her with a general indicator that she is not getting her needs met, that there is danger around the corner, and that she should avoid taking risks. Caroline's current state might be considered vulnerable to losing the capacity for desire, interest and pleasure (Experiential). In addition, it seems likely that Caroline is confused and frustrated about her negative feelings, and has likely has beliefs that she should not be so negative or that there is something fundamentally wrong with her. If so, these justifications about emotions would contribute to a vicious maladaptive pattern (Experiential and Justification Systems). Caroline is emotionally overwhelmed and needs to recognize that her mood system is more sensitive and reactive than others. However, when it is not effectively regulated and certain primary emotions are cut-off (Experiential and Defensive Systems), it can be a defining feature of a negative spiral in that Caroline expresses strong negative reactions which becomes upsetting and produces negative consequences, especially in her relationships (Experiential and Relational Systems).

Regarding Caroline's relationships, there was evidence that she has a very strong desire to be loved and appreciated. There was also evidence that at least at times she feels insecure about her sense of being lovable (Relational and Justification System). This combination likely creates complications for Caroline in her relationships. For example, it might result in her feeling quite dependent on

others and/or result in her inhibiting her own needs and interests to maintain harmony and avoid criticism or anger in others For example, if she is involved in a relationship exchange and has her own needs for power or autonomy, she may fear expressing them in an assertive way because the other individual might then react in an angry or blaming way (Relational and Defensive Systems). It is also quite possible that Caroline sometimes blames or criticizes herself in order to maintain an affiliative connection. This might result in minimizing conflict and allow her to keep her relationships intact on the surface; however, instead of feeling fulfilled and closer to others, it is possible that she feels diminished in comparison (Relational System). There was also evidence she struggles to find the right balance between autonomy and interdependency. It seems she both craves connection, but at the same time fears intimacy, dependency, or being trapped or controlled by others. Finally, it is likely that she expects others to judge her harshly which likely contributes to her anxiety, stress, tension, and sadness (Relational and Experiential Systems).

In regards to Caroline's self-concept, she is and is in the process of forming her own identity both professionally and personally (Justification System). Caroline tends to have high standards for herself and will engage in harsh self-criticism when these standards are not met. Taken together, these harsh criticisms and core beliefs of worthlessness and low self-esteem likely create negative thought patterns that have contributed to her difficulties (Justification System). Her main way of coping with these feelings is to search for meaningful relationships to make her feel whole and improve her feelings of self-worth. However, she is still in the process of

understanding her owns needs and how to communicate these needs with others. For example, Caroline's suicidal ideation seems to relate to her feelings of being overwhelmed and pessimistic as well as a need to be closer to others (Relational and Experiential System). The aforementioned factors have prevented Caroline from finding meaningful relationships and developing a sense of competency (Relational and Justification System).

Taken as a whole, Caroline is experiencing significant socio-emotional difficulties, namely in the form of anxiety, depression and interpersonal relationships. These general areas of difficulty appear to be interrelated and are likely contributing to difficulties in other domains of functioning.

The goal in this section has been to provide a concrete example of an individual that is suffering from similar problems with adaptation as those who will be incorporated into the current treatment. The case of Caroline serves as a translation between the way various orientations understand human functioning and how these various approaches can be understood through a holistic framework. Now that the foundation for this bridge has been built, the next section provides an outline of the treatment modules that were used in the current intervention. Application of this intervention will be discussed at length in the results section as well as assessment and conceptualization of the two individuals who participated in the current study: James and Sarah.

Outline of the Manual: "Treating Caroline"

Phase 1 (sessions 1-2). This phase focused on developing rapport and a shared understanding of the clients' functioning via the unified approach. An overview of the treatment structure was provided during the beginning of the first session (e.g.,

psychoeducational aspects, length, and phase development). During this phase, the aim was to foster movement that develops awareness through assessment, conceptualization, and area(s) of focus.

***Assessment*.** As will be discussed in the methods section, participants were screened prior to entering the treatment program and given a brief write-up concerning the five systems of adaptation as it relates to their well-being. The assessment portion of this treatment began prior to treatment to ensure recruitment of the target profile; however, in a clinical setting, the assessment would be incorporated into the first phase of treatment. In both cases, the clinician would discuss this information with the clients, with a particular focus on gathering information on the clients' developmental history, life narrative, and symptom profile.

Conceptualization. Having a shared **conceptualization** is an integral aspect to forming and maintaining a positive therapeutic alliance. This conceptualization address the etiology and maintenance of the clients' patterned ways of responding and the degree to which these patterns are adaptive and/or maladaptive in relation to the client's valued states of being. Clients will be offered an updated version of the written feedback that they received during the recruitment phase (in a typical treatment setting, they would be offered this conceptualization for the first time).

Area(s) of focus. Short and long-term goals were identified from the conceptualization and through **Module 1:Values** during the second phase of the intervention. Exploration of values in the context of the clients' life history guided the area(s) of focus in the next phase of treatment and created a link between them.

Phase 2 (sessions 3-9). This phase began by introducing key concepts to frame

the participants' experience and reviewed the domains of adaptation. Modules for the intervention were based on a group psychotherapy intervention constructed from Henriques and Stout's (2012) Unified Component Systems Approach to Conceptualizing People in Psychotherapy (Glover, 2013). A total of six modules were used in the current intervention. Appendix L contains the modules and exercises used during the intervention and a treatment manual that was developed (see Appendix A and B for detailed treatment outlines for each client).

The modules within this phase focused on the major problem area(s) that were identified in the first phase of treatment, guided by a holistic view of the clients' functioning (i.e., the five domains of adaptation). Participants explored and were educated about values, habits, emotions, relationships, defenses, and justifications. The therapist and participants collaboratively developed an understanding of the way they function in each domain and developed ideas about how they could improve their adaptive functioning. Each domain was divided into different modules that form a "treatment menu" that can be used interchangeably, depending on the clients' individual needs. Each module began with a psychoeducational component about the specific domain (e.g., Influence Matrix, Domains of Human Consciousness, Malan Triangles of Person and Conflict), followed by discussion and application to the client's functioning. The clinician referred to the material presented depending needs of the individuals as an educational tool (i.e., with examples) and assisting the client processes the material in application and reflection

***Module 1: Values*.** Although values are a part of the **Justification System**, exploration of an individual's goals and values are essential factors in determining the

degree to which an individuals' functioning is contributing to or thwarting adaptive functioning. In the current intervention, participants were given a list of thirty values and asked to choose five that were most important to them and five others that they wanted to work on during treatment. These values and the activities they could do in accordance with that value helped formulate treatment trajectory for each client. The focus on values is similar to ACT's notion that values provide to lead a more purposeful life and acting in accordance with these values helps achieve long-term goals (Hayes et al., 2006). Also, positive psychology emphasizes character strengths and virtues that are similar across cultures (e.g., wisdom, courage, humanity, justice, temperance, and transcendence) and may serve in developing a more integrative intervention for living in accordance with these virtues (Dahlsgaard, Peterson, & Seligman, 2005).

Module 2: The Habit System. The clients were introduced or referred back to the Two Domains of Justification and Domains of Human Consciousness to address the concept that their thoughts and actions are separate (i.e., differences between impulses, reasons, decisions, etc.). The clients were taught how to examine the function of their behavior(s) (both past and present), how to observe the various signs that may lead them to engage in the unwanted behavior, and how to articulate the ways in which their maladaptive behavior(s) might be negatively impacting their lives and/or helping them avoid unwanted experiences. They were also guided through an exercise of examining their valued states of being that they can use as a source of inspiration and encouragement throughout the treatment. If needed, education would be provided on sleep hygiene, benefits of exercise on mental health, emotional eating

patterns, etc. As previously discussed, behaviorally oriented therapies would target this domain if the clients wanted to alter certain maladaptive habits.

Module 3: The Experiential System. Clients were introduced or referred back to the Two Domains of Justification and Domains of Human Consciousness to address the concept that emotions are the organizing force of experiential system. If the Malan Triangle of Conflict had already been introduced, the clinician referred back to authentic, activating emotions (McCullough et al., 2004). The clients evaluated how their emotions are activated in response to their perceptions of events relative to their goals and needs (e.g., becoming upset after failing a test). Then, depending on the clients the following topics were discussed: (1) The distinction between emotions and moods (e.g., moods are general states of mine and emotions are connected to a specific event); (2) Education about primary and secondary emotions and their role in the adaptive/maladaptive function of emotions (EFT: Greenberg, 2002; 2004); and (3) Discussion about emotional regulation: under-regulation and over-regulation.

Emotion-focused techniques were used to help the clients experience feelings regarding a past or current event while noticing various emotions, physiological reactions, thoughts, etc. Mindfulness exercises were utilized to help clients understand the difference between thoughts, feelings, and behaviors. If **Module 4: Defensive System** had been previously discussed, The Malan Triangle of Conflict was used to further discuss defensive reactions to feared emotions (e.g., feeling guilty when healthily asserting oneself). Other possible interventions might be DBT mindfulness and distress tolerance skills (Linehan 1993a; 1993b); principles of acceptance (ACT: Hayes 2004); and systematic desensitization of feared affect (McCullough, 2004).

Module 4: The Defensive System. Clients were introduced to this module by reflecting on if they had ever blocked out certain feelings, made excuses to themselves or others, or avoiding something that made them anxious. They were introduced or referred back to the distinction between the Experiential and Justification Systems. The defensive system was introduced through discussion of a time when the client felt tension between these two systems. The Malan Triangle of Conflict to address their defensive structure and how anxiety can mask authentic, adaptive emotions. They examined various coping strategies (e.g., isolation, withdrawal) and defense mechanisms they have used to inhibit or avoid thoughts, feelings or impulses associated with anxiety. The clients were asked to provide examples of when they may have used or encountered various defense mechanisms (e.g., repression, denial, or intellectualization). When they could not provide an event, the clinician would provide certain examples.

Module 5: The Relationship System. The clients were introduced to the relationship system through a discussion about attachment as the developmental foundation for human relationships and asked to reflect on their own attachment histories and times when they have or have not felt valued by others. Clients were asked to reflect the strategies they used during these times to increase their sense of security in the relationship. The Influence Matrix (IM) was introduced to illustrate how relationships are organized by emotions, the dynamic nature of relationships, and ways humans use dimensions of power, love, and freedom to attain relational value with others. As will be discussed in the results section, clients provided many examples of various situations involving family, friends, romantic partners, and

coworkers that could be understood using the IM framework. In other interventions, elements from Interpersonal psychotherapy (IPT: Weissman, et al., 2000), Schema Therapy (ST: Young et al, 2003), and interpersonal process techniques (Teyber & McClure, 2010) might help individuals learn origins of their maladaptive schema and begin to function more adaptively in current relationships.

Module 6: The Justification System. Clients were introduced or referred back to the Two Domains of Justification and Domains of Human Consciousness to address the concept that their thoughts, feelings, and actions are separate. The concept of justifications was introduced, and clients were asked to reflect on the degree to which they filter or alter their justifications based on their environment. Differences between adaptive and maladaptive justifications were discussed (i.e., degree to which they accurate, flexible, and helpful) with specific examples given by the clinician and clients. Common errors in justification were offered and discussed and the notion of "Catch It, Check It, Change It" was discussed as a way to notice and alter maladaptive justifications for behavior.

Phase 3 (session 10). The last session was scheduled for one hour and thirty minutes. The Well-Being Interview was administered at the beginning of the session. Once finished, the clients and clinician went through both interviews to reflect on their responses (e.g., level of insight, changes, disappointments, hopes). The clients' reflections on the previous sessions guided the remainder of the session. The clinician gave feedback about her experience of the clients throughout the process and recommendations for future directions (e.g., treatment).

Chapter 4

Methods

This section will begin with the rationale for using a pragmatic framework used to create an intervention that integrates the various aforementioned perspectives. After providing this framework, the study design will be discussed to illustrate how the quantitative data was embedded into a primarily case study research design. Lastly, elements of participant recruitment and inclusion, treatment manual development, treatment implementation, assessment, data collection and analysis will be discussed, as well as ethical guidelines and considerations.

Concurrent Embedded Research Design

This study used a concurrent embedded mixed-methods design. The quantitative data was embedded into a multiple case study research design and analyzed to enhance findings from qualitative data (Creswell & Plano Clark, 2007; Stake, 1995). This study utilized a mixed-methods approach due to pragmatic assumptions that qualitative and quantitative data offer complementary strengths and should be utilized to answer different types of research questions (Creswell & Plano Clark, 2007). To address the feasibility and utility of an integrative psychoeducational program, this design gives priority to the qualitative methodology because the qualitative outcome data represents the major aspect of data collection and analysis in the study.

Participant Setting and Recruitment

This study used a non-random, convenience sample, to recruit undergraduate students (ages 18-21) for a well-being screening. An approved advertisement for a well-being screening was sent via bulk email to undergraduate students on a mid-sized

university campus. This message advised willing individuals of the participation requirements and to contact the researcher via email to setup the screening. Thirty-one students responded to the advertisement and 19 individuals completed both the interview and online portions of the assessment. The well-being screening lasted approximately two hours and consisted of three components. The first part was structured interview administered by one of five graduate clinicians (i.e., The Well-Being Interview-WBI, see Appendix C) and lasted approximately thirty minutes (see Informed Consent, see Appendix D). The WBI assesses the systems of character adaptation and contexts of development both quantitatively and qualitatively. The second portion was a series of norm referenced, self-report questionnaires administered online, via *Qualtrics*. Participants were asked to contact the graduate student interviewer once they completed the surveys. These measures are listed below and discussed in more detail in the Measures section:

a. Measure of personality traits (Big Five Inventory, BFI)
b. Measures of relational patterns (Personality Styles Inventory-PSI; The Influence Matrix - Social Motivation Scale-IMSMS, see Appendix E)
c. Measure of depressive symptoms (Center for Epidemiological Studies-Depression-CES-D)

Once the data were analyzed, participants were called back for a thirty-minute feedback session with the same graduate clinician where they received a one-to-two page written assessment concerning domains of functioning. All individuals who participated in the screening were directed to appropriate services within the university or in the community; however, those who endorsed symptoms that are commonly exhibited by

individuals with dependent and avoidant personality features (e.g., mild depressive and/or anxiety symptoms, feelings of shame and/or guilt) were offered participation in a free individual psychoeducational program through a university-based community mental health center.

Participants

In total, five individuals met the criteria (2 males, 3 females) for the intervention and three agreed to participate. The four the individuals who did not participate gave the following reasons: did not want to be videotaped, did not have time to complete treatment, and agreed to participate but did not respond to experimenter's attempts to make contact. This paper focuses on the two of the clients who completed the intervention in spring 2014: "James" (male, Caucasian, age 21) and "Sarah" (female, Caucasian, age 20). James and Sarah received similar treatments within the same one-month period, and their course of treatment demonstrates how individual characteristics (e.g., symptom severity, attachment history, personality, life stressors, etc.) may impact appropriateness for a psychoeducational treatment. Below is a brief background description of each participant.

James. "James" was a 21-year-old, single male who was completing his junior year of college and in the process of finding an internship for summer break. He reported a history of strong family connections, close friends, and previous meaningful romantic relationships. James appeared to be well adjusted in his development until he experienced two traumatic losses two years prior, a friend's suicide and witnessing his partner's mother's death. Since these deaths, James found himself becoming more isolated and nostalgic of the past when he was safe and had a strong support network.

Sarah. "Sarah" was a 20 year-old, single female who was also completing her junior year of college and was getting ready for a summer abroad. Sarah was concerned about her lifelong struggle to feel secure enough in her relationships to show vulnerability and harsh self-criticism. Sarah reported that she would become intensely critical of perceived shortcomings when she felt overwhelmed, depressed, and isolated. Sarah noted that this tendency was the most prevalent during high school, but it was also notable in the ambivalence she felt toward her long-term romantic partner and in her passive role in multiple relationships.

Procedures

The following procedures accompanying the intervention included: 1) Screening participants and obtaining informed consent; 2) Pre-intervention assessments; 3) Implementing the intervention; and 4) Post-intervention assessment. Below is an outline of these steps.

1) **Screening participants and obtaining consent**. Individuals who entered the aforementioned well-being screening were eligible for the intervention if they met certain criteria. They were between the ages of 18 and 22 and report significant levels of depression as measured by the Center for Epidemiological Studies-Depression (CES-D: Total symptoms is greater than or equal to 16). They also reported lower than average value in their relationships as measured by the Influence Matrix-Social Motivation Scale (IMSMS: *M*=less than 1.4). From norms established by the IMSMS on a university based sample, it is estimated that 10-15% of university students fit this profile (Age, *M*=18.78, *SD*=.917, range 18-22; Gender, 74% female). Lastly, individuals who presented as more submissive

or dependent as measured by the IMSMS, Personality Styles Inventory, and clinician judgment, will be considered eligible for the intervention. During the feedback session of the well-being screening, individuals who met criteria for the intervention were given the opportunity to enroll in ten-session psychoeducational intervention at an outpatient community mental health center with a doctoral student clinician (see Informed Consent, Appendix F). Potential participants were told that they had high levels of negative affect, problems with identity and that their needs for relational value were not being met.

2) **Conducting the Pre-Intervention Assessment**. In addition to the measures on the well-being screening (WBI, etc.), between the first and second sessions, participants completed two self-report questionnaires as a pre-intervention assessment and asked to bring them back to their next session. The following measures were included in the assessment and described in more detail in the Measures section.
    a. Demographic and background questionnaire (Life Information Survey, Appendix G)
    b. Measure of childhood experiences of caregivers (Parental Bonding Instrument-PBI)
3) **Intervention Implementation.** The treatment consisted of 10 sessions (50-minute sessions, last session was 90-minutes) for each client and was conducted by Ms. Lauren Mays. Each of these participants met with Ms. Mays twice per week over the course of five weeks. James and Sarah completed the intervention between April-May 2014. An outline of Sarah and James's treatment is included

in Appendices A and B respectively and the treatment manual is included in Appendix L. After each session, clients filled out weekly rating scales, described in the Measures section, to assess their progress throughout treatment and ways to improve future sessions.

4) **Conducting a Follow-Up Intervention Assessment**. The clients were given the second administration of the Well-Being Interview during the last session. This session was ninety minutes to allow for completion of the WBI, comparison of pre- and post-intervention responses, reflection of treatment, and feedback. After the treatment was completed, clients were asked to complete the same battery of questionnaires that were administered in the online pre-intervention assessment. There were additional open-ended questions asked regarding content learned, evaluation of treatment, and assessment of progress (see Appendix K).

Measures

Each participant was assessed pre and post- intervention and throughout the treatment. The pre-intervention assessment was completed as part of the well-being screening by trained graduate student clinicians. The well-being screening was administered to the clients before and after the intervention. This screening consisted of a five measures, including a semi-structured interview and four self-report measures, administered via *Qualtrics*. In addition to the well-being screening, James and Sarah also completed a demographic and background questionnaire and a self-report measure concerning parenting styles. A weekly rating scale was also administered after each session to measure changes in client functioning and session satisfaction treatment. These measures are described in detail below.

Well-Being Interview (WBI; Asselin, 2012). The WBI is a structured clinical interview designed to assess ten different domains of subjective and psychological well-being. The following ten domains are assessed on the WBI grouped into three broad categories: 1) Domains of Life Satisfaction - Overall Well-Being, Interests and Engagement in Life, Meaning and Purpose; 2) The Five Domains of Adaptation; and 3) External Domains – Stressors/Affordances and Trajectory. Each domain contains qualitative descriptions of functioning in each domain. After a brief description, participants rate their subjective level of functioning in in each domain using a 7-point scale (1 = Low, 7 = High). Each domain also contains forced choice data (yes, no and maybe/sometimes) and the clinician's rating of their functioning on the same seven-point scale. See Appendix C for a copy of this measure.

Big Five Inventory (BFI). The BFI is a 44-item measure self-report measure of the Big Fiver personality traits – extraversion, agreeableness, conscientiousness, neuroticism, and openness (BFI: John, Donahue, & Kentle, 1991). The items are responded to using a 5-point Likert scale (1 = Disagree Strongly, 5 = Agree Strongly). Evidence of the psychometric properties of the BFI has been gathered in previous studies (e.g., Benet-Martinez & John, 1998; John & Srivasatava, 1999).

Center for Epidemiological Studies-Depression (CES-D). The CES-D is a 20-item self-report measure of how often symptoms associated with depression were experienced over the past week such as restless sleep, poor appetite, and feeling lonely (Radloff, 1977). Response options range from 0 to 3 for each item (0 = Rarely or None of the Time, 1 = Some or Little of the Time, 2 = Moderately or Much of the time, 3 = Most

or Almost All the Time). Scores range from 0 to 60, with high scores indicating greater depressive symptoms.

Influence Matrix - Social Motivation Scale (IMSMS). The IMSMS is an 84-item self-report measure designed to capture both state and trait relational process dimensions used to attain relational as described by the Influence Matrix. These strategies constitute the eight subscales of the IMSMS: Power (Dominance = 10 items, Submission = 10 items), Love (Affiliation = 10 items, Hostility = 10 items), Freedom (Autonomy = 12 items, Dependency = 12 items), and Relational Value (High RV = 10 items, Low RV = 10 items). Participants respond to each of these questions about themselves and their behavior in relationships on a 5-point Likert scale (1 = Strongly Disagree, 5 = Strongly Agree). See Appendix G for a copy of this measure.

Parental Bonding Instrument (PBI). The PBI is a 25-item self-report measure of both maternal and paternal behaviors (Parker et al., 1979). Participants are asked to remember their childhood experiences (until age 16) of the various attitudes and behaviors exhibited by their parents and rate each parent separately. Both the mother and father forms ask participants to respond to the same 25-items on a 4-point Likert scale (Very Like, Moderately Like, Moderately Unlike, Very Unlike). Parental behaviors are grouped into two subscales (Care and Overprotection) and grouped within four quadrants (Affectionate constraint - High care, High Protection; Affectionless Control - High Protection, Low Care; Optimal Parenting = High Care, Low Protection; Neglectful Parenting = Low Care, Low Protection). The subscales are categorized as “Low” and “High” based on different cutoff scores for mothers and fathers (Mothers: Care = 27.0, Protection = 13.5; Fathers: Care = 24.0, Protection = 12.5).

Personal Style Inventory (PSI). The PSI is a 48-item self-report measure of the two personality dimensions: Sociotropy and Autonomy (Robins, Ladd, Welkowitz, Blaney, Diaz & Kutcher, 1994). Respondents answer along a 6-point Likert scale (strongly disagree to strongly agree). Sociotropy is scored along 3 subscales: Excessive Concern about What Others Think, Dependency, and Pleasing Others. Autonomy is scored along 2 subscales: Need for Control and Defensive Separation.

Weekly Outcome Rating Scales. These rating scales are divided into weekly assessment of client's functioning and the client's perception of the session. Clients answer along a 7-point Likert scale "extremely poor/unsatisfied/incompetent" to "extremely good/satisfied/competent." Client's functioning is measured in four domains: Overall well-being, personal functioning, relationships, and direction in your life. The session is also measured in four areas: Relationship and connection with the therapist, therapist competence, importance and value of the session, and attitude about the therapy. In total, scores range of 4 to 28 and higher scores reflecting more favorable outcomes. See Appendix H.

Data Analysis

Descriptive statistics were obtained for demographic variables, such as age, race, gender, years of education, etc. This study was a collection of data from individual participants and was compared to group means for norm-referenced tests (e.g., severity of depressives symptoms measured on CES-D). Data collected at pre-treatment was measured against data at post-treatment; however, because of the small sample size of the study and the nature of research questions, qualitative data was the primary focus of the analyses.

The case study approach allows for flexibility for accommodating and analyzing the various types of data that will be collected during the current study. According to Stake (1995), this case study would be considered an instrumental design, meaning that these case studies are being used to refine Henriques and Stout's (2012) framework for a psychoeducational intervention and to gain a better understanding of the target population. In terms of feasibility, clinician memos were a key aspect of understanding the process of implementing treatment. Utility was more complex in that it took the participants' perspectives into account.

Chapter 5

Results

This study sought to explore the feasibility and utility of an integrative approach to a brief psychoeducational intervention in two college students based on a treatment protocol created by Glover (2013). In this section, results from both administrations of the IMSMS, PSI-II, CES-D, BFI, and WBI are provided and discussed within qualitative assessments and case conceptualizations for James and Sarah to highlight the individual differences in these two presentations. These individual differences will be referenced throughout the discussion of feasibility and utility of the psychoeducational treatment. Thus, the following variables of feasibility and utility will be discussed through comparing and contrasting each case: 1) implementation of treatment protocol adapted from Glover (2013); 2) professional judgment of the overall implementation; 4) clients' level of satisfaction to the individual sessions as assessed through verbal feedback and weekly rating scales; and 5) posttest evaluation of material covered in sessions.

