BRIEF PSYCHODYNAMIC THERAPY WITH A TRADITIONAL COLLEGE STUDENT DIAGNOSED WITH ADJUSTMENT DISORDER: A CASE STUDY

A Doctoral Dissertation
presented to
the Graduate Department of Clinical Psychology
University of Indianapolis

In partial fulfillment
of the requirements for the degree
Doctor of Psychology

Megan Pethtel

March 2023

BRIEF PSYCHODYNAMIC THERAPY WITH A TRADITIONAL COLLEGE STUDENT DIAGNOSED WITH ADJUSTMENT DISORDER: A CASE STUDY

The signatures below certify that the Doctoral Dissertation of

Megan Pethtel

has been approved by the Graduate Department of Clinical Psychology of the University of Indianapolis in partial fulfillment of the requirements for the degree Doctor of Psychology

Approved:

Debbie M. Warman, PhD
Dissertation Advisor

Lisa S. Elwood, PhD
Committee Member

Trevor A. Yuhas, PsyD
Committee Member

3/28/2023
Date

Accepted:

John Kuykendall, PhD
Dean, College of Applied Behavioral Sciences

3/28/2023
Date

ABSTRACT

There is minimal research that examines effective treatment for individuals diagnosed with Adjustment Disorder (AD) (O'Conner & Cartwright, 2012; Carta et al., 2009; Zelveine & Kazlauskas, 2018). The current case study aimed to examine the effectiveness of brief psychodynamic therapy as a treatment with a traditional aged college student diagnosed with AD. Specifically, the current case study examined an individual diagnosed with AD receiving weekly therapy in a college counseling center for a total of 6 sessions. The client was administered the CCAPS-62 on three separate occasions (e.g., before his intake session, after his third therapy session, and before his sixth and final therapy session). The RCI was calculated using pre, mid, and post mean ratings for each CCAPS-62 subscale. Cutoff scores were also calculated using means and standard deviations from normal and clinical populations, which were provided by the Center for Collegiate Mental Health (CCMH) annual report (2010). The client's scores on some subscales (e.g., Social Anxiety, Eating Concerns, Hostility, and Substance Use) post treatment fell below cutoff points, suggesting the client ended treatment closer to the normal population than to the clinical population for those subscales. Results from the RCI suggest the client demonstrated reliable change on the Depression, Academic Distress, Family Distress, and Substance Use subscales from pre to mid treatment and on the Depression, Generalized Anxiety, Social Anxiety, Academic Distress, Family Distress, and Substance Use subscales from pre to post treatment.

Table of Contents

BRIEF PSYCHODYNAMIC THERAPY WITH A TRADITIONAL COLLEGE STUDENT DIAGNOSED WITH ADJUSTMENT DISORDER: A CASE STUDY

Introduction

Case Study

Overview. Psychotherapy research has appeared to gain new interest in being able to study an individual case more in depth (Rice & Greenberg, 1984; Scruggs & Mastropieri, 1998; Yin, 2009). When conducting research, case studies, also referred to as single-case designs, can evaluate interventions' effects and can examine questions often developed from between-group studies. Single-case designs are considered to be true experiments and have the capability of demonstrating causal relationships and ruling out threats to validity. Single-case designs are able to make inferences about interventions' effects by comparing different conditions that are usually presented to a singular participant over time (Brockardt et al., 2008; Kazdin, 2022; Yin, 2009). An example of a case study includes research conducted by Watson and colleagues (2002) where they used an effective program on a single nine-year-old boy in order to eliminate thumb sucking behaviors.

In single-case designs, a participant's performance is usually observed repeatedly over time. This allows the investigator to study the pattern of the participant's performance initially, before the intervention is introduced, which is referred to as the baseline phase. After the intervention has begun, the investigator can then study changes and if those changes occur in relation with the introduction of the intervention (Brockardt et al., 2008; Kazdin, 2022; Scruggs & Mastropieri, 1998; Yin, 2009). In single-case designs, the examiner holds the ability to further examine the processes that help to promote therapeutic change by analyzing the interaction between the therapist and client (Greenberg, 1986). This ability to further examine the

interaction between the therapist and patient allows the examiner to have a better understanding of the processes that encourage therapeutic change and allows for effective clinical treatments to be examined (Jones, 1993).

According to sources (Brockardt et al., 2008; Kazdin, 2022; Yin, 2009), data gathered during the baseline phase can inform the investigator about the participant's current level of functioning and the severity of the behavior needing to be changed. Multiple data points during the baseline can also predict the participant's behavior if the intervention were not introduced. However, it is possible that participants' behaviors could change over time without any interventions. In order to be sure of future performance, baseline data would need to be continuously collected before introducing the intervention, which cannot always be done given the purpose of therapy - to provide therapeutic interventions (Brockardt et al., 2008; Kazdin, 2022; Yin, 2009).

When reviewing the data once plotted on a graph, the line on a graph shows the direction of the data points collected, which is referred to as a trend line. During the baseline observation period, data might show a horizontal trend line that shows the behavior is remaining steady over time, neither increasing nor decreasing. After the intervention has begun, a decelerating trend line would demonstrate the problematic behavior has decreased. Alternatively, an increasing trend line would demonstrate the problematic behavior has increased (Brockardt et al., 2008; Kazdin, 2022).

Strengths and limitations. Single-case designs have provided researchers with solid methodology that has been utilized in countless studies over the span of several decades (Kazdin, 2022; Yin, 2009). Single-case designs have examined psychological processes in research with both animals and diverse human populations. Single-case designs have been used with

participants ranging from infancy through late adulthood; participants who had clinical presentations ranging from conduct disorder, autism spectrum disorder, substance use disorders, and anxiety disorders; and participants in settings ranging from educational settings, home settings, military settings, college dorms and athletics, and more. It is from these single-case designs that evidence-based interventions have emerged (Kazdin, 2022). In fact, many early breakthrough discoveries in psychological science were the result of single-organism methods (Ebbinghaus, 1913; Pavlov, 1927; Skinner, 1938; Watson, 1925).

Over the last few decades, psychotherapy research has experienced a revived interest in these intensive individual case studies. This revival of case studies has been influenced by multiple factors both in clinical research and clinical practice (Jones, 1993). To begin, there has been more consideration of controlled clinical trials' limitations for being able to provide information about how clients change through psychologically mediated interventions and more acknowledgment that being able to understand the processes that develop therapeutic change requires closely analyzing the therapist-patient relationship and interaction (Greenberg, 1986). Notably, multiple researchers over time have shown interest in how laboratory-validated interventions end up translating to clinical practice (Jacobson & Christensen, 1996; Westen & Bradley, 2005; Westen, Novotny, & Thompson-Brenner, 2004). Additionally, there is the demand to test clinical theoretical models. Last but certainly not least, is the notion that psychotherapy research has previously had little influence on theory building and clinical practice (Jones, 1993). However, the case study method establishes itself in naturalistic observations and still upholds the primary means of clinical inquiry, teaching, and learning in psychotherapy (Jones, 1993).

In line with this renewed interest in case studies, the American Psychological Association's (APA's) Division 12 Task Force on Promotion and Dissemination of Psychological Procedures has specifically named time-series designs as important methodological approaches that can properly test treatment efficacy and/or effectiveness (Chambless & Ollendick, 2001). Additionally, the APA Task Force on Evidence-Based Practice (2005) even endorsed single-case studies as contributing to effective psychological clinical practice. Despite this endorsement, and even with sincere interest in learning what works for their clients, clinicians are still sometimes intimidated by research and are often unfamiliar with the single-case time-series option (Borckardt et al., 2008).

When considering the single-case design, it is important to note both its advantages and disadvantages. According to Kazdin (2022) and Yin (2009), one of the biggest concerns discussed about single-case studies is its external validity. Specifically, the concern is about whether or not the findings from single-case studies are generalizable to others. Searle (1999) also notes concern about the generalizability of the results, given the individual being studied could be atypical. However, single-case design research has long been connected with interventions created from both human and nonhuman animal research, which have shown to be widely generalizable. Single-case design research findings have demonstrated interventions that are widely applicable (Kazdin, 2022). When discussing concerns of generalizability, it is also important to remember that both between-group and single-case designs face challenges with this issue of generalizability. In both instances, a key solution is being able to replicate findings with new participants, though between-group studies typically handle concerns regarding the generalizability of findings better than single-case studies. Because between-group designs often study moderators, which are variables that might influence the direction or magnitude of change,

this helps investigators to better understand the generalizability of the intervention utilized in the study based on participants' characteristics (Kazdin, 2022).

Additional disadvantages of single-case designs include the difficulty for the investigator, who is often the therapist, to remain objective if the nature of the work requires a large amount of contact with the participant being studied. It is also possible that the investigator is selective about what appears in the final report (Searle, 1999). If a case study includes retrospective material, it is possible that this information is not accurate. For example, it can be difficult to determine if an adult's recollection of early childhood events is indeed accurate or not (Searle, 1999). There are also concerns about if client's improvements during treatment were in fact actually because of the treatment implemented or because of some external factors in the client's environment and independent of the client and treatment altogether. Even when alternative explanations can be ruled out and the intervention appears to be the cause of improvement, it can be difficult to determine what features of the intervention can actually account for the improvement (Borckardt & Nash, 2008).

Despite these limitations of single-case designs, they still have multiple strengths and contributions unique to single-case designs that are worth noting. First, single-case designs expand the scope of opportunities for the study of intervention programs in normal everyday life as administered relative to diverse goals, settings, and domains (Kazdin, 2022). Single-case designs offer rich, in-depth insight into an individual or group that is usually far more detailed and recognizes the uniqueness of individuals. Single-case designs also acknowledge the importance of the subjective feelings of the participants being studied as well as can sometimes highlight extraordinary behaviors and even open new areas of study (Searle, 1999). This was demonstrated by Skeels (1966) when research on deprived babies revealed that intelligence

scores are not set at birth but can indeed be impacted by life experiences. Single-case designs can also be pooled together to create a large amount of detailed information that can then be sorted and analyzed, which can then highlight variables to be further studied. Single-case designs are valuable exploratory tools that can lead to the generation of hypotheses for future research (Kazdin, 2022; Searle, 1999; Yin, 2009).

Additional advantages of single-case designs include how they can provide a way to evaluate change and the impact of interventions for a single participant without needing to accumulate a large number of participants and then assign these participants to different control or comparison groups. In this sense, single-case designs can provide a method of evaluating change and impact of interventions for a particular participant or a particular setting. Single-case studies are able to address the danger of believing someone is making a difference without ever actually evaluating to see if one has indeed made a difference (Kazdin, 2022; Yin, 2009).

According to Kazdin (2022) and Yin (2009), single case designs also allow for an intervention to be gradually implemented on a small-scale before applying it to a larger scale. This allows for an intervention to be tried and then modified as needed before applying the intervention to a larger group or to other individuals. During between-group research, the intervention is pre-planned and administered in full to keep with the plan. The impact of the intervention is then evaluated at the end of treatment during the posttest assessment. During single-case designs, ongoing feedback is provided and can allow for informed decision making to help clients while the intervention is still in effect. This ongoing assessment during the intervention phase of treatment helps to make single-case designs user-friendly to both the investigator and to the participant (Kazdin, 2022; Yin, 2009).

Kazdin (2022) highlights single-case designs also allow investigators the chance to examine rare presentations within individuals who would not likely be studied in between-group research. Often times, an individual could be presenting with a primary concern that is not rare but is entangled with other conditions or circumstances that would make it difficult to do a group study to develop or test an intervention on that individual. Single-case studies, however, allow for exactly that. In single-case studies, examiners are able to research and study an individual with a rare primary concern, or an individual with a common primary concern that is entangled with other challenging conditions and circumstances, to develop or test the effectiveness of an intervention (Borckardt et al., 2008; Kazdin, 2022; Yin, 2009).

Single case design methods. When conducting a single-case study, multiple methods may be utilized, such as time series analysis, reliable change index (RCI), or percentage of nonoverlapping data (PND). A time-series analysis allows investigators to regularly track symptoms of one, or a few, clients across baseline and intervention phases in hopes to produce data that address whether and when an intervention is effective (Borckardt et al., 2008; Kazdin, 2022).

There are multiple types of time-series analyses that all share the fundamental feature of tracking change in at least one target symptom across phases and examining if there is a relationship between implementing the intervention and the status of the target symptom. The simplest time-series analysis includes just two phases: the pretreatment baseline phase, referred to as phase A, and the treatment phase, referred to as phase B (Borckardt & Nash, 2008; Kazdin, 2022). Another variation of this time-series analysis includes four phases: phase A, phase B, followed by another phase A and phase B. This design is similar to the simple A-B designs and tracks the impact of an intervention on the target symptom but is then followed by a 3rd phase

where the intervention is no longer implemented before then being resumed in the 4th and final phase. By examining a client's data from the baseline and treatment phases, researchers then may have the ability to determine if a client has made statistically significant change when comparing the baseline and treatment phases (Borckardt & Nash, 2008; Kazdin, 2022).

This design is able to nicely address questions of cause and effect. Improvements made during the first intervention phase, however, do not always decline when the intervention is taken away. The goal of therapy, after all, is for clients to continue making improvements even after they have terminated from therapy. Additional notable limitations of this design include the ethical question of removing an intervention that is helping a distressed client as well as the logistical reality of clients being understandably hesitant to agree to discontinue an intervention that is working for them (Borckardt & Nash, 2008; Kazdin, 2022).

In addition to time-series analysis, percentage of nonoverlapping data is another method utilized when conducing single-case studies. To calculate the PND, the investigator draws a line through the most extreme data point from the baseline phase that follows the expected direction of treatment effect and extends through the treatment phase (Scruggs & Mastropieri, 1998). Once data is collected and visually analyzed, the portion of plotted data points in the treatment phase that do not overlap with plotted data points from the baseline phase are considered to be statistically reliable (Kazdin, 1978).

One notable advantage of the PND approach includes its ability to provide meaningful information about the intervention's effectiveness through a visual presentation of data points Additionally, PND combining efforts are seen as generally accurate reflections of the research studies they review (Scruggs & Mastropieri, 1998). Despite these notable strengths, some investigators have still argued that PND is not able to accurately represent the experiment,

stating that reducing data to one-number summaries of overlap seen across data abandons some of the most interesting information (Salzburg et al., 1987). Additional concerns have been raised about the PND method not adequately assessing meaningful trends in the data (White, 1982), the PND method not being sensitive to powerful treatment effects (White et al., 1989), and that PND statistics effect size estimates may approach 0.0 with more and more observational data, regardless of treatment efficacy (Allison & Gorman, 1994).

Another popular method used in single-case studies, and the method that will be utilized in the current study, is the reliable change index. According to De Souza Costa and Jardim de Paula (2015), the RCI is a statistical procedure that allows investigators to compare two psychometrically derived scores from items such as scales, tests, or questionnaires. The RCI evaluates whether a client's score's difference at two points in time is more likely to be explained by measurement error or if it is because of real significant change. Mathematically, the RCI can be defined as a client's change in score on a psychometrically supported measure divided by the standard error of the difference, which is dependent on the psychometric measure's standard error. The psychometric measure's standard error includes the standard deviation from the normative sample and the test-retest reliability. The results of this mathematical equation represent a standard score (De Souza Costa & Jardim de Paula, 2015).

To understand the RCI, we must first understand that there are multiple ways to identify variability in treatment response and to determine if changes are clinically significant, which is typically demonstrated when the client returns to normal functioning (Jacobson et al., 1999). For any individual, the magnitude of change should be statistically reliable and should be further than the range of what might reasonably be associated to chance or measurement error. This results in a two-part criterion for clinically significant change. First, the magnitude of change has

to be statistically reliable. Second, by the end of therapy, clients must end up in a range that shows them as indistinguishable from the population classified as normal functioning. Clients who show statistically reliable change and who end within normal limits on the variable of interest are classified as recovered; clients who show statistically reliable change but are still somewhat dysfunctional and not within normal limits are classified as improved but not recovered; and clients who end in the functional range but do not show statistically reliable change are unable to be classified. Being able to apply this to treated clients allows one to identify the percentage of clients who recovered, the percentage of clients who improved but did not recover, and the percentage of clients who remained unchanged or regressed (Jacobson et al., 1999).

In order to demonstrate that a client has moved from the dysfunctional to the functional range of functioning over the course of therapy, three mathematical criteria were proposed in the form of cutoff points (Jacobson et al., 1999). Cutoff point A is achieved when the client's level of functioning falls outside the range of the dysfunctional population, with range being defined as 2 standard deviations more than the population's mean in the direction of functional behavior. Cutoff point B is achieved when the client's level of functioning falls within the range of the normal population, with range being defined as 2 standard deviations less than the normal population's mean. Cutoff point C is when the client's level of functioning suggests that they are statistically more likely to be among the functional population than they are to be with the dysfunctional population.

Preferably, cutoff points are based on norms collected for both dysfunctional and normal populations. If the cutoff point is crossed when therapy is terminated, then the client can be labeled as recovered. If the cutoff point is not crossed at the termination of therapy, then the

client can be labeled as still dysfunctional, regardless of if the change was statistically reliable or not. The RCI then, as the second criterion for determining clinically significant change, is utilized to ensure that the magnitude of change exceeds the margin of measurement error by diving the magnitude of change during therapy by the standard error of the difference score (Jacobson et al., 1999).

When using the RCI method, there are some noteworthy strengths and weaknesses that should be taken into consideration. Jacobson and Revenstorf (1988) identified conditions where the RCI was either irrelevant or misleading as a criterion for defining clinically significant change. Jacobson and Revenstorf (1988) explained the RCI method is irrelevant for any clinical data that surpasses the cutoff point because that alone defines a magnitude of change that is only possible with statistically significant change. Thus, the RCI is no longer necessary to determine clinically significant change. They also argued that the RCI method is misleading when used on its own for clinically significant change, without using cutoff points. It is important to note that when the RCI is used on its own, cannot determine if the change was clinically significant (Jacobson & Revenstorf, 1988).

Additional weaknesses include the RCI method working best only when adequate norms are available for both normal and dysfunctional populations as well as the concern over having discrete cutoff points, although Jacobson and Revenstorf (1988) suggested that by forming confidence intervals around cutoff points, one could define boundaries of these intervals using the RCI, allowing participants who fell outside the boundaries to be reliably classified and participants who fell inside the boundaries to not be reliably classified. Additionally, the RCI method is not able to establish a causal relationship between the intervention being used and the outcomes this treatment may be associated with. The RCI method is not able to determine

clinically significant deterioration. Although the RCI is necessary when crossing a cutoff point, it does not prove that change is real by itself and cannot be used to validate a measure (Jacobson et al., 1999).

Despite these limitations, the RCI method is one of the favored methods to evaluate significant changes associated with both psychotherapy and psychopharmacological treatment, as it supplies a combination of both statistical and clinical components. It has been referred to as a useful method to define the favorable outcome of an intervention on an individual clinical basis and has been highly recommended as being able to objectively describe improved symptoms beyond measurement error. Overall, the RCI is known as a solid method to measure changes in symptoms in both psychiatric and psychological interventions (De Souza Costa & Jardim de Paula, 2015).

Client Information

Presenting concerns. Client is an undergraduate student at a small university in Indiana in his early twenties. He identifies as a white gay cisgender male. Client attended his intake session in February 2020. He presented with concerns about "past issues" that had recently resurfaced, as well as with adjustment related concerns. He reported that he found himself dwelling on his past experiences and identified having a turbulent previous month because of the big changes that had reportedly taken place in his life, which he noted as unwelcome changes.

Client reported that the following changes had recently taken place in his life: his family, who was previously ten minutes away from him, moved twelve hours away from him and left him feeling lonelier than before; he recently quit his job, which he had held for four years; his lifelong high school friends all moved away; he was placing more focus on his personal life; and he recently learned his mother was very ill, which was reportedly extra stressful for the client

because of his mom's reported fear of doctors that acted as a barrier to her receiving the proper medical help. During the intake, client reported feeling "bogged down" and identified having many interpersonal stressors. He stated it was hard to stop thinking about some of his past interpersonal experiences (e.g., his relationship with his ex-boyfriend) to the point where his sleep, focus, homework, and social life were being negatively impacted. He reported feeling "melancholy" and stated sleeping approximately two to five hours of sleep each night, with reported difficulty falling asleep at night. Client reported eating two meals per day, endorsed a normal appetite, and denied any disordered eating behaviors.

At the time of the intake, client stated that he wanted to continue with therapy to explore the possibility of medication. During the first therapy session, client was unable to identify any goals for treatment and identified he was attending therapy because of a friend who had referred him for services. Client provided verbal and written consent for his information to be used for this case study.

Developmental/Social History. Client is reportedly the oldest of three children, with his parents married and living together. Per client report, his brother is 6 years younger than him and his sister is 12 years younger than him. He reported that his relationship with his parents has fluctuated over the years and is currently "not at its best". He identified that his family's recent move has been challenging for them and has negatively impacted his parent's relationship with one another. Client identified having a closer relationship with his mother than his father. Because of client's mother's reported illness and her "fear of doctors", client reported often worrying about her. Client reported never feeling close to his father and identified his father as a "disciplinary figure" rather than a father figure. Client's father, per client report, has been

diagnosed with “Bipolar”, which has made it difficult for client to be able to navigate any relationship with his father.

Client reported having a “good” relationship with his siblings but did not elaborate on their relationship any further. He identified his support system as his fraternity brothers and reported enjoying living in his fraternity house because he felt supported there. Client is currently single, but he did report one previous serious relationship, which will be discussed in more detail in the trauma history section below.

Trauma History. During the intake, client reported witnessing his father physically abuse his mother when he was 8 years old. He stated that he went to stay at his grandmother’s house, which was reportedly close by, after the incident and reported that the incident was reported to the police. He reported remembering that his father had to go to court but denied being able to remember any further details.

Toward the end of treatment, client also identified being in a previous relationship that was traumatic for him. He reported meeting this individual, who client identified as a male, soon after graduating high school. He noted dating this male for approximately one year over the course of his freshman year in college. During this relationship, client reported doing things he would not normally do to make his boyfriend happy. For example, he reported his boyfriend did not want their relationship to be monogamous, so client agreed to a non-monogamous relationship in an effort to make his boyfriend happy. He even stated he switched college majors because of the pressure his boyfriend put on him. Client reported that this relationship was overall very bad for him and identified that during his relationship he had isolated himself from all his other friends. Client identified only having his boyfriend and his family at that time.

During client's relationship with this boyfriend, he reported experiencing a traumatic "interaction" with another male. Because his boyfriend did not want their relationship to be monogamous, client reportedly often felt pressure to also have relations with other men. This led client to be intimate with someone he did not know but had been talking to online. Client said that when he first met this person face to face, he immediately knew they were not who they claimed to be. Client identified feeling fearful but reported not knowing how to actually stop the interaction from taking place. He described that this interaction as mildly violent and painful, but again reiterated that he was unsure how to ask the other individual how to stop. Client reported that the interaction resulted in multiple wounds on his back, which resulted in the client bleeding afterward. He described himself as feeling more scared than ever that night. Client noted he has not had any contact with that individual since the interaction. He reported that he tried to move past this situation by "throwing" himself into his relationship with his boyfriend, but he identified still feeling guilty and mortified about the event that occurred. After this event, client reported he continued to be intimate with his boyfriend out of fear of losing his attention to the other men his boyfriend was being intimate with, although he reported he did not enjoy the intimacy.

Medical/Mental Health History. Client denied any significant medical history but did endorse family history of multiple sclerosis on his mother's side of the family and history of heart disease on his father's side of the family. Client reported this to be his first time in therapy, though he endorsed a history of "anxiety, trauma, and depression". He also reported being prescribed anti-anxiety medication by his primary care physician in spring 2017 for six months. He reported one previous suicide attempt in 2019 but denied any hospitalizations because of mental health concerns. Client reported a history of depression on his father's side of the family,

with his father reportedly being diagnosed with and medicated for Bipolar Disorder. He also identified that his paternal great grandparents, his paternal great aunts, and his paternal great uncles all died by suicide.

Self-Harm/Suicidal Ideation History. During the intake, client endorsed a sporadic history of self-harm, specifically cutting. He identified that this behavior began first in high school and resurfaced in September 2019. He reportedly typically cuts his upper arm. His last time cutting was reported to be right after Christmas 2019. Client identified that after cutting himself, he often felt less frustrated and less agitated long enough for him to be able to fall asleep. Despite reporting occasional thoughts of wanting to cut himself, client denied any cutting behaviors while in therapy. Client also reported recurrent suicidal thoughts at least once per day, usually at night, which he reported often preoccupy him. Client described these suicidal thoughts as usually thinking about cutting deeper and in different spots and by imagining how everything would just be gone.

Client's noted suicide attempt in 2019, which was mentioned above, reportedly happened when he was lying in his bedroom in the dark, was "thinking about things", and was feeling particularly frustrated with his inability to get out of his thoughts. He claimed he tried to "slice [himself] deeply" on his left wrist. He denied going to the hospital because of his cut, but instead reported that he cleaned himself up, went to bed, woke up the next morning and went to class like he usually did. He denied any suicide attempts as well as any intent to complete suicide over the course of therapy. Client identified his fraternity brothers as protective factors and reported one of his close friends, who eventually became his roommate, removed all sharp objects from his room so he could not use them to cut himself.

Diagnosis. Based on the client's presenting concerns and history, the client was diagnosed with 309.28 (F43.23) Adjustment Disorder with mixed anxiety and depressed mood. This is supported by the client's report of all the recent changes he was experiencing in his life within the past 3 months, such as his family moving, his friends moving, learning his mother was sick, and him quitting his job, that were causing the client significant emotional distress that seemed more severe than expected. Although client reported a history of "anxiety, trauma, and depression" and reported a history of self-harm and suicidal thoughts, the client's primary presenting concerns for current treatment were related to his adjustment related difficulties. Per the client's report, he was experiencing challenges related to coping with recent changes in his life, thus leading to a diagnosis of AD.

At the time of diagnosis, the therapist differentiated between several other mental health diagnoses, such as Generalized Anxiety Disorder (GAD), Major Depressive Disorder (MDD), and PTSD. GAD is often characterized by feelings of excessive worry most days over the course of six months. During these six months, individuals with GAD typically experience symptoms such as restlessness, fatigue, trouble concentrating, irritability, muscle tension, and trouble sleeping. Individuals with GAD may experience symptoms for as little as six months or as long as years at a time (American Psychiatric Association, 2022). Although this client reported experiencing periods where he was unable to control his worry, he reported this to only occur occasionally rather than more days than not. The client also reported trouble falling asleep at night, but he did not endorse other symptoms characteristic of GAD over the course of the previous six months, such as feeling restless or fatigued, trouble concentrating, irritability, or muscle tension occurring more days than not. Further, the client endorsed often feeling worried about specific stressors rather than in general about a number of different activities.

MDD is characterized by the presence of five or more symptoms over a two-week period, with at least one of the symptoms including depressed mood or loss of interest. Additional common symptoms of MDD include changes in weight and/or appetite, trouble sleeping, psychomotor agitation, fatigue, feelings of worthlessness, feelings of hopelessness, trouble concentrating, and thoughts of death. Similar to GAD, MDD can last anywhere from as little as two weeks to months or years at a time (American Psychiatric Association, 2022). Although this client reported having a "melancholy" mood and feeling "bogged down" occasionally, he did not endorse these to be present more often than not. This client also failed to endorse any changes in weight or appetite nor any feelings of psychomotor agitation, fatigue, or feelings of worthlessness or hopelessness. The client had a history of suicidal ideation, but he only reported passive suicidal ideation during the first and sixth therapy sessions and denied any suicidal ideation, active or passive, throughout the rest of treatment.

The final differential diagnosis considered, PTSD, occurs after an individual has either experienced or witnessed a traumatic event, such as actual or threatened death, serious injury, or sexual violence. Individuals with PTSD experience various symptoms from separate clusters, such as intrusive symptoms associated with the traumatic event, avoidance of triggers related to the traumatic event, negative changes in mood and thoughts related to the traumatic event, and increased reactivity and arousal. These symptoms typically last at least for 30 days one month following the traumatic event occurred and can last for several months or years at a time (American Psychiatric Association, 2022). During his fifth therapy session, this client disclosed a history of sexual abuse occurring approximately two years prior. However, the client did not endorse intrusive symptoms related to the abuse, nor did he report any feelings of increased reactivity or arousal.

Therefore, given client's presentation and report of symptoms and the nature of adjustment related concerns as they relate to college students, AD with mixed anxiety and depression appeared to be the best fit for this client. Because of the additional symptoms the client was reporting, such as low mood and feeling down and trouble with feeling nervous and worried, the addition of the specifier with mixed anxiety and depressed mood was included to account for the client's feelings of anxiety and depressed mood. This allowed the client's diagnosis to encapsulate those symptoms that otherwise did not meet full criteria for additional diagnoses.

Adjustment Disorder

Adjustment disorder background and symptoms. AD is a severe reaction to an identifiable stressor or stressors (American Psychiatric Association, 2022; O'Conner & Cartwright, 2012; Carta et al., 2009; O'Donnell, et al., 2019). These different stressors that result in AD can appear as minor stressors to some but can be majorly distressing to the individual who experiences the stressor themselves. It is critical that clinicians, as well as other observers, recognize the importance of how stressors are perceived by the individual rather than how the stressors may appear to others. Among stressors, continuous stressors are considered more likely to cause AD, although O'Conner and Cartwright (2012) highlight that the effects of AD are often moderated by social support.

AD was first introduced into the third edition of the DSM (American Psychiatric Association, 1980). It then appeared in the DSM-IV-TR (American Psychiatric Association, 2000) with minor changes made to the disorder and now appears in the current DSM-5 TR (American Psychiatric Association, 2022) with the following diagnostic criteria:

A) The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s); B) These symptoms of behaviors are clinically significant, as evidenced by one of both of the following: 1) Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation, 2) Significant impairment in social, occupational, or other important areas of functioning; C) The stress-related disturbance does not meet criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder; D) The symptoms do not represent normal bereavement; and E) Once the stressor or its consequence have terminated, the symptoms do not persist for more than an additional 6 months (American Psychiatric Association, 2022, pg. 1133-1134).

AD has the following six subtypes: AD with depressed mood, AD with anxiety, AD with mixed anxiety and depressed mood, AD with disturbance of conduct, AD with mixed disturbance of emotions and conduct, and AD unspecified (American Psychiatric Association, 2022).