Pre and Post Intervention Data: James and Sarah

Norm-Referenced Questionnaires. James and Sarah's scores for both administrations of the IMSMS, PSI-II, CES-D, and BFI are provided in Table 1. As a point of comparison, means and standard deviations based on larger comparison groups have also been provided (Robbins et al. 1994; Srivastava et al. 2003; and Lewinsohn et al., 1997). James and Sarah's scores were highlighted in the table if they were greater than 1 *SD* from the comparison group *M* to provide a general context of their functioning.

Table 1

Summary of Pre and Post Scores of Well-Being Screening Questionnaires and Comparison Group Norms

Scale	Sarah		James		Comparison
	Pre	Post	Pre	Post	*M (SD)*
Influence Matrix-Social Motivation Scale					
IMSMS Dominance	2.50[a]	2.50[a]	2.80	2.50[a]	3.269 (0.57)
IMSMS Submission	3.40[a]	3.40[a]	3.40[a]	3.00	2.711 (0.58)
IMSMS Affiliation	4.60[a]	4.20 [a]	3.80	4.00	3.921 (0.53)
IMSMS Hostility	2.10[a]	2.60	2.90	3.00	2.779 (0.61)
IMSMS Autonomy	2.75 [a]	3.00	3.50	4.17[ab]	3.38 (0.49)
IMSMS Dependency	3.08	3.58[ab]	3.17	2.75	3.07 (0.49)
IMSMS High Relational Value	3.20[a]	3.00[a]	3.60	4.00	3.752 (0.52)
IMSMS Low Relational Value	2.70[a]	3.20	2.80	2.50	2.354 (0.66)
IMSMS Power	-.90[a]	-.90[a]	-.06	-.50[a]	0.56 (0.95)
IMSMS Love	2.5[a]	1.60[b]	.90	1.00	1.14 (0.90)
IMSMS Freedom	-.33[a]	-.58	.34	1.42[ab]	.30 (.82)
IMSMS. Relational Value	.50	-.20[ab]	.8	1.5	1.40 (1.04)
Personal Styles Inventory					
PSI-II Sociotropy	96	108	94	96	95.8 (15.9)
PSI-II Autonomy	68	74	97	95	82.6 (15.1)
Center for Epidem Studies-Depression	24	26	16	13	>16 cutoff
Big Five Inventory					
BFI Extroversion	2.75	2.75	2.25[a]	2.38	3.25 (.90)
BFI Agreeableness	4.11	3.89	3.56	3.22	3.64 (.72)
BFI Contentiousness	3.67	3.67	3.33	3.44	3.45 (.73)
BFI Neuroticism	3.00	3.00	2.75	2.13[a]	3.32 (.82)
BFI Openness	3.50	3.50	4.20	3.90	3.92 (.66)

Note*:* Subscales are grouped according to broad dimensions. *M* and *SD* based on comparison groups; IMSMS (N=238) and PSI-II (N=411; Robbins et al. (1994) with undergraduate students; BFI for age 21 (N=6076; Srivastava et al., 2003); and CES-D has cutoff score (>16) and larger scores indicate increased severity of depressive symptoms across age groups (Lewinsohn et al., 1997).

[a] At least one *SD* from the *M;* [b] Change between pre and post scores is at least one *SD*

IMSMS. Before the intervention, Sarah's scores on ten of the twelve subscales were at least one SD from the undergraduate comparison group. Dominance, Hostility, High Relational Value, Power, and Freedom were below the mean and Submission, Affiliation, Low Relational Value, and Love were above. In posttest administration, Hostility, Autonomy, Love, and Freedom moved within the normal limits, according to the previous criteria; however, Sarah's scores on Dependency significantly increased and Relational Value decreased. Moreover, Sarah's scores on Dependency, Love, and Relational Value changed at least one *SD* between pre and posttest analyses. James's initial scores were more similar to the comparison group and only his Submission score met the *SD* criteria, but was no longer significant in posttest scores. In the posttest, James's Dominance score lowered slightly, making it more than one *SD* lower than the comparison group. Additionally, James' posttest Autonomy scores were both one *SD* higher than his pretest scores and the comparison group.

PSI-II. Neither Sarah nor James's scores met the *SD* criteria and therefore were not considered to be outside the normal range for either Sociotropy or Autonomy.

CES-D. Based on the established cutoff of 16, Sarah's scores met criteria for moderate Major Depressive Disorder during both times according to CES-D criteria. James's initial scores met criteria for possible Mild Depressive Disorder during the first administration (pre=16) but not at posttest (post=13).

BFI. Neither Sarah's pre nor posttest data met the *SD* criteria. James's pretest scores demonstrated he was more introverted during pre but did not remain significant during the posttest administration. Moreover, his post-treatment scores demonstrated significantly less neuroticism than the comparison group of same aged peers.

Well-Being Data. The Well-Being Interview (WBI) provides both quantitative and qualitative scores of participants' self-reported functioning on 10 domains of well-being. The quantitative scores are measured on a 7-point Likert scale (1 "Low" to 7 "High") and both administrations of James and Sarah's subjective scores are presented in Table 2. These scores provide and initial point of comparison, but the emphasis of these results will be based on themes from the qualitative responses. Similar to Glover (2013), the clinician's rating of client functioning was not included in the data analysis because in previous measures using the WBI, rater's assessment is generally negligible (i.e., within one point of the participant's self-reported rating). Both James and Sarah's pre and post intervention qualitative responses to each of the thirteen questions on the WBI are included in Tables 8 and 9 of Appendix J.

Table 2

Summary of Pre and Post Well-Being Interview Scores

	Sarah		James	
Scale	Pre	Post	Pre	Scale
Satisfaction with Life	5	5	5	5
Interests, Engagement, and Involvement	6	5	4	6
Meaning and Purpose	3	3	5	7
Medical Health	5	6	7	7
Emotional Regulation [a]	4	6	4	6
Relationships	5	5	4	5
Coping, Defenses, Resiliency [a]	5	6	4	7
Narrative Identity	6	6	5	6
Stressors and Affordances	4.5	3.5	5.5	6.5
Trajectory	5	6	7	5
Total	48.5	51.5	50.5	60.5

[a] *Denotes areas of functioning where both participants had similar changes (e.g., Sarah and James both improved on Emotional Regulation and Coping, Defenses, and Resiliency).*

James and Sarah's responses on the "Meaning and Purpose" scale are presented to illustrate how numeric ratings and qualitative explanations are used to compare function of each participant and their responses to treatment. Sarah's initial answer denoted lack of direction and a desire to isolate from others to discover purpose, while her second response illustrated feeling insignificant and finding purpose through caring for others. Sarah's score of "3" indicates low satisfaction during both time periods; however, her first response seems more diffuse while her second response highlights her affilitative nature. James's response at time 1 discussed the desire to enter the workforce, provide for a family, and be competent. His second response included similar themes but added having meaning on a "personal level." James's score increased ("5" to "7") and indicates a higher level of satisfaction than Sarah at the beginning of treatment and an increased sense of meaning and purpose.

James and Sarah's pre-treatment quantitative scores were relatively the same overall; however, James reported increased functioning across seven of the ten measures and remained unchanged on two. James reported a decreased level of satisfaction in his life trajectory ("7" to "5") sense of trajectory. Both responses focused on his career ambitions and desire to care for a family, but his second response indicated an appreciation for the effort needed to feel his desired level of success (i.e., "I now know there are a few steps between now and then"). Sarah reported an increase on four domains, a decrease on two others, and the remaining four were unchanged (see Table 2). James and Sarah had similar changes in the positive direction across two domains: "Emotional Regulation" and "Coping, Defenses, and Resiliency." Notably, both Sarah and James moved from neutral to positive direction on "Emotional Regulation." On

"Coping, Defenses, and Resiliency" Sarah's score increased slightly ("5" to "6"), while James's score increased by three points ("4" to "7").

On "Emotional Regulation," Sarah's first response noted experiencing intermittent depressive symptoms and stress leading her to struggle to find motivation and purpose. At time 2, Sarah said, "I'm doing pretty well with [managing difficult emotions." She noted an ability to remain calm during tense situations, but she is more reactivation to stressors when under pressure. James's responses at time 1 noted this was his "weakest area" he will "limit" what he shares with others, and has found it difficult to cope with recent losses. His second response indicated good stress management and use of cognitive techniques, but also included his struggle with nostalgia. Even though these responses both indicated an increase in perceived functioning, James's response indicated use of techniques learned during the intervention, but Sarah's response was more diffuse. However, her initial response was focused on past experiences, while her second response was more positive and based on current functioning.

On "Coping, Defenses, and Resiliency," both participants demonstrated an increase in their perceived ability to deal with stress in a resilient way, but James's response was more pronounced. James seemed to be utilizing some of the techniques learned during the intervention to deal with interpersonal function; however, there seems to be difficulty coping with negative responses from others. Sarah's responses at both time points indicated a distinction in the way she handles interpersonal and academic stress. She noted an acceptance of significant academic stress and lack of coping mechanisms ("a lot of times, I have to get through it"). At time 1 she noted being skilled at calming the stress of others, but at time 2 she noted increased emotional understanding

and assertiveness ("If it's with people, I try to figure out and try to figure out my feelings, like anger, and try to understand motives behind it" and "I take firm actions sometimes"). James's responses reflected an ability to manage stress well, but his first response highlighted his tendency "internalize," and his second response emphasized his "pride" in taking "one step at a time." Both James and Sarah's responses seem to reflect some of the material covered, but the distinction in their scores likely reflects qualitative differences in distress (also see Table 1). For example, James and Sarah indicated "criticism" and "disappointment" made them feel defensive or vulnerable, respectively. James reported he engages in perspective taking as way to determine what it meant by the criticism and if he can gain any constructive feedback. However, Sarah mentioned increased efforts to meet others' expectations to avoid rejection and discussed the feelings of shame and isolation she felt from losing the election. When talking about the election, her response indicated counter-dependent qualities to ward off the shame ("Who needs them anyway") it triggered from core insecurities. In fact, this event seemed to be more upsetting to Sarah than the loss of her long-term romantic relationship. During the second interview, Sarah mentioned this relationship as a source of stress, but she did not mention her partner in any other area of well-being.

While their quantitative responses concerning "Narrative Identity" were relatively similar, Sarah and James's qualitative responses were in sharp contrasted. James's response reflected a thoughtful and optimistic narrative about the various aspects of his functioning. Sarah's responses were negative-neutral and qualified each positive sentiment with a negative attribute. Both of their responses for time 2 are below.

James: "*I feel better about myself and am becoming more of an adult. I eliminated immature behaviors - decreased partying and no more illegal substances. In the relational domain, I am increasing expressing emotions, not suppress things that are there. I am also more able to express things to myself. I have an increase in self-esteem. I'm proud of myself for overcoming challenges. I feel optimistic and that wasn't always the case*."

Sarah: "*I'm doing pretty alright. College is a positive step. I'm pretty smart, meaning I get good grades. I'm usually not original, but if I'm given guidelines, I can be creative. I am a kind and caring person. I want to make an impact on the community and better than neutral. I'm doing alright*."

These responses may represent differences in their reactions to obstacles and their ability to access positive beliefs about themselves under stress. Both James and Sarah were achievement motivated, but James found "pride" in his accomplishments even when faced with rejection (i.e. not getting an internship). Sarah's interpersonal stressors were particularly difficult and extended beyond her academic stress, creating a harsher picture of her overall functioning. In sum, both clients seemed to increase their perceived emotional regulation and coping skills after the treatment implementation. James appeared to have more positive responses to the questions than Sarah after the intervention and showed increased usage of material learned.

Assessments of James and Sarah

Assessment of James. James was experienced as an intelligent, kind, and driven individual who was family oriented and motivated to achieve. At the start of

treatment, James reported increased feelings of isolation and a significant disturbance in his sleeping patterns (e.g., restless). Moreover, he endorsed mild depressive symptoms relating to occasional fatigue, decreased motivation, and poor concentration. James had experienced more severe symptoms for about six-to-nine months after the two sudden deaths, but he had improved and remained at his current level of functioning since the beginning of the academic year (approximately eight months). James had initially coped through daily marijuana use, but he had discontinued use because it could have jeopardized his professional future.

James felt compelled to minimize expressing his own needs in order to maintain a sense of composure and calmness. He tended to regulate his interactions in a way that was more passive and compliant to the needs of those around him. His strategy appears to have been to attempt to meet his own needs or to operate as if he might not have as many emotional needs as others or that they are not as important. This led him to feel that he did not have much influence on others and that he typically did not rely on others for emotional validation or support. Overall, his presentation indicated that his basic human desire to be known and understood by others was not being met through the strategies he was using.

Assessment of Sarah. Sarah's caring nature and internal criticism seemed to be the most prominent features of her presentation. She was also experienced as quite personable and having a good sense of humor. She readily empathized with others and was compassionate to those who she felt were suffering and was authentically motivated to support others. At the start of treatment, Sarah met criteria for a Major Depressive Episode according to the *Diagnostic and Statistical Manual of Mental*

Disorders, Fifth Edition (DSM-5, American Psychiatric Association, 2013). She presented with depressed mood, anhedonia, fatigue, disrupted sleep (e.g., hypersomnia, restless), and poor concentration. In addition to her current presenting symptoms, Sarah reported a history of self-harm (e.g., cutting) beginning her sophomore year of high school. She denied engaging in self-harm since beginning college; however, she endorsed current urges to cut when she was overwhelmed or upset with herself.

In her relationships Sarah would internalize the others' interests to fulfill her desire to be accepted and valued by them. Sarah primarily worked in cooperative and reciprocal ways (i.e., affiliation) and often hid or denied her own emotional needs. Within this relational pattern of being a strong support system for others, Sarah was motivated to attain affection and minimize conflict and became highly sensitive to signs of potential rejection or criticism from the outside world. This dynamic left Sarah insecure about being known and valued by important others and she became self-attacking when she perceived rejection because outward aggression would have violated this relational pattern.

Case Conceptualizations: James and Sarah

Case Conceptualization of James. Although he described himself as more introverted, James was able to open up to his family and a select few individuals. James's experience of two significant losses around similar and crucial times developmentally likely activated a number of existential anxieties – the uncertainty of life, recognition of his own mortality, feelings of rejection, loss or abandonment, and the inevitable suffering

that comes with caring. Due to the feelings that were activated by these events, it is not surprising that James would want to return to happier, simpler times.

Interpersonally, James was able to effectively manage momentary anxiety and embarrassment; however, this avoidance strategy impeded his ability to fully and adaptively in accordance with his desire to be more authentic and confident in his relationships. These existential conflicts that emerged following these losses might have led James to adopt a more counter-dependency relational style. He tended to suppress emotional reliance on others and hide core aspects of himself, likely to avoid the perceived negative the consequences of relying on or needing others. This position was also suggested in the way he described his dating history as "passionate during, heartbreaking afterwards" and that he had "very little confidence" at the start of treatment. It appeared that he had experienced a great deal of intimacy with his partner, and he might have used this avoidance strategy to keep himself from being further wounded. Understanding this difficulty being emotionally close to others, resistance to seeking help, perfectionistic ideals for his own behavior, and discomfort being vulnerable are essential elements to address in the disconnection he felt.

Case Conceptualization of Sarah. Sarah initially endorsed a positive view of self, but she also had frequent experiences of dissatisfaction and self-criticism. Externally, she presented as a relatively easy-going, agreeable person who was responsible, content and effective. However, this persona masked a complex emotional picture of another self-state, one where she felt vulnerable, weak and depressed and also highly self-critical. Sarah's conflicted sense of self and sensitivity to rejection likely developed within her family environment where she found it difficult to be soothed (e.g.,

high level of control, lack of warmth). Sarah reported that her mother in particular could be critical at times and would call her a "grump" when she was in the midst of depressive episodes. A central aspect to this dynamic was her mother's unpredictable moods and quickness to anger. She quickly turned self-attacking and experienced both her external and internal worlds as antagonistic. Sarah likely learned the best way to manage her environment was to avoid criticism and direct much of her distress inward (e.g., self-criticism, self-harm). She developed perfectionistic ideals that drove her to appear both competent and happy and to inhibit her emotional reactivity, negativity, and weakness.

She appeared to reconcile these parts of herself by adopting an "other-oriented" relational style. This style of relating allowed her to be positive and agreeable, but it also created a central dilemma. Her strong self-criticism activated the more negative parts of herself and led her to feel precisely the way she was defended against, thus resulting in more self-criticism and a downward cycle. She would become angry and resentful having to repeatedly subjugate her own interests; however, she would suppress these negative reactions because they threatened her connections, which created more anxiety and inner confusion. Her style of relating and her use of avoidance to cope with negative emotions made her particularly vulnerable to stressors. Unfortunately, her identity was such that she wished she were not vulnerable.

Intervention Implementation

As is described in Chapter 3 and fully included in Appendix L, a protocol for the *Character Adaptations SysTem Intervention (CAST)* was constructed using Glover's (2013) format. Similar to Glover's analysis, the manual was considered to provide a comprehensive overview of the five character adaptation systems. With the exception of

Module 1:Values, the researcher structured the remaining five modules (Habits, Emotions, Defenses, Relationships, and Justification) to be used interchangeably depending on the client's goals and clinician's judgment. Both Sarah and James received each module in the same order for consistency; however, their treatments varied in flow and materials covered (detailed session outlines are provided in Appendices A and B respectively). The following themes are discussed below concerning observations made throughout implementation: (1) Omitting modules based on adaptive functioning; (2) Adjusting application of information; (3) Balancing written material with discussion and therapeutic alliance; (4) Sensitivity to clients' perception of their own functioning; and (5) Consideration of client characteristics.

Omitting modules based on adaptive functioning. Neither client was given **Module 2: Habits**[1] because James seemed to already be engaging in healthy habits, and Sarah was taking initiatives to exercise more regularly and eat a more balanced diet. The more knowledge clients may have about the various modules and the higher their functioning; it may not be necessary to give each module. These decisions should be made with the client throughout the assessment process and all five domains of adaptation should be covered to provide a holistic frame.

Adjusting application of information. Both Sarah and James were given handouts during the sessions; however, the clients' functioning and level of interest guided the amount of time spent reading or addressing each section. For example, when discussing **Module 3: Emotions**, James was interested in learning about activating and inhibitory emotions and use of intellectualization. On the other hand, the clinician

[1] See Glover (2013) for a sample of this module.

discussed emotions with Sarah over the course of two sessions and minimal attention was paid to handouts. Sarah was given the material to review at her leisure, but the literature was not covered during the session because she was experiencing a significant amount of distress after losing an election. This clinician spent the majority of those sessions validating Sarah's experience and attending to the therapeutic process (e.g., emotional experience and expression, internal criticism, implications for relational value, and defensive structure) and altered the way material was presented for the remaining sessions. The intervention became more of an introduction to future psychotherapy as it became clear Sarah would be interested in longer-term treatment.

Balancing written material with discussion and therapeutic alliance. Each module contained varying amounts of theory, examples, exercises, and diagrams. Although not intended, and maybe a product of the clinician's therapeutic style, the sessions tended to move away from the written text and focus on diagrams and main themes as they applied to the clients' real-world experiences. Themes were highlighted in session, but James would read the materials outside of sessions to gain a better understanding of the concepts and bring them back each meeting. With James, the sessions were used to illustrate and review topics and aimed at James's ability to explicitly integrate them into tangible experiences. Sarah would rarely bring up previous material, but she would readily process experiences about her romantic partner, friendships, and family relationships. During one session, Sarah was discussing emotional reactions to perceived rejections from others and apologized for keeping the therapist from addressing certain topics. This clinician used the exchange as an opportunity to explore ways in which Sarah's fears about rejection could also be present

within the therapy relationship. In longer-term treatment, it may have been beneficial for this clinician to maintain more ambiguity after this initial discussion; however, because of the brief treatment model, this clinician assured Sarah that it was an experimental treatment and the structure was flexible. In future implementation, the treatment manual could be presented in a shortened format (i.e., highlight key concepts and diagrams within sessions) and more detailed information could be given to read after each session.

Sensitivity to client self-perception of functioning. James and Sarah's perception of their own functioning impacted their ability to internalize the material provided to improve adaptive functioning. James had a relatively positive self-image and could tolerate feedback about interpersonal strategies he was using to navigate his needs for autonomy and dependency. He was able to identify multiple relationships where autonomy-dependency themes were impacting his ability to form more meaningful relationships outside of his family. Sarah seemed to internalize the written feedback as failures in her ability to form meaningful relationships and became increasingly self-critical when discussing interpersonal dynamics. Considering Sarah's insecure attachment history, it may have been more beneficial to highlight the filtering between the domains of consciousness (i.e. Experiential and Justification) and justification (i.e., private and public) than discussing defensive structure or relationship dynamics.

Consideration of client characteristics. This clinician observed that the brief and psychoeducational format of this intervention would be most appropriate for securely attached individuals experiencing milder symptoms of anxiety and depression. Some of the material in the manual might also benefit individuals with insecure attachment histories and more severe psychopathology if utilized within a longer-term, less

structured psychotherapy with an empathically attuned therapist. For example, when discussing attachment theory and defensive structure, James was able to assimilate the information into his preexisting schema of secure attachments; however, when the general integrity of basic framework was maintained through the use of two main diagrams: Domains of Consciousness and Two Contexts of Justification: Public and Private. These diagrams seemed to complement theory by providing a more straightforward way to integrate the various domains, and they also allowed the clients to generate their own insights and questions. For those who can tolerate direct examination of their defensive and relational structures, the Influence Matrix and Malan Triangle of Conflict graphics also seem to function well as complements to theory.

This intervention is understood as an expansion of Glover's (2013) previous implementation of the treatment manual. Feedback from participants of that study provided indicated that the vocabulary, complexity of concepts, and amount of material covered were not easily accessible. However, James and Sarah did not endorse these sentiments and commented that the format was appropriate given their interests and functioning. This may indicate that the material covered in the manual may be more appropriate for college-aged and higher functioning individuals. In contrast to the previously utilized group format, the current intervention allowed for more individualization of the material that may have: 1) afforded more detailed explanations of concepts; 2) application and discussion of specific life examples; 3) selection of topics based on their functioning; and 4) consistent monitoring by clinician of the clients' experiences. In addition to these factors, the following section discussions how the use of systematic assessment and feedback provides increased

individualization and application of the concepts discussed during treatment.

Use of systematic assessment. In addition to the psychoeducation provided through the modules, another potentially beneficial aspect of the intervention was the various assessment procedures that brought together nomothetic tests, clinician feedback, client's adaptation within bio-psycho-social contexts, and client feedback. The clients were given clinician generated feedback and/or information based on this approach in three ways over the course of treatment: 1) Written feedback and discussion of the Well-Being Screening; 2) Written conceptualization; and 3) Psychoeducation modules.

Well-being screening feedback and discussion. The Well-Being Screening occurred before the current intervention, and the written feedback briefly introduced the five systems of adaptation and highlighted the clients' functioning within each domain. The clinical researchers found that the screening provided a brief overview of functioning, but more qualitative data would be needed to provide a richer conceptualization. General feedback from the researchers and clinicians found that the screening served the participants in two ways: it provided a basic scaffolding of the various domains of functioning and communicated general insights into more adaptive ways of being. If the written feedback from the Well-Being Screening were contraindicated (e.g., someone might view the feedback as overly critical, complex trauma), an introduction to functioning in each domain should still be provided to establish a basic framework from which the client and clinician can generate questions and themes before the modules are presented.

Written conceptualization. In the beginning of the CAST intervention, both

James and Sarah were given the opportunity to reflect further on each domain. They were also encouraged to provide more detail about their current functioning and developmental history. This clinician found it beneficial to have the basic framework from the Well-Being Screening because she was able to offer insights into possible ways the clients' developmental histories could have impacted their current functioning and engage in a dialogue with them about their reactions. This collaborative effort cumulated in a written conceptualization that was presented to the clients during the fifth or sixth session[2]. This clinician noted that James was engaged and curious about the conceptualization and found the narrative helpful in contextualizing the remaining modules of the intervention. On the other hand, this clinician intended to provide Sarah with an empathic description of the function of her self-criticism and interpersonal strategies; however, Sarah seemed to perceive the feedback as evidence of her inadequacies. While this clinician still holds that the conceptualization is an integral piece of the intervention, more consideration is necessary in how it is offered to the client.

Client Satisfaction and Reactions

Weekly Rating Scales Data. Review of weekly rating scale data suggested that participants felt a strong therapeutic alliance with the therapist, thought the clinician was competent, and perceived the sessions were valuable. There was little variation on their average evaluations for sessions across the four domains measured (Sarah = 6.5; James = 6.2). Sarah demonstrated consistently positive attitudes towards therapy, but James began the intervention with some ambivalence about its value (e.g.,

[2] Sarah's conceptualization was supposed to be offered during the fifth session but was delayed because of the distress she was experiencing.

marked “4” or “Mixed or Neutral” on initial session). Average weekly functioning scores were based on overall well-being, personal functioning, quality of relationships, and general life direction. There was little difference in average functioning across domains (Sarah = 5.3; James = 5.6); however, Sarah’s scores revealed more variability due to one session when she had experienced a significant stressor (e.g., overall well-being dropped by 3 points and other domains decreased by two data points during session 5). Participants had the option of including qualitative comments and questions in addition to their numerical ratings. Only James chose to submit comments and questions with his weekly rating scales (see Table 7 of Appendix I). His responses suggested that he was engaged with the material and was thoughtful about the sessions.

Posttest Evaluation of Material Covered in Sessions. As a part of the posttest assessment, James and Sarah were asked to complete fourteen follow-up questions regarding the intervention in addition to the same battery of questionnaires from the Well-Being Screening (see Tables 1 and 2). These follow-up questions covered: overall experience of the intervention, what was liked best/least about the intervention, degree goal(s) of intervention were accomplished, and experience of individual modules. Both James and Sarah completed the surveys via *Qualtrics* before returning for the termination session. Some of the responses are highlighted in this section but questions and answers are included fully in Appendix K.

Both James and Sarah responded positively to their overall experience in intervention: James highlighted increased knowledge and application of coping strategies and Sarah mentioned increased insight. When asked what they liked best,

James noted techniques and having his first positive experience with a therapist, and Sarah again described increased insight and perspective. They both responded affirmatively to questions regarding the intervention's objective of helping clients understand aspects of their psychology. James mentioned the individualized nature of the topics discussed helped him identify his "behavioral and psychological tendencies in an effort to make them more adaptive." Sarah said she understood her "own thinking process and social tendencies a lot better now." When asked to state their specific goals, James's goal was similar to the clinician's understanding of increasing his confidence in relationships. However, Sarah's goal was more negative, stating her objective was to "get insight as to why [she does not] succeed socially as well as other people." They both said they "somewhat" met their goals. When asked to define the Systems of Adaptation, their responses indicated broad understanding and application of the modules covered.

They were then asked to reflect on a meaningful session or event during the intervention. James highlighted the strong therapeutic relationship, and Sarah mentioned a time (during session 5) when the therapist asked her to reflect on her reluctance to express her sadness and frustration. In verbal feedback, both James and Sarah noted enjoying the sessions but found it difficult to find time for the sessions within the five week time period. James was not interested in pursuing psychotherapy after the intervention and seemed to prefer the structure of the psychoeducational intervention. However, Sarah was interested in continuing with psychotherapy and seemed to find more value in the experiential exercises and focus on insight.

In summary, both James and Sarah reported increased understanding of their

own functioning and some positive changes towards their treatment goals. Through the use of systematic assessment, the hope is that a deeper understanding would emerge over time.

Chapter 6

Discussion

This study was exploratory in nature and designed to extract themes, areas of further inquiry, and limitations of applying an intervention grounded in Henriques' unified theory of psychology (Henriques, 2011). Within the psychotherapy integration movement, Henriques classifies his approach as overlapping with, but also qualitatively different from assimilative integration (i.e., assimilates and integrates areas of emphasis from major theories) and theoretical integration (i.e., major approaches explained within one framework). It overlaps with these two approaches to psychotherapy integration because the unified approach provides a novel way to theoretically unify and assimilate and integrate many key insights from the major approaches to individual psychotherapy. These include elements such as the dual processing view and centrality of emotion from neo-humanistic Emotion Focused lens, the manner in which relational needs and motives guide individuals and how they filter out subconscious motives and feelings that might be threatening in a way that is central to psychodynamic theory, the manner in which verbal cognitions justify pathways that can be either adaptive or maladaptive and feedback on feelings and actions as emphasized by the cognitive approach, and the way basic habits are formed via association and operant principles as heralded by traditional behaviorists. In this way the approach is similar to other visions of unifying psychotherapy (e.g., Magnavita, 2008); however, it is different from other approaches, both in psychotherapy integration and unified psychotherapy in that it "explicitly concerns itself with the deep philosophical, theoretical, and conceptual issues that have plagued the field since its inception" (Henriques, 2011, p. 211).

Specifically, unlike other approaches, Henriques' unified approach comes with a new meta-theoretical apparatus which is explicitly designed to address some of the most deep and profound theoretical and philosophical problems faced by the field of psychology. Henriques' explicitly defines the field of psychology (Henriques, 2004), explains how it relates to but also is conceptually separate from the profession (Henriques & Sternberg, 2004) and how it exists in the pantheon of human knowledge more generally (Henriques, 2008). This novel macro-level view sets the stage for the field of psychology in general and psychotherapy in particular to evolve from disciplines that are centered on behavioral research methodology and specific empirically supported techniques respectively to one that affords scientists and practitioners a conceptual map and workable theory of the person that can be researched and explored to foster change.

This means that instead of racing horses via treatments grounded in one or the other paradigms, we now have a conceptual bridge that allows for both researchers and practitioners to see the whole. This perspective creates a shared language and structure among paradigms that can ultimately change the relationship between the science and practice of psychotherapy. Originating out of the ToK System (see figure 1 for review), the five character adaptation systems embedded within biological, learning, and social contexts provides a "conceptually-rich gestalt of human functioning which broadens the framework" that clinicians and researchers can use to organize a client's narrative (Stout, 2010, p. 164). By examining the degree of adaptive functioning within the five domains, the clinician can theorize the etiology and maintenance of the clients presenting concern(s) and use this to guide intervention. This project attempted this conceptual system into a protocol that can be assessed and delivered to clients. Our goal was to help

participants deeply understand themselves via educating them about the five systems of adaptation and applying that model to gain insight and awareness toward adaptive change.

For the first time, we now have a broad way to view human psychology through a theoretical lens that allows for the effective assimilation and integration of the major paradigms in psychology and psychotherapy (i.e., behaviorism, cognitivism, humanistic and psychodynamic approaches). This unified lens was illustrated this through the case of "Caroline", by outlining how these theoretical perspectives focus on certain aspects of an individual's psychology when approaching conceptualization and treatment. Caroline's functioning was then explored through Henriques and Stout's (2012) Unified Component Systems Approach to Conceptualizing to illustrate the process by which this framework assimilates and integrates key ideas of major approaches. The current study recruited individuals who presented with characteristics similar to Caroline in an effort to demonstrate how this unified framework not only applies to weaves together these insights theoretically but also provides a method for integrating application and implementation of these various treatment modalities.

The primary objective of this dissertation was to explore the feasibility and utility of an individualized psychoeducational intervention, Character Adaptation SysTem (CAST), derived from a group therapy manual grounded in an integrated approach to conceptualization (Glover, 2013; Henriques and Stout, 2012). Two individuals were recruited from a sample of undergraduate students and agreed to participate in ten individual sessions over the course of five weeks. The following section highlights the overall treatment implementation, general themes, and limitations based on observations

from these two cases. Finally, these observations are situated within the broader context of psychotherapy integration movement.

Treatment Implementation and Assessment

Feasibility and utility were evaluated through the clinician's professional judgment of the overall implementation and the clients' verbal feedback during treatment and posttest evaluations. Both participants attended all ten sessions, completed weekly rating scales, and finished both pre- and post-intervention assessments. The treatment's three-phase structure (e.g., Sessions 1 to 3 – Developing conceptualization and goals, Sessions 3 to 9 – Treatment Modules based on Glover (2013), and Session 10 – Termination) provided a stable, yet flexible format throughout implementation. Both participants covered the same Modules in Phase 2, but there were differences in administration: The material was covered 1) through different methods (e.g., worksheets, personal experiences, etc.); 2) in a partially altered sequence (e.g., conceptualization offered at different point in treatment); and 3) for varied durations (e.g., over the course of one or more sessions). The greatest amount of variability in treatment structure occurred during the second phase; however, this was expected as it reflects the majority of treatment and the clinician's continuous refinement of the protocol. Overall, James and Sarah responded favorably to the treatment's structure and implementation; however, individual differences potentially impacted the treatment's effectiveness. The treatment's capacity to impact James and Sarah's subjective distress is discussion below and demonstrates the importance of grounding interventions in a comprehensive biopsychosocial and developmental framework.

Importance of Integration between Personality, Psychopathology, and Intervention

James and Sarah were selected from a sample of undergraduate students for the current intervention because of their tendency to utilize more submissive, dependent relational styles to protect themselves from rejection. This presentation was chosen because is has been widely researched from a variety of orientations, thus allowing for clear integration of personality theory, psychopathology, and treatment. Although they were recruited to fit a certain profile, their dissimilarities in severity of symptoms, attachment history, and treatment focus seem to have affected their response to the intervention.

Severity of Symptoms. Both Sarah and James reported an increased ability to regulate emotions and to cope with stress in a resilient way as a result of the intervention; however, they began treatment with significantly different levels of negative affect. James's initial score just met the cutoff for mild depression and was subclinical in post-treatment analysis; however, Sarah's symptoms were considered moderate at both time points. The psychoeducation, multiple assessments, and written conceptualization provided James and Sarah with a framework and techniques; however, it seems that these elements, within the current framework, did not seem to have a significant impact on symptomatic distress. In fact, Sarah's symptoms appeared to be slightly worse at the end of treatment. A unified approach to intervention holds that symptoms are important, yet insufficient, in determining treatment outcomes. For example, Sarah had just ended a long-term romantic relationship and was in the process of completing her final exams when the post-treatment assessments were administered. Having *CAST* as an underlying framework allowed the clinician to provide Sarah with a strengths-based narrative and emphasize the relative stability of her symptoms in the context of these life stressors. By

only looking at one part of the elephant (i.e., merely examining symptoms), there is little consideration for resiliency and contextual factors.

Attachment History. The different outcomes for these two individuals provide valuable insights into the importance of attachment history when considering treatment options. McCullough Vaillant (1997) echoed these observations in her assertion that the following processes must occur within the therapeutic relationship for individuals to alter maladaptive relational patterns: "1) Inner representations of others as trustworthy and caring, especially the therapist; 2) a new sense of self as worthy and able to receive care; and 3) the ability to grieve what has for so long been missing" (p. 346). James's secure attachment history likely enabled him to connect with the clinician and access his internal representations of stable, loving relationships in response to the material covered (e.g., Influence Matrix). There were elements of trust and care in the therapeutic relationship with Sarah; however, without an internalized structure of relational value and sense of worthiness. Similar to James, the brief psychoeducational framework provided Sarah with an overview of her functioning within the domains of adaptation; she largely viewed this feedback as further evidence of her own inadequacies. James's attachment history may have allowed him to integrate the material provided in a psychoeducational format; however, Sarah would likely benefit from longer-term supportive psychotherapy that would allow her fulfill the components highlighted by McCullough Vaillant.

Treatment Focus. Another important factor seemed to be their overall experience of treatment. In follow-up questions regarding the material covered both of them were able to articulate the main concepts presented in the sessions and accurately apply them to personal experiences; however, they differed in areas of interest. James was

particularly satisfied with the techniques offered by the treatment, while Sarah emphasized gaining perspective and insight into her functioning. However, when asked if the intervention helped them understand aspects of their psychology, they both responded affirmatively (e.g., Sarah said "Yes it definitely did", James said, "Very much so"). The following section highlights the importance of the various assessment methods in this intervention as a way to individualize treatment and help clients gain insight in a way that fosters adaptive change.

Use of Therapeutic Assessment

This intervention provided multiple opportunities for both the clinician and the clients to reflect on assessment results and material presented. This approach has some commonalities with Therapeutic Assessment (TA), a humanistic method of evaluation that aims for the client and clinician to "come away with a deeper understanding of the client's dilemma of change, an understanding that heals shame and points towards new ways of being for the client" (Finn & Tonsager, 2002, p.16). The assessments and psychoeducational material presented could be classified as **empathy magnifiers**, meaning that they were used to increase communication and understanding between the clinician's conceptualization and the client's subjective worldview (Finn & Tonsager, 1997). Henriques and Stout's (2012) Unified Component Systems Approach to Conceptualizing provides a systematic way to present this information to the client that also creates a shared language.

The value of TA with this intervention can be readily appreciated when examining James and Sarah's reactions to the written conceptualization. James noted that the conceptualization given to him during session 5 offered a useful frame for

understanding ways his previous experiences were impacting his interpersonal functioning. On the other hand, Sarah appeared to use this feedback as evidence of her own shortcomings. Instead of providing her with a written conceptualization, it may have been more appropriate for Sarah to examine some of the screening assessment results with the clinician. While Sarah examined results, the clinician could have offered some possible observations, emphasize more strength-based insights, and explore ways her developmental history impacted her current functioning. Having Sarah direct this process, rather than the clinician, may allow treatment to follow at a more accessible pace. Using the Influence Matrix and IMSMS as an example, the clinician could have provided Sarah with a basic IM framework without providing an interpretation of her IMSMS scores. This information might have been more effectively utilized as a way to explore some of Sarah's strategies, without preemptively offering internal motives. Instead, the clinician could have intervened through the felt experience within the therapeutic relationship.

Limitations

A case study paradigm has a number of limitations, this study included. There was a small sample, no control condition, and only one clinician involved in treatment implementation. Although there was some quantitative pre and posttest data, the short duration of treatment and testing effects did not allow for definitive conclusions to be made. The quantitative data was more useful for nomothetic comparison; however, most of the observations were qualitative in nature and subject to the clinician's bias in interpretation. She was invested in positive outcomes for both clients, but she was also searching for overall factors affecting treatment outcome. Additionally, the treatment clinician initially only conducted the initial well-being screened for James, and their

relationship likely affected his initial decision to pursue treatment. If so, this may be further evidence supporting the importance of the therapeutic alliance in treatment adherence and outcome.

The differences between clients are both insights into treatment factors; however, they can also function as limitations. For example, the differences in participants' genders could reflect a socialization of gender roles in response to treatment. Moreover, the clinician varied treatment implementation based on her own professional judgment and client feedback, which were subject to a variety of factors unknown to either of them (e.g., life events, comfort with therapy, ability to understand information, way information was presented, etc.). The case study methodology allowed for flexibility in application, but in future studies, more controlled or systematic implementation would be needed.

Further Directions for Psychotherapy Integration

The utility of this framework lies in its ability to translate terminology from different perspectives and map their overlap and distinctive qualities onto human functioning. Intervention, then, occurs based on the functioning of various systems of adaptation, rather than from a single perspective. This project fits into the current integrative and unified psychotherapy movement, by providing a more directive educational approach in the intervention than many therapies because we wanted to explore whether and how clients can be directed to understand these systems and benefit from them. Most clinician's identify as integrative or eclectic; however, a future area of study could be focused on the impact of clinicians having this specific map of conceptualization in treatment implementation. This treatment protocol could further be

implemented with undergraduate students within an individualized or group psychotherapy format. The flexibility of this manual allows for a general psychotherapy designed to enhance well-being or adapted to provide psychoeducation and support for a specific focus (e.g., self- or other-oriented, adjustment, depression, social anxiety, etc.). However, special considerations need to be further explored regarding individual characteristics of clients who would need additional support. From this study, there is potential for this map can be used explicitly via psychoeducation or implicitly through the clinician's ability to organize a client's personal narrative that resonates with the client and allows for adaptive change.

Appendix A

Session Outlines: Sarah

- **Phase 1. Introduction, Assessment, and Conceptualization**
    - **Sessions 1 and 2 – *Overview and Character Adaptations***
        - **Introduction** to psychoeducational intervention
        - **Key Concepts**. Explanation/overview of key ideas/terms: Adaptive Living, Narrative, and Domains of Adaptive
        - **Assessment** - Began exploring presenting concern(s) and gathering developmental history to better understand etiology and maintenance of these patterns. Explored adaptability and valued goal states.
        - **Discussion**. Follow-up questions about Life Information Survey and Parental Bonding Inventory.
- **Phase 2. Character Adaptation Systems**
    - **Session 3 – Module 1: *Values and Goals.***
        - **Psychoeducation.** Description of values and their importance in goals and motivation.
        - **Values Exercise**. List of 30 values and descriptions were given to Sarah. She was asked to choose and describe five values from the list. Sarah chose *compassion, friendship, exciting life, creative expression, and happiness*. As a part of the exercise, Sarah then chose *health, self-respect, belonging, social contribution, and wisdom* as five values she would like to work towards.
        - ***Goal***. *To gain insight into interpersonal dynamics and identify/focus on her needs.* Sarah's original goal sought to determine what she was doing "wrong" in relationships and it took a great deal of effort to formulate a positively framed goal.
        - **Discussion**. Values were discussed within developmental context and family origins. Specifically, Sarah's values seemed to highlight needs for power, affiliation, and a healthy balance between autonomy and dependency. Adaptive qualities were explored relative to goal state of attaining social influence and relational value.
    - **Session 4 – Module 4*. Defensive System***

- **Psychoeducation.**
  - **Domains of Consciousness.** This handout was explored to demonstrate differences between thoughts and experience.

  - **Malan triangle of defense** (Malan, 1979; image/impulses/affect, defense, anxiety) was discussed broadly, but the handout was not given because of this clinician was unsure of Sarah's reactions. This clinician gathered information through previous assessments regarding Sarah's tendency to inhibit anger. This clinician offered an initial conceptualization through the Malan Triangle that activation of shame and guilt might be inhibiting her from healthy assertion. It became apparent that exploring defenses was too distressing given Sarah's negative self-view and self-criticism. Sarah's reaction guided this clinician to emphasize a self-view that recognizes both strengths and weaknesses with compassion, normalize autonomy-dependency needs, and offer ways to develop the ability to self-sooth (McCullough et al., 2003).

- **Meditation Exercise**. "Mindful Focusing" asked Sarah to attend to each of the five senses. This exercise was used to complement discussion of distinguishing thoughts from experiences.

- **Discussion**. Distinction and filtering between the experiential and justification systems. This discussion was intended to highlight some of Sarah's automatic negative self-evaluations and gently challenge them.

- **<u>Session 5 – Module 3. *Experiential System*</u>**

  - **Conceptualization Not Given**. Session was intended to offer Sarah the written conceptualization. However, Sarah was experiencing a significant amount of distress and rejection after losing an election (e.g., tearfulness, negative self-talk, questioning relationships).

  - Session was dedicated to providing Sarah with a safe and supportive environment where she could explore the full range of her emotional reactions and articulate her own needs. For example, Sarah initially held back her sadness, but she became tearful shortly after this clinician reflected her reticence to cry and wondered about the function of her holding back.

  - **Mindfulness Exercise**. Asked Sarah to feel the "stress and emotional discomfort in [her] body" and was guided with self-compassionate phrases or questions. She wept throughout this exercise and said it was both

helpful to hear a compassionate voice, but she also found it difficult to generate this voice internally.

- **Session 6 – *Conceptualization Offered***

  - The **Conceptualization** was read aloud and each paragraph was discussed. The text was organized around the disconnection between Sarah's outwardly easy-going, agreeable self and her internal sense of vulnerability and distress. Much discussion focused on developmental origins of this split, ways Sarah's other-oriented interpersonal style was used to attain relational value, and the function of her harsh internal criticism. Sarah did not outwardly disagree with the feedback, but she stressed her increased capacity for empathy as a main factor in her interpersonal functioning. This clinician validated the importance of Sarah's compassion for others and gently asked Sarah to reflect on why she was not entitled to the same consideration.

  - **Exercise**: Sarah was asked to imagine seeing her internal critic having a conversation with someone in a restaurant. She reflected that it would be upsetting if she were to actually see this interchange take place because of the harsh tone and severity of the internal critic.

- **Session 7 – Module 5. *The Relationship System***

  - The written conceptualization was reviewed to allow Sarah a chance to reflect on the content. She mentioned her confusion about the different parts of herself and wondered if she could present her more "depressed self" to others and wear different clothes. Her confusion was further explored with the context of the relational system.

  - **Psychoeducation**.
    - Sarah learned about different **attachment** styles and the concept of relational value as is applies to early caregiver attachments.

    - **The Influence Matrix** (Henriques, 2011) was briefly introduced and the dimensions of power, love, and freedom.

  - **Discussion.** Sarah was asked to reflect on her attachment history. Sarah was more ambivalent about her family relationships than she had been in previous sessions. She saw herself as more securely attached and seemed to resist previously discussed information that indicated early insecure attachment bonds that were inconsistent and lacked warmth. This clinician did not insist on further exploration of parental relationships and moved the conversation to current relationships. Sarah discussed her tendency to feel insecure in interpersonal relationships and her general dissatisfaction with her current romantic relationship.

- **Session 8 – Module 5. *Relationship System Continued***

  - **Psychoeducation. The Influence Matrix** (Henriques, 2011) was discussed in more detail.

  - **Discussion.** Sarah provided examples of her relationships and process dimensions and associated emotions were discussed. Sarah discussed her desire to connect with others and the rejection she felt after losing the election. She mentioned that she frequently doubts herself and does not believe that others are not as invested in their relationships. Sarah further discussed her dissatisfaction with current romantic partner and seemed to project her own desire to date other people onto him (i.e., suggesting that he date other people to know if she is the right person for him).

- **Session 9 – *Module 6. Justification System***

  - **Psychoeducation.**
    - Material was presented on the nature of justifications and how they serve to legitimize actions.

    - **Review of Defensive System.** This clinician attempted to revisit the defensive system and introduce defense mechanisms within the justification system to explain how defenses (e.g., intellectualization, rationalization) can be adaptive and maladaptive. Sarah was asked to provide examples from her daily life, but she became uncomfortable when processing the thoughts, images, feelings against which she was defending. This clinician then gave some generic examples to help Sarah understand the concepts with minimal distress.

  - **Exercises.**
    - *Adaptive and Maladaptive Justifications* and *Common Cognitive Errors* were discussed. Unlike the defense mechanisms, Sarah was able to easily apply these concepts to her own experiences. This clinician was able to deepen Sarah's experience through asking Sarah about the feelings and behaviors associated with the examples she provided.

    - "*3 C's for adaptive justifications: Catch It, Check It, Change it*." This exercise functioned well as a complement to the cognitive errors. Sarah seemed to have more difficulty coming up with adaptive alternative statements to a scenario where she believed a perceived failure was based in her own shortcomings.

- **Phase 3. Termination**

- **Session 10 –** ***Reflections of Goals and Process of Treatment***

  - **Re-administration of Well-Being Interview**

  - **Review of goals**. Sarah ended her long-term romantic relationship a couple days before the session and found it difficult to reflect on progress made. She noted an increased ability to cope with stressors, but she denied any changes in symptoms. She was eager to start psychotherapy when she returned from abroad.

Appendix B

Session Outlines: James

- **Phase 1. Introduction, Assessment, and Conceptualization.** James had worked with the treatment clinician during the Well-Being Screening. Therefore, this first phase of treatment consisted of only one session to introduce the key concepts and reflect on some of his hopes and fears about engaging in the process.

- **Phase 2. Character Adaptation Systems**

    - **Session 2 – Module 1: *Values and Goals*.**

        - **Psychoeducation.** Description of values and their importance in goals and motivation.

        - **Values Exercise**. From the life of values, James said the most important were *family, health, wisdom, inner harmony, and loyalty*. James chose *happiness, avoiding nostalgia, power, integrity, and exciting life* as values he would like to work towards.

        - ***Goal****. To become more assertive and comfortable in his relationships.*

        - **Discussion**. Values were discussed within James's goals to engage fully in his current relationships, rather than be "nostalgic" about "easier times" in his life. James suggested that his choice of *power, integrity and inner harmony* were largely a reflection of his desire to be more secure and less reactive to criticism from others.

    - **Session 3 – Module 4*. Defensive System***

        - **Psychoeducation.**

            - Henriques's **Domains of Consciousness** and **Two Domains of Justification** were introduced to highlight public and private filtering in the context of defense. The importance of harmony between the systems was discussed.

            - **Malan Triangle of Defense** (Malan, 1979) handout was given. James discussed his tendency to intellectualize and distance himself from the experiential system to project a more stoic and competent image to himself and others.

            - **Defense Mechanisms** (e.g., intellectualization, rationalization) were provided to discuss how they function to block and legitimize actions.

James initially sought a great deal of reassurance that he was using defense mechanisms (intellectualization and suppression) adaptively. This clinician encouraged James to consider various scenarios, and he was able to engage in thoughtful discussion about the varying degrees of adaptability in relation to context.

- **Meditation Exercise**. "Mindful Focusing"

- **Discussion**. Distinction and filtering between the experiential and justification systems. James noted that he could express more "feminine" qualities (e.g., noticing beauty of a flower, creative expression) with his friend who committed suicide a year earlier, with previous romantic partners, and with his family. He discussed that he hides these parts of himself because he fears that others might criticize him or see him differently.

- **Session 4 – *Defensive System* Continued and Module 4. *Experiential System***

  - **Psychoeducation.**

    - The **Malan Triangle of Defense** (Malan, 1979) was reviewed. James was then introduced to activating and inhibiting emotions within this context of defense. He was able to grasp the concepts broadly, but he focused on the benefits of allowing himself to grieve in contrast to the depression he felt after the two loses he experienced.