According to the American Psychiatric Association (2022), AD is a common diagnosis, with roughly 5% to 20% of individuals in outpatient mental health treatment settings having a principle diagnosis of AD. AD can occur at any point in an individual's life span, although young people are reportedly more vulnerable to the disorder because of their less well-developed coping skills and resources (O'Conner & Cartwright, 2012). The prevalence of AD in child and adolescent community samples fluctuate between 2% and 8% (American Psychiatric Association, 2000; Strain & Newcorn, 2003). AD appears to be more common among

disadvantaged persons (Vanin, 2008) and among individuals who have previously experienced trauma (O'Conner & Cartwright, 2012).

Among individuals diagnosed with AD, their symptoms can widely vary. Some of the emotional and cognitive symptoms of AD could include hopelessness, sadness, lack of enjoyment, crying episodes, anxiety, irritability, suicidal ideation, worry, difficulty concentrating, and feeling overwhelmed. Some of the behavioral symptoms of AD could include sleep disturbances, fighting, reckless driving, mismanaging finances, truancy, and vandalism. Additionally, AD can have negative effects on close relationships, performance at school and work, and parenting (Carta et al., 2009; O'Conner & Cartwright, 2012). AD has come to be known as the cornerstone between major psychiatric disturbance and normal functioning. Strain and Diefenbacher (2008) further elaborate that AD straddles the border between normal and significant distress experienced when faced with acute and chronic stressors. Because of this, less research has focused specifically on AD than other Diagnostic Statistical Manual (DSM) disorders (Carta et al., 2009; O'Conner & Cartwright, 2012).

Empirical support for treating adjustment disorders. When considering how to effectively treat individuals with AD, interventions are necessary to ease distress and to reduce the risk of suicide and future psychopathology, especially with younger individuals. Primary goals of interventions specific to AD include symptom relief, restoring typical functioning, and preventing the development of more serious disorders. Additional treatment goals might include helping clients understand their roles in stressful life events, reviewing and reinforcing positive steps clients take to deal with stress, learning to avoid and cope with stressors, and helping clients perceive their experiences as opportunities for growth and development (Carta et al., 2009; O'Conner & Cartwright, 2012).

Some of the recommended interventions for individuals with AD include support groups, individual therapy, and family therapy. Time-limited, or brief, interventions that support the client's attempts to identify and understand stressors, to establish and strengthen coping skills, and to build supportive relationships are desirable. Furthermore, it is important that interventions be specifically tailored to each individual depending on their current and previous difficulties (Carta et al., 2009; O'Conner & Cartwright, 2012).

Despite the apparent need for effective interventions for individuals with AD, not many treatment outcome studies for AD exist in the literature, especially when compared to the extensive literature that exists for other disorders (Carta et al., 2009; O'Conner & Cartwright, 2012; Zelveine & Kazlauskas, 2018). Multiple factors can help to explain the lack of research pertaining to AD. First, by definition, AD is a brief disorder that is a reaction to stressors and often fades on its own (O'Conner & Cartwright, 2012). Because ADs are often short-lived and can resolve on their own over time, this may explain the lack of including AD in various research studies (Carta et al., 2009).

AD can involve a wide range of stressors, which makes the population of individuals who meet criteria for AD largely heterogeneous. Furthermore, individuals with AD are occasionally a part of treatment outcome studies focused on related disorders when they have related symptoms, such as depression or anxiety. It is possible that these different factors led potential researchers to conclude that treatment outcome studies specific to AD are either difficult, unjustified, or unnecessary because interventions that are effective for other DSM disorders should also be effective when treating less severe versions of the same symptoms that develop in individuals with AD (O'Conner & Cartwright, 2012).

Contrary to this belief of ADs being short-lived and able to resolve over time is a study conducted by O'Donnell and colleagues (2016) that found trauma survivors diagnosed with AD three months after the trauma exposure were 2.67 times more likely to eventually meet criteria for additional, more severe, mental health disorders after 12 months when compared to individuals who had no AD diagnosis at 3 months post-exposure. This study (O'Donnell et al., 2016) provides support for effective intervention for individuals diagnosed with AD, rather than simply allowing time to resolve the matter on its own.

Among current research, psychotherapy stands as the preferred treatment for AD (Kaplan & Sadock, 1998). However, a lack of controlled clinical trials of different psychotherapies makes it challenging to answer which form of psychotherapy may be most effective (Carta et al., 2009). Few between-group studies for AD have been conducted thus far. Some current studies, which provided support for treatment of AD and demonstrated a decrease in reported symptoms, have included a variety of therapeutic approaches, such as cognitive-behavioral therapy (Steinhardt & Dolbier, 2008) and brief group psychodynamic therapy (Ben-Itzhak et al., 2012).

Maina and colleagues (2005) acknowledged the effectiveness of brief dynamic psychotherapy and of brief supportive psychotherapy when treating minor depressive episodes. Although this study did not examine the effectiveness of brief psychodynamic therapy in AD, it provides possible direction for future studies given the overlap between AD and depressive diagnoses (Maina et al., 2005). Another study found interpersonal psychotherapy to be effective when working with patients who were human immunodeficiency virus (HIV)-positive with depressive symptoms (Markowitz et al., 1998).

Brief Psychodynamic Therapy

Qualities of brief psychodynamic therapy. When discussing brief psychodynamic therapy, it is important to acknowledge that it is a modification from traditional psychodynamic therapy (Levenson, 2017). As a modification from traditional psychodynamic therapy, brief psychodynamic therapy leans on different common components of psychodynamic theories, like the importance of childhood experiences and developmental history (Fonagy, 1999), unconscious influences on behavior (Freud, 1900), repetitive behavior, transference and countertransference (Freud, 1936), the role of conflict (Freud, 1931), and the therapeutic alliance. A therapist working within a brief psychodynamic therapy model, compared to a therapist working within a traditional psychodynamic therapy model, is more likely to highlight client's strengths and resources when facing life issues instead of focusing on regression and fantasy. Because of this difference, some popular psychodynamic techniques, such as lying on a couch or free association, are not utilized (Levenson, 2017; Strupp & Binder, 1984).

According to Levenson (2017) and Strupp and Binder (1984), another modification made from traditional psychodynamic therapy in brief psychodynamic therapy is the greater emphasis placed on the client's present life rather than their previous childhood life. In addition to using modified psychodynamic interventions, brief psychodynamic therapy also utilizes techniques from other therapeutic models, such as experiential-process therapy and cognitive-behavioral therapy (Abbass, 2015; Fosha, 2000; Lilliengren et al., 2016; McCullough & Magill, 2009; Safran & Muran, 2000). Although the brief psychodynamic therapist might think and conceptualize psychodynamically, they are free to use a variety of intervention strategies (Levenson, 2017).

Messer and Holland (1998) acknowledge that there are several different models of brief psychodynamic therapy. Some brief psychodynamic therapies have been developed primarily

from ego psychology and drive theory (Freud, 1923), and typically focus on conceptualizations that highlight aggressive, sexual, and dependent impulses and defenses, as well as oedipal conflicts (Messer & Holland, 1998). Other brief psychodynamic therapies, however, are largely focused on object relations and interpersonal relations, which help to identify problems from a perspective of maladaptive interpersonal patterns (Levenson & Strupp, 1997), focus on client's wishes, responses of others and responses of the self (Luborsky, 1997), focus on schemas and role relationships (Horowitz & Eells, 1997), and focus on problematic beliefs and how they play out between the client and therapist (Curtis & Silberschatz, 1997).

Additionally, Mann (1991) detailed a brief 12 session therapy that consists of ideas stemming from self-psychology, specifically the use of empathy to help heal client's long-standing feelings of pain. Because there are so many brief psychodynamic therapy models to choose from, the current study will focus on a contemporary brief, time-limited psychodynamic therapy, as proposed by Levenson (2017) and originally Strupp and Binder (1984).

There are multiple qualities that help to characterize brief psychodynamic therapy (Levenson, 2017; Levenson et al., 2002; Strupp & Binder, 1984) . The main factor that differentiates brief psychodynamic therapy from long-term psychodynamic therapy is its defined focus. In brief psychodynamic therapy, therapists must focus on a central theme, topic, or problem to help guide their work with their clients because of its brief nature. Additionally, it should be noted that in brief psychodynamic therapy, therapists and clients usually have limited goals. Brief psychodynamic therapy is not meant to be a once and for all "cure" but should provide clients with opportunities to foster changes in behavior, thinking, and feelings as it pertains to the main problem explored in session. Brief psychodynamic therapy should help clients learn more adaptive coping skills, help clients develop better interpersonal relationships,

and/or help client's gain a better sense of one's self. Therefore, brief psychodynamic therapy is seen as a chance for clients to begin a process of change that hopefully persists even after therapy is over (Levenson, 2017; Strupp & Binder, 1984).

Another quality of brief psychodynamic therapy is its time limited nature (Levenson, 2017; Strupp & Binder, 1984). Messer and Holland (1998) described that brief psychodynamic therapy can range anywhere from 1 to 40 sessions, although it appears that most brief psychodynamic clinicians working today set a standard of 12 to 20 sessions as their model (Barber et al., 2013; Levenson, 1995; Strupp & Binder, 1984). Levenson (2017) and Strupp and Binder (1984) explain that brief psychodynamic therapists believe that by limiting the length of therapy sessions clients are allowed, clients are encouraged to have a sense of individuation and autonomy as well as positive expectations for treatment. In fact, there is evidence that providing these shorter time limits could encourage clients who might have otherwise prematurely terminated in a longer, open-ended therapy format to stay in therapy longer until they can successfully terminate (Hilsenroth, Ackerman, & Blagys, 2001). Another common belief among brief psychodynamic therapists is the belief that psychological change happens outside of the therapy room and that by setting time limits on therapy, this actually intensifies the therapeutic work done (Bolter, Levenson, & Alvarez, 1990).

Additionally, in brief psychodynamic therapy, the therapist needs to be an active participant in the therapy process (Levenson, 2017; Strupp & Binder, 1984). It is important for the therapist to remember, however, that activity is only necessary in order to maintain the focus of therapy, to foster a positive therapeutic alliance, and to make progress within their allotted time. This requires the therapist to have an awareness of the therapy goals and a plan for how to achieve them, all while remaining sensitive to the client's presentation and to the context of the

clinical material. A therapist's activity in sessions can range from supportive interventions such as validation, reassurance, and strengthening adaptive defenses to more exploratory interventions such as confrontation and interpretation. The therapist's level of activity should be dependent on the different factors during the session, such as the strength of the therapeutic alliance, and on the characteristics of the client, such as their psychological health and their quality of interpersonal relationships (Levenson, 2017; Strupp & Binder, 1984).

An additional quality of brief psychodynamic therapy is the therapeutic alliance, which has commonly been thought to include the emotional bond between therapist and client, the agreement on treatment goals, and the agreement on the plan on how to accomplish those treatment goals (Levenson, 2017; Strupp & Binder, 1984). The strength of the therapeutic alliance, especially from the client's view, has been consistently shown to be one of the strongest components in predicting treatment outcomes (Martin, Garske, & Davis, 2000; Zilcha-Mano, Dinger, McCarthy, & Barber, 2014). Furthermore, Heinonen and colleagues (2014) discovered that therapists with an engaging and encouraging relational style with their clients were able to foster working alliances with their clients, especially in the case of short-term therapies. Being able to develop a positive therapeutic alliance as quickly as possible is important in all therapy models but is especially important when working with a brief therapy model where the therapist might have fewer chances to repair any ruptures in the therapeutic relationship (Levenson, 2017; Strupp & Binder, 1984).

According to Levenson (2017) and Strupp and Binder (1984), some additional qualities of brief psychodynamic therapy include the important ability of the therapist to quickly formulate the client's case and begin intervening and the therapist's necessary willingness to terminate with clients in carefully considered style because of the short-term nature of the

therapy. The final major difference between long-term psychodynamic therapy and brief psychodynamic therapy includes the idea of establishing a therapeutic contract. Although the specifics of contracts vary and are not always written and should not necessarily be considered as legal contacts, there needs to at least be a mutual understanding between the therapist and client that their work together will be time limited and focused in scope (Levenson, 2017; Strupp & Binder, 1984).

Theoretical background. It is important to know that this theoretical approach intertwines three different theories: attachment theory, interpersonal-relational theory, and experiential-affective theory. Let us first explore the components of attachment theory, which helps to provide the motivational explanation for brief psychodynamic therapy (Levenson, 2017; Strupp & Binder, 1984).

Attachment theory suggests that infants exhibit a collection of natural behaviors in an effort to maintain physical closeness to caregivers (Bowlby, 1969). From an attachment theory perspective, people are designed to gravitate toward others considered to be older and wiser, especially during times where one feels stressed or threatened. As infants, humans are genetically programmed to seek attention from caregivers they depend on (Bowlby, 1969). One notable name in the attachment theory world, Mary Ainsworth, developed a now famous experiment to examine the attachment patterns of infants called the Strange Situation (Ainsworth, 1967). From this experiment, Ainsworth identified multiple distinct attachment patterns: secure attachment and insecure attachment (e.g., avoidant attachment and anxious-ambivalent attachment).

Another notable name in the attachment theory world, John Bowlby, developed a triad between attachment, separation, and loss that displayed the importance of the emotional quality

of early childhood in order to understand psychopathology (Bowlby, 1969, 1973, 1980). Although attachment initially referred to an infant's proximity seeking, Bowlby later explained how attachment needs and behaviors continue later throughout the life cycle, with even adults turning to other adults, especially in stressful times (Bowlby, 1988).

Bowlby (1988) explains that individuals have this internal psychological organization that consists of very specific features, such as representational models of the self and of attachment figures, that develops over time and is continuously built upon through early life experiences with caregivers. Therefore, a child has both an internalized expectation about how others will treat them and an internalized model of how they see themselves, feel about themselves, and treat themselves based on how they have been treated by others. Bowlby hypothesized that a child with a secure attachment learns to think that there are not any forms of the self that cannot be noticed, responded to, and dealt with (Levenson, 2017; Strupp & Binder, 1984).

Children who do not have a secure attachment, on the other hand, learn that they cannot count on others to keep them safe when they are threatened. Children with an insecure attachment pattern have negative models of the self and/or others. These children have a difficult time being able to correct these negative internalized models because of their difficulties with cognitively and emotionally attending to incoming information that disconfirms their internal model. Because these working models are originated and then maintained out of awareness, this cycle only continues (Levenson, 2017; Strupp & Binder, 1984). Additionally, insecurely attached children's internal working models persist partially because of the ongoing interactions these children have with the very individuals who contributed to this in the first place. For example,

someone who had harsh parents as an infant and child is likely to continue to have those harsh parents through toddler and adolescent ages (Wachtel, 2008).

Bowlby viewed attachment as significant from birth through death, although adults typically do not need the proximity to another human in order to physically survive like infants do (Levenson, 2017; Strupp & Binder, 1984). According to Pietromonaco and Barrett (2000), adults feel secure when their attachment figures confirm they are loved, capable of love, and competent. In time, this sense of security internalizes within adults and is carried with them throughout life. Bowlby (1969) recognized that people, celebrities, and even institutions, as well as the mental representations of these figures, could be identified as attachment figures and sources of comfort to people. Recently, Shaver and Mikulincer (2008) were able to demonstrate that when people were asked to visualize the faces of their attachment figures, this promoted positive feelings, reduced painful feelings, and fostered empathy for those people.