    - **Emotional Regulation**. James learned about emotion over- and under-regulation. He discussed his tendency to over-regulate his emotions (mainly painful affects) and cope with them by suppressing them or internalizing them in an effort to conceal them from others.

  - **Exercise.** James was asked to think of a recent emotionally charged event and answer questions regarding antecedents, goals, and bodily sensations. He reflected on the feelings of sadness and rejection he felt after learning one of his peers was hired for an internship over him. James allowed himself to briefly experience his initial feelings, but he then decide to distract himself by watching sports. He was understandably upset, but he engaged in some perspective taking and was able consider how this prepared him for other internship applications.

- **Session 5 – *Conceptualization Offered***

  - The **Conceptualization** was read and each paragraph was discussed. Much of the discussion focused on James's use of avoidance strategies to keep himself from being further wounded by loss. He examined

conflicting needs to be emotionally close and distant from others. Notably, James referred back to this conceptualization during each of the remaining sessions. He found it to be relevant to his concerns and helped create a narrative about specific ways his behavior has changed since he experienced the losses.

- **Session 6 – Module 5*. Relationship System***

  - James was given the opportunity to reflect on the conceptualization. It reportedly motivated him to take a chance and discuss his disappointment about applying for internships with his roommate. James was encouraged by the result because his roommate was supportive and also voiced some of his own struggles.

  - **Psychoeducation**.

    - James was introduced to different **attachment** styles and the concept of relational value in the context of early caregiver attachments. He described his early attachments as warm and attentive that were congruent with a secure attachment. James was able to identify that he had adopted more avoidant strategies because he had become more insecure after his last romantic relationship and wanted to reduce his dependency.

    - **The Influence Matrix** (**IM**: Henriques, 2011) was briefly introduced and the dimensions of power, love, and freedom. His insights regarding use of avoidance strategies and the written conceptualization and were then explained within the **IM** framework.

  - **Discussion.** James provided examples of various interpersonal situations and mapped them along the process dimensions of power, love, and freedom. He further noticed that his tendency to use autonomy not only kept him from needing others, but it also was useful at avoiding power dynamics. He also resonated with the shame associated with submissive strategies and compared that to the shame he feels when he anticipates criticism.

- **Session 7 – *Module 6. Justification System***

  - **Psychoeducation.**

    - Henriques's **Two Domains of Justification** was reviewed to further demonstrate the connection between the systems of adaptation.

    - Material was then presented on the nature of justifications and how they serve to legitimize actions.

- **Exercise/Discussion.** James had written about an internship interview on his Weekly Rating Scales after session 6. He had not received an offer or rejection by the start of this session. James was given a handout on *Common Cognitive Errors* and asked to reflect on some of these thoughts he was having in regards to his imagined outcome. James was able to identify multiple assumptions he had made anticipating disappointment and surrounding his "fear of failure."

- **Sessions 8 and 9 – *Justification System Continued***

  - **Psychoeducation.**

    - **Defense Mechanisms** (e.g., intellectualization, rationalization) were reviewed in the context of justification with an emphasis on how they are used to legitimize actions

  - **Exercises.**

    - *Adaptive and Maladaptive Justifications* and were discussed. James found this exercise helpful, yet straightforward. He engaged in more complex examples regarding his expectations and coping strategies. He was most concerned about the "accuracy or inaccuracy" of his justifications and found that he was less secure in making those decisions on his own. This clinician engaged James in discussion regarding his hesitancy to engage others in supporting or challenging his interpretations.

    - "*3 C's for adaptive justifications: Catch It, Check It, Change it*." This exercise functioned well as a complement to the *Common Cognitive Errors in Justification* and provided James more skills to determine the accuracy and adaptability of his justifications. James had recently learned he did not get any of the internships for which he had interviewed. This clinician validated his disappointment in conjunction with helping him utilize the 3 C's to practice developing more adaptive justifications. He focused a great deal on the expectations he had for himself and had used this interview process to develop a more realistic view of the effort it will take to reach his career goals.

- **Phase 3. Termination**

  - **Session 10 – *Reflections of Goals and Process of Treatment***

    - **Re-administration of Well-Being Interview**

- **Review of goals**. James reflected on his increased insight/ability to be more open in his relationships. He felt his capacity to cope had improved because of the skills learned during the intervention.

Appendix C

The Well Being Interview

Preamble: The purpose of this interview is to gain an understanding of how you are currently feeling about yourself and your life. You will be asked a number of questions to help get a sense of how you are functioning in relation to a number of areas, including: satisfaction with life, relationships with family and friends, attitudes, general outlook, daily habits, sense of purpose, resiliency, and overall happiness.

Instructions: The first part of each section will ask you to provide a general narrative in regards to how you have been feeling in relation to a specific area of well-being. Please look back over the past months and offer a brief description and evaluation of how you are doing in that domain. Specific 'yes' or 'no' questions will be asked to better clarify your experiences.

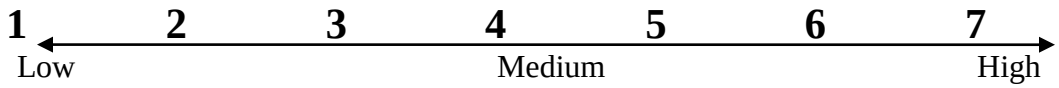
Section I: Overall Well-Being

A. Satisfaction with Life

In a couple of sentences, please describe for me your levels of life satisfaction. Feel free to provide examples:

_____
_____
_____
_____
_____
_____
_____
_____

An individual with high life satisfaction feels pleased with most major domains, is at peace with the past, and generally feels fulfilled and happy. In contrast, someone with low life satisfaction often wishes things were different, experiences problems in several major areas and often feels unhappy or unfulfilled. Given this please rate your level of life satisfaction on a scale of 1 to 7:

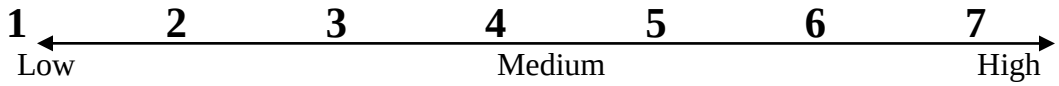


I'd now like to ask you a few specific questions. Please answer yes, sometimes (maybe) or no.

1. Do you consider yourself to be happy? Yes Sometimes No
2. Do you think you are flourishing as a person? Yes Sometimes No

3. Overall, are you satisfied with your life? Yes Maybe No
4. **Are there many things you'd change about your life if you could?**
Yes Maybe No

*****ADMINISTRATERS RATING OF CLIENT'S LIFE SATISFACTION*****

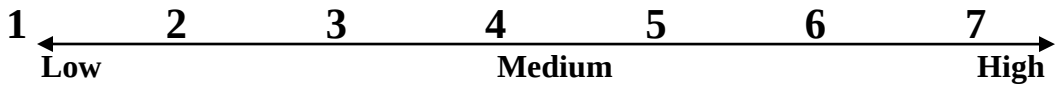


B. Interests, Engagement, and Involvement in Life

In a couple of sentences please describe your level of engagement in life and the number and kinds of activities that you find enriching, interesting, or pleasurable. Feel free to provide examples:

_____
_____
_____
_____
_____
_____
_____
_____

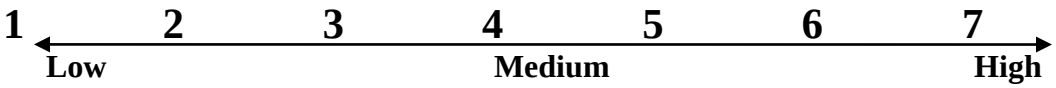
Someone who is high in engagement often feels there is not enough time in the day to do all the things that could be done, often is involved in interesting or exciting activities and frequently planning what to do next. In contrast, someone low in engagement often feels bored, uninterested, or that they are just going through the motions. Given this please rate your level of engagement in life on a scale of 1 (low) to 7 (high):



I'd now like to ask you a few specific questions about your engagement in life. Please answer yes, maybe (or somewhat or sometimes), or no.

1. Are there many activities that you find entertaining, interesting, or exciting
Yes Sometimes No
2. **Do you often feel bored and that there is nothing to do?**
Yes Sometimes No
3. Do you have many hobbies or interests? Yes Sometimes No
4. Do you feel you engage life to the fullest? Yes Sometimes No

*****ADMINISTRATORS RATING OF CLIENT'S LIFE INTERESTS, ENGAGMENT AND INVOLVEMENT*****

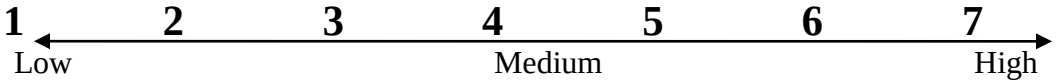


C. Meaning and Purpose in Life

In a couple of sentences, please describe for me the degree of purpose or meaning you believe that your life has. Feel free to provide examples:

_____
_____
_____
_____
_____
_____

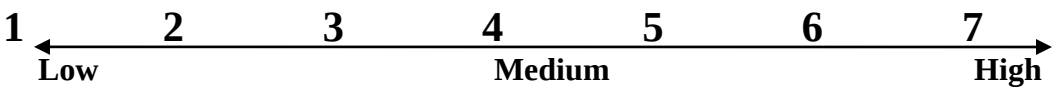
A person with a high sense of purpose sees their life as having meaning, they work to make a difference in the world, and often feel connected to ideas or social movements larger than themselves. Such individuals have a sense that they know what their life is about. Individuals low in this quality often question if there is a larger purpose, do not feel their life makes sense, and attribute no higher meaning or value to life other than the fulfillment of a series of tasks. Given this please rate your degree of purpose or meaning in life on a scale of 1 to 7:



I'd now like to ask you a few specific questions. Please answer yes, sometimes or no.

1. Do you feel connected to higher causes or forces? Yes Sometimes No
2. Do you feel like your life can make a difference for the better? Yes Sometimes No
3. Do you feel like your life has a purpose? Yes Sometimes No
4. **Do you sometimes feel as if life has no meaning? Yes Sometimes No**

*****ADMINISTRATORS RATING OF CLIENT'S LIFE MEANING AND PURPOSE*****



Section II: Domains of Adaptation

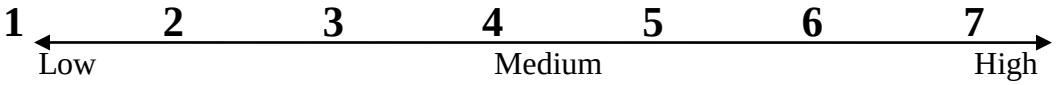
A. Health and Fitness Habits

Medical Health

A1. In a couple of sentences please reflect on your medical health and the degree to which you are a healthy individual. Feel free to provide examples:

_____
_____
_____
_____
_____
_____
_____

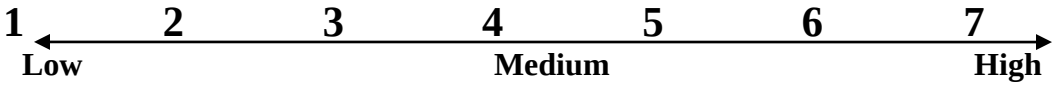
An individual high in medical health rarely has physical pain, does not have chronic health problems, and is able to accomplish the tasks in daily living without a problem. In contrast, a person low in medical health often has pain or discomfort, frequently misses work or requires visits to the doctor or has to continually manage problems related to their biological functioning. Given this please rate your level of medical health on a scale of 1 to 7:



I'd now like to ask you a few specific questions. Please answer yes, sometimes or no.

1. Are you usually free of pain or discomfort? Yes Sometimes No
2. **Do you have chronic health problems? Yes Sometimes No**
3. Overall, do you consider yourself a healthy person? Yes Sometimes No
4. **Does poor health negatively impact your happiness? Yes Sometimes No**

*****ADMINISTRATERS RATING OF CLIENT'S MEDICAL HEALTH*****

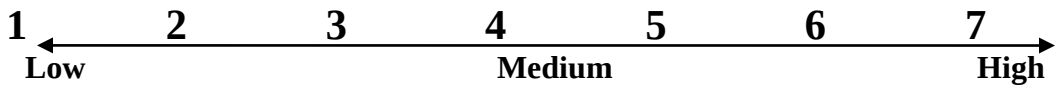


Fitness and Healthy Habits

A2. Please describe for me your level of physical fitness and the extent to which you engage in healthy habits. Feel free to provide examples:

_____
_____
_____
_____
_____

An individual high in fitness and healthy habits regularly exercises, has healthy body shape and weight, has good strength, flexibility, and endurance, and engages in healthy eating and sleeping patterns. In contrast, a person who is low in fitness and healthy habits rarely exercises, feels weak or easily run down, and does not have healthy eating or sleeping patterns and may regularly use unhealthy substances. Given this please rate the degree to which you engage in health habits on a scale of 1 to 7:



I'd now like to ask you a few specific questions. Please answer yes, sometimes (maybe) or no.

Exercise

1. Do you regularly engage in exercise (3xs week or more)? Yes Sometimes No
2. Do you have good endurance (e.g., could run a mile or two)? Yes Sometimes No
3. **Do you sometimes feel weak or out of shape?** Yes Sometimes No
4. **Are you overweight?** Yes Maybe No

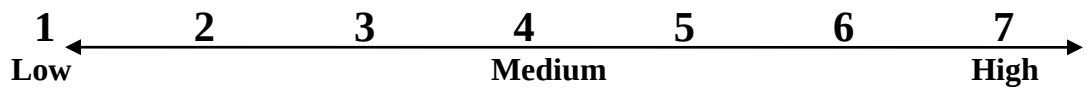
Sleep and Eating

1. Do you have good sleep habits? Yes Sometimes No
2. Do eat a balanced diet? Yes Sometimes No
3. **Do you frequently over-eat or starve yourself?** Yes Sometimes No

Substance Use

1. **Do you smoke more than a ½ pack a day?** Yes Sometimes No
2. **Do you regularly drink alcohol?** Yes Maybe No
3. **Do you use illegal substances regularly?** Yes Maybe No

***** ADMINISTRATORS RATING OF CLIENT'S FITNESS AND HEALTHY HABITS *****

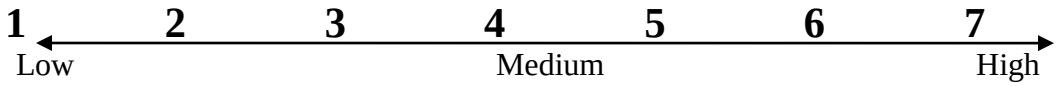


B. Emotions and Emotional Regulation

Please take a minute to think about your emotional life, including the emotions that you often feel and emotions that you may try to regulate or not experience. In a couple of sentences, please provide an appraisal of how you are functioning in the domain of emotions and emotion regulation. Feel free to provide examples:

_____
_____
_____
_____
_____

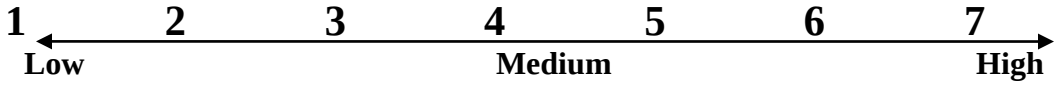
Someone who is functioning well in this domain is able to experience the full range of emotions, is able to regulate their emotions when necessary, and generally feels more positive as opposed to negative feeling states. In contrast, someone who is having trouble in this domain has difficulty in effectively controlling their emotions or connecting to them appropriately, often feels overwhelmed or afraid of their emotions, and tends to feel more negative than positive feeling states. Given this please rate the degree to which you engage in emotional regulation on a scale of 1 to 7:



I'd now like to ask you a few specific questions about your emotions. Please answer yes, maybe (or somewhat or sometimes), or no.

1. Do you feel more positive than negative feeling states?
   Yes Maybe No
2. **Do you experience a significant amount of anger or hostility?**
   Yes Sometimes No
3. **Do you experience a significant amount of guilt or shame?**
   Yes Sometimes No
4. Do you experience a significant amount of joy and contentment?
   Yes Sometimes No
5. Are you able to connect with how you feel? Yes Sometimes No
6. **Do you act on your emotions in a way you later regret?**
   Yes Sometimes No

*****ADMINISTRATORS RATING OF CLIENT'S EMOTIONS AND EMOTION REGULATION*****



C. Relationships

Please take a minute to reflect on the quality of your relationship with others. Feel free to provide examples:

_____
_____
_____
_____
_____
_____
_____

An individual with positive relationships feels connected, respected, and well-loved. They can share aspects of themselves, experience intimacy, and usually feel secure. In contrast, individuals with poor relationships often feel unappreciated, disrespected, unloved, disconnected, hostile, rejected, or misunderstood. They tend to feel insecure and sometimes alone or distant from others. Given this, please rate the quality of your relationships with others on a scale of 1 to 7:

1 2 3 4 5 6 7

Low Medium High

I'd now like to ask you a few specific questions about your relationships. Please answer yes, maybe (or somewhat or sometimes), or no.

Family of Origin

1. Do you feel well-connected to your family of origin? Yes Maybe No
2. Growing up, did you have a good relationship with your parents? Yes Sometimes No
3. **Did you have serious, longstanding conflicts with members of your family? Yes Maybe No**
4. Was your family close to a positive ideal? Yes Maybe No

Peers and Friends

1. Do you get along well with your peers? Yes Maybe No
2. Do you have good friends you can trust? Yes Maybe No
3. **Do you feel lonely or isolated? Yes Sometimes No**
4. **Do you feel your peers don't respect you? Yes Sometimes No**

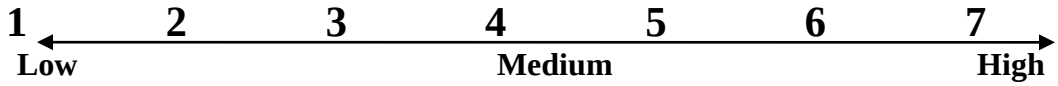
Romantic Relationships

1. Are you satisfied with your romantic relationship(s)? Yes Maybe No
2. Do you know how to love and be loved romantically?

Yes Maybe No

3. **Are you concerned you will not find a happy romantic relationship?**
   Yes Sometimes No
4. **Are you experiencing significant conflicts in your romantic life?**
   Yes Maybe No

*****ADMINISTRATERS RATING OF CLIENT'S RELATIONSHIP QUALITY*****

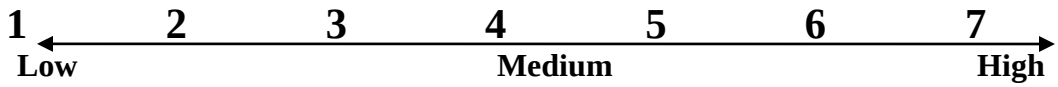


D. Coping, Defensiveness, and Resiliency

Please take a minute to describe your capacity to deal with stressors, and consider the extent to which you feel you are effective in managing your life and coping with difficulty in a resilient way. Feel free to provide examples:

_____
_____
_____
_____
_____
_____

Individuals high in resiliency and who have good coping strategies are able to deal with significant stressors without becoming overwhelmed with negative emotions or completely disconnecting from their feelings. They also have good insight into what makes them tick. In contrast, people who have difficulty in this area often feel insecure and overwhelmed or try not to deal with what is bothering them. Given this, please rate your ability to cope effectively and be resilient on a scale of 1 to 7:



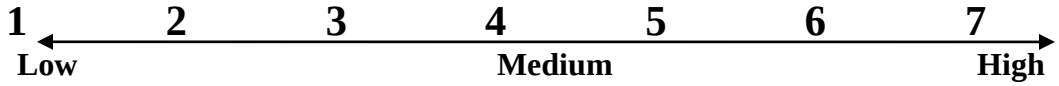
I'd now like to ask you a few questions about your coping. First, could you share a little bit about the kinds of things that make you feel defensive or vulnerable and explain how you cope?

_____
_____
_____
_____
_____
_____

Now, I want to ask a few specific questions. Please answer yes, maybe (or somewhat or sometimes), or no.

1. Do you use humor to cope? Yes Sometimes No
2. **Do you try to avoid painful feelings? Yes Sometimes No**
3. **Are there parts of yourself or your life that you try not to think about? Yes Maybe No**
4. Do you deal well with criticism? Yes Sometimes No
5. **Have you ever had a crisis you could not deal with? Yes Maybe No**
6. Do you normally feel calm, relaxed or centered? Yes Sometimes No
7. Do you have the ability to "bounce back" and "recover" from adversity? Yes Sometimes No
8. Do you have the ability to adapt to most situations? Yes Maybe No
9. **Do you often feel vulnerable, insecure or threatened? Yes Maybe No**

*****ADMINISTRATORS RATING OF CLIENT'S COPING DEFENSIVENESS AND RESILIENCY*****



E. Narrative Identity

Please take a minute to reflect on who you are and how you evaluate your self. Consider the degree of positive and negative attitudes you have about yourself, your past behaviors and the choices that you have made. In a couple of sentences, please describe your attitudes about your self. Feel free to provide examples:

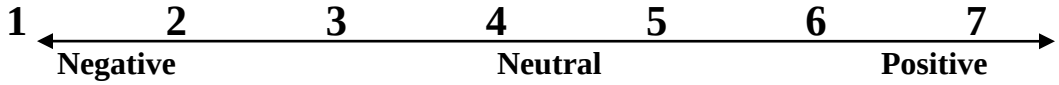
_____

_____

_____

_____

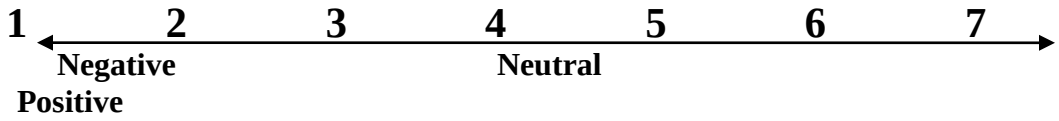
Someone with a positive view of self is pleased with who they are and accepting of multiple aspects of themselves, both good and bad. In contrast, individuals with a negative view of self are often self-critical, confused about their identity, and may wish they were different in many respects. Given this, please rate your overall view of self on a scale of 1 (negative) to 7 (positive):



Now, I want to ask a few specific questions about your self. Please answer yes, maybe (or somewhat or sometimes), or no.

1.	Do you see yourself as an admirable person?	Yes	Sometimes	No
2.	**Do you constantly second guess your decisions?**	**Yes**	**Maybe**	**No**
3.	**Do you wish you were someone else?**	**Yes**	**Sometimes**	**No**
4.	Are you confident in your abilities?	Yes	Sometimes	No
5.	Do other people know "the real you"?	Yes	Maybe	No
6.	Are you able to accept your limitations or weaknesses?	Yes	Maybe	No
7.	Do you take pride in what you have accomplished in life?	Yes	Maybe	No
8.	**Are you often critical or disappointed in yourself?**	**Yes**	**Maybe**	**No**

*****ADMINISTRATERS RATING OF CLIENT'S ADMINISTRATORS RATING OF CLIENT'S NARRATIVE IDENTITY*****



Section III Stressors and Affordances, and Trajectory

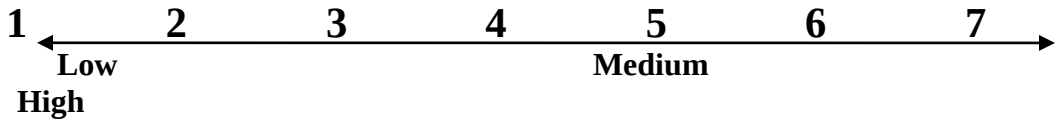
A. Stressors and Affordances

In a couple of sentences, please describe the demands and stressors you have faced or are facing over the past months. Feel free to provide examples:

_____
_____
_____
_____
_____
_____
_____
_____

Consider, for example, your financial situation, the responsibilities placed on you by your work (or studies) and your current living situation. Given this, please rate your level of life stressors and demands on a scale of 1 (low) to 7 (high):

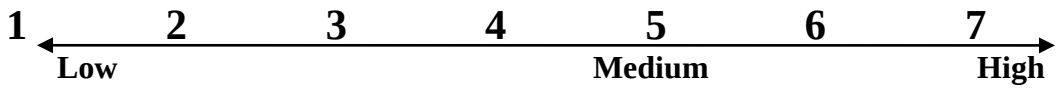
(REVERSE SCORED)



Now, I want to ask a few specific questions about domains that frequently cause stress. Please answer yes, maybe (or somewhat or sometimes), or no.

1. **Are you stressed about your finances? Yes Maybe No**
2. **Does your living situation cause you significant stress?**
   Yes Maybe No
3. **Does your occupation/studies place heavy responsibilities on you?**
   Yes Maybe No

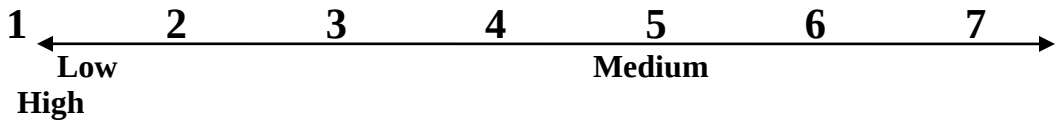
*****ADMINISTRATORS RATING OF CLIENT'S LIFE STRESSORS*****
(REVERSE SCORED)



In a couple of sentences, please describe the opportunities you have in your environment for enrichment, pleasure or fulfillment. Feel free to provide examples:

_____
_____
_____
_____
_____
_____
_____
_____

Consider your access to technology, your financial resources, the opportunities given to you by your work (or studies). Given this, please rate your opportunities for enrichment, pleasure or fulfillment on a scale of 1 (low) to 7 (high):

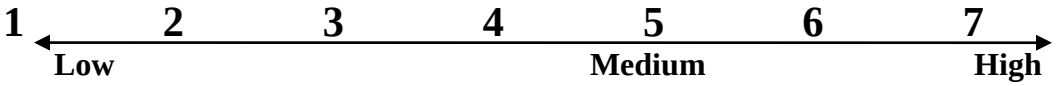


I'd now like to ask you a few specific questions. Please answer yes, maybe (or somewhat or sometimes), or no.

1. Do you have the financial resources to buy what you want?
   Yes Maybe No

2. Does your living situation give you the opportunities to have comfort as well as new, interesting experiences? Yes Maybe No
3. Does your occupation/studies give you enriching opportunities? Yes Sometimes No

*****ADMINISTRATORS RATING OF CLIENT'S AFFORDANCES*****

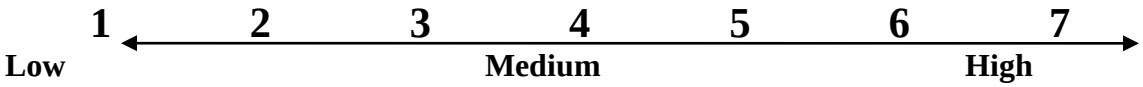


B Trajectory

In a couple of sentences please reflect on where and/or the direction you feel your life is headed. Feel free to provide examples:

_____
_____
_____
_____
_____
_____
_____

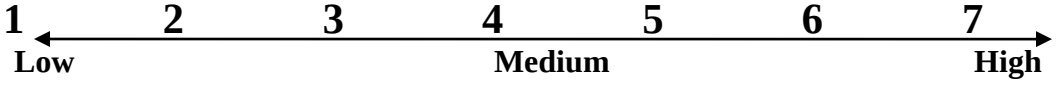
Consider whether you feel you are on a good developmental pathway and that things will continue to get better (or, perhaps, remain very good). Or if you feel that you have stagnated or feel somewhat stuck or maybe even that things will get worse. Given this, please rate your level of satisfaction with your life trajectory on a scale of 1 to 7:



I'd now like to ask you a few specific questions. Please answer yes, sometimes or no.

1. Do you feel things are getting better? Yes Sometimes No
2. Do you feel like you are growing as a person? Yes Sometimes No
3. **Do you feel stuck or in a rut? Yes Sometimes No**
4. **Do you think your best days are behind you? Yes Sometimes No**

*****ADMINISTRATORS RATING OF CLIENT'S LIFE TRAJECTORY*****



*****ADMINISTRATORS RATING OF CLIENT'S PRESENTATION*****

Once you have completed the WBI, please take a moment to describe the client's overall presentation. Specifically, comment on their engagement in the process, cooperation, amount of eye-contact, dress, speech (volume, rate, tone), and/or anything else that may have stood out about them or the way in which they interacted with you.

_____
_____
_____
_____
_____

1. Where their responses believable? Yes Maybe No
    a. Additional Comments:

_____
_____
_____

2. Did they have good insight/awareness of self? Yes Maybe No
    a. Additional Comments:

_____
_____
_____

3. Was their mood congruent with affect? Yes Maybe No
    a. Additional Comments:

_____
_____
_____

4. Were they oriented to state, place, and time? Yes Maybe No
    a. Additional Comments:

_____
_____
_____
_____

Appendix D

Informed Consent: Well-Being Screening

Consent to Participate in Research

Identification of Investigators & Purpose of Study
You are being asked to participate in a research study conducted by Lauren Mays, M.A. and Gregg Henriques, Ph.D. from James Madison University. The purpose of this study is to explore the benefits of getting a well-being checkup, much like annual checkups conducted by medical doctors. Specifically, our aim is to further explore and understand well-being and adjustment in college students as well as take a closer look at the various domains which influence well-being. Well-being can be most commonly referred to as healthy mental functioning.

Research Procedures
Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. This study consists of a brief in person interview that will take place in Miller Hall at James Madison University and some questionnaires that will be administered online after the interview. You will be asked to provide answers to a series of questions related to various domains which influence your well-being. The interview is a structured clinical interview that will assess your level of well-being and will take approximately 30 minutes. Questions will be presented in the following formats: open-ended, forced choice, and likert scale rating responses. The questionnaires will be administered online to individual participants through *Qualtrics and should* take no more than one hour to complete.

After combining the results from the interview and questionnaires, there will be a short feedback session on your overall well-being as well as possible ways that you can improve it. This feedback session will take place in the counseling suites in Miller Hall and take approximately 30 minutes. The interviews and feedback sessions will be video recorded with your permission, and stored securely in the researcher's office in a locked file cabinet in Johnston Hall. In order to participate in this study, you must be at least 18-years-old and agree to be recorded so we can accurately evaluate your responses. A member of the research team to will review the video to evaluate your responses.

Time Required
Participation in this study will require approximately 2 hours of your time. You will be required to meet the researcher two times. Once for the interview and another time for the feedback session. Each meeting should take about 30 minutes each and will be conducted in Miller Hall for you convenience. The online surveys can be completed at any location where you can access the internet and should take no more than one hour to complete.

Risks
The investigator perceives the following are possible risks arising from your involvement with this study. Risks of this study are the same risks that you would experience when you achieve additional insight about yourself that makes you feel uncomfortable. You may also have

the same risks that are associated with sharing your feelings and answering questions in the presence of a clinician. For example, interviews may cover intimate sections of your life (e.g., family history, sexuality) and discussing these may feel uncomfortable. In addition, it is possible in any experiment that harmful effects, which are not now known, could occur. Of course, we will take every precaution to watch for and prevent any harmful side effects. If participants are deemed to be an imminent threat to themselves or others they will be offered emergency and support services and Counseling and Student Development.

Benefits

Potential benefits from participation in this study include experiencing a greater self-understanding; such as how you became the way you are, why you do the things you do, and how you may do things differently and more positively in the future. You may also increase your coping skills and have more tools for adaptive living. Furthermore, you will likely learn new information about your overall psychological well-being. Each of these things could help you improve your overall quality of life and have the added benefit of helping you improve your relationships. Lastly, as a result of your participation, you may be able to engage in ongoing psychotherapy (12 to 16 sessions) at Counseling and Psychological Services at James Madison University (an approximate value of $60-$80) specifically designed to meet your individual needs. Participation in psychotherapy is completely voluntary, and even if you choose to participate, you may leave the study at any time. You will be provided an additional consent form for this part of the study to ensure that you have complete knowledge of the procedure, time requirements, risks, and benefits.

Research also benefits future patients and society in general. We do not guarantee or promise, however, that you will receive any of these benefits.

Confidentiality

The results of this research will be used in the writing and potential publication of a doctoral dissertation; as well as, presented at national psychology conferences. The researcher retains the right to use and publish non-identifiable data. If you sign this consent form allowing us to disclose the types of information outlined, you can later cancel your authorization in writing, and we will not disclose any further information after we receive your cancellation. The only exceptions to these strict confidentiality rules are rare instances where clinicians are required to reveal particular information by federal or state laws. Such exceptions include when we believe that there is a substantial likelihood that a client will cause serious physical harm to her/himself or another person unless protective measures are taken. In these cases, the researchers will contact the appropriate authorities to minimize harm. Another exception that could be applicable to this research is if we receive a request for information by a threat assessment team at a public institution of higher education.

The results of this project will be coded in such a way that the respondent's identity will not be attached to the final form of this study. Researchers will be able to identify individuals' questionnaires completed online to ensure accurate feedback for the well-being screening; however, the online database will only be coded by the participant's subject number. Participant names and identification codes will be kept separate from their responses, therefore ensuring confidentiality. Completion of the semi-structured interview will be hand and video recorded. Participant names and identification codes will be kept separate from their responses. This list will be kept in a locked file cabinet in the primary investigators locked office. Recordings of the interview will be made on DVD's, and kept in a locked file

cabinet in the primary investigators locked office as well. These DVD's will be destroyed after the interview is transcribed and de-identified. All data collected from the online surveys will be saved on a secure drive on the JMU network that can only be accessed with a JMU username and password. At no time will participants' responses and identifying information will be associated with their name. The results of this project will be coded in such a way that the respondent's identity will not be attached to the final form of this study.

While individual responses are confidential, aggregate data will be presented representing averages or generalizations about the responses as a whole. All data will be stored in a secure location accessible only to the researcher. Upon completion of the study, all information that matches up individual respondents with their answers *(including video recordings)* will be destroyed. In addition to the well-being screening, final aggregate results will be made available to participants upon request.

Participation & Withdrawal
Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind.

Questions about the Study
If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the final aggregate results of this study, please contact:

Lauren Mays, M.A.
Graduate Psychology
James Madison University
Maysle@jmu.edu

Gregg Henriques, Ph.D.
Graduate Psychology
James Madison University
Telephone: (540) 568-7857
henriqx@jmu.edu

Questions about Your Rights as a Research Subject
Dr. David Cockley
Chair, Institutional Review Board
James Madison University
(540) 568-2834
cocklede@jmu.edu

Giving of Consent
I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

☐ I give consent to be video taped during my interview. _____ (initials)

_____ _____
Name of Participant (Printed) Date

_____ _____
Name of Participant (Signed) Date

_____ _____
Name of Researcher (Signed) Date

Appendix E

The Influence Matrix - Social Motivation Scale-IMSMS

The following set of questions deals with how you feel about yourself and your relationships with others. Please rank each item on a scale from 1 to 5, with a 1 being Strongly Disagree and a 5 being Strongly Agree and check the appropriate box. Please keep in mind that there are no right or wrong answers.

	1 Strongly Disagree	2 Disagree	3 Mixed/ Neutral	4 Agree	5 Strongly Agree
1. Other people often ignore me.	o	o	o	o	O
2. I have many close, meaningful relationships.	o	o	o	o	O
3. I am easily defeated in social conflicts.	o	o	o	o	O
4. I can be mean and insensitive.	o	o	o	o	O
5. I am more independent than most.	o	o	o	o	O
6. The idea of losing someone is terrifying to me.	o	o	o	o	O
7. I like to be taken care of.	o	o	o	o	O
8. I try hard to get other people to like me.	o	o	o	o	O
9. When I achieve a goal, I get more satisfaction from reaching the goal than from any praise I might get.	o	o	o	o	O
10. I blame people who deserve to be blamed.	o	o	o	o	O
11. I am a very giving person.	o	o	o	o	O
12. I have trouble saying 'no' to people.	o	o	o	o	O
13. I don't shy away from social conflict.	o	o	o	o	o
14. I am a competitive person.	o	o	o	o	o
15. I enjoy taking care of other people.	o	o	o	o	o
16. Other people have told me I complain too much.	o	o	o	o	o
17. I can accept rejection or disapproval from others without being too upset.	o	o	o	o	o
18. I don't need other people to make me feel good.	o	o	o	o	o
19. Other people know I will retaliate if I am attacked.	o	o	o	o	o

20. Other people have told me I am too needy.	o	o	o	o	o
21. I am more dominant than most.	o	o	o	o	o
22. Other people view me as submissive.	o	o	o	o	o
23. I often feel vulnerable in social situations.	o	o	o	o	o
24. I empathize easily with the feelings of others.	o	o	o	o	o
25. Other people have told me I can be a harsh critic.	o	o	o	o	o
26. Other people see me as self-reliant.	o	o	o	o	o
27. I tend to be a leader rather than a follower.	o	o	o	o	o
28. I am very sensitive to criticism.	o	o	o	o	o
29. Other people look up to me.	o	o	o	o	o
30. Other people will make sacrifices for me if I need them to.	o	o	o	o	o
31. I often find myself thinking about my friends and family.	o	o	o	o	o
32. I generally don't compare well with others on most measures of success.	o	o	o	o	o
33. I am confident in my social exchanges with others.	o	o	o	o	o
34. Other people often tell me I am kind.	o	o	o	o	o
35. I tend to be fairly passive when stating my needs or desires.	o	o	o	o	o
36. I have a lot of failures relative to my friends and family.	o	o	o	o	o
37. I am well loved.	o	o	o	o	o
38. Other people have a lot of influence on what I do and think.	o	o	o	o	o
39. I am well-respected by my friends and family.	o	o	o	o	o
40. I will punish others if necessary.	o	o	o	o	o
41. I consider other people's interest and needs when making decisions about what I should do.	o	o	o	o	o
42. I control other people more than they control me.	o	o	o	o	o
43. Other people know they can count on me to help.	o	o	o	o	o
44. I let people know when I am angry.	o	o	o	o	o

45. If I think someone may be upset at me I have a strong desire to apologize.	o	o	o	o	o
46. I depend on others for guidance and assistance.	o	o	o	o	o
47. My relationships with others are not stable or trustworthy.	o	o	o	o	o
48. I am secure in my relationships.	o	o	o	o	o
49. I crave the approval and acceptance of others.	o	o	o	o	o
50. I don't get entangled in the lives of others.	o	o	o	o	o
51. Other people have told me I am assertive.	o	o	o	o	o
52. I often make sacrifices for others.	o	o	o	o	o
53. Other people can control me pretty easily.	o	o	o	o	o
54. In arguments with others, I tend to give in quickly.	o	o	o	o	o
55. Other people have told me I am a suspicious person.	o	o	o	o	o
56. Other people do not have much influence over the decisions I make.	o	o	o	o	o
57. I tend to be a sympathetic person.	o	o	o	o	o
58. I am an admired person.	o	o	o	o	o
59. I have difficulties relating to others.	o	o	o	o	o
60. I don't do as well socially as other people do.	o	o	o	o	o
61. I worry a lot about what other people think of me.	o	o	o	o	o
62. I can be close to others and give them space at the same time.	o	o	o	o	o
63. I often put other people's needs above my own.	o	o	o	o	o
64. Other people have told me that I am controlling.	o	o	o	o	o
65. I am more hostile than most people.	o	o	o	o	o
66. I don't need much reassurance from other people.	o	o	o	o	o
67. I need to be near other people in order to feel secure.	o	o	o	o	o
68. I sometimes feel neglected by important people in my life.	o	o	o	o	o
69. Other people view me as	o	o	o	o	o

successful.					
70. I have a lot if influence with my peers.	o	o	o	o	o
71. I set my own standards and goals for myself rather than accepting those of others.	o	o	o	o	o
72. I am sometimes aggressive toward others.	o	o	o	o	o
73. Making others happy makes me feel good.	o	o	o	o	o
74. I don't hesitate to tell people what is on my mind.	o	o	o	o	o
75. I try hard to avoid criticism or conflict.	o	o	o	o	o
76. Other people pay attention to what I have to say.	o	o	o	o	o
77. I don't have as many friends as I would like.	o	o	o	o	o
78. I have been criticized and rejected more than most people.	o	o	o	o	o
79. What other people say doesn't bother me.	o	o	o	o	o
80. I am not afraid to fight with others to get what I want.	o	o	o	o	o
81. I am a 'take charge' kind of person.	o	o	o	o	o
82. I tend to give in to what other people want.	o	o	o	o	o
83. Other people often criticize me.	o	o	o	o	o
84. I tend not to care much about what other people think of me.	o	o	o	o	o

Appendix F

Informed Consent: Psychoeducational Intervention

Consent to Participate in Research

Identification of Investigators & Purpose of Study

You have been selected to participate in a research study conducted by Lauren Mays, M.A. and Gregg Henriques, Ph.D. from James Madison University. The purpose of this study is to further explore and understand how to create an in intervention designed to meet your individual needs. Specifically, we hope to use the feedback that you received from the Well-Being Screening to create mutually agreed upon goals that will enhance your overall life satisfaction across various domains of well-being.

Intervention Procedures

Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. This study consists of weekly 50-minute sessions that will take place at Counseling and Psychological Services at James Madison University (located in Blue Ridge Hall). The goal is to have between 8 to 10 sessions. The first 2 to 3 sessions will focus on the feedback you received plus more detailed information about your history. In order to participate in this study, you must be at least 18-years-old and agree to be recorded so we can accurately evaluate your responses. A member of the research team to will review the video to evaluate your responses.

If you participate in this research, you will work collaboratively with either a doctoral student clinician or licensed psychologist and will both spend time thinking about your life and whether the choices you have made have led to a happier, better life or a life with more negative outcomes. You will also have opportunities to learn about your habits, feelings, emotions, ideas that you may not be readily aware of, your way of explaining life events, and your personal relationships affect your present well-being. You will also work on developing your own personal life story and how you were able to get through difficult times and how you may even be a better person because of it. Lastly, you will conclude the research by completing a series of questionnaires that will help you determine your growth and areas of future exploration.

Time Required

Participation in this study will consist of 8 to 10 biweekly 50-minute sessions. Each meeting will occur at Blue Ridge Hall, and the length of participation will depend on the collaborative goal setting in which you and your clinician will engage during the initial sessions. There will also be some additional questionnaires to complete after the first two sessions (approximately 1 hour) and after the completion of the intervention to assess outcomes (approximately 1 hour).

Risks

The investigator perceives the following are possible risks arising from your involvement with this study. Similar to the well-being screening, the risks of this study are the same risks that you would experience when you discuss intimate aspects of your life in detail and when you achieve additional insight about yourself that makes you feel uncomfortable. You may also have

the same risks that are associated with sharing your feelings and answering questions about yourself in the presence of a clinician. In addition, it is possible in any experiment that harmful effects, which are not now known, could occur. Of course, we will take every precaution to watch for and prevent any harmful side effects.

Benefits

Much like the Well-Being Screening, potential benefits from participation in this study include experiencing a greater self-understanding; such as how you became the way you are, why you do the things you do, and how you may do things differently and more positively in the future. You may also increase your coping skills and have more tools for adaptive living. Furthermore, you will likely learn new information about your overall psychological well-being. Each of these things could help you improve your overall quality of life and have the added benefit of helping you improve your relationships. Research also benefits future patients and society in general. We do not guarantee or promise, however, that you will receive any of these benefits.

Alternatives to Participating in this Study

Alternatives to participating in this study include participation in services offered through James Madison University. The Counseling and Student Development Center offers free, short-term psychotherapy to students (540-568-6551). Counseling and Psychological Services (CAPS) offers psychotherapy to students for $5 (540-568-1735). Obviously, you may choose to not participate in this study.

Confidentiality

The results of this research will be used in the writing and potential publication of a doctoral dissertation; as well as, presented at national psychology conferences. The results of this project will be coded in such a way that the respondent's identity will not be attached to the final form of this study. Researchers will have access to the questionnaires completed online for the Well-Being Screening and to the written feedback provided. Participant names and identification codes will be kept separate from their responses, therefore ensuring confidentiality. The clinician will videotape each session and take notes (following CAPS guidelines). Participant names and identification codes will be kept separate from their responses. This list will be kept in a locked file cabinet in the primary investigators locked office in Johnston Hall. Recordings of the interview will be made on DVD's, and kept in a locked file cabinet at CAPS. These DVD's will be destroyed after the intervention has been completed and transcriptions made are de-identified. All data collected from the online surveys will be saved on a secure drive on the JMU network that can only be accessed with a JMU username and password. At no time will participants' responses and identifying information will be associated with their name. The results of this project will be coded in such a way that the respondent's identity will not be attached to the final form of this study.

While individual responses are confidential, the researcher retains the right to use and publish non-identifiable data. In addition to presenting averages or generalizations about the responses as a whole, some quotes from the intervention may be used to illustrate aspects of the intervention. However, all identifying information will be recoded and there will be no way that you could be identified from your responses. All data will be stored in a secure location accessible only to the researcher. Upon completion of the study, all information *(including video recordings)* that matches up individual respondents with their answers will

be destroyed. In addition to your own outcomes from the intervention, final aggregate results will be made available to participants upon request.

According to CAPS policy, the only exceptions to these strict confidentiality rules are rare instances where clinicians are required to reveal particular information by federal or state laws. Such exceptions include when we believe that there is a substantial likelihood that a client will cause serious physical harm to her/himself or another person unless protective measures are taken. In these cases, the researchers will contact the appropriate authorities to minimize harm. Another exception that could be applicable to this research is if we receive a request for information by a threat assessment team at a public institution of higher education.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the final aggregate results of this study, please contact:

Lauren Mays, M.A.
Graduate Psychology
James Madison University
Maysle@jmu.edu

Gregg Henriques, Ph.D.
Graduate Psychology
James Madison University
Telephone: (540) 568-7857
henriqx@jmu.edu

Questions about Your Rights as a Research Subject

Dr. David Cockley
Chair, Institutional Review Board
James Madison University
(540) 568-2834
cocklede@jmu.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

☐ I give consent to be video taped during my interview. _____ (initials)

_____ _____
Name of Participant (Printed) Date

_____ _____
Name of Participant (Signed) Date

_____ _____
Name of Researcher (Signed) Date

Appendix G

Life Information Survey

I. BACKGROUND INFORMATION

Name: _____ Date: _____
Age: _____ Date of Birth: _____
Race/Ethnicity: _____
Marital Status (circle one): single engaged married remarried
separated divorced widowed

If married, what are your spouse's name, age, and occupation?

_____
_____

In your own words, please describe your current problem(s), provide information about when the problem(s) began, and what (in your opinion) is causing the problem(s). Try and be specific in your answer.

_____
_____

Have you had any health or medical problems?

_____

Have you ever been knocked unconscious or had an injury to your head?

_____

Have you ever seen a psychologist, psychiatrist, or other mental health professional? If yes, please describe (list any previous diagnoses).

_____
_____

Are you currently taking any medication(s)?

_____

Have you had any legal problems?

_____
_____

Please describe your religious orientation or if you have a specific philosophy of life.

_____

II. FAMILY HISTORY

Father's/Stepfather's Name:
_____
Is he living or deceased? _____ If deceased, how old were you at the time of his death? _____
Cause of death? _____
Father's/Stepfather's age (now or at time of death):
_____
Father's/Stepfather's occupation:
_____

Describe what your father/stepfather is/was like as a person:
_____
_____

Describe your relationship with your father/stepfather:
_____
_____

Mother's/Stepmother's Name:
_____
Is she living or deceased? _____ If deceased, how old were you at the time of her death? _____
Cause of death? _____
Mother's/Stepmother's age (now or at death): _____
Mother's/Stepmother's occupation:_____

Describe what your mother/stepmother is/was like as a person:
_____
_____

Describe your relationship with your mother/stepmother:
_____
_____

Has either of your parents been married previously? If yes, please describe the circumstances of the previous marriage(s).
_____
_____

How would you describe your parents' relationship?
_____
_____

Do you have any brothers or sisters? _____ If yes, please provide their name(s) and age(s) in the space provided:

Have you had any problems with one or more of your siblings?

Did your parents have a lot of money or was your family on a tight budget?

Describe how your parents disciplined you when you were growing up (or describe how your parents discipline you now).

How was emotion expressed in your family? Were there lots of fights?

Was your family open in talking about difficult issues or not?

Does anyone in your family have a problem with drugs or alcohol?

Does any member of your family suffer from any kind of mental or behavioral disorder?

Has anyone in your family ever been hospitalized for emotional or mental problems?

Is there anyone in your family who has/had serious health problems?

Is there anyone in your family who has/had legal problems?

III. PERSONAL HISTORY

Where were you born? _____

Were there any complications or problems with your birth or early development?

_____

Where did you live while you were growing up (or where do you live now)?

_____

_____

What was your childhood like (or how would you describe your childhood)?

_____

_____

Was (or is) anyone in your family (including you) physically, sexually, or emotionally abused?

_____

_____

Describe the most difficult, painful, or scary experiences you had (or have had) while growing up.

_____

_____

What was it like for you to go through puberty and adolescence (or what has puberty or adolescence been like so far)?

_____

_____

Identity Issues

How would you describe yourself as a person?

_____

_____

When are the times when you feel the most competent? The most incompetent?

_____

_____

Do you have a strong, consistent sense of yourself as a person or do you often feel conflicted and confused about who you are?

_____

_____

Do you feel like you can control what happens to you or do you feel like much of your life is beyond your control?

_____
_____

Do you tend to be critical of yourself? Are there times when you are more critical than others?