Although there is not a specific attachment therapy approach for adults, there is a lot of importance in the role of attachment theory for therapeutic formulation and intervention (Levenson, 2017; Strupp & Binder, 1984). Bowlby (1988) defined the five following tasks for the therapist to complete throughout therapy: be a trusted aid and provide a secure base so clients can examine the painful parts of their lives; help clients explore their expectations and biases in connecting with others; encourage clients to connect early parenting experiences to current functioning; help clients view the past as it is and help them identify healthier alternative ways of thinking and behaving; and help clients examine the therapeutic relationship as clients' working models of self and others occur in therapy. Additionally, Bowlby (1988) believed that the therapist should explore a client's past only when it is useful in helping to understand the client's current feelings and ways of coping with their interpersonal world.

According to Levenson (2017) and Strupp and Binder (1984), the next theory underlying brief psychodynamic therapy is interpersonal-relational theory, which helps to form the frame for brief psychodynamic therapy. Harry Stack Sullivan is often noted for first acknowledging the importance of the interpersonal dimension for psychotherapy when he pushed for interpersonal relatedness over the previous Freudian position that biological drives determined the development of personality (Sullivan, 1953). Sullivan believed that through interactions with their parents, children develop self-other role relationship patterns, which later emerge in strategies that help one to avoid or manage anxiety and to maintain self-esteem. These strategies are also known as interpersonal coping styles. Sullivan originated the term "participant observer" to explain how in therapy sessions, the therapist is an expert observer that makes note of what is happening during the therapy session, as well as a full participant in the interaction taking place between the therapist and the client.

The interpersonal perspective of therapy mirrors a larger shift taking place in psychoanalytic thinking and practice that was previously usually framed as a one-person, focus within model instead of the current two-person, focus between model (Levenson, 2017; Strupp & Binder, 1984). In fact, Messer and Warren (1995) noticed that most psychoanalytic schools are becoming more relationally oriented and less drive oriented. This increase in using interpersonal perspectives can be seen not only in psychoanalysis, but in other therapy models as well, such as cognitive therapy (Castonguay & Beutler, 2005) and behavioral therapy (Kohlenberg & Tsai, 1991). For a clinician in practice, this change to a more relational approach has wide implications, such as what qualifies as pathology, how one conceptualizes a client and their clinical situation, what interventions might be most helpful, and how outcomes are evaluated (Levenson, 2017; Strupp & Binder, 1984). Pincus and Ansell (2003) acknowledged that the

existence of others and how they help interpersonal learning can have effects on self-regulation, field regulation, and emotion regulation. This brings us to the final component of brief psychodynamic's theoretical underpinnings: experiential-affective theory.

According to Levenson (2017) and Strupp and Binder (1984), the experiential-affective theory is an important component of brief psychodynamic therapy because it focuses on the critical change agent part of the model. For psychodynamic therapies, a key feature has been focusing on affect and emotion expression (Hilsenroth, 2007). Early emotion theorists, such as Frijda (1986), Lazarus (1991), and Tomkins (1963) stressed the functions of emotions as motivating, adaptive, and organizing to oneself and to others. Psychodynamic therapists have long spent time acknowledging and exploring the emotions of their clients, but now practitioners and theorists from other therapeutic orientations are acknowledging the key role emotions have in creating change. Back in 2009, Schore declared that we were in an "emotional revolution". He further explained that within the field of psychology, there had previously been a focus on behavioral and cognitive theories during the 20th century, but during the 21st century the emphasis will increasingly be on emotions (Schore, 2009).

Despite this shifted focus toward emotions, clients are not always consciously aware of their feelings. Therefore, helping clients become aware of their emotions, experience their emotions, and process their emotions are critical components of experiential therapy models (Greenberg, 2012; Greenberg, Rice, & Elliot, 1993). For decades now, being able to be emotionally aware and emotionally intelligent, being able to reprocess emotions, and being able to regulate emotions have been indicated as signs of mental health (Goleman, 1995; Linehan, 1993; Schore, 1994). According to Fonagy, Gergely, Jurist, and Target (2002) and Siegel (2007),

someone's ability to regulate their emotions is heavily motivated by their early experiences with caregivers.

Siegel (2007) proposed that parents who can accommodate their child's emotional state and can stabilize their child's emotions help their child to develop circuits in the brain that promote emotion regulation. This ability to regulate emotions then helps their child to have a source of resilience as they grow, which then evolves into their ability to regulate themselves and engage in empathic relationships with others. This attunement to emotions is not only the pathway to a healthy psychological life, but it may also be the pathway to the development of healthy brain structures and functions and to improved interpersonal and intrapsychic functioning. Once these children who are able to regulate their emotions grow up and have their own children, they can then help build healthy brain structures and functioning in their own children, leading another generation to developing these resilient characteristics (Siegel, 2007).

Additional research has supported the use of experiential-affective therapy. Diener, Hilsenroth, and Weinberger (2007) conducted a meta-analysis that consisted of 10 process-outcome studies and discovered that client improvement was significantly related to the extent that therapists accessed and processed emotional experiences. Lilliengren and colleagues (2016) have suggested that experiential dynamic therapy tend to outperform other active methods of treatment. Additional research has found that the depth of emotional experience during therapy is related to positive outcomes, regardless of the theoretical orientation used and with a variety of disorders (Lilliengren et al., 2016; Thoma & McKay, 2015; Whelton, 2004).

Assumptions and goals. According to Levenson (2017) and Strupp and Binder (1984), one of the basic assumptions of the brief psychodynamic therapy model is the idea that people are naturally motivated to seek out and maintain human relatedness, which can be a major

motivating factor for all human beings. Another basic assumption of the brief psychodynamic therapy model is that maladaptive relationship patterns and their connecting emotions are developed early in life, become schematized, and then underlie many presenting concerns. Often times, how we relate during adulthood connects back to our early relationships with caregivers. These early experiences then form mental representations or working models of someone's interpersonal world. These working models then become the foundation that informs an individual about the nature of human relatedness, their own sense of self, and the actions and behaviors necessary to receive and maintain attention from others.

Additional basic assumptions, according to Levenson (2017) and Strupp and Binder (1984), of brief psychodynamic therapy are as follows: relationship patterns and their connecting emotions continue because they are managed in current relationships and are consistent with the individual's sense of self and others, also known as circular causality; clients are viewed as stuck, not sick; the focus in therapy is on changing maladaptive relationship patterns and their connected emotions; the therapist is concerned with what goes on within the session and between the therapist and client rather than with specific content; the therapist and client focus on one of the client's main problematic relationship pattern; the therapist acts as both an observer and a participant; and the process of change will continue even after the client terminates from therapy.

When it comes to brief psychodynamic therapy, there are two major goals to keep in consideration. The first major goal of this brief psychodynamic therapy model is to provide clients with new experiences within themselves and relationally with others (Levenson, 2017; Strupp & Binder, 1984). By allowing clients to experience this type of experiential learning, they should hopefully encounter healthier and more functional relational interactions that can work to challenge their repetitive maladaptive patterns and promote more positive, less guarded, and

widened sense of self, in addition to more positive outlook toward others. This first goal highlights client's ability to feel differently and become aware of feeling differently as well as to act differently and then become aware of acting differently.

Experiential learning is also emphasized in this therapy because of the power this type of learning can have on bring about change in clients (Levenson, 2017; Strupp & Binder, 1984). In an effort to spark this change, experiential learning should take place at both interpersonal and intrapersonal levels for our clients. In order for clients to have new interpersonal experiences, they need to take a risk with the therapist and with other individuals in their lives when faced with something that is typically avoided, such as feelings of anxiety, hopelessness, or shame. When clients are able to take this risk and observe how others react, this helps to create a new experience for the client themselves and for other people involved in the interaction. As clients engage in different behaviors than before, these behaviors can be rewarded and lead to new patterns beginning to replace old patterns. It is important to note that since clients' previous, dysfunctional interpersonal styles developed through sequences of various antecedents and consequences, they can also learn to develop a more functional interpersonal style through new sequences of antecedents and consequences. Over time then, these new experiences can then help to shift the client's previous internal working model.

In addition to new interpersonal experiences, clients also need new intrapersonal experiences to help replace maladaptive emotional states with more positive emotional states. This can be done by therapists providing corrective emotional experiences to clients as well as therapists being empathic toward clients (Levenson, 2017; Strupp & Binder, 1984). According to Siegel (2006), therapists who are empathic toward their clients do more than just helping clients

feel better in the moment, but they help clients to create new cases of neural activity that can help to improve client's self-regulation.

According to Levenson (2017; Strupp & Binder, 1984), the second major goal of this brief psychodynamic therapy model is to provide clients with new understandings about emotional shifts within themselves and about relational shifts between themselves and other people. By doing this, there is hope that clients will be able to reflect on their emotions and relations with others as well as make meaning of their emotions and relations with others. Again, this goal must be done both interpersonally and intrapersonally for clients. In an effort to help clients grow intrapersonally, therapists need to carefully attend to emotions that clients are experiencing and expressing during therapy sessions and help clients better be able to understand these emotions and understand their meaning.

To help clients grow interpersonally, therapists should help clients be able to identify and understand their interpersonal patterns and how these became developed and then maintained. Some common therapeutic techniques therapists might use at this point in therapy include reflection, clarification, interpretation, confrontation, and discussing patterns that emerge in the therapy room between the client and therapist. To help clients better understand their interpersonal patterns, therapists can bring to light repeated patterns that have occurred between client and therapist, between client and previous significant others, and between client and current significant others (Levenson, 2017; Strupp & Binder, 1984).

This can help clients start to realize their patterns that occur with different people in their lives. Once clients gain this new perspective, they can then begin to consider their role in maintaining these dysfunctional interactions and can gain the ability of self-observation. As clients begin to be able to identify these dysfunctional patterns and relate them to their emotions,

they can then start having awareness in the moment when these dysfunctional interactions begin to occur. This awareness then allows clients to recognize opportunities to be able to break the cycle of dysfunctional interactions and behave differently. It is important here for therapists to realize their role in normalizing client's behavioral and emotional reactions by helping clients learn how their now dysfunctional behaviors were at one point in their life functional and had some sort of purpose for the client (Levenson, 2017; Strupp & Binder, 1984).

Interventions. According to Levenson (2017) and Strupp and Binder (1984), interventions for this treatment model are known to be therapeutic strategies that are extremely entangled into the interpersonal relationship between the client and therapist. It is worth noting that any intervention that is related and able to aid the goals of new experiences and new understandings are able to be used. Because of the brief nature of brief psychodynamic therapy, it is important that therapists become comfortable with initiating interventions even before they have all the information they desire. To help with this, tentative statements that allow for client feedback begin to build feelings of collaboration between client and therapist. Interventions can simply draw clients to see and feel things differently and from a different perspective.

During brief psychodynamic therapy, it is important that the therapist works with clients in a respectful and nonjudgmental manner, validating their perceptions and feelings, and inviting their collaboration over the course of therapy. It is also important that therapists demonstrate active listening to the client, acknowledge client's strengths, and address any obstacles and opportunities that might influence the therapy process (Levenson, 2017; Strupp & Binder, 1984). Marcolino and Iacoponi (2003) conducted a study to examine the influence of the therapeutic alliance among clients receiving brief psychodynamic therapy and discovered that clients who

had higher levels of therapeutic alliance during the first therapy session had more favorable outcomes at the end of treatment.

In addition to developing and maintaining that therapeutic alliance, therapists should also: help clients access, label, and process their emotions; utilize empathic exploration to better understand the client; maintain focused questions that pertain to the established goal; facilitate exploration of client's relationships with significant others as well as with the therapist; facilitate exploration of cyclical maladaptive patterns as well encourage new adaptive behaviors to replace the previous maladaptive behaviors; promote change directly to the client by providing the client with chances to have new experiences and new understandings; and discuss the time-limited nature of brief therapy (Levenson, 2017; Strupp & Binder, 1984).

Thinking specifically about the importance of emotions, there is large support that emotional processing during therapy sessions and across treatment can be considered a core agent of change for clients engaged in therapy (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Jaycox, Foa, & Morral, 1998; Magnavita, 2006; Pos, Greenberg, Goldman, & Korman, 2003; Whelton, 2004). McCullough and colleagues (1991) as well as other studies (Hill, Helms, Spiegel, & Tichenor, 1988; Hilsenroth, Ackerman, Blagys, Baity, & Mooney, 2003; Town, Hardy, McCullough, & Stride, 2012; Diener, Hilsenroth, & Weinberger, 2007) have been able to demonstrate that the number of emotion-oriented interventions was related to client's outcome at the end of brief psychodynamic therapy treatment.

Empirical support for brief psychodynamic therapy. According to Lambert (2004), a large number of psychotherapy research conducted in the United States involves brief therapies that last no longer than 20 sessions. In a study done by Falkenstrom, Josefsson, Berggren, and Holmqvist (2016), they found that the rate of change is indeed quicker for clients who attend

fewer number of therapy sessions. In 2013, Lambert studied the effectiveness of psychotherapy and observed that approximately 50% of clients responded to therapy by the 8th session. Hansen and associates (2002) discovered that approximately 60-70% of clients showed improvement within 13 sessions, while additional studies (Hoglend, 2003; Kopta, Howard, Lowry, & Beutler, 1994; Shapiro et al., 1995) have found that clients with both acute and chronic symptoms demonstrated clinically meaningful change between 13 and 18 sessions.

When looking at the efficacy of brief psychodynamic therapy, Barber and colleagues (2013) gathered the results from multiple studies and found that psychodynamic therapies, most of which were reportedly short-term, appeared to be superior to control groups at the time of termination and during later follow-ups in regard to depressive, anxiety, and personality disorders. Additional meta-analyses found that brief psychodynamic therapy was superior to waiting list control groups and was just as effective as other psychotherapy treatments, such as cognitive-behavioral therapy and solution focused therapy, and medications (Abbass et al., 2008; DeMaat et al., 2008; Leichsenring, Rabung, & Leibing, 2004). Knekt and associates (2008) conducted a randomized trial to examine the effectiveness of short-term and long-term psychodynamic therapy and found that the participants from the brief psychodynamic therapy group were able to demonstrate maintained positive improvements throughout the 3-year post follow up.

Empirical support for brief psychodynamic therapy with AD. In clinical settings, AD is a common diagnosis (Carta et al., 2009). Because quick intervention could help to prevent further complications for individuals diagnosed with AD, such as relationship problems or decreased functioning at places like school or work, being able to provide effective treatment for these clients is important (Strain & Diefenbacher, 2008). According to Strain and Diefenbacher

(2008), the main goals for therapy when working with an individual diagnosed with AD should include restoring their mental balance, uncovering the concerns and conflicts the client reports experiences, identifying coping skills and supportive relationships to aid in reducing current and future stressors, and helping the client regain perspective on the challenge they have encountered. Despite this need for effective quick intervention for individuals diagnosed with AD, AD is often overlooked by researchers (Azocar & Greenwood, 2007; Carta et al., 2009; Casey, 2009) and few studies have examined the treatment of clients with AD as their primary diagnosis (Stirman et al., 2005).

Recently, a study examined the effect of 12 sessions using client-centered therapy among clients diagnosed with AD. This study discovered that these clients did indeed experience symptom relief at the end of treatment and found that this effect was maintained during the 2-year post-treatment evaluation period (Gorschenek et al., 2008). Similarly, another study found that client-centered therapy with clients diagnosed with AD was superior to clients in control groups that went untreated (Altenhofer et al., 2007). Psychodynamic therapy has been found to be superior to untreated control groups for clients diagnosed with Minor Depressive Disorder (Maina et al., 2005). Since minor depression and AD share some of their characteristics (Casey, 2009), one might be able to hypothesize that psychodynamic therapy may also be superior to untreated control groups for clients diagnosed with AD (Ben-Itzhak et al., 2012).

The amount of literature comparing the overall effectiveness of brief psychodynamic therapy versus longer psychodynamic therapy in general is limited, which has led to not enough evidence to support choosing between a brief or long-term therapy when working with clients diagnosed with different psychiatric disorders (Knekt et al., 2008). In an attempt to fill this gap, Ben-Itzhak and colleagues (2012) conducted a study to compare the effectiveness of brief

psychodynamic therapy, which consisted of 12 therapy sessions, to intermediate length psychodynamic therapy, which consisted of one year of therapy, when working with clients diagnosed with AD to see if there was any benefit from intermediate length therapy versus brief therapy. Their study found that after 3 months of therapy, clients from both groups showed significant improvement. Furthermore, the improvement achieved by both therapy groups was equally continued at the 9-month follow up after terminating from therapy. These results help to provide evidence that brief psychodynamic therapy is not inferior to long-term psychodynamic therapy when trying to restore previous psychological functioning prior to developing an AD (Ben-Itzhak et al., 2012).

Additionally, Bloom (1997) and Steenbarger (1992a) conducted lengthy reviews of research on brief therapy, and both discovered there to be strong evidence supporting the effectiveness of brief therapy, even stating that brief therapy is often as effective as long-term therapy.

Empirical support for brief psychodynamic therapy in college counseling. When considering brief therapy in college counseling centers, it is important to critically examine both the advantages and limitations of brief, time-limited models. Some notable limitations of brief therapy in college counseling centers include the argument that it is important to allow students the freedom and autonomy to decide when to engage in services and when to terminate services, given their developmental stage (Widseth & Webb, 1992). Furthermore, May (1988) supported this limitation by noting the important difference between a goodbye that is chosen by the student and a goodbye that is forced. It is also possible that students respond to time-limits in a negative manner that might hinder their ability to build an alliance with the therapist. Allowing

the students to choose just how much therapy they want when facing a development crisis could be especially important (Ghetie, 2007).

Some college counseling center clinicians oppose time-limited therapy because they argue that therapy with college students is already inherently brief, with the median number of sessions between 4 to 5 (Rockland-Miller & Eells, 2006), thus making it questionable what the purpose of further limiting treatment is (Whitaker, 1994). Finally, a study conducted by Gyorky, Royalty, and John (1994) discovered that college counseling centers with imposed time-limits had longer wait lists and were not able to serve a high percentage of the study body when compared to college counseling centers without any imposed time-limits.

Despite these limitations of brief therapy in college counseling centers, there are also many notable advantages that should be considered, such as the apparent support that brief, time-limited treatment has been shown to be effective in college counseling centers and in other treatment settings (Ghetie, 2007). Supporting this notion, Anderson and Lambert (1995) completed a meta-analysis that consisted of more than 20 empirical studies of brief psychodynamic therapy and discovered a moderate mean effect size. Additional studies have found that even very brief treatments, defined as consisting of less than 5 sessions, have been shown to be effective (Michel, Drapeau, & Despland, 2003; Pinkerton & Rockwell, 1994; Vonk & Thyer, 1999). Medalie (1987) noted that in college counseling centers, brief therapy can be effective in preparing students for long-term therapy completed at settings outside of counseling centers.

Additional arguments have been made that brief, time-limited treatment can reduce wait lists, is cost effective, and allows clinicians to have more time for other services, such as outreach (Ghetie, 2007). Further supporting brief therapy in college counseling centers, Wolgast,

Lambert, and Puschner (2003) completed a study on the dose-response rate in college students in an effort to conclude how many therapy sessions are needed for significant change to occur. From their study, they discovered that 24% of students obtained significant change after the 7th therapy session and 51% of students obtained significant change after their 14th therapy session (Wolgast, Lambert, & Puschner, 2003).

Looking specifically at college counseling centers, multiple research studies have demonstrated that short-term therapy is indeed practiced in these settings, as evidenced by the consistently low average number of therapy sessions students attend (Gallagher, R., & Bruner, L., 1995, 1996, 1997). Archer and Cooper (1998) have outlined six different reasons as to why brief therapy models should be utilized within college counseling centers, such as: the expanding evidence supporting the effectiveness of brief therapy with a wide range of clients and presenting problems; the suitability of the types of developmental and situational problems students often present with for brief therapy; the reality of clinicians in college counseling centers needing to limit their scope in order to equally reach as many students as possible; the need for consultation and prevention type work to address different important issues campus wide; the need for outreach and program development; and the growing demand for services as more students find themselves more accepting of therapy.

As previously alluded to, the types of developmental problems that students often present with at college counseling centers, in addition to the reality of time limitations posed by academic calendars, have led most college counseling centers to adopt brief therapy models (Cooper & Archer, 1999; Steenbarger, 1992b). It should be noted that although some clinicians and authors make the argument that college counseling centers should indeed provide brief therapy for most students, typically lasing around 5 to 10 sessions, students in need of long-term

therapy should be properly assessed and either referred elsewhere for services or be given an exception and allowed long-term therapy if they are not able to obtain services elsewhere (Stone & Archer, 1990).

Empirical support for brief psychodynamic therapy with members of the LGBTQ+ community. When trying to determine an appropriate and effective approach for particular clients, clinicians are faced with a critical decision of the therapeutic process (Fassinger, 1999). While working with clients who are highly verbal and are relatively well-functioning individuals who want to obtain better understandings of their past and how it relates to their current behaviors, psychodynamic approaches appear to be useful (Corey, 1996). For clients who identify as part of the LGBTQ+ community, psychodynamic therapy's focus on clients' own history and family history may be appropriate, especially when considering analyzing the type of experience a client might have during their process of coming out. Developing a better understanding of the dynamics between the client and their parents could help LGBTQ+ clients who report problems in seeking or accepting social support and in achieving intimacy, as well as help LGBTQ+ clients better understand typical and dysfunctional relationship patterns. As LGBTQ+ clients form strong attachments to their therapists, it is possible that this is the first time the client has been able to be open and honest with someone, has felt known and understood by someone, or experienced an accepting relationship with someone. Since LGBTQ+ clients could have countless numbers of concerns that they bring into the therapy room, an integrative approach is essential to effectively working with these clients (Fassinger, 1999).

It is also important to address the high suicide rate of LGBTQ+ youth, who have up to four times the risk of attempting suicide compared to their counterparts that identify as heterosexual. LGBTQ+ youth that come from families who are not accepting of them have up to

eight times the risk of attempting suicide (McDaniel, Purcell, & D'Augelli, 2001). Often times, LGBTQ+ youth can feel isolated and unsure of who to trust. These youth might not seek out mental health services because of their own fears of treatment or because of previous negative experiences with mental health professionals (Fauman & Hopkinson, 2010). This further highlights the importance of building rapport with clients who identify as members of the LGBTQ+ community as well as the importance of quick and effective interventions.

Case Formulation

Based on the client's background information, it appeared that in regards to his current treatment, there were a few different major events that contributed to this client's development and functioning: his past and possibly current relationship with his parents; his previous relationship with his ex-boyfriend; the reported sexual trauma the client experienced at the age of 18; and the recent negative changes in client's life (e.g., his family moving away; his quitting his job he previously had for 4 years; his lifelong friends moving away; his learning of his mother's illness; and his placing more focus on his personal life).

First, it was important to consider this client's attachment and how it related to his current functioning. Based on the client's reported relationship with his parents, it is possible that his parent's inability to appropriately respond to him while growing up could have led the client to developing an insecure attachment with his parents that persisted throughout his life thus far. Specifically, it is possible that the client developed an anxious-ambivalent attachment pattern. Furthermore, when considering this client's relationship with his ex-boyfriend, it seemed that this relationship that had the client constantly worrying about whether he was good enough for his ex-boyfriend and constantly worrying about his boyfriend leaving him could have further reinforced this insecure attachment pattern. This also demonstrated the possibility that the client

learned, from this attachment pattern, that he was not able to count on others to keep him safe as well as learned to view himself and others in a negative manner.

Taking the interpersonal-relational theory into consideration, which explains that children develop self-other role relationship patterns through interactions with their parents, it is possible that the client witnessed a dysfunctional type of relationship between his mom and dad growing up that then became the client's idea of what a "typical" relationship looks like. This was demonstrated by the client's relationship with his ex-boyfriend and was then possibly further engrained in the client through the sexual abuse he experienced at the age of 18. Building on the client's foundation of an insecure attachment style from his relationship with his parents, it is possible that his relationship with his ex-boyfriend and the sexual abuse the client experienced both further enhanced this attachment style for this client, who seemed to have repeatedly been exposed to unhealthy relationships throughout his life.

When considering the experiential-affective theory and how emotions are motivating, adapting, and organizing to the client and to others, it was important to consider the impact the client's dad possibly had on him. The client reported an inability to form a relationship with his father because the client never knew how his father was emotionally going to act. This suggested that the client's dad was poor at regulating his own emotions and therefore could have modeled this poor emotion regulation to the client, rather than modeling appropriate emotion regulation. That lack of emotion regulation for the client could help to explain the client's history of self-harm as a way to cope in the past.

Treatment Plan

An important component of this brief psychodynamic therapy was the time-limited aspect of treatment. Although the time-limited component of therapy was never outright discussed at

the start of therapy, the structure of the academic calendar and the client's knowledge that therapy services would be ending at the end of the semester made it clear that the therapist and client had roughly 12 weeks to meet for individual therapy sessions on a weekly basis. Because of the impact the COVID-19 pandemic had on the university, the client's therapy lasted a total of six individual therapy sessions.

Although the client originally came into therapy without any clear treatment goals, the client later identified a goal of wanting to "come to terms" with what had previously happened between him and his ex-boyfriend. In accordance with the brief psychodynamic therapy model and the therapist's conceptualization of the client, the therapist had the following goals for the client's treatment plan: to build a strong therapeutic alliance with the client; to provide the client with a healthy and functional relationship to challenge his maladaptive relationship pattern in place; and to provide the client with new understandings about his emotions as they occur within him and as they occur within relationships with others. In order to achieve these goals, the therapist utilized appropriate interventions outlined in the brief psychodynamic therapy model, such as: working collaboratively with the client; validating the client's perceptions and feelings; demonstrating active listening to the client; helping the client access, label, and process his emotions; using empathic exploration; facilitating exploration of the client's relationships with others as well as with the therapist; and facilitating exploration of cyclical maladaptive patterns.

Clinical Research Question

Current research on effective treatments for individuals diagnosed with AD is minimal (Carta et al., 2009; O'Conner & Cartwright, 2012; Zelveine & Kazlauskas, 2018). However, previous research has demonstrated some support for a variety of therapeutic approaches in the treatment of AD, such as cognitive-behavioral therapy (Steinhardt & Dolbier, 2008) and brief

group psychodynamic therapy (Ben-Itzhak et al., 2012). Despite the lack of research surrounding the effectiveness of brief psychodynamic therapy with individuals diagnosed with AD, there have been studies that have found brief psychodynamic therapy to be effective when treating individuals with minor depressive episodes (Maina et al., 2005).

Given the current limited research on the effectiveness of brief psychodynamic therapy with individuals diagnosed with AD, there is a significant need for research that provides support for effective treatment for work with individuals diagnosed with AD. The current case study examined a client diagnosed with AD who received outpatient treatment in a college counseling center. The treatment modality used in the current case study was a form a brief psychodynamic therapy. Although the current case study aimed to have roughly 12 individual therapy sessions with the client, the impact of the COVID-19 pandemic caused the current case study to take place over the course of six individual therapy sessions.

The current study aims to provide further evidence supporting brief psychodynamic therapy as an effective treatment with this traditional aged college student diagnosed with AD. Based on the existing literature previously reviewed, the client's presentation, and the treatment plan for the client, the current study will ask the following two questions: Is this client better off than before therapy began? Which of this client's symptoms improved and which did not improve? The current study hypothesizes that the client will show improvements in treatment.

Method

Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62; Lock et al., 2011)

The CCAPS-62 is a 62-item measure that was designed to evaluate a variety of psychological symptoms common to disorders found in the college population. The CCAPS-62 has eight

subscales: Depression, Generalized Anxiety, Social Anxiety, Academic Distress, Eating Concerns, Hostility, Family Distress, and Substance Use. Individuals completing the measure are asked to rate themselves on a 5-point Likert-scale ranging from 0 (*not at all like me*) to 4 (*extremely like me*) over the course of the last 2 weeks. Of the 62 items on this measure, nine of the items are reverse scored. Subscale scores are calculated by adding together individual item scores, with higher scores indicating more distress. Average item ratings on each subscale can also be calculated across subscales.

After the CCAPS was developed, Titanium Software, a common electronic medical record system used in college counseling centers, partnered with the Center for Collegiate Mental Health to incorporate the CCAPS within the Titanium software. This allows therapists in university counseling centers to seamlessly administer, score, and generate reports using the CCAPS (Penn State Student Affairs: Center for Collegiate Mental Health, 2023). In the current study, Titanium software was utilized to administer, score, and generate reports with percentile scores for the client's CCAPS-62.

According to Locke and colleagues (2011), subscale scores have demonstrated acceptable internal consistency and test-retest reliability, as well as convergent validity in a largely non-clinical college population. In their study's sample, the test-retest reliability coefficients were r = .93 for Depression, r = .89 for Eating Concerns, r = .87 for Substance Use, r = .78 for Generalized Anxiety, r = .91 for Hostility, r = .83 for Social Anxiety, r = .92 for Family Distress, and r = .92 for Academic Distress. Cronbach's alpha were a =.92 for Depression, a =.85 for Generalized Anxiety, a =.85 for Social Anxiety, a =.83 for Academic Distress, a =.87 for Eating Concerns, a =.85 for Hostility, a =.84 for Family Distress, and a =.85 for Substance Use. These

test-retest reliability coefficients can be seen in *Table 1* in the Empirical Findings section to further clarify how the RCI was calculated.

For the current study, the CCAPS-62 was administered via the Titanium software program on three separate occasions, with the first CCAPS-62 being completed by the client upon arriving for his intake session, again after three individual therapy sessions, and then again before his final, sixth, individual therapy session. Average item rating scores for each subscale were calculated and utilized using each individual item response on every subscale and can be seen in *Table 2,* in the Empirical Findings section.

Reliable Change Index

For the current study, the RCI was calculated utilizing pre, mid, and post means for each subscale within the CCAPS-62. *Table 2* details the average item rating scores for each subscale at pre, mid, and post phases of treatment and can be seen in the Empirical Findings section. Cutoff scores for each CCAPS-62 subscale were also calculated utilizing means and standard deviations for males in normal and clinical populations, which were provided by the Center for Collegiate Mental Health (CCMH) annual report (2010) and can be seen in *Table 3* in the Empirical Findings section.

Course of Treatment

In accordance with the brief psychodynamic therapy model and in accordance with the University's academic calendar, therapist and client were originally planning to meet for approximately 12 individual therapy sessions on a weekly basis for 50 minutes each. Because of the COVID-19 pandemic, however, the therapist and client were only able to meet for six weekly individual therapy sessions for 50 minutes each. The client consistently attended his scheduled therapy sessions and was actively engaged in his treatment during sessions.