_____
_____

What would you describe to be your greatest strengths?

_____
_____

What are some of the words important people in your life might use to describe you?

_____
_____

Do other people know the "real" you?

_____
_____
_____

Coping

How do you cope with difficult problems? Do you try to approach it directly or are you more likely to wait and hope it goes away?

_____
_____

Do you think of yourself as someone who is effective in dealing with stress? As someone who is resilient?

_____
_____

If someone upsets you, are you able to talk with them about it?

_____
_____

Are there any emotions that make you feel particularly uncomfortable? (Do you have trouble being angry or sad or vulnerable?)

_____
_____

IV. SCHOOL/CAREER INFORMATION

How would you describe yourself as a student?

_____

_____

What were your grades like in middle and high school?

_____

What were your best subjects? Your worst?

_____

How did you do on the SATs? (Verbal, Math, Analytic, Writing)

_____

Have you ever had problems with your teachers?

_____

Have you ever had problems learning or performing well in school?

_____

Describe your study habits (approach to tests, amount of time studying, location, note taking strategies). Do you feel you have good study skills? Have you ever attended a study skills workshop?

_____

_____

Do you currently have questions or concerns about what you want to do with your life (or what do you want to do with your life)?

_____

_____

Have you had problems getting or keeping a job (or do you have problems in school)?

_____

_____

Please describe how you feel about your current occupation (or describe how you feel about school).

_____

_____

V. RELATIONSHIP HISTORY

Are you having conflicts with important people in your life? If so, please describe.

_____

_____

Who is the person you trust the most?

_____
_____

Do you tend to feel secure in your relationships with other people or not?

_____
_____

Is it easy for you to get close to people? Are you able to share intimate details of what you think?

_____
_____

Do you worry a lot if someone doesn't like you? Do you work hard to please others?

_____
_____

Are there times in which you have felt needy and vulnerable and wanted to be taken care of?

_____
_____

Would you describe yourself as a competitive person? Do you see yourself as a leader?

_____
_____

Have you often felt like you give a lot to other people, but then you are taken advantage of or that the giving has not been reciprocated?

_____

Please describe your dating history.

_____
_____

If applicable, please describe your most significant intimate relationship so far.

_____
_____

Are you currently involved in an emotionally intimate relationship? If yes, please describe how that relationship is going for you.

_____
_____

Have you been involved in a sexually intimate relationship? Yes _____ No _____
Are there any relevant details you wish to provide about your sexual relationship(s)?

_____

_____

Is your present sex life satisfactory?

_____

_____

Have you had questions about your sexual identity?

_____

_____

VI. Suicide and Homicide Screen

Have you ever had thoughts of harming or killing yourself?

_____

_____

If yes, what thoughts did you have? When was the last time you had these thoughts? When was the most intense period of suicidal thinking you have had?

_____

_____

Have you ever acted on your suicidal thoughts, that is, made a suicide attempt or been particularly reckless because you were thinking about dying? If so, how many?

_____

_____

Have you felt suicidal recently? If so, please describe.

_____

_____

Have you ever had thoughts of hurting someone else? If so, please describe.

_____

_____

DSM-IV Screen

Instructions: Please read each question carefully and circle "Yes" or "No". If you are at all uncertain about your answer, please circle "Unsure".

Current Major Depressive Episode

1. In the last month, has there been a time when you were feeling depressed or down? Yes Unsure Definitely No

1a. In the last month did you lose interest or pleasure in things you usually enjoyed? Yes Unsure Definitely No

1b. Did this last as long as two weeks? Yes Unsure Definitely No

(5 of 9 depressed mood most of the day, nearly every day for two weeks; loss of interest; weight/eating change; in/hypersomnia; agitation or retardation; fatigue; shame or guilt; poor concentration; thoughts of death or dying)

Past Major Depressive Episode

2. At some other time in the past, have you felt depressed or down?
   Yes Unsure Definitely No

2a. At that time, did you lose interest or pleasure in things you usually enjoyed?
   Yes Unsure Definitely No

2b. Did this last as long as two weeks?
   Yes Unsure Definitely No

COMMENTS:

Dysthymia:

3. For the past couple of years, have you been bothered by depressed mood?
   Yes Unsure Definitely No

Present and Past Manic Episodes/Bipolar Disorder:

4. In the last month, has there been a period of time when you were feeling so good, "high", excited or hyper that other people thought you weren't your normal self or that you were so hyper you got into trouble?
   Yes Unsure Definitely No

5. At some other time in the past, have you felt so good, "high", excited or hyper that other people thought you weren't your normal self or have been so hyper you got into trouble?
   Yes Unsure Definitely No

Psychotic Screen:

6. Has it ever seemed like people are talking about you or taking special notice of you?
   Yes Unsure Definitely No

7. Has it ever seemed like people go out of their way to give you a hard time?
   Yes Unsure Definitely No

8. Did you ever feel that you were especially important in some way, or that you had some special powers to do things other people couldn't?
   Yes Unsure Definitely No

9. Did you ever hear things that other people couldn't hear such as noises or voices?
   Yes Unsure Definitely No

10. Did you ever have visions or see things that other people couldn't see?
    Yes Unsure Definitely No

COMMENTS:

Panic Disorder:

11. Have you ever had a panic attack when you suddenly felt frightened, anxious or extremely uncomfortable?
    Yes Unsure Definitely No

Agoraphobia:

12. Were you ever afraid of going out of the house alone, being in crowds, standing in a line, or traveling on buses or trains?
    Yes Unsure Definitely No

Social Phobia:

13. Is there anything that you have been afraid to do or felt uncomfortable doing in front of other people, such as speaking, eating, writing or being social?
    Yes Unsure Definitely No

Specific Phobia:

14. Is there anything you are especially afraid of such as flying, seeing blood, getting a shot, heights, closed places or certain kinds of animals?
    Yes Unsure Definitely No

COMMENTS:

Obsessive Ideation:

15. Have you ever been bothered by thoughts that didn't make any sense and kept coming back to you even when you tried not to have them?
    Yes Unsure Definitely No

Compulsive Behaviors

15a. Was there ever anything that you had to do over and over again and couldn't resist doing, like washing your hands again and again, counting up to a certain number, or checking something several times to make sure you had done it right?
    Yes Unsure Definitely No

Post-Traumatic Stress Disorder

16. Have you ever experienced an extremely traumatic event like a major disaster, a serious accident, or seeing another person get seriously harmed or killed?
    Yes Unsure Definitely No

Generalized Anxiety Disorder

17. In the last six months, have you been particularly nervous or anxious?

Yes Unsure Definitely No

Hypochondriasis

18. Do you worry a lot that you have a serious disease that the doctors have not been able to diagnose?
    Yes Unsure Definitely No

Anorexia Nervosa

19. Has there been a time when you weighed much less than other people thought you ought to weigh?
    Yes Unsure Definitely No

Bulimia Nervosa

20. Have you ever had times when your eating was out of control?
    Yes Unsure Definitely No

Alcohol

Have you ever had a drink of alcohol?
How much did you drink this past week? Is that normal?
Have you ever done something you later regretted when drinking?
Have you ever had blackouts from drinking?
Have you ever had fights with anyone about your drinking?
Have you ever driven while intoxicated?
Have you ever tried to stop drinking? Were you successful?

Substance Use

Have you ever tried illicit substances? If so, which ones? (marijuana, coke/crack, LSD, mushrooms, PCP, methamphetamines, uppers, downers, qualudes, ecstasy)
In the last 30 days, how often have you used?
Have you ever used prescription or over the counter drugs in a manner not prescribed by a physician (e.g., they weren't yours or you used them much more than recommended)?
Have you ever engaged in any other "mind altering" activities? (e.g., sniffing glue, asphyxiation?)
For any of the above answered yes
Did X ever cause you problems?
Did you ever do X more than you would have liked?
Did you ever get into fights because of X?

COMMENTS:

Do you have other symptoms or problems not listed above?

Appendix H

Weekly Rating Scales

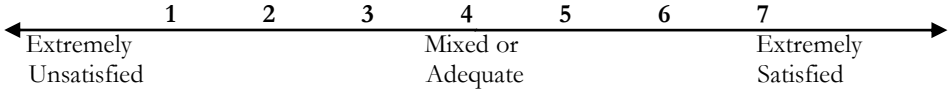
WEEKLY RATING SCALES-FUNCTIONING

Name _____Age (Yrs):____ Sex: M / F Session # ____ Date:_____

With this scale, we want to get a sense of how you have been doing in the past week, including today. Please circle the number that represents how you have been doing, where low numbers represent not doing well and higher numbers mean that you are feeling good in those areas. NOTE that your therapist may ask you about your ratings to help understand your experience as clearly as possible.

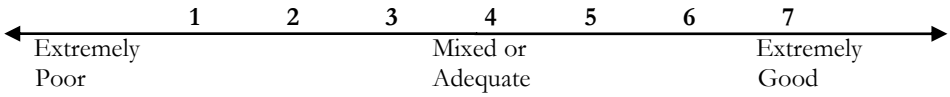
I. OVERALL WELL-BEING

This refers to how you think your life is going overall, your general level of satisfaction with your life. A '1' means virtually nothing is going well, that you are unsatisfied with virtually every aspect. A '7' means you think virtually everything is going great.



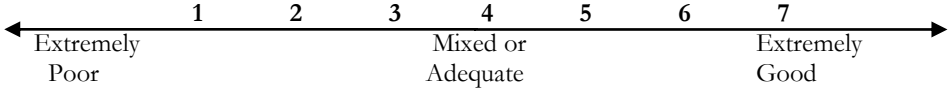
II. PERSONAL FUNCTIONING

This refers to how you think you are functioning in terms of your thoughts and feelings, symptoms, and being able to do what needs to be done. A "1" means that you have had intensely negative thoughts and feelings, seriously problematic symptoms, or had much trouble functioning. A '7' means that you have been feeling great, have been free of symptoms, and have been able to function extremely well.



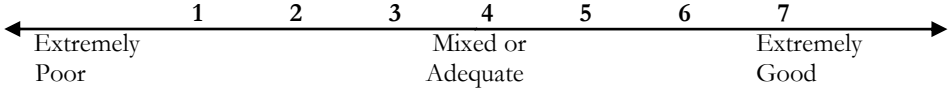
III. RELATIONSHIPS

This refers to how things have been going in your relationships with important people in your life. A '1' means things have been going very badly, that you have had serious conflicts, or been very disconnected from important others. A '7' means they have been going extremely well, that you have felt intimate, connected, and respected.



IV. DIRECTION OF YOUR LIFE

This refers to how you feel about the situation in your life and whether it is getting better or worse. A '1' means that during most of the week you thought things were getting much worse. A '7' means you thought things are getting much better.



Comments or Questions:

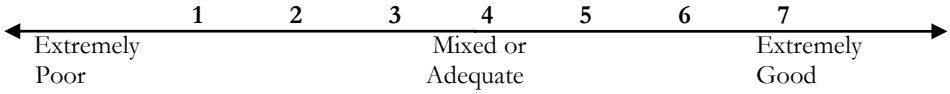
WEEKLY RATING SCALES-SESSION

Name _____Age (Yrs):____ Sex: M / F Session # ____ Date:_____

Please rate today's session on the following five items by circling the appropriate number. NOTE that your therapist may ask you about your ratings to help understand your experience as clearly as possible.

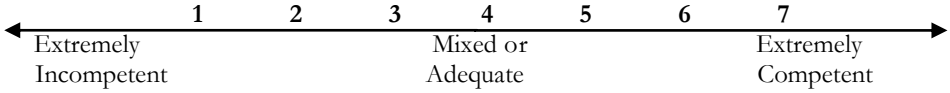
I. RELATIONSHIP AND CONNECTION WITH THE THERAPIST

This refers to how connected you felt to your therapist during the session. A '1' means you felt very distant, misunderstood, or that you could not trust your therapist during the session. A '7' means that you felt very positively connected, that you were well-understood, and that you could trust your therapist.



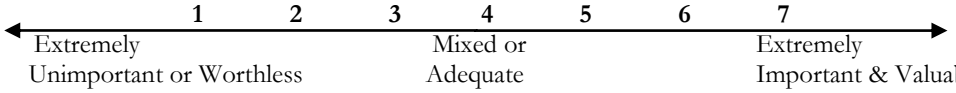
II. THERAPIST COMPETENCE

This refers to how effective you think your therapist was at handling the issues discussed. A '1' means you felt the therapist seemed very incompetent and did a poor job helping you. A '7' means you thought the therapist showed great skill in managing the session and working toward effective solutions.



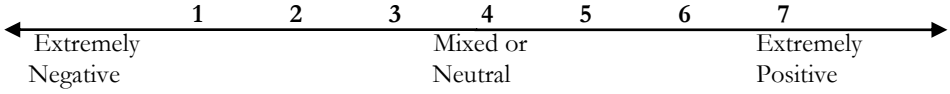
III. IMPORTANCE AND VALUE OF THE SESSION

This refers to what you think about the importance of the topics discussed and the value of the session. A '1' means that the topics seemed very unimportant OR the work was not at all valuable; a '7' means the topics were very important AND the work done was extremely valuable.



IV. ATTITUDE ABOUT THE THERAPY

This refers to what you think about the therapy after today's session, specifically whether you think the therapy is helping and/or if you are hopeful it will help in the future. A '1' means that you have a very negative attitude about the therapy and don't believe it has or will help at all. A '7' means you have a very positive attitude about the therapy and believe it will or has helped tremendously.



Comments or Questions:

Appendix I

Weekly Rating Scales: Data

Table 3

Weekly Rating Scale Scores - Functioning (James)

	Overall Well-Being	Personal Functioning	Relationships	Life Direction
Session 1	5	5	4	6
Session 2	6	5	5	6
Session 3	5	5	6	6
Session 4	5	6	6	5
Session 5*	6	6	5	6
Session 6	6	6	6	6
Session 7	6	6	6	6
Session 8	5	5	6	6
Session 9	6	6	5	6
Session 10	X	X	X	X

Note. *Functioning measured through the Well Being Interview during the last session for each participant.*
*Written conceptualization given during this session.

Table 4

Weekly Rating Scale Scores - Session (James)

	Relationship with Therapist	Therapist Competence	Value of Session	Attitude about Therapy
Session 1	6	6	7	4
Session 2	7	6	6	6
Session 3	6	5	6	5

Session 4	7	6	7	5
Session 5*	7	6	7	6
Session 6	7	7	6	7
Session 7	7	6	6	6
Session 8	7	6	6	6
Session 9	7	7	6	6
Session 10	7	7	6	5

Table 5

Weekly Rating Scale Scores - Functioning (Sarah)

	Overall Well-Being	Personal Functioning	Relationships	Life Direction
Session 1	5	6	5	6
Session 2	5	5	6	6
Session 3	5	6	6	6
Session 4	6	6	6	6
Session 5	3	4	4	4
Session 6*	5	5	5	6
Session 7	5	5	6	6
Session 8	4	5	6	6
Session 9	5	5	5	6
Session 10	X	X	X	X

Note. *Functioning measured through the Well Being Interview during the last session for each participant.*
*Written conceptualization given during this session.

Table 6

Weekly Rating Scale Scores - Session (Sarah)

	Relationship with Therapist	Therapist Competence	Value of Session	Attitude about Therapy
Session 1	6	7	6	6
Session 2	6	7	6	6
Session 3	6	7	7	6
Session 4	6	7	7	6
Session 5	6	7	6	6
Session 6*	7	7	7	7
Session 7	7	7	7	7
Session 8	6	7	6	7
Session 9	6	7	6	6
Session 10	7 6	7 7	7 6	7 7

Table 7

Weekly Rating Scale Comments and Questions by Session: James

	Comments or Questions
Session 1	"Lauren is a very receptive and sympathetic listener and I feel comfortable talking with her."
Session 3	"Liked the solace from the mindfulness exercise."
Session 5	"Really liked the write up both in quality and perspective."
Session 6	"A lot will be riding on an internship phone interview Fri., will be happy/sad next time depending on the result.
Session 9	"Liked tying in personal examples and ability to answer my questions in a way that made sense."
Session 10	"Amazing to see the difference between the first well-being screening to now."

Appendix J

Well-Being Interview: Data

Table 8

Well-Being Interview Written Responses Pre-Post Intervention (James)

Pre-Post Intervention Well-Being Question 1

Question	In a couple of sentences, please describe for me your levels of life satisfaction.
Pre	It's good and getting better. Last year was tough for personal reasons, and I'm still struggling with some things.
Post	"It's good now. It'll get better after finding work. I'm disappointing that I didn't find an internship, but I learned a lot from them. I will be able to apply that in the future. I'm looking forward to the summer and having fun with friends. I'm nervous about summer plans. I'm hoping to do something."

Pre-Post Intervention Well-Being Question 2

Question	In a couple of sentences please describe your level of engagement in life and the number and kinds of activities that you find enriching, interesting, or pleasurable.
Pre	I like sports. I play intramural basketball, and I like watching sports. I spend a lot of time with family and friends - people I can count on. I'd rather rely on them than meet new people.
Post	There are a lot of things with sports. It's baseball season. Playing basketball. I'm going to continue to look for jobs. I might be more ready for the application period in the fall. I was elected vice president of the organization that I'm been on for a couple years. It's a change from just being a member.

Pre-Post Intervention Well-Being Question 3

Question	In a couple of sentences, please describe for me the degree of purpose or meaning you believe that your life has.
Pre	To enter the professional workforce; to start a family some day and support them and be capable and motivated. I'm majoring in geographic science.
Post	I have meaning on a personal level. I have high academic standards and wanting to get a job. My family has strong expectations for me to succeed in each aspect of yourself. For purpose, I want to provide for a family and opportunities for the professional world.

Pre-Post Intervention Well-Being Question 4

Question	In a couple of sentences please reflect on your medical health and the degree to which you are a healthy individual.
Pre	I eat healthy. I love junk food, but I try to limit myself. I'm trying to gain weight right now. I'm a member of the RMH Wellness Center and play basketball there a lot.
Post	I'm healthy. I have a lot of time to eat healthier. Putting good in, you get good out. I do physical activity - weight training and doing weekly and daily workouts. Taking care of your body and mind is critical.

Pre-Post Intervention Well-Being Question 5

Question	Please describe for me your level of physical fitness and the extent to which you engage in healthy habits.
Pre	I already answered that in the previous section.
Post	Already answered.

Pre-Post Intervention Well-Being Question 6

Question	Please take a minute to think about your emotional life, including the emotions that you often feel and emotions that you may try to regulate or not experience. In a couple of sentences, please provide an appraisal of how you are functioning in the domain of emotions and emotion regulation.
Pre	This is my weakest area- I'm introverted. I internalize a lot and limit myself to what I'm sharing with others. There were some personal losses last year and I find myself struggling with them a lot.
Post	I'm really good at managing stress. I'm even-keeled and rarely tense or anxious. For my emotional heath, I have nostalgic feelings an pain. I try to rationalize things and maintain a homeostasis.

Pre-Post Intervention Well-Being Question 7

Question	Please take a minute to reflect on the quality of your relationship with others.
Pre	I have a close circle of friends that I can trust and depend on. Going out and being social is not something that I want to do. I'm content with having close friends.
Post	My family has always been my strongest/stable/secure relationships - not an issue. I have a small but good circle of friends who I trust. I'm introverted and would like to be more extroverted. I'm content with the quantity and quality of the relationships I have. If the future, I would like a romantic partner.

Pre-Post Intervention Well-Being Question 8

Question	Please take a minute to describe your capacity to deal with stressors, and consider the extent to which you feel you are effective in managing your life and coping with difficulty in a resilient way.
Pre	I internalize a lot. I want to be capable of handling everything and it on myself. I do a pretty go job of managing it myself.
Post	I feel relaxed even in stress. I budget my time and resources. I take care of my body - exercise and limit the amount of sugar and fat. I take one step at a time and get pride out of it.

Pre-Post Intervention Well-Being Question 9

Question	I'd now like to ask you a few questions about your coping. First, could you share a little bit about the kinds of things that make you feel defensive or vulnerable and explain how you cope?
Pre	Talking about past losses last year forces everything that happened to resurface, and I get a little insecure.
Post	Increase criticism from others. I feel uncomfortable with that. I deal with it both directly and indirectly and try to understand where they are coming from. It might get one sided.

Pre-Post Intervention Well-Being Question 10

Question	Please take a minute to reflect on who you are and how you evaluate your self. Consider the degree of positive and negative attitudes you have about yourself, your past behaviors and the choices that you have made. In a couple of sentences, please describe your attitudes about your self.
Pre	This year has been a year. I'm motivated to pursue. I get lost in thought. It's good for finding out what I like. I'm making progress and making healthy choices about myself.
Post	I feel better about myself and am becoming more of an adult. I eliminated immature behaviors - decreased partying and no more illegal substances. In the relational domain, I am increasing expressing emotions, not suppress things that are there. I am also more able to express things to myself. I have an increase in self-esteem. I'm proud of myself for overcoming challenges. I feel optimistic and that wasn't always the case.

Pre-Post Intervention Well-Being Question 11

Question	In a couple of sentences, please describe the demands and stressors you have faced or are facing over the past months.
Pre	The biggest is finding an internship in what I want to do. It feels overwhelming. I have a hard time motivating myself to put applications out there.
Post	Academic stressors- trying to keep my grades up. Stress from accidents- dramatic effect and I feel comfortable moving forward.

Pre-Post Intervention Well-Being Question 12

Question	In a couple of sentences, please describe the opportunities you have in your environment for enrichment, pleasure or fulfillment.
Pre	Resources are available. I have a good pool of resources. I have friends with the same interests and common activities. I have a good buddy who I can talk to and we take advantages of resources.
Post	Academically, huge opportunity to learn about the world. I am getting a cohesive understanding of my studies. I still want to get an internship and job. There are some obstacles and I didn't expect things to be this hard or difficult in getting an internship. I kind of feel like I'm forced to settle, but I still seem some benefits in the application and interview process that I can take with me. I've increased my psychological and physical health. I'm looking towards having a satisfying and healthy, a complete life.

Pre-Post Intervention Well-Being Question 13

Question	In a couple of sentences please reflect on where and/or the direction you feel your life is headed.
Pre	Ideally I would like to find a job in the intelligence community. I want to be set up well to have a family and support them and provide for my parents someday. I'm just finishing school and deciding on post-graduation plans. I'm looking to go into the military or air force.
Post	Ideally a career in the intelligence community. I'm definitely working towards that, but I now know there are a few steps between now and then. I definitely think striving for knowledge, work, and history. I am more able to handle and infer interview questions. I would still like to have a family someday and provide for them financially and emotionally. It's important to maintain relationships.

Table 9

Well-Being Interview Written Responses Pre-Post Intervention (Sarah)

Pre-Post Intervention Well-Being Question 1

Question	In a couple of sentences, please describe for me your levels of life satisfaction.
Pre	Pretty satisfied and successful as a student. I don't know what direction I'm heading, but college is in a good direction.
Post	Pretty well. Lots of stress this time of year. My life is going in a pretty good direction. I've been giving myself breaks from work.

Pre-Post Intervention Well-Being Question 2

Question	In a couple of sentences please describe your level of engagement in life and the number and kinds of activities that you find enriching, interesting, or pleasurable.
Pre	At University, I'm the treasurer of the lacrosse[3] club, in an honors fraternity, skiing, watching Netflix. I'm also working on an artsy idea. I probably could be more engaged, but I'm at a good level for now.
Post	It's going pretty well. I wish I had more time for things like that. I try to take advantage of the time I do have.

Pre-Post Intervention Well-Being Question 3

Question	In a couple of sentences, please describe for me the degree of purpose or meaning you believe that your life has.
Pre	I'm still looking for that. I think I will find it after college- in the real world. I don't know what to do right now. I will find out when I'm independent and individual. I'll find out when I'm on my own and not living with others.
Post	I don't think I have much at this point or if I'm doing anything significant with it now. I feel like just another person in the crowd. I'm working towards it by doing community service and having a family one-day, by doing something that positively impacts other people.

Pre-Post Intervention Well-Being Question 4

Question	In a couple of sentences please reflect on your medical health and the degree to which you are a healthy individual.
Pre	Pretty healthy. No serious medical issues, no broken bones or stitches, no serious illness.
Post	Overall, pretty healthy. Nothing horrible or long-term. I'm adequately fit. I could improve my diet, but I'm working on it.

[3] Changed to protect identity

Pre-Post Intervention Well-Being Question 5

Question	Please describe for me your level of physical fitness and the extent to which you engage in healthy habits.
Pre	I try to stay active. It's hard to find time. It's easier this semester because I'm in Health @ UREC. It's easier at home without other things. I probably have a poor diet - picky about taste and texture. I eat carbs but ration it down. I like sleep if I can, but it's hard with school.
Post	I probably should be going to the gym more often, but I've been really busy with schoolwork. I'm still pretty capable. I've been going to UREC this semester, which has motivated me to workout more.