Through the course of the client's treatment, the therapist engaged as an active participant in collaboratively discussing and reflecting on the client's experiences. To accomplish treatment goals, the therapist utilized techniques from brief psychodynamic therapy. Because of the integrative nature of this brief psychodynamic therapy, the therapist also utilized techniques from other various theoretical orientations to facilitate conversations and discussion surrounding the client's thoughts about his mental health problems, himself and others, and his life experiences.

Session one. The client was unable to initially identify goals for his treatment during the first session, but simply explained pursuing therapy after a friend recommended it to him. Given the briefness of this brief psychodynamic therapy, the therapist quickly formulated ideas and began utilizing interventions. Thus, the therapist and client began by discussing the events that led the client to pursue therapy (e.g., close friends and family moving away, quitting his job, placing more focus on his personal life, and learning of his mother's illness).

During the first session, the therapist and client also began discussing the client's reported poorly developed sense of self and feelings of not belonging, specifically as it pertained to his degree field at the university. This is also when the client first introduced his past relationship with his ex-boyfriend, whom he dated for approximately one year during his freshman year of college. The therapist also assessed the client's level of risk, during which the client endorsed passive suicidal ideation without any intent. The client denied any self-harm behaviors and denied any active suicidal ideation.

Through validating the client's reported experiences and maintaining empathic responses, the therapist was able to begin her attempt at building a strong therapeutic alliance with the client. This validation and empathy also functioned as an introduction into providing the client with a corrective emotional experience and increasing the client's ability to self-regulate. During

this first therapy session, the therapist also utilized reflections to demonstrate active and engaged listening, as well as basic interpretations to also demonstrate active listening and to elicit further elaboration from the client at times. This first session also allowed the therapist to begin building an understanding of the client's previous and current relationship patterns.

Session two. The therapist continued building a strong therapeutic alliance with the client during the second session. Again, this was done by validating the client and empathically listening. During this session, the therapist and client began discussing the client's relationship with both his mom and dad. The client shared details regarding a recent experience with his mom where they got into a disagreement and the client's mom told the client he had been acting "just like his father". The therapist provided a reflective statement providing a basic interpretation about the apparent negative impact that statement had the client. The therapist and client then explored the impact of this statement and the client's beliefs of how he views himself compared to how he views his father. This allowed the therapist to confront the client about some of his feelings surrounding his father.

During this second session, the therapist also gained more understanding of the client's relationship with his mom and dad, but more specifically with his dad. The therapist and client discussed the relationship dynamic and patterns the client frequently experienced with his dad, which he described as challenging. The client noted that because his father struggled with Bipolar Disorder, he had little to no relationship with his dad because the client never knew how his dad was going to act. The client described a relationship pattern filled with uncertainty and volatility. With this knowledge of the client's fragile relationship with his dad, the therapist was able to begin emphasizing consistency and predictability within the therapeutic relationship in hopes of promoting an example of a healthy relationship for the client. The therapist also

emphasized validating the client's emotional experiences in order to provide the client with corrective emotional experiences to override his previous experiences of being invalidated by his dad.

Given the flexibility of this brief psychodynamic therapy model, the therapist pulled techniques from other therapy models to assist the client in making progress toward therapy goals. In this session, that included having the client externalize his thoughts in an attempt to help the client separate his own thoughts from thoughts that may be rooted in anxiety. The client again denied any self-harm behaviors and any active suicidal ideation. Because the client was able to discuss his adaptive coping skills used when any thoughts of self-harm occur (e.g., turning lights on, taking a shower, brushing his teeth, and listening to music), the therapist was able to encourage the client to continue utilizing his adaptive coping skills as necessary.

Session three. By the third therapy session, it seemed the client and therapist had the foundation for a strong therapeutic alliance. This allowed the client to begin feeling safe enough within the therapy space to share various stressors from the therapist that may have been viewed as more severe by the client, such as his previous relationship with his ex-boyfriend. Through exploration, the client and therapist were able to explore the impact his past relationship had on his current relationships. The therapist was able to use clarification techniques to explore more in depth the impact this was having on the client (e.g., in his communication with others, in his interactions with others, and in his development of trusting relationships with others).

Given the therapeutic alliance at this point, the therapist was also able to begin confronting some of the client's stated thoughts and/or feelings in the session in hopes of guiding the client to new understandings about his thoughts and/or feelings. For example, when the client began discussing the blame he put on himself for his actions in his past relationship with his ex-

boyfriend, the therapist was able to confront this feeling of blame and encourage the client to understand that feeling from a different perspective (e.g., “Are you to blame? Or were you being manipulated?”) all while maintaining a supportive and empathic stance as the therapist.

Session four. After spending some time during the fourth session reviewing goals for treatment, the client was able to identify a goal for therapy, which included being able to “come to terms” with his previous relationship between him and his ex-boyfriend. It was during this session that the client appeared to become more actively focused on this specific goal, which in turn allowed the therapist to become more actively focused and engaged on this specific goal. The client introduced some feelings he had surrounding his previous relationship (e.g., anger and resentment), which allowed the therapist to facilitate conversations with the client about those feelings and the client’s understanding of those feelings. As the client shared thoughts surrounding his current pattern in relationships with men, the therapist was able to provide interpretations regarding the therapist’s understanding of how the client’s past relationship was impacting the client’s current relationships.

The client reported several impacts, such as a fear of being manipulated again and a decreased ability to trust others. The therapist again made a conscious effort to again emphasize a stable, healthy, and functional therapeutic relationship with the client in hopes of challenging the maladaptive relationship patterns he previously experienced among his father and ex-boyfriend. The therapist also validated the client’s hesitations toward men given his previous experiences while encouraging the client to gain new understandings of how different men in his life may be different than his ex-boyfriend.

Session five. During the fifth therapy session, the client decided to disclose details to the therapist about a previous sexual assault he experienced the summer before his freshman year of

college. The client detailed the experience to the therapist and discussed how it resulted it him trying to move past the experience by throwing himself into his relationship with his ex-boyfriend. Given the client's goal of wanting to "come to terms" with what had previously happened between him and his ex-boyfriend, this allowed the client to explore his feeling surrounding the sexual assault and his relationship with his ex-boyfriend in a safe space while being supported by the therapist.

The therapist and client were able to explore the client's feelings of blame and anger toward himself. The therapist actively used reflections to communicate active listening, interpretation to help the client label difficult feelings, and empathy and validation to provide the client with reassurance that he is in a safe environment and healthy relationship. This marked an important step in the therapeutic relationship, as it likely signified that the client felt safe and secure enough to share such a vulnerable experience with the therapist. In turn, this allowed the client to process his emotions surrounding the sexual assault and his past relationship in a safe and nonjudgmental environment, which allowed the client an opportunity to continue developing self-regulation skills and continue building new understandings about his different emotions.

It was at the end of his fifth therapy session that the client first identified feeling "genuinely" better since before treatment began. He identified having the ability now to think about and sit with those past memories, whereas prior to counseling he would not have been able to do so.

Session six. Because of the COVID-19 pandemic, as previously stated, the client's therapy sessions were abruptly cut short. After receiving news that the campus would be closing and all students would have to return home, the therapist and client were able to meet for a sixth and final therapy session. Much of the time in this session was spent processing the implications

of COVID-19 and campus closing. The client reported being in great distress over having to leave campus and live at home with his parents once again. The therapist validated these feelings and assisted the client in clarifying possible options to help make the transition home smoother (e.g., transitioning to see a therapist at home if possible, spending time outside and at nature parks, adopting a cat as a companion). The therapist also took the time to emphasize the strength of the therapeutic alliance that had been built over the course of the last six therapy sessions.

Although the client reported experiencing suicidal ideations shortly after receiving the news about the campus closing, he denied any intent to act on these thoughts and denied any active suicidal ideation at the time of the final therapy session. The client reported that although he was feeling sad, he was not feeling as sad as he might have in the past. The therapist was able to reassure the client that he had built tools and coping skills that allowed him to handle the situation better than he would have prior to the start of therapy treatment. The client also denied any self-harm since before starting treatment. The therapist tried to provide the client with one last corrective emotional experience by providing the client with closure about their therapeutic relationship ending. The therapist also attempted to implement a healthy relationship pattern by praising the client's effort during therapy sessions throughout treatment and by providing the client with hope about his future.

Empirical Findings with Analysis

Results were based on the six individual therapy session with the client using a brief psychodynamic approach. Results were examined utilizing the client's CCAPS-62 scores from before his first session (pre), before his fourth session (mid), and after his sixth session (post). Pre, mid, and post mean ratings were hand calculated by averaging the client's reported responses for each individual subscale item using the CCAPS report generated by Titanium. The

RCI was calculated for pre- to mid- treatment, for mid- to post-treatment, and for pre- to post-treatment using the following formula, where X_2 represents the post-treatment mean rating, X_1 represents the pre-treatment mean rating, and S_{diff} represents the standard difference (Jacobsen et al., 1984).

$$RC = \frac{X_2 - X_1}{S_{diff}}$$

Cutoff scores for each of the CCAPS-62 subscales were calculated using means and standard deviations for males both normal and clinical populations provided by Center for Collegiate Mental Health annual report (2010) shown in *Table 3* using the following formula, where s_1 represents the standard deviation of the normal population, s_2 represent the standard deviation of the clinical population, $\bar{X}_1$ represents the mean of the normal population, and $\bar{X}_2$ represents the mean of the clinical population (Jacobson & Truax, 1991).

$$Cutoff = \frac{(s_1 \times \bar{X}_2) + (s_2 \times \bar{X}_1)}{s_1 + s_2}$$

The results from the cutoff scores helped to determine if the client made clinically significant progress and the RCI helped to determine if the progress the client made was reliable. By calculating the RCI and using cutoff scores for each of the specific CCAPS-62 subscales, this helped to answer the clinical question of if the client is better off than before therapy began. In order for the client to demonstrate reliable change throughout treatment, the RCI must be greater than 1.96, as pre-determined by Jacobson and Truax (1991). RCI scores below 1.96 demonstrate no reliable change throughout treatment and RCI scores below -1.96 demonstrate deterioration throughout treatment. Examining the results from the specific subscales indicated which symptom areas improved for the client and which did not. Using these criteria, it is possible to

classify the client as one of the following: Recovered (passed cutoff point for clinically significant change and passed RCI criteria), Improved (only passed RCI criteria), Unchanged (passed neither criteria), and Deteriorated (passed RCI in the negative direction) (Jacobson & Truax, 1991). *Table 2* shows average individual subtest ratings scores for the client on each subscale during the pre-, mid-, and post-phases of treatment, while *Table 4* shows the RCI and cutoff points for pre- to post, pre- to mid, and pre- to post treatment.

Table 1

CCAPS-62 Subtest Test-Retest Reliability Coefficients

CCAPS-62 Subscale	Test-Retest Reliability Coefficient
Depression	0.93
Generalized Anxiety	0.78
Social Anxiety	0.83
Academic Distress	0.92
Eating Concerns	0.89
Hostility	0.91
Family Distress	0.92
Substance Use	0.87

Note. Test-Retest Reliability Coefficients provided by Locke and colleagues (2011).

Table 2

CCAPS-62 Client's Average Individual Subtest Rating Scores for Pre, Mid, and Post Phases of Treatment

CCAPS-62 Subscale	Pre-Treatment	Mid Treatment	Post Treatment
Depression	2.62	1.69	2
Generalized Anxiety	3.22	2.56	1.78
Social Anxiety	2.29	2.29	0.57
Academic Distress	3	2	2
Eating Concerns	0.33	0.33	0.33
Hostility	0.86	0	0.43
Family Distress	3	1.33	1.83
Substance Use	2.17	1	0.33

Table 3

CCAPS-62 Means and Standard Deviations of Males in Clinical and Non-Clinical Populations

CCAPS-62 Subscale	Clinical Population	Non-Clinical Population
Depression	1.44 (0.94)	0.80 (0.74)
Generalized Anxiety	1.35 (0.88)	0.87 (0.68)
Social Anxiety	1.72 (0.96)	1.46 (0.84)
Academic Distress	1.84 (1.03)	1.24 (0.84)
Eating Concerns	0.69 (0.69)	0.76 (0.68)
Hostility	1.00 (0.88)	0.70 (0.70)
Family Distress	1.08 (0.89)	0.70 (0.71)
Substance Use	0.86 (0.89)	0.82 (0.89)

Note. Standard Deviations shown in parentheses. Means and Standard Deviations were provided by the Center for Collegiate Mental Health (CCMH) Annual Report (2010).

Table 4

RCI and Cutoff Points for Pre to Post, Pre to Mid, and Mid to Post Treatment

CCAPS-62 Subscale	Pre to Post	Pre to Mid	Mid to Post
Depression			
RCI	2.21*	3.32*	-1.11
Cutoff Point	1.08	1.08	1.08
Findings	**Improved**	**Improved**	**Unchanged**
Generalized Anxiety			
RCI	3.20*	1.47	1.73
Cutoff Point	1.08	1.08	1.08
Findings	**Improved**	**Unchanged**	**Unchanged**
Social Anxiety			
RCI	3.50*	0.00	3.50*
Cutoff Point	1.58*	1.58	1.58*
Findings	**Recovered**	**Unchanged**	**Recovered**
Academic Distress			
RCI	2.86*	2.86*	0.00
Cutoff Point	1.51	1.51	1.51
Findings	**Improved**	**Improved**	**Unchanged**
Eating Concerns			
RCI	0.00	0.00	0.00
Cutoff Point	0.73*	0.73*	0.73*
Findings	**Unchanged**	**Unchanged**	**Unchanged**
Hostility			
RCI	1.54	3.07*	-1.54
Cutoff Point	0.83	0.83*	0.83
Findings	**Unchanged**	**Recovered**	**Unchanged**
Family Distress			
RCI	4.18*	5.96*	-1.79
Cutoff Point	0.87	0.87	0.87
Findings	**Improved**	**Improved**	**Unchanged**
Substance Use			
RCI	4.09*	2.60*	1.49
Cutoff Point	0.84*	0.84	0.84*
Findings	**Recovered**	**Improved**	**Unchanged**

Note. * indicates statistically reliable change for the RCI and clinically significant change for cutoff points.

The client's mean reported scores on the Eating Concerns subscale were identical at pre-treatment, mid-treatment, and post-treatment. His average reported score was low, lower than both clinical and non-clinical population means. As a result, the client's Eating Concerns will not be further discussed. Results of cutoff points, found within *Table 4*, demonstrate the client's average individual subtest ratings scores mid treatment, found within *Table 2*, fell below the cutoff point and closer to the normal population than clinical population on the Hostility subscale, though this improvement was not maintained through the end of treatment. Results of cutoff points demonstrate the client's average individual subtest ratings scores post treatment fell below the cutoff point and closer to the normal population than clinical population on the Social Anxiety and Substance Use subscales.

Results from RCI scores, also found within *Table 4*, demonstrate the client's average individual subtest rating scores from pre to mid treatment reflect statistically reliable change on the Depression, Academic Distress, Hostility, Family Distress, and Substance Use subscales. Minimal findings emerged for mid- to post treatment; the only finding that emerged was for Social Anxiety, which demonstrated statistically reliable change. In terms of pre- to post-treatment findings, the client's average individual subtest rating scores from pre- to post-treatment reflect statistically reliable change on the Depression, Generalized Anxiety, Social Anxiety, Academic Distress, Family Distress, and Substance Use subscales.