Pre-Post Intervention Well-Being Question 6

Question	Please take a minute to think about your emotional life, including the emotions that you often feel and emotions that you may try to regulate or not experience. In a couple of sentences, please provide an appraisal of how you are functioning in the domain of emotions and emotion regulation.
Pre	I get small bouts of depression. I was treated for it back in high school. Sometimes with schoolwork, I just can't see the point, just something I don't want to work with. Just to try to push through. I often question purpose and being stressed out about coursework feeds into it.
Post	I'm doing pretty well with that. I am usually able to stay calm and be appropriate. I'm good in tense situations and good at knowing how to handle the conflict. When stress, I have some mood swings. Insignificant things can start bugging me.

Pre-Post Intervention Well-Being Question 7

Question	Please take a minute to reflect on the quality of your relationships with others.
Pre	I had very close friends back in high school. I'm not connecting on the same level here. I'm not sure if it's a different culture or if just different from my hometown. But still have good friends. My boyfriend and I have been going for 2 years, 3 months. It's a good relationship. He is nice, kind, caring. He graduated in December. It's contributed to my depression symptoms. I fell excited when he's coming, sad when he leaves.
Post	Some are going well. There are some people who I can mutually open up to. We enjoy spending time together. My relationships with people from my major seem superficial. It's hard for me to branch out. None of them came to my birthday or the vice president thing [where they didn't vote for me]. I get asked to hangout with others, but when I ask them they don't come. Sometimes I can have deeper conversations.

Pre-Post Intervention Well-Being Question 8

Question	Please take a minute to describe your capacity to deal with stressors, and consider the extent to which you feel you are effective in managing your life and coping with difficulty in a resilient way.
Pre	It depends on the type of stress. If another person is feeling stressed, I'm good at keeping the situation calm, diffusing tension, comforting others. With me, it's academics. I eat a lot at an unhealthy level, have a small breakdown then plow through and get stuff done.
Post	It depends on the type of stress. If it is with people, I try to figure out and try to figure out my feelings, like anger, and try to understand motives behind it. I talk things out calmly, instead of letting it escalate. I take firm actions sometimes. With other stuff, like schoolwork or with my long-distance relationship, a lot of times, I have to get through it.

Pre-Post Intervention Well-Being Question 9

Question	I'd now like to ask you a few questions about your coping. First, could you share a little bit about the kinds of things that make you feel defensive or vulnerable and explain how you cope?
Pre	Feeling disappointment from someone you look up to. I get really sad - tell myself that I did my best, the thing I did wasn't all that important, the person isn't compressing them, or you'll do better next time- stays with me. I worry how other people perceive me. There is always an annoying person in the group. I wonder if that is me. I wonder if that's why I haven't connected.
Post	I don't like being singled out in any way: if I've performed poorly, being left out, or didn't live up to expectations. It makes me feel isolated and sad. I was really trying to put in a lot of effort [into the lacrosse club] and feel good I tried my hardest. Who needs them anyway?

Pre-Post Intervention Well-Being Question 10

Question	Please take a minute to reflect on who you are and how you evaluate your self. Consider the degree of positive and negative attitudes you have about yourself, your past behaviors and the choices that you have made. In a couple of sentences, please describe your attitudes about your self.
Pre	I'm down to earth. I'm intelligent - GPA ranked against others. I'm outgoing- if someone offers an activity, I'll agree or want to. I like to try new things, not always the best decision, but I get good experiences.
Post	I'm doing pretty all right. College is a positive step. I'm pretty smart, meaning I get good grades. I'm usually not original, but if I'm given guidelines, I can be creative. I am a kind and caring person. I want to make an impact on the community and better than neutral. I'm doing all right.

Pre-Post Intervention Well-Being Question 11

Question	In a couple of sentences, please describe the demands and stressors you have faced or are facing over the past months.
Pre	Schoolwork is a big one. My long distance relationship with my boyfriend. Some financial stress. Sometimes things just go wrong. A few weeks ago, my winter boots broke. Little things add up.
Post	Schoolwork and some drama with friends. I've had to be a support for them.

Pre-Post Intervention Well-Being Question 12

Question	In a couple of sentences, please describe the opportunities you have in your environment for enrichment, pleasure or fulfillment.
Pre	Not too often. My free time is spent watching TV or something on the computer. I would like to have more time for things like that.
Post	When I'm free, I try to find good ways to spend it. I like to do something small, like playing with an app on my phone or Facebook. Sometimes I need to relax. I went on a ski trip this year. I like to do art once in awhile. I doodle and sometimes like to start a larger project. Like a painting.

Pre-Post Intervention Well-Being Question 13

Question	In a couple of sentences please reflect on where and/or the direction you feel your life is headed.
Pre	My current plan after college is to be with my boyfriend. I plan to take a year off before grad school. The plan is to head where he will be and figure out from there. To find a job and hopefully use my degree. I don't know exactly what type of job I would like. I see myself looking forward to spending life with my boyfriend and eventually starting a family. I look forward to that more than my occupation.
Post	I really don't know where my life is headed. My plans are changing. I might head back up to the Northeast. The changes are both worrying and freeing.

Appendix K

Intervention Follow-up Survey

Table 10

Follow-up to Intervention

Follow-up to Intervention Question 1

Participant	Please describe your experience with this intervention
James	Was very enlightening. Learned lots about coping strategies and adaptive & maladaptive behaviors. Has been difficult to implement these strategies effectively in my life so far.
Sarah	It was very interesting to see and look into the way I was feeling and why I act the way I do.

Follow-up to Intervention Question 2

Participant	What did you like the least?
James	How gradual and forecasted the results are/will be
Sarah	Talking about hard topics

Follow-up to Intervention Question 3

Participant	What did you like the best?
James	Learning about different techniques, relating well to a therapist for the first time.
Sarah	Getting more perspective on issues, and insight to why I react the way I do.

Follow-up to Intervention Question 4

Participant	This intervention was focused on helping you understand aspects of your psychology, do you feel it accomplished that? Why or why not?
James	Very much so. A lot of the literature and topics covered were directed to me personally, which really helped target and identify my behavioral and psychological tendencies in an effort to make them more adaptive.
Sarah	Yes it definitely did. I understand my own thinking process and social tendencies a lot better now.

Follow-up to Intervention Question 5

Participant	What was your goal for the sessions?
James	To change certain behavioral tendencies and to be more confident and guided in doing so.
Sarah	To get insight as to why I don't succeed socially as well as other people seem to.

Follow-up to Intervention Question 6

Participant	How well do you feel you met that goal? (6pt scale)
James	Somewhat
Sarah	Somewhat

Follow-up to Intervention Question 7

Participant	What is relational value to you?
James	A complex interaction that conveys how strongly or weakly someone is regarded in a relationship. Very dynamic and can be shaped
Sarah	Relational value is the significance of our exchanges as friends.

Follow-up to Intervention Question 8

Participant	What strategies do you use in relationships?
James	Affiliation, trying to be involved, protecting what I think is right and avoiding conflict
Sarah	I'm not selfish - its got to be give and take / I'm there for them when they need me / try to share positive experiences and work through negative ones

Follow-up to Intervention Question 9

Participant	One of these systems was the Experiential System. What was that? What did you take away from it?
James	Being able to physically sense emotions and how they can indicate a larger emotional/psychological process and indicate feelings on a more subliminal level.
Sarah	Experiential system is was a person experiences and includes exchanges between people. I learned that this is filtered twice, first by the subconscious and second by conscious thinking.

Follow-up to Intervention Question 10

Participant	One of these systems was the Relational System. What was that? What did you take away from it?
James	A multidimensional justification system that describes the degree and attachment of interactions with others. I learned that I need to try to be more open and confident expressing feelings and emotions in order to avoid poor relational value.
Sarah	It involves a person's relationships with others. I learned better the definition of this and what is healthy and what can be unhealthy.

Follow-up to Intervention Question 11

Participant	One of these systems was the Defensive System. What was that? What did you take away from it?
James	Techniques that inhibit or exacerbate reactions to certain stimuli that invoke emotion. Often, the defensive system is an effective agent in minimizing stress, discomfort, anger but can also be maladaptive if allowed to suppress/prolong undesired emotions. I learned it will be more effective to lessen the amount of internalization I use to cope with troublesome emotions.
Sarah	It' s a person's defenses to prevent themselves from feeling bad. I learned more thoroughly what specific defenses are.

Follow-up to Intervention Question 12

Participant	One of these systems was the Justification System. What was that? What did you take away from it?
James	A system that explains why particular emotions or feelings are aroused and if resultant behaviors are misguided or justified. I need to try and be more assertive and dominant when I feel like a boundary is crossed rather than being submissive and autonomous.
Sarah	This is what a person does to justify his or her actions. Sometimes we can delude ourselves with it just like a defensive mechanism.

Follow-up to Intervention Question 13

Participant	What moment(s) stuck out for you in the session or in multiple / sessions? These could be about information learned, emotions, / relationship with clinician, written/verbal feedback etc.
James	Clinician's expressed care and memory/sensitivity of difficult situations/emotions
Sarah	What I remember the most was when I was crying because of what had happened the previous day and I was asked, "why are you trying to hold it in?" I still don't have a great answer for that.

Follow-up to Intervention Question 14

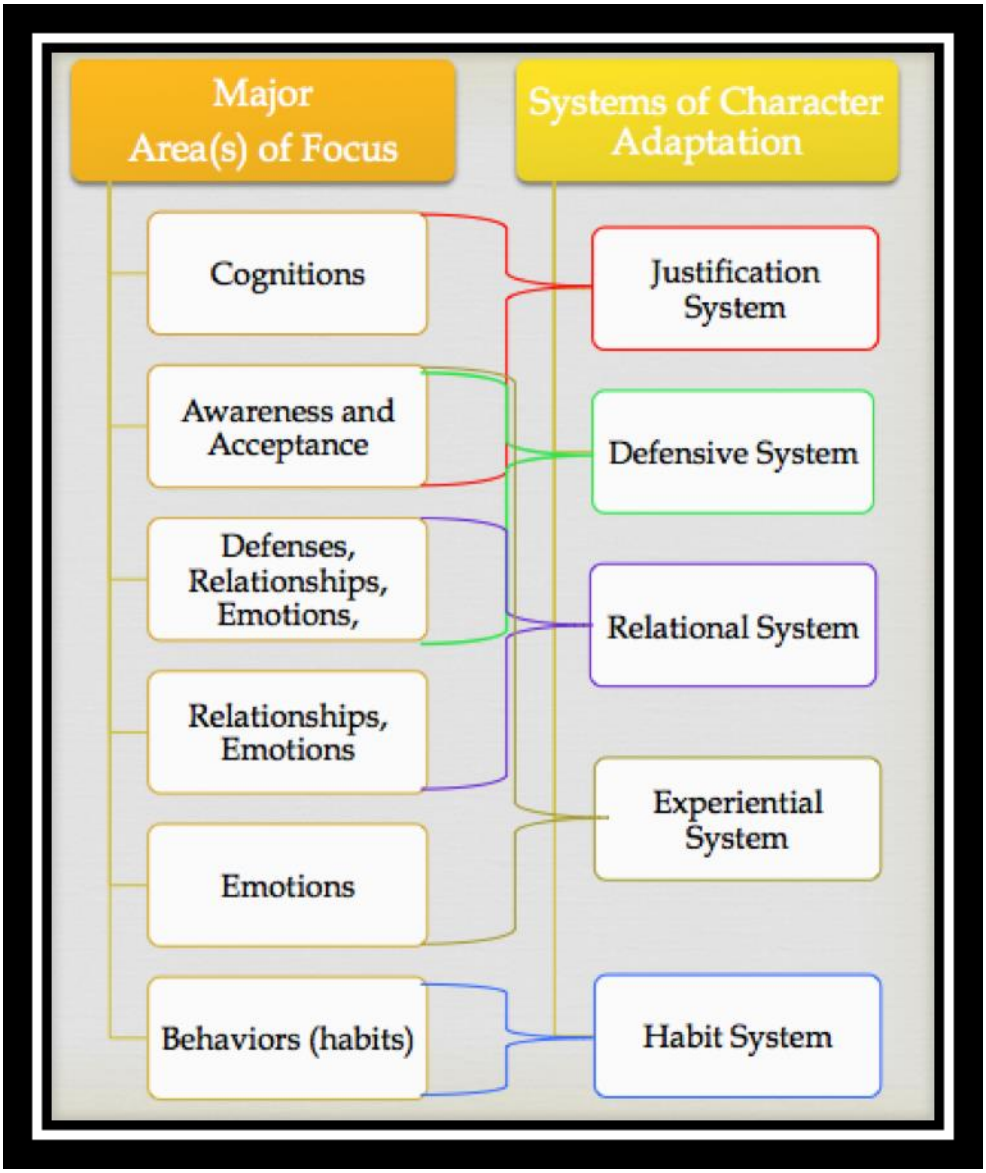
Participant	Please describe your favorite session.
James	No Response
Sarah	I like talking about the defensive and justification systems because they made a lot of sense to me.

Appendix L

Treatment Manual

Character Adaptation Systems Treatment (CAST)

Psycho-education Intervention



Key Concepts

There are several key concepts that will be introduced to you. The goal of these concepts is to help frame your experience, which in turn will help you make better decisions, grow, and change in productive ways.

- **Adaptive Living** - refers to living in a way that maximizes your well-being and dignity to the best of your ability, given the stressors and opportunities in your environment. We ask you to make a commitment to move toward adaptive living.

- **Narrative Identity -** refers to the story of your life. If someone were to write a novel with you as its primary character, this would be your narrative identity. We can think of it in terms of key events, key characteristics, key plot lines and conflicts. We will sometimes refer to your narrative identity as your **justification narrative**, because your narrative identity often sets the stage for how you justify your actions.

- **Domains of Adaptation -** In order to better understand yourself and how you function, we will examine your behavior and personality through the lens of five different domains or systems of adaptation. They are the following:

    - **Habit System** - The habit system consists of your everyday patterns of behavior. This would include elements like sleep, eating, exercise, substance use, and so on. Habits can also be thought of as what we do without thinking, and are often triggered by specific things in the environment

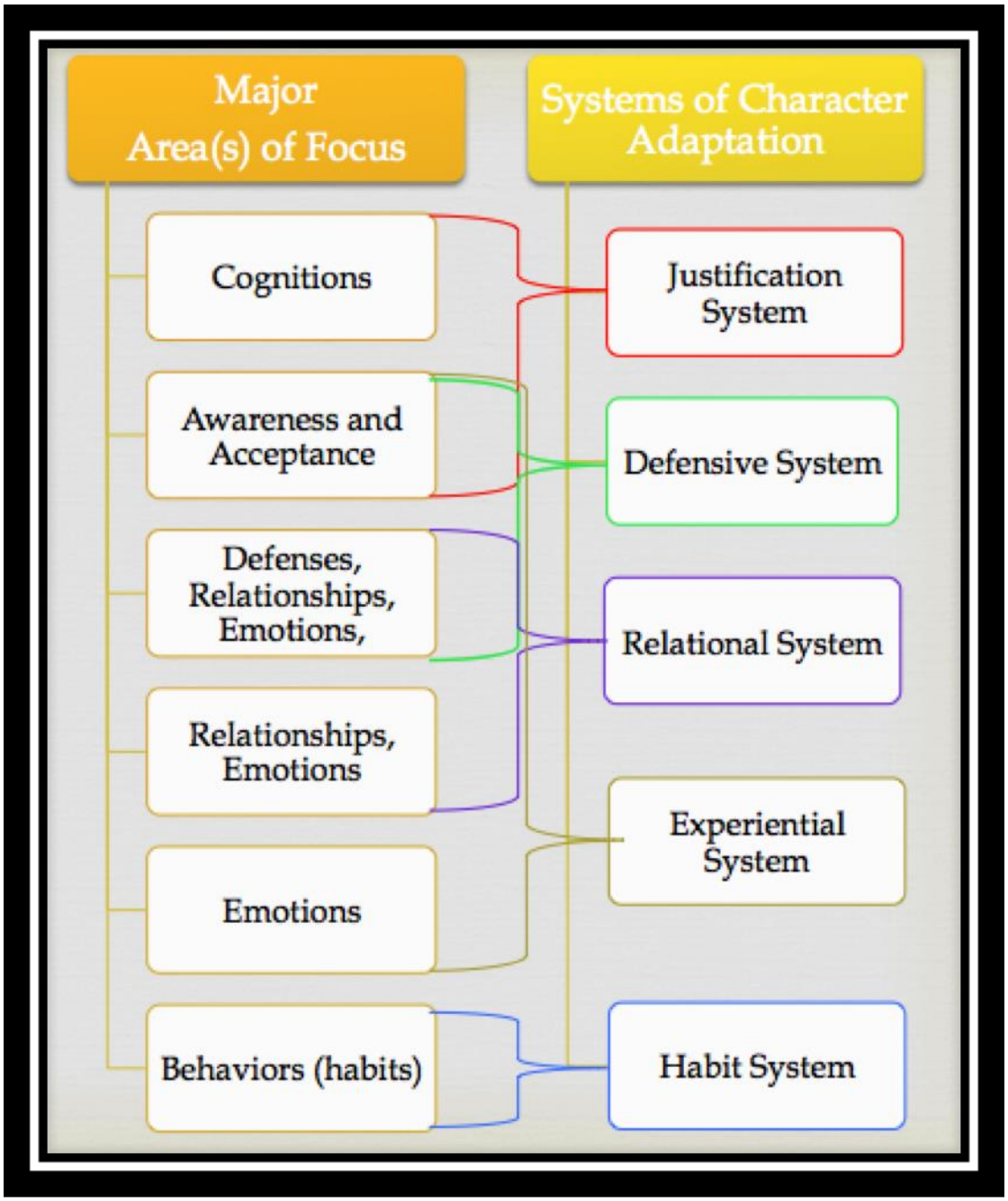
    - **Experiential System** - The experiential system refers to your first person feelings, perceptions, and drives. Your emotions organize your experiential system. Which emotions are dominant for you? Which emotions are hard?

    - **Relationship System -** Your relationship system refers to your models of your self in relationship to other people. It starts to be developed with early relationships with important others. Important relationship system themes include being respected and honored as opposed to being rejected or abandoned, and motives like power, love, freedom and dependency.

    - **Defensive System -** The defensive system is how we cope and try to maintain harmony between the various systems. When we feel anxious, our defensive system gets activated. Important defense mechanisms include repression (stuffing feelings) and rationalization (making excuses).

    - **Justification System** - This is your language-based system of thinking. Our language-based thought is organized into systems of justification, which tell us what is legitimate or what is not. There are two big domains of justification, the private and the public. The private domain of justification is what you tell yourself, how you make sense of what you feel, and your reasons why you did what you did. The public domain is what you tell other people.

Systems of Character Adaptation



Module 1: Values Worksheet

Today we are going to create short and long-term goals. But to understand your goals, we need to know what your values are, for your values are what you hold dear in your life.

- Values are a set of underlying principles and qualities that we use to decide what is and isn't important in our life.
- Goals are envisioned states that we can move toward.

Everyone has a different set of values, and ways in which the values can be carried out. Both values and the way we carry out values can shift and alter over a lifetime – values are like a compass, giving a general direction, while goals and actions are more like the pathways we take to get to specific places.

Emotional pain can definitely influence the directions we take in life. It can mean different functional abilities, changed roles, leaving a job, and needing to spend time with health care providers.

This can, without meaning to, get in the way of living a life that is still moving towards the things we value. Some values we hold conflict with trying to reduce pain, while others become more or less important because of the way pain affects life.
To live well despite having significant troubles, having goals that are in line with your values is vital. We don't often think about what is important and why it is so important!

In this exercise, we're going to decide which values are very important to you. A list of values has been provided to help you get started. To help you, think about what you would do with your life if I could wave a magic wand and all the pain, and all the thoughts and feelings and memories you have about your pain would no longer have any impact on you.

What would you do with your life?
What would you start, stop, do more of, or less of?
How would you behave differently?
What would show the world that this magic had happened?

Values List[4]

1. **Accomplishment:** Make a lasting contribution; produce results; reach goals
2. **Aesthetics:** Appreciate and contribute to the beauty of your surroundings, of objects, of ideas.
3. **Belonging:** Be accepted as a worthwhile member of a group.
4. **Compassion:** Stand with and support others in their need and distress.
5. **Creative Expression:** Express ideas in novel, innovative and original ways.
6. **Diversity:** Value and respect differences in people, ideas, situations.
7. **Exciting Life:** Maintain a stimulating and active life; take risks; try new things.
8. **Fairness:** Distribute benefits and burdens to others appropriately.
9. **Family:** Protect and care for those you love and are related to by birth or by law.
10. **Friendship:** Develop intimate and caring bonds with others.
11. **Happiness:** Feel joy and emotional well-being.
12. **Health:** Maintain soundness of body and mind.
13. **Honesty:** Telling the truth to yourself and others.
14. **Independence:** Take actions free from the control of others.
15. **Inner Harmony:** Develop inner peace, free of internal conflicts and confusion.
16. **Integrity:** Consistency of thought/words/actions: 'what I think is what I say and do'.
17. **Justice:** Treat everyone the same unless there are relevant moral reasons to treat them differently.
18. **Loyalty:** Do one's duty, honor allegiances and commitments to obligations.
19. **Pleasure:** Seek enjoyment and satisfaction of the senses.
20. **Power:** Exercise control, authority and influence over others.
21. **Recognition:** Gain positive feedback and perhaps notoriety for a job well done.
22. **Respect:** Treat other people, animals and the environment with dignity and care.
23. **Security:** Be free from fear or danger; exist in a stable environment.
24. **Self-Respect:** Treat yourself with dignity and care, develop self-esteem.
25. **Social Contribution:** Work for the good of society, advance the common good.
26. **Stewardship:** Care for resources and processes entrusted to you.
27. **Spirituality:** An inner sense of something greater than oneself
28. **Variety:** Engage in frequent changes in activities, locations and people.
29. **Wealth:** Accumulate money and possessions.
30. **Wisdom:** Understand what is true, right and lasting

[4] **This list of values was retrieved from:**
http://aip.ucsd.edu/_images/Final%20ValuesWorksheet%20and%20Reflection%20Form.pdf

My top five values and descriptive statements

Value	Descriptive Personal Statement of Activities that Relate
Ex. Wisdom	I read books about science
Ex. Health	I exercise regularly

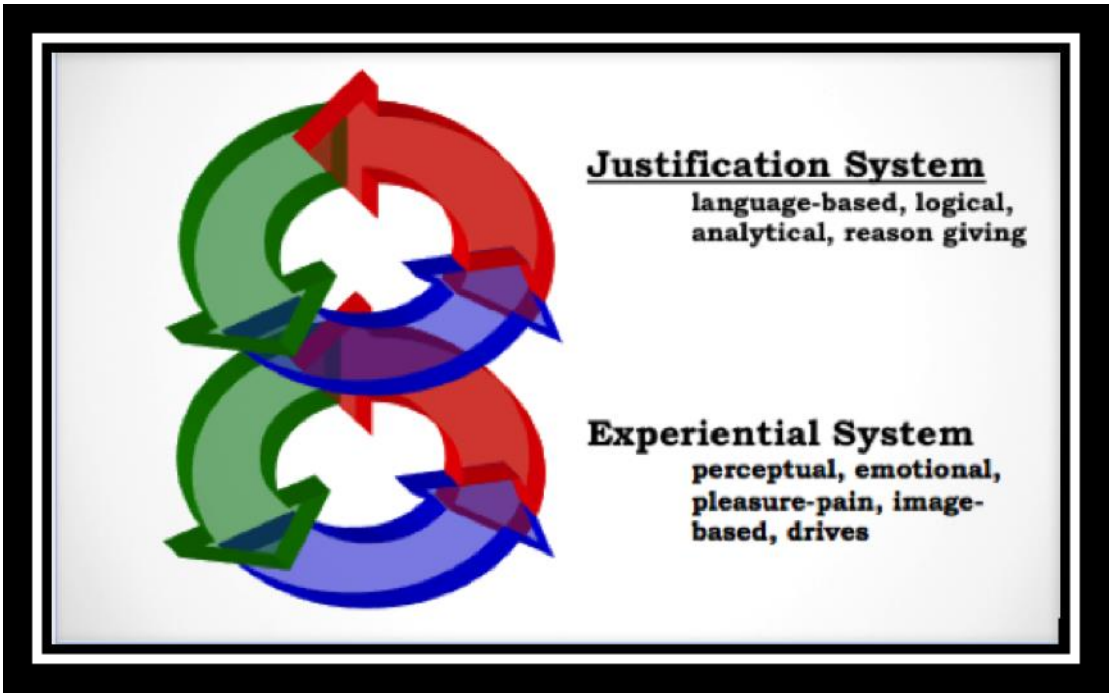
List a value that you want to work on and something that you could do in accordance with that value.