Discussion of Findings

Currently, although some studies have demonstrated the effectiveness of brief psychodynamic therapy when treating minor depressive episodes (Maina et al., 2005) and when working with patients who were HIV-positive with depressive symptoms (Markowitz et al., 1998), little research examining treatment outcomes for Adjustment Disorder (AD) exists (Carta

et al., 2009; O'Conner & Cartwright, 2012; Zelveine & Kazlauskas, 2018). The current case study aimed to examine the effectiveness of brief psychodynamic therapy as a treatment with a traditional aged college student diagnosed with AD.

In this current study, the therapist's use of brief psychodynamic therapy provided findings that suggest the client Recovered from pre to post treatment on the Social Anxiety and Substance Use subscales. The findings also suggest the client Improved from pre- to post-treatment on the Depression, Generalized Anxiety, Academic Distress, and Family Distress subscales. From pre- to mid-treatment, results indicate the client Improved on the Depression, Academic Distress, and Family Distress subscales. However, findings suggest the client remained Unchanged on every subscale from mid- to post-treatment, with the exception of the Social Anxiety subscale, suggesting that the majority of changes the client experienced in treatment occurred earlier, as opposed to later, in treatment.

The client's change throughout treatment on the Social Anxiety and Substance Use subscales generate various questions regarding why those subscales saw significant, and reliable, change, while others did not. When thinking about types of clients and problems seeking help within a brief amount of time, some data exists that indicates during brief treatment, a client's overall well-being is the first to make a positive change, followed then by improvements in symptoms and later on positive changes in characterological and interpersonal factors (Howard et al., 1993).

One study (Hilsenroth et al., 2001) found that by the ninth session of a brief psychodynamic therapy, clients reported the biggest area of change to be their sense of well-being, followed by their overall feelings of distress. In this study, the final area to see improvements during treatment were social and interpersonal functioning. In one meta-analysis

(Barber et al., 2013) researchers discovered that psychodynamic therapies, most of which were considered brief, were superior to control conditions and produced as effective results compared to alternative therapies at termination and follow-up for clients diagnosed with depressive disorders, anxiety disorders, and personality disorders.

In the current study, it is possible that the client's overall sense of well-being began to improve first throughout treatment in the early sessions. Given this client's diagnosis of AD, and O'Conner and Cartwright's (2012) emphasis that the effects of AD can be moderated by social support, it is possible that the support therapy provided this client allowed the client to begin experiencing relief with some of his symptoms, as reflected in the client's Improved scores on the Depression, Academic Distress, Family Distress, and Substance Use subscales from pre- to mid-treatment. Although the client began to see improvements of the Depression, Academic Distress, Family Distress, and Substance Use subscales from pre- to mid-treatment, those four subscales went Unchanged from mid- to post-treatment, which may be a reflection that the client's early improvements were sustained through the rest of treatment.

The onset of COVID-19 occurred during the mid- to post-treatment phase for this client. It is possible this caused an increase in the client's distress and symptoms, thus reflecting minimal improvement in the client's subscales from mid- to post-treatment. Individuals can experience symptoms of AD at any point in life, but younger individuals may be more vulnerable to developing this disorder because of fewer coping skills to utilize in moments of stress (O'Conner & Cartwright, 2012). Inchausti and colleagues (2020) discuss how one particular group at risk for psychological challenges includes individuals who experienced psychopathology prior to the pandemic, which may be exacerbated by the pandemic and the impact of the pandemic. It is possible that the stressors related to the onset of COVID-19

exacerbated this client's mental health challenges, which this client may have lacked appropriate coping skills to effectively manage, thus resulting in the client's reported symptoms to remain Unchanged from mid- to post-treatment.

Despite this possible stress with the onset of COVID-19 toward the end of treatment, the client still Improved on the Depression, Generalized Anxiety, Academic Distress, and Family Distress subscales from pre- to post-treatment and Recovered on the Social Anxiety and Substance Use subscales. Thus, despite the client not making significant, reliable changes from mid- to post-treatment, the client was still able to demonstrate significant, reliable change from pre- to post-treatment on the Social Anxiety and Substance Use subscales and demonstrate reliable changes from pre- to post-treatment on the Depression, Generalized Anxiety, Academic Distress, and Family Distress subscales. Although the current treatment only lasted six sessions, one review of effective psychotherapies by Lambert (2013) noted a large number of clients make reliable improvements after just seven therapy sessions. These results provide evidence that even in as little as six therapy sessions, this client was able to begin seeing significant, reliable change in some of his mental health symptoms.

When examining the current study, a considerable limitation to be considered includes the onset of the COVID-19 pandemic, which resulted in the client's treatment being cut short from approximately 12 therapy sessions to only six therapy sessions. It is also possible the stress the client reported experiencing after hearing the news of campus closing early because of COVID-19 could have impacted his mid to post treatment scores.

An additional limitation includes the choice of the CCAPS to monitor the client's functioning and the overall typical goals for brief psychodynamic therapy. As a reminder, according to Levenson (2017) and Strupp and Binder (1984), brief psychodynamic therapy aims

to provide a client with positive new experiences of themselves and others and new understandings of themselves and others. This form of therapy often aims at fostering new relational experiences and enhancing one's attachment in hopes that will then impact other areas of one's life. With this knowledge, it is important to consider how any possible progress may or may not be reflected on the CCAPS, given its subscales. If someone improves relationally and strengthens their attachment style, it is possible that change may not be reflected on a measure looking at mental health symptoms, like the CCAPS (Travis et al., 2001). Thus, a measure that further examined both intrapersonal and interpersonal changes may have provided different results.

Another limitation of the current study includes the client's history of sexual abuse. Given the information reported at the start of treatment, the therapist and clinical supervisor concluded an AD diagnosis to be the most appropriate diagnosis for the client's current functioning. However, the client's eventual disclosure to the therapist of prior sexual abuse might suggest a trauma-related diagnosis may have been appropriate. It is possible this alternative diagnosis may have informed the therapist to approach treatment in an alternative way. However, this represents a real-world scenario where therapists must provide treatment with sometimes limited information the client is willing to share.

Additional limitations include those commonly associated with single subject research studies, such as issues of generalizability (Kazdin, 2022; Searle, 1999), uncontrollable variables (Cronbach, 1975), and the objectivity of the therapist throughout the research study (Searle, 1999). Because the current study is a case study, it is important to consider that one individual was studied. The client examined in the current study is a unique individual with his own life experiences and mental health challenges who likely does not reflect the experiences and

challenges of other individuals with similar life experiences and mental health challenges. Kazdin (2022) and Searle (1999) highlight how although a case study might discover findings that suggest what might take place in similar circumstances, further research is necessary to determine the generalizability of the case study.

Despite these limitations, this case study provides research for a real-world application of brief psychodynamic therapy with a traditional aged college student diagnosed with AD. While other studies have examined the effectiveness of brief psychodynamic therapy with individuals experiencing minor depressive episodes (Maina et al., 2005) and with depressive symptoms (Markowitz et al., 1998), the current study allowed brief psychodynamic therapy to be examined after being utilized with someone diagnosed with AD. A significant strength of a case study includes the ability to examine the effectiveness of a modality in real-world scenarios (Kazdin, 2022).

Given the limited current research, further research on the effectiveness of brief psychodynamic therapy with individuals diagnosed with AD would be beneficial for the psychology field. Further case studies examining effective treatments for individuals diagnosed with AD would provide useful information and insight into possible effective approaches to treatment. Alternative measures may be utilized to further examine common symptoms reported by individuals with AD. Research studies who utilize a group design could also be used in order to examine the external validity of brief psychodynamic therapy, among other therapies, with individuals diagnosed with AD.

References

Abbass, A. (2015). *Reaching through resistance: Advanced psychotherapy techniques*. Kansas City, MO: Seven Leaves Press.

Abbass, A., Sheldon, A., Gyra, J., & Kaplin, A. (2008). Intensive short-term dynamic psychotherapy for *DSM-IV* personality disorders: A randomized controlled trial. *Journal of Nervous and Mental Disease, 196*, 211-216. http://dx.doi.org/10.1097/NMD.0b013e3181662ff0

Allison, D., & Gorman. (1994). "Make things as simple as possible, but no simpler." A rejoinder to Scruggs and Mastropieri. *Behaviour Research and Therapy, 32*, 885-890.

Altenhofer, A., Schulz, W., Schwab, R., et al. (2007). Psychotherapy of adjustment disorders. Is psychotherapy if limited to 12 sessions sufficiently effective? *Psychotherapeutics, 52*, 24–34.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). Washington, DC: Author.

Anderson, E., & Lambert, M. (1995). Short-term dynamically oriented psychotherapy: A review and meta-analysis. *Clinical Psychology Review*, *15*(6), 503-514.

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*, 271– 285.

Archer, J., & Cooper, S. (1998). *Counseling and mental health services on campus: Handbook of*

contemporary challenges and opportunities. San Francisco: Jossey-Bass.

Azocar, F., & Greenwood, G. (2007). Adult adjustment disorder: A review of its current diagnostic status: A Brief Report. *The Internet Journal of Mental Health, 4,* 3.

Barber, J., Muran, J., McCarthy, K., & Keefe, J. (2013). Research on dynamic therapies. In Lambert, M. (Ed.), *Handbook of Psychotherapy and behavior change* (pp. 443-494). New York, NY: Wiley.

Ben-Itzhak, S., Bluvstein, I., Schreiber, S., Aharonov-Zaig, I., Maor, M., Lipnik, R., & Bloch, M. (2012). The effectiveness of brief therapy versus intermediate duration psychodynamic psychotherapy in the treatment of adjustment disorder. *Journal of Contemporary Psychotherapy, 42,* 249-256. http://dx.doi.org/10.1007/s10879-012-9208-6

Bloom, B. (1997). *Planned Short-term psychotherapy: A clinical handbook* (2nd ed.). Boston: Allyn & Bacon.

Bolter, K., Levenson, H., & Alvarez, W. (1990). Differences in values between short-term and long-term therapists. *Professional Psychology: Research and Practice, 21,* 285-290. http://dx.doi.org/10.1037/0735-7028.21.4.285

Borckardt, J., & Nash, M. (2008). How practitioners (and others) can make scientifically viable contributions to clinical-outcome research using the single-case time-series design. *The International Journal of Clinical and Experimental Hypnosis, 50*(2), 114-148.

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

Carta, M., Balestrier, M., Murru, A., & Hardoy, M. (2009). Adjustment disorder: Epidemiology,

diagnosis and treatment. *Clinical Practice and Epidemiology in Mental Health.* http://dx.doi.org/10.1186/1745-0179-5-15

Casey, P. (2009). Adjustment disorder: Epidemiology diagnosis and treatment. *CNS Drugs, 23*(11), 927–938.

Castonguay, L., & Beutler, L. (2005). *Principles of therapeutic change that work*. New York, NY: Oxford University Press.

Center for the Study of Collegiate Mental Health. (2010, March). *2010 Annual Report* (Publication No. STA 11-000).

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

Cooper, S., & Archer, J. (1999). Brief therapy in college counseling and mental health. *Journal of American College Health, 48*(1), 21-28. http://dx.doi.org/10.1080/07448489909595668

Corey, G. (1996). *Theory and practice of counseling and psychotherapy* (5th ed.). Pacific Grove, CA: Brooks-Cole.

Cronbach, L. (1975). Beyond the two disciplines of scientific psychology. *American Psychology, 30*(2), 116-127.

Curtis, J., & Silberschatz, G. (1997). The Plan Formulation Method. In Eells, T. (Ed.), *Handbook of psychotherapy case formulation* (pp. 116- 136). New York Guilford Press.

DeMaat, S., Dekker, J., Schoevers, R., van Aalst, G., Gijsbers-van Wijk, C., Hendriksen, M., . . . de Jonghe, F. (2008). Short psychodynamic supportive psychotherapy, antidepressants and their combination in the treatment of major depression: A mega-analysis based on three randomized clinical trials. *Depression and Anxiety, 25*, 565-574.

http:/dx.doi.org/10.1002/da.20305.

De Souza Costa, D., Jardim de Paula, J. (2015). Usefulness of the reliable change index for psychology and psychiatry in clinical practice: A case report of cognitive-behavioral therapy. *Clinical Neuropsychiatry, 12*(5), 135-138.

Diener, M., Hilsenroth, M., & Weinberger, J. (2007). Therapist affect focus and patient outcomes in psychodynamic psychotherapy: A meta-analysis. *American Journal of Psychiatry, 164,* 936–941. http://dx.doi.org/10.1176/ appi.ajp.164.6.936

Ebbinghaus, H. (1913). *Memory* (H. Ruyer & C. E. Bussenius, Trans.). New York: Teachers College, Columbia University.

Fassinger, R. (2000). Applying counseling theories to lesbian, gay, and bisexual clients: Pitfalls and possibilities. In Perez, R., DeBord, K., & Bieschke, K. (Eds), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 107-131). American Psychological Association.

Fauman, B., & Hopkinson, M. (2010). Special populations. In Kay, J. & Schwartz, V. (Eds.), *Mental health care in the college community* (pp. 247-266). John Wiley & Sons Ltd.

Fosha, D. (2000). *The transforming power of affect: A model for accelerated change*. New York, NY: Basic Books.

Gallagher, R., & Bruner, L. (1995). *National survey of counseling center directors*. Alexandria, VA: International Association of Counseling Services.

Gallagher, R., & Bruner, L. (1996). *National survey of counseling center directors*. Alexandria, VA: International Association of Counseling Services.

Gallagher, R., & Bruner, L. (1997). *National survey of counseling center directors*. Alexandria, VA: International Association of Counseling Services.

Ghetie, D. (2007). The debate over time-limited treatment in college counseling centers. *Journal of College Student Psychotherapy, 22*(1), 41-61. http://dx.doi.org/10.1300/J035v22n01_04

Gorschenek, N., Schwab, R., & Eckert, J. (2008). Psychotherapy of adjustment disorders. *Psychotherapy, Psychosomatic and Medical Psychology, 58*(5), 200–207.

Greenberg, L. (1986). Research strategies. In L. S. Greenberg & W M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp.707-734). New York: Guilford Press.

Gyorky, Z., Royalty, G., & John, D. (1994). Time-limited therapy in university counseling centers: Do time-limited and time-unlimited centers differ? *Professional Psychology: Research and Practice*, *25*(1), 50-54.

Hansen, N., Lambert, M., & Forman, E. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9*, 329-343. http://dx.doi.org/10.1093/clipsy.9.3.329

Heinonen, E., Lindfors, O., Harkanen, T., Virtala, E., Jaaskelainen, T., & Knekt, P. (2014). Therapists' professional and personal characteristics as predictors of working alliance in short-term and long-term psychotherapies. *Clinical Psychology & Psychotherapy, 21*, 475-494.