Value	Descriptive Personal Statement of Activities that Relate

Domains of Consciousness

The Human Mind: Two Streams of Consciousness in One

Take a minute to think about your conscious experience. What is it made up of? One of the most important discoveries in psychology has been the discovery that the human mind is really two streams of consciousness in one. One stream of consciousness is made up of sensory-feeling states. This includes feeling pain, seeing red, or having a visual image of your house. We call this stream the **experiential mind**. The other stream of consciousness is made up of your language-based thoughts and the reasons and stories we develop to make sense of the world. We call this the **justifying mind**, because it allows us to explain ourselves to others and ourselves.

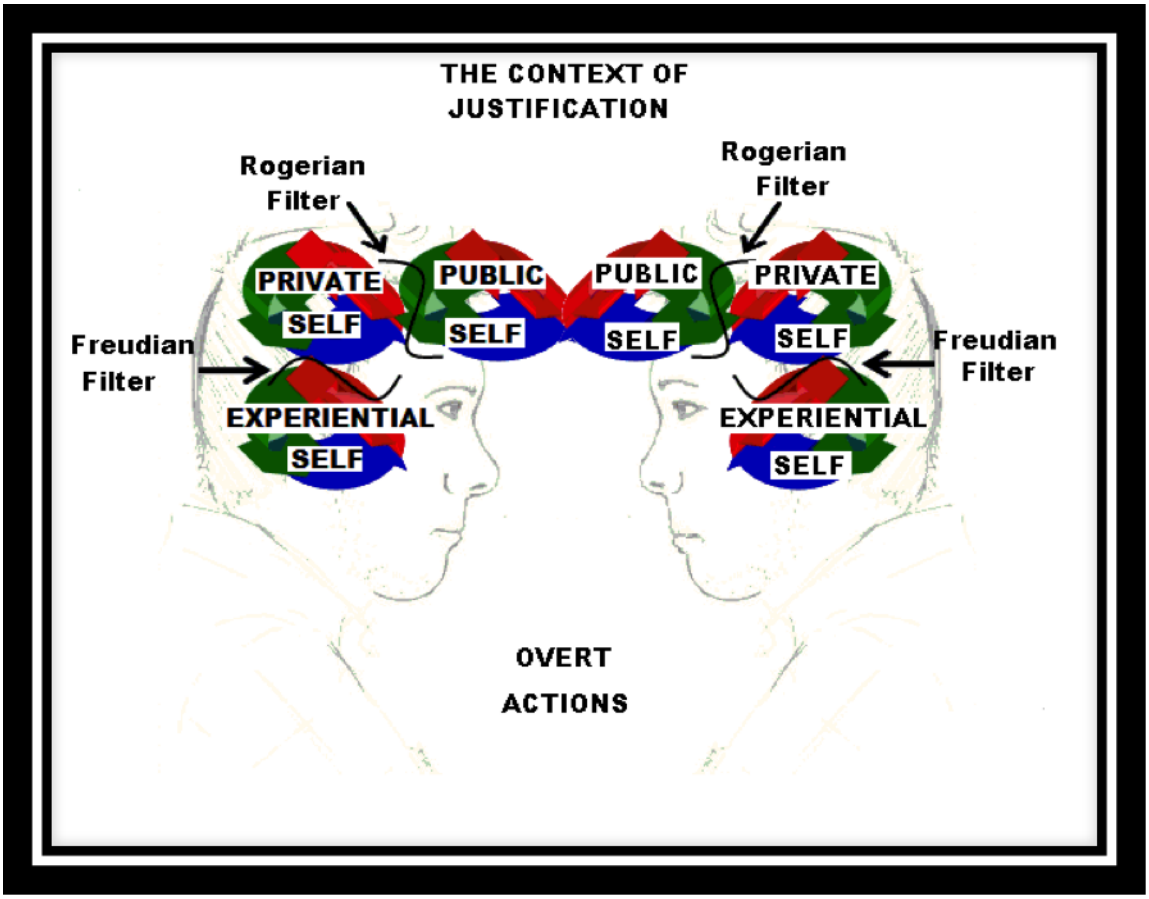


The Two Domains of Justification: Public and Private

For adults there are two important domains of justification, the private and the public. The private domain is your inner 'self talk'. It is what you say to your self when you are making sense out of things. For example, when you wake up, you might have a conversation with yourself about what you are going to do today, your attitude about your situation, or your thoughts about other people.

The Public domain of justification is what you share with the outside world; it is what you tell other people about what you think and feel.

There is FILTERING between the public and the private domains. Think for a moment. What if other people could access all your private thoughts and know exactly what you were thinking? If that would leave you feeling exposed, then you can see that the two domains are different and that you don't share all of your private thoughts.



Module 3: Emotions

The Organizing Force of the Experiential System

The experiential system consists of your sensory-feeling states, like seeing red or feeling hungry or sad (Recall the Domains of Consciousness).

EMOTIONS are the organizing force of the experiential system. Emotions are **ACTIVATED** in response to our perceptions of events relative to our goals. For example, if you wanted to do well on a test (goal), and you saw that you did poorly (perception of event), you would likely feel sad or disappointed. Or, if you hoped someone would be your friend (goal) and you asked him or her to do something with you and they said yes (perception of event) then you would likely feel happy.

Note that emotions are different than MOODS. Moods are general states of mind that last for many hours, and sometimes days or weeks, and often are not connected to a specific event. Emotions last for minutes to hours, and are connected to a specific event. But if you are in a bad or good mood, you are much more likely to have positive or negative emotional reactions to events.

Although some times in our culture we are told that emotions are bad or that you are weak if you feel strong emotions, we now know that emotions are very important and crucial to adaptive living. Emotions do several very important things.

1. **They tell us whether what happened was good or bad**
2. **They organize the body to respond to the situation**
3. **They organize the mind to think of similar situations**
4. **They create urges or impulses to act**
5. **They result in facial expressions that communicate to others**

Activating and Inhibitory Emotions

Emotions come in two broad categories: Activating and Inhibitory emotions. Activating emotions (e.g., anger), move us to open up, engage, or approach a goal that we desire, or when we prevent something bad from happening. Inhibitory emotions (e.g., shame) move us to close down, withdraw, or avoid something.

Emotions also tend to be positive or negative. Positive emotions are activated either when we are approaching a goal that we desire (we have an unexpected good thing happen to us), or when we prevent something bad from happening. Negative emotions are activated either when we perceive something happening we want to avoid (an unexpected bad thing happens), or when we fail to get something good.

Activating Emotions

	ADAPTIVE	MALADAPTIVE
Grief	**Grief** feels like a relief (resolves and lead to acceptance).	**Depression** feels like hopelessness, despair, futility, self-hate.
Anger	**Anger** gives relief and a solution.	**Aggression** makes things worse.
Care	**Care** brings people closer	**Need** is addictive and cloying

Inhibitory Emotions

	ADAPTIVE	MALADAPTIVE
Anxiety	**Anxiety** signals the need to protect self and others (e.g., softening anger expression).	Excessive or traumatic **anxiety** paralyzes, blocking adaptive action.
Shame/ Guilt	**Shame and guilt** can lead to genuine healing remorse, making amends.	**Shame and guilt** leading to self-hate, self-loathing, or self-attack.
Contempt/ Disgust	**Contempt/disgust** is used in healthy outrage.	**Contempt/disgust** is used to inappropriately attack others or the self.

Here is a way of thinking about basic emotion categories together…

	INHIBITORY	ACTIVATING
Positive Emotions	Calm/Relaxed	Excitement/Joy
Negative Emotions	Sadness/Depressed	Fear/Anxiety

Emotions and Well-Being

Emotions are key to well-being. Researchers have shown that individuals who can both get in touch with how they are feeling and can effectively regulate their feelings have better mental health. Emotional regulation refers to how you experience and relate to your feelings. There are two broad categories of problems with emotion regulation: Under-regulation and Over-regulation.

Under-regulation (or excessive emotionality) happens when we get overwhelmed by our feelings, and cannot effectively manage the action impulses in an adaptive way. Excessive emotion usually is related to extreme fears or beliefs about a situation, and these beliefs activate more and more of the emotion. For example, someone who experiences a disappointment, and then believes that this disappointment means the end of his or her happiness, in turn feels worse and worse. People, who under-regulate their emotions, may benefit from learning coping strategies to better regulate, but still experience their emotions. For example, the individual might learn to talk to him or herself after a disappointment (e.g., ""While this bad thing happened, it is not the end of the world").

Over-regulation (or emotional cutoff) happens when people do not allow themselves to feel what they are truly feeling. This is because they believe the emotional experience is too painful, or not acceptable to others, or will lead them to doing things that they do not want to do. Individuals who engage in emotional over-regulation need to learn how to become aware and accept their feelings, they need to give voice to what the feeling is telling them, and learn that the feelings will not overtake them or last forever. They also need to learn that they can separate impulses from their feelings.

Emotional Intelligence

Individuals with high emotional intelligence can experience and accept the feelings they are having (they are not cut-off and the feelings are not stuffed), and can give voice (put in to words) what made them feel that way.

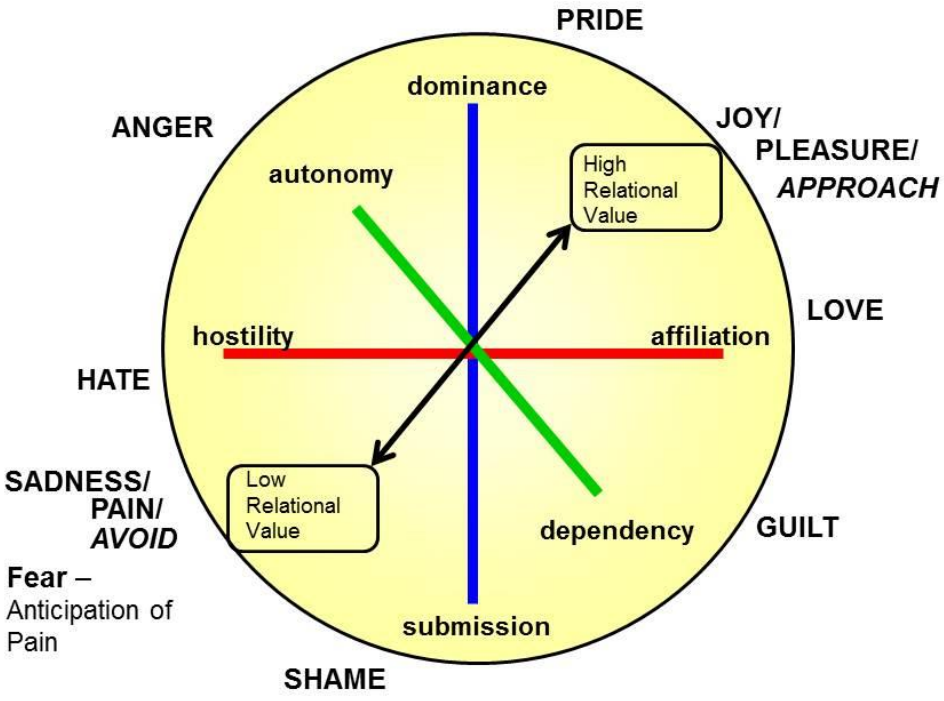
A good way to approach your emotions is to ask yourself, given the current situation, "How much emotion and what kind of emotion do I WANT TO FEEL?" If you have experienced a loss, or are facing a threat, it would be appropriate to feel some

Module 5: The Relationship System

Humans are social creatures and relationships are extremely important to our mental health. Apart from physical needs like food, oxygen and basic safety needs, relationship needs are probably the most important needs we have.

We are going to learn today about the **relationship system**, which grows out of the **experiential (feeling) system**. The relationship system refers to how we experience ourselves in relationship to important people in our lives.

To learn the key elements of the relationship system, we will first start with the **attachment**, which is the developmental foundation of relationships, **social influence/relational value**, which is the key variable we monitor in relating to others, and **power, love, and freedom**, which are ways in which we relate to others.



Attachment

When a baby comes into the world, it is completely dependent on the care of others. If no one cared for the baby it would not be able to care for itself, and it would quickly die. Being cared for is one of the most important things a baby needs, and when babies are born, they are biologically 'prepared' to form an attachment. An attachment is a bond with a caregiver. The most common bond is with the parent (especially the mother), but it can be formed with anyone who is a regular caregiver.

Secure Attachment

Babies learn much about themselves through the way the caregiver relates to them. If they find that they can depend on the caregiver and that the caregiver will be there to love, protect and delight in them, then they will learn basic trust and feel **secure.** The caregiver consistently responds to the child's distress in sensitive, nurturing way. This allows the child to feel comfortable expressing a **full range** of emotions. This enables them to explore the environment and develop a healthy sense of self. These babies and infants are said to have a "**secure attachment**."

Insecure Attachment

If, however, the caregiver does not express love, does not know how to meet the baby's needs or does not regularly protect them from harm, then the baby develops what is called an "**insecure attachment**." Babies who have an insecure attachment do not have a healthy relationship system because their basic relationship needs are not met. We will be focusing on two of these insecure attachments: Anxious-Ambivalent and Anxious-Avoidant.

Anxious-Ambivalent

First, some insecurely attached babies become hyper-dependent and hypersensitive. If they sense their needs are not met, they become very upset, cry easily, become irritable and basically do everything they can to draw attention to themselves. Their strategy can be summed up by the statement, "If you are not going to take care of me well, at least you won't forget about me!"

In Adulthood: People, who have high anxiety about the relationship, tend to worry a great deal about their partner's availability, responsiveness, and attentiveness to meet their attachment needs. They are hyper-vigilant to signs of rejection and instability in the relationship.

Anxious-Avoidant

The next kind of insecurely attached baby, anxious-avoidant, is hyper-independent and unemotional. These babies seem 'tougher,' more distant, and less dependent on anyone. They learn and expect to take care of their own emotional needs because they cannot depend on or trust others to meet those needs. Their strategy can be summed up by…"If you are not going to take care of me well, I will just look out for myself."

In Adulthood: Highly avoidant individuals have difficulty with intimacy and avoid their own needs and the needs of others. As a result, they have a tendency to be hyper-autonomous and are uncomfortable with distress and emotional closeness.

Relational Value

Although the relationship with the primary caregivers forms the base of our relationship system, as we develop and grow, we must interact with and form relationships with many different kinds of people. (e.g., siblings, peers, friends, romantic relationships).

Because of these changes in our relationships, our attachment system becomes generalized. Now instead of a focus just on our caregiver, we begin to monitor our **relational value** in relationships in general. Our relational value is the extent to which we are important to other people and other people care about our interests and us. Another way to describe relational value is the extent to which we see ourselves as being valued by others.

We monitor our relational value and try to **approach situations that signal we are high influence** and **avoid being low influence**. Thus, we are motivated toward situations in which we are respected, loved, and admired. When we get signals that others value us in this way, we feel positive feelings like pride, joy and love In contrast, when we perceive that we are disrespected, unloved, rejected, criticized or abandoned, we feel bad (think experiential system here).

This relates to attachment in that securely attached people have a foundation that makes them feel they have high influence and insecurely attached people have a sense that they are low influence.

Power, Love, and Freedom:
The Dimensions Underlying Social Influence

If relational value is one of the key resources we monitor in our relationships, how do we go about getting relational value? On the surface, it seems there are many possible ways to get relational value. We can be attractive, we can tell people what to do, we can give people money or attention, we can get nice things and share them with others, and so on.
While there are almost an infinite number of different things we can do, there are three kinds of relational exchange patterns we can engage in.

POWER
One way to get relational value is to compete with others for it. If we win games, or dominate people in conversation, or get a high-ranking score on a test, we are achieving relational value through competition. People who compete successfully have high social influence, both directly through domination, and indirectly because we want to be around successful people.

LOVE
We can also influence others by giving and cooperating with them. Think about it this way. Who would you rather be around, someone who is competing with you, trying to dominate you and being better at you in everything, or someone who is giving, loving and kind? We want to be around people who are giving, loving and kind. And being giving, loving and kind often results in high relational value for the giver

FREEDOM
While cooperating and competing are the two ways we achieve influence, there is also the problem of people getting influence over us. We can try to compete and fail, or we can be giving and not get anything back. **One way to deal with this is to distance ourselves and become more self-reliant and free from influence of others.**

The following diagram is called The Influence Matrix, and it maps the dimensions that we have been talking about.

The Influence Matrix

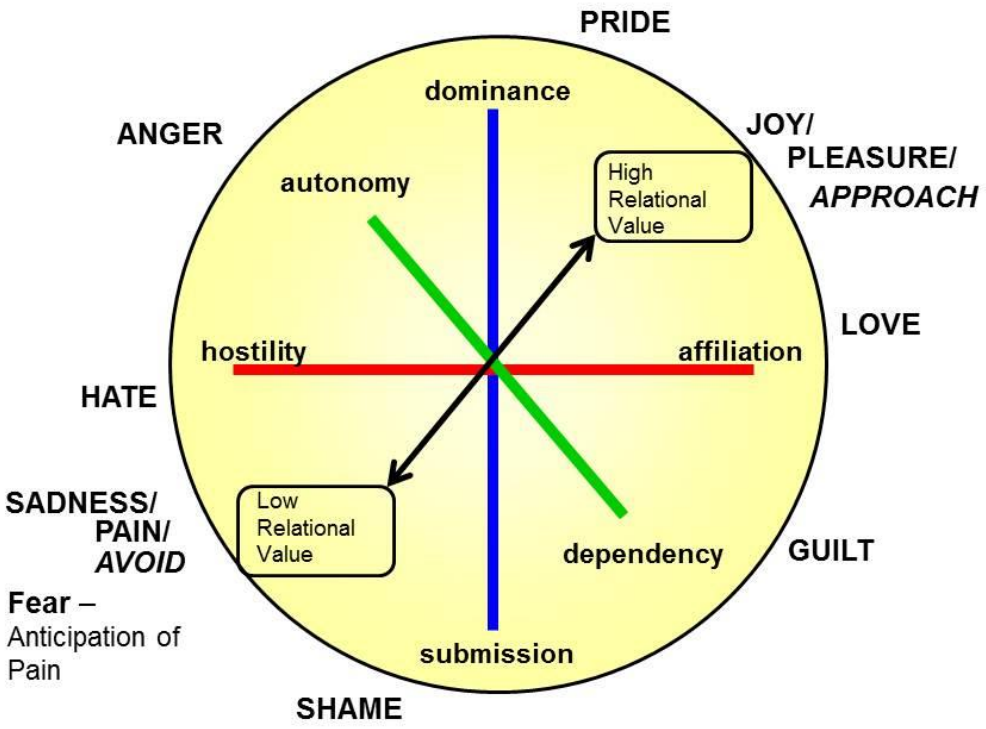
The Influence Matrix provides a map of your relationship system. Your relationship system is the map of yourself in relationship to other people. There are three domains of the relationship system.

1. There are the important people in your life. Take a minute to think about the important people in your life. This would be your friends, your family, people you have conflicts with, people that are dependent on you, and people that you have control over.

2. There are the content issues in your relationships. These are the actual things you do with other people (the time you spend with them, the things you share, or the things you have conflicts about).

3. There is the PROCESS by which you exchange things with others. These are the dimensions shown by the Influence Matrix

IMPORTANT: Remember that the relationship system is part of the experiential system, so it also relates directly to our feeling states. This diagram shows how different emotions relate to different aspects of the experiential system.



Module 6: The Justification System

We have learned about the **habit system** (your daily routines and lifestyles), the **experiential system** (your sensory-feeling states organized by emotion), the **relationship system** (your attachment and influence with others), and the **defense system** (how you block experiences and avoid threats). Today we are learning about the last domain of adaptation, the justification system.

The Justification System

Your justification system is the knowledge that you have that you can explicitly share with others through language. This includes the **beliefs and values you have about the world, yourself, and the future**. This system of beliefs and values is what allows you to understand how the world works, what is good and bad, and how you explain your actions to others. There are three main elements: What are they? Where are they? And How are they connected into a justification system?

1. **WHAT EXACTLY ARE JUSTIFICATIONS**? Justifications are the **reasons we use to legitimize actions or claims**. So, for example, if you are pulled over by the police and you ask why and he tells you that you were speeding, then that is a justification. If a friend asks you to help and you say you would like to but are busy, that also is a justification.

2. **Justifications are EVERYWHERE!!**
   Arguments, debates, rules, laws, and excuses all involve the process of explaining why one's claims, thoughts or actions are warranted. These processes are both uniquely human and everywhere in human affairs. In virtually every form of social exchange, from warfare, to politics, to family struggles, to science, humans are constantly justifying their behavior to themselves and others.

3. **Your JUSTIFICATION SYSTEM is the connection of explanations that allow you to make sense of your world, your self, and other people**. At a broad level, your justification is your worldview. These are your ideas of how the world works, your morals (what you believe is right and wrong), and your political ideas. At a specific level, your justification system is also how you make sense of who you are. It is your narrative identity, that is, the story and explanation of why you do what you do.

Reflection and Discussion

Some people are very concerned with what other people might think if they expressed their opinions and so they monitor and filter their thoughts out. Other people boldly share what they think, although sometimes it might get them into trouble.

1. Do you tend to be one or the other?
2. Do you filter a lot of your private thoughts or do you tell it like it is, even if others may not like to hear it?

Adaptive and Maladaptive Justifications

The justification system is a very important adaptational system. The way you make sense out of yourself, other people, events and the world has a big impact on your actions and your feelings. Consider the following example:

> Mary is a 9th grader who wants very much to do well in math, but she is scared that she won't and her father has told her that she will probably have trouble. After the first week of class, the teacher has the student takes a quiz. Mary gets a C. She then thinks, "This is horrible. A 'C' sucks. I am stupid and I will never understand math, which means I will never get into college and get a good job.

1. How do you think Mary will feel as she thinks these thoughts?
2. What do you think she will do in the future?
3. Do you think this was an adaptive or maladaptive justification?

Now imagine that Mary said something different to herself after getting a C.

> "I am not happy with a C. I knew it was going to be hard. Although math might not be my best subject, I can do better if I try harder and I don't get down on myself."

4. Now how do you think Mary will feel as she thinks these thoughts?
5. What do you think she will do in the future?

Some Common Errors in Justification

"To succeed, jump as quickly at opportunities
as you do at conclusions." Benjamin Franklin

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1. **All-or-nothing thinking:** You see things in black and white categories. For example, if your performance falls short of perfect, you see yourself as a total failure. Words like "always", and "never" are often associated with all or nothing thinking.

2. **Global Attack** – It is only natural to blame our selves or someone else when something bad happens. However, attacking the core of the self or another in global terms ("I am a horrible person", "You are stupid") does not lead to positive pathways to change. Instead, the blame should be focused on the situation.

3. **Personalization:** You blame yourself or sense that other people are blaming you for some bad event, even though they did not explicitly say anything and you were not really responsible.

4. **Jumping to conclusions:** You make a negative interpretation even though there are no definite facts that convincingly support your conclusion.

    a. **Mind reading:** You conclude that someone is reacting negatively to you based on limited information and don't bother to check it out.

    b. **The Fortune Teller Error:** You expect that things will turn out badly and feel convinced that your prediction is an already-established fact.

5. **Should statements:** You try to motivate yourself with "shoulds" and "shouldn'ts," as if you had to be whipped and punished before you could be expected to do anything. "Musts" and "oughts" are also offenders. The emotional consequence is guilt. When you direct should statements toward others, you feel anger, frustration, and resentment. (Consider statements like "I must be happy all the time", or "I must always be successful", or "Other people must always like me.")

The 3 C's for Adaptive Justifications

Catch It, Check It, Change It:

"Get your facts first, then you can distort them as you please." Mark Twain

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If we sometimes engage in maladaptive self-talk, how do we learn to develop more adaptive justifications? There are three steps to learning how to change maladaptive thinking patterns to more adaptive thinking patterns.

1. **CATCH IT:** The first step is that we must have **awareness** of our self-talk. Often, our thoughts happen so fast that we are not even aware of them. We need to 'catch' the thought. *You can also use your experiential system as "cues" to build this awareness.

2. **CHECK IT:** The second step is to "check" the thought. There are two questions that we ask of each thought.

    1. **Is the thought accurate?**
    When thinking about its accuracy, we need to consider the **evidence** and consider if there are any other possible interpretations that would also account for the evidence.

    2. **Is the thought helpful?**
    Here we need to think about our **goals** and ask if the thought moves us to our goals. If it paralyzes us, it probably is not the best thought.

3. **CHANGE IT:** The final step is to change it. Normally the first thought has a grain of truth to it, but is too global or is unhelpful**.** To change the thought, **identify the grain of truth** but also add more realistic, adaptive alternatives.

4. **LET'S PRACTICE IT…**
    1. Look at When/Where the thought occurred
    2. Where did it happen?
    3. What were you feeling?
    4. What's a more adaptive alternative?

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