Hill, C., Helms, J., Spiegel, S., & Tichenor, V. (1988). Development of a system for categorizing client reactions to therapist interventions. *Journal of Counseling Psychology, 35*, 27–36. http://dx.doi.org/10.1037/0022-0167.35.1.27

Hilsenroth, M. (2007). A programmatic study of short-term psychodynamic psychotherapy:

Assessment, process, outcome, and training. *Psychotherapy Research, 17*, 31-45. http://dx.doi.org/10.1080/10503300600953504

Hilsenroth, M., Ackerman, S., & Blagys, M. (2001). Evaluating the phase model of change during short-term psychodynamic psychotherapy. *Psychotherapy Research, 11*, 29-47. http://dx.doi.org/10.1080/713663951

Hilsenroth, M., Ackerman, S., Blagys, M., Baity, M., & Mooney, M. (2003). Short term psychodynamic psychotherapy for depression: An examination of statistical, clinically significant, and technique specific language. *Journal of Nervous and Mental Disease, 191*, 349– 357. http://dx.doi.org/10.1097/01.NMD.0000071582.11781.67

Horowitz, M., & Eells, T. (1997). Configurational analysis: States of mind, person schemas, and the control of ideas and affect. In Eells, T. (Ed.), *Handbook of psychotherapy case formulation* (pp. 166-191). New York Guilford Press.

Howard, K., Lueger, R., Maling, M., & Martinovich, Z. (1993). A phase model of psychotherapy outcome: Causal mediation of change. *Journal of Consulting and Clinical Psychology, 61*, 678-685.

Inchausti, F., MacBeth, A., Hasson-Ohayon, I., Simaggio, G., (2020). Psychological intervention and COVID-19: What we know so far and what we can do. *Journal of Contemporary Psychotherapy, 50*, 243-250.

Jacobson, N. S., & Christensen, A. (1996). Studying the effectiveness of psychotherapy: How well can clinical trials do the job? *American Psychologist, 51,* 1031–1039.

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

Jacobson, N. S., & Revenstorf, D. (1988). Statistics for assessing the clinical significance of psychotherapy techniques: Issues, problems, and new developments. *Behavioral Assessment, 10,* 133-145.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59(1),* 12-19.

Jaycox, L., Foa, E., & Morral, A. (1998). Influence of emotional engagement and habituation on exposure therapy for PTSD. *Journal of Consulting and Clinical Psychology, 66,* 185–192. http://dx.doi.org/10.1037/0022- 006X.66.1.185

Jones, E. (1993). Introduction to special section: Single-case research in psychotherapy. *Journal of Consulting and Clinical Psychology, 67,* 371-372.

Kaplan, H., & Sadock, B. (1998). *Synopsis of psychiatry*. (8th et.). Baltimore, Maryland: Williams & Wilkins.

Kazdin, A. (1978). Methodological and interpretive problems of single-case experimental designs. *Journal of Consulting and Clinical Psychology, 46,* 629-642.

Kazdin, A. (2022). *Research design in clinical psychology* (5th ed.). New York, NY: Cambridge University Press.

Knekt, P., Lindfors, O., Harkanen, T., Valikoski, M., Virtala, E., Laaksonen, M., . . . the Helsinki Psychotherapy Study Group (2008). Randomized trial on the effectiveness of long- and short-term psychodynamic psychotherapy and solution-focused therapy on psychiatric symptoms during a 3-year follow-up. *Psychological Medicine, 38*(5), 689–703.

Kopta, S., Howard, K., Lowry, J., & Beutler, L. (1994). Patterns of symptomatic recovery in

psychotherapy. *Journal of Consulting and Clinical Psychology, 62*, 1009-1016. http://dx.doi.org/10.1037/0022-006X.62.5.1009

Lambert, M. (Ed.). 2004. *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.). New York, NY: Wiley.

Lambert, M. (2013). Introduction and historical review. In Lambert, M. (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 3-20). Hoboken, NJ: Wiley.

Leichsenring, F., Rabung, S., & Leibing, E. (2004). The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: A meta-analysis. *Archives of General Psychology, 61*, 1208-1216. http://dx.doi.org/10.1001/archpsyc.61.12.1208

Levenson, H. (1995). *Time-limited dynamic psychotherapy: A guide to clinical practice*. New York, NY: Basic Books.

Levenson, H. (2017). *Brief dynamic therapy* (2nd ed.). American Psychological Association.

Levenson, H., Butler, S., Powers, T., & Beitman, B. (2002). *Concise guide to brief dynamic and interpersonal psychotherapy.* Washington, DC: American Psychiatric Press.

Levenson, H., & Strupp, H. (1997). Cyclical maladaptive patterns: Case formulation in time-limited dynamic psychotherapy. In Eells, T. (Ed.), *Handbook of psychotherapy case formulation* (pp. 84-115). New York Guilford Press.

Lilliengren, P., Johansson, R., Lindqvist, K., Mechler, J., & Andersson, G. (2016). Efficacy of experiential dynamic therapy for psychiatric conditions: A meta-analysis of randomized control trials. *Psychotherapy: Theory, Research, & Practice, 53*, 90-104. http://dx.doi.org/10.1037/pst0000024

Locke, B., Buzolitz, J., Lei, P., Boswell, J., McAleavey, A, Sevig, T., . . . Hayes, J. (2011).

Development of the Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62). *Journal of Counseling Psychology, 58*, 97-109. doi:10.1037/a0021282

Luborsky, L. (1997). The core conflictual relationship theme: A basic case formulation method. In Eells, T. (Ed.), *Handbook of psychotherapy case formulation* (pp. 58-83). New York Guilford Press.

Maina, G., Forner, F., & Bogetto, F. (2005). Randomized controlled trial comparing brief dynamic and supportive therapy with waiting list condition in minor depressive disorders. *Psychotherapy and Psychosomatics, 74*(1), 43–50.

Magnavita, J. (2006). The centrality of emotion in unifying and accelerating psychotherapy. *Journal of Clinical Psychology, 62*, 585–596. http://dx.doi.org/10.1002/jclp.20250

Mann, J. (1991). Time limited psychotherapy. In Crib-Christoph, P., & Barber, J. (Eds.), *Handbook of short-term dynamic psychotherapy* (pp. 17-44). New York Basic Books.

Marcolino, J., & Iacoponi, E. (2003). The early impact of therapeutic alliance in brief psychodynamic psychotherapy. *Therapeutic Alliance and Brief Psychotherapy, 25*(2), 78-86.

Markowitz, J., Kocsis, J., Fishman, B., Spielman, L., Jacobsberg, L., Frances, A., Klerman, G., & Perry, S. (1998). Treatment of depressive symptoms of human immunodeficiency virus-positive patients. *Archives of General Psychiatry, 55(*5), 452-457.

Martin, D., Garske, J., & Davis, M. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450. http://dx.doi.org/10.1037/0022-006X.68.3.438

May, R. (1988). Boundaries and voices in college psychotherapy. In R. May (Ed.),

Psychoanalytic psychotherapy in a college context (pp. 3-21). New York, NY: Praeger Publishers.

McCullough, L., & Magill, M. (2009). Affect-focused short-term dynamic therapy: Empirically supported strategies for resolving affect phobias. In R. A. Levy & J. S. Aboln (Eds.), *Handbook of evidence-based psychodynamic psychotherapy* (pp. 249-277). New York, NY: Humana Press. http://dx.doi.org/10.1007/978-1-59745-444-5_11

McCullough, L., Winston, A., Farber, B., Porter, F., Pollack, J., Laikin, M., Trujillo, M. (1991). The relationship of patient–therapist interaction to outcome in brief psychotherapy. *Psychotherapy, 28,* 525–533. http://dx.doi.org/10.1037/0033-3204.28.4.525

McDaniel, J., Purcell, D., & D'Augelli, A. (2001). The relationship between sexual orientation and risk for suicide: Research findings and future directions for research and prevention. *Suicide and Life-Threatening Behavior, 31*(1), 84-105.

Medalie, J. (1987). Psychotherapy referral as a therapeutic goal of college counseling. *Journal of College Student of Psychotherapy, 1*(4), 83-103.

Messer, S., & Holland, S. (1998). Therapist interventions and patient progress in brief psychodynamic therapy: Single-case design. In Bornstein, R., & Masling, J. (Eds.), *Empirical studies of the therapeutic hour* (pp. 229-257). American Psychological Association. http://dx.doi.org/10.1037/10275-007

Messer, S., & Warren, C. (1995). *Models of brief psychodynamic therapy: A comparative approach*. New York, NY: Guilford Press.

Michel, L., Drapeau, M., Despland, J. (2003). A four session format to work with university students: The brief psychodynamic investigation. *Journal of College Student Psychotherapy, 18*(2), 3-14.

O'Conner, B., & Cartwright, H. (2012). Adjustment disorder. *Handbook of Evidence-Based Practice in Clinical Psychology*, 493-506.

O'Donnell, M., Agathos, J., Metcalf, O., Gibson, K., & Lau, W. (2019). Adjustment disorder: Current developments and future directions. *International Journal of Environmental Research and Public Health, 16,*2 537.

O'Donnell, M., Alkemade, N., Creamer, M., McFarlane, A., Silove, D., Bryant, R., Felmingham, K., Steel, Z., & Forges, D. (2016) A longitudinal study of adjustment disorder after trauma exposure. *American Journal of Psychiatry, 173*, 1231-1238.

Pavlov, I. P. (1927). *Conditioned reflexes: An investigation of the physiological activity of the cerebral cortex* (G. V. Anrep, Trans.). New York: Oxford University Press.

Penn State Student Affairs: Center for Collegiate Mental Health. (2023). *How to access the CCAPS 34 & 62*. https://ccmh.psu.edu/how-to-access-ccaps-34-62-

Pinkerton, R., & Rockwell, W. (1994). Very brief psychological interventions with university students. *Journal of American College Health, 42*, 156-162.

Pos, A., Greenberg, L., Goldman, R., & Korman, L. (2003). Emotional processing during experiential treatment of depression. *Journal of Consulting and Clinical Psychology, 71*, 1007–1016. http://dx.doi.org/10.1037/ 0022-006X.71.6.1007

Rice, L., & Greenberg, L. (Eds). (1984). *Patterns of change: Intensive analysis of psychotherapy process*. New York: Guilford Press.

Rockland-Miller, H., & Eells, G. (2006). The implementation of mental health triage systems in university health systems. *Journal of College Student Psychotherapy, 20*(4), 39-51.

Safran, J., & Muran, J. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York, NY: Guilford Press.

Salzburg, C., Strain, P., & Baer, D. (1987). Meta-analysis for single-subject research: When does it clarify? When does it obscure? *Remedial and Special Education, 8,* 43-49.

Scruggs, T. E., & Mastropieri, M. A. (1998). Summarizing single subject research. *Behavior Modification, 22,* 221-242.

Searle, A. (1999). *Introducing research and data in psychology: A guide to methods and analysis*. New York: NY: Routledge.

Shapiro, D., Rees, A., Barkham, M., Hardy, G., Reynolds, S., & Startup, M. (1995). Effects of treatment duration and severity of depression on the maintenance of gains after cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting and Clinical Psychology, 63,* 378-387. http://dx.doi.org/10.1037/0022-006X.63.3.378

Siegal, D. (2006). An interpersonal neurobiological approach to psychotherapy. *Psychiatric Annals, 36,* 248-256.

Siegel, D. (2007). *The mindful brain.* New York, NY: Norton.

Skeels, H. (1966). Adult status of children with contrasting early life experiences. *Monograph of the Society for Research in Child Development, 31*(3).

Skinner, B. F. (1938). *The behavior of organisms*. New York: Appleton-Century-Crofts.

Steenbarger, B. (1992a). Toward science-practice integration in brief counseling and therapy. *The Counseling Psychologist, 20*(3), 403-450.

Steenbarger, B. (1992b). Intentionalizing brief college student therapy. *Journal of College Student Psychotherapy, 7*(2), 47-61.

Steinhardt, M., & Dolbier, C. (2008). Evaluation of resilience intervention to enhance coping strategies and protective factors and decrease symptomology. *Journal of American College Health, 56,* 445-453.

Stirman, S., DeRubeis, R., Crits-Christoph, P., & Rothman, A. (2005). Can the randomized controlled trial literature generalize to nonrandomized patients? *Journal of Consulting and Clinical Psychology, 73*(1), 127–135.

Stone, G., & Archer, J. (1990). College and university centers in the 1990s. *The Counseling Psychologist, 18*, 593-607.

Strain, J., & Diefenbacher, A. (2008). The adjustment disorders: The conundrums of the diagnoses. *Comprehensive Psychiatry, 49*(2), 121–130.

Strain, J., & Newcorn, J. (2003). Adjustment disorders. In R. E. Hales & S. C. Yudofsky (Eds.), *Textbook of clinical psychiatry* (4th ed., pp. 765-780). Washington, DC: American Psychiatric Publishing

Strupp, H. & Binder, J. (1984). *Psychotherapy in a new key.* New York: Basic Books.

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

Town, J., Hardy, G., McCullough, L., & Stride, C. (2012). Patient affect experiencing following therapist intervention in short-term dynamic psychotherapy. *Psychotherapy Research, 22,* 208–219. http://dx.doi.org/10.1080/10503307.2011.637243

Travis, L., Binder, K., Bliwise, N., & Horne-Moyer, H. (2001). Changes in clients' attachment styles over the course of time-limited dynamic psychotherapy. *Psychotherapy, 38*(2), 149-159.

Vanin, J. (2008). Adjustment disorder with anxiety. In J. R. Vanin & J. D. Helsley (Eds.), *Anxiety disorders: A pocket guide for primary care* (pp. 129-143). New York, NY: Humana Press.

Vonk, M., & Thyer, B. (1999). Evaluation of the effectiveness of short-term treatment at university counseling centers. *Journal of Clinical Psychology, 55*(9), 1095-1106.

Watson, J. B. (1925). *Behaviorism*. New York: Norton.

Watson, T., Meeks, C., Dufrene, B., & Lindsay, C. (2002). Sibling thumb sucking: Effects of treatment for targeted and untargeted siblings. *Behavior Modification, 26*, 412-423.

Westen, D., & Bradley, R. (2005). Empirically supported complexity. *Current Directions in Psychological Science, 14*, 266–271.

Westen, D., Novotny, C. M., & Thompson-Brenner, H. K. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin, 130*, 631–663.

Whelton, W. (2004). Emotional processes in psychotherapy: Evidence across therapeutic modalities. *Clinical Psychology & Psychotherapy, 11*, 58–71. http://dx.doi/org/10.1002/cpp.392

Whitaker, L. (1994). Managed care: Who cares about psychotherapy? *Journal of College Student Psychotherapy*, *9*(2), 7-17.

White, D., Rusch, F., Kazdin, A., & Hartmann, D. (1989). Applications of meta-analysis in individual subject research. *Behavioral Assessment, 11*, 281-296.

White, O. (1982). A critique of the effectiveness of applied behavior analysis research. *Advances in Behavior Research and Therapy, 4*, 75-96.

Widseth, J., & Webb, R. (1992). "Toddler" to the inner world: The college student in psychotherapy. *Journal of College Student Psychotherapy*, *6*(3-4), 59-75.

Wolgast, B., Lambert, M., & Puschner, B. (2003). The dose-response relationship at a college counseling center: Implications for setting session limits. *Journal of College Student Psychotherapy, 18*(2), 15-30.

Yin, R. (2009). *Case Study Research Design and Methods.* (4th ed.). Thousand Oaks, CA: SAGE

Publications, Inc.

Zelviene, P., & Kazlauskas, E. (2018) Adjustment disorder: Current perspectives. *Neuropsychiatric Disease and Treatment, 14*, 375-381.

Zilcha-Mano, S., Dinger, U., McCarthy, K., & Barber, J. (2014). Does alliance predict symptoms throughout treatment, or is it the other way around? *Journal of Counseling and Clinical Psychology, 82*, 931-935.