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Interpreting Empirical Assessments from a Behavioral Perspective:

A Rationale for Why and How

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BY
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Historically behaviorists have rejected the use of traditional assessment procedures in clinical treatment and practice. This is mainly because traditional assessment has been used to diagnose symptoms and syndromes, and to identify personality traits and types, rather than to facilitate a functional analysis. Behavioral assessment is about gathering data from direct, in situ observation and manipulation. The behavioristic emphasis is on idiographic assessment to inform conceptualization, rather than comparing the individual to normative data. It rejects global trait descriptions and the diagnosis of symptoms and syndromes. However, over the years there has been a shift to an approach that utilizes psychometric assessment tools (Cone, 1988). Yet, despite this, many behaviorists still reject the use of such tools in favor of observational and self-report methodologies. However, the belief that assessment tools can only be used when the interpretation is congruent with the theoretical roots of the instrument is false.

This paper provides a rationale on why and how to utilize assessment tools effectively within the behavioral framework through idiographic assessment. Empirical assessment instruments can provide guidance to the behaviorist that may prove useful in the idiographic formation of a behaviorally-based treatment plan. This perspective is consistent with the behavioral principle of pragmatism. The paper will focus on two of the major traditional instrument tools, the Minnesota Multiphasic Personality Inventory and the Rorschach inkblot test.

One of the arguments against the utility of empirical assessment tools is that they have poor predictive ability. Traditional assessment tools have been used to identify a sign of a person’s true personality, which in theory would provide predictive ability of his behavior in a broad range of situational contexts. However, as Walter Mischel (1968) has repeatedly shown in his research, the predictive utility of a trait-based approach to personality still remains weak. The interaction between a trait measure and a specific situation may provide more information about specific behavior than the isolated predictor. The trait or variable may be any construct on which individuals differ (Endler
& Magnusson, 1976). Thus, the better use of such scores and tests is not to attempt to predict a person’s behavior in all situations based on a single personality trait, but rather to focus on the variability in individuals’ behaviors in context to describe conditional behavior relations. This is consistent with behavioral principles, to increase predictive precision.

Another practical rationale for the usefulness of empirical assessment tools is it allows for the collection of information that may not arise during clinical interview (or in situations when the subject is observed). This may be due to the client’s lack of understanding of his problems, which also may be due to the vague and diffused nature of his problems. Data obtained from traditional assessment tools may offer additional information to create a conceptualization of the client. This is not to replace a thoughtful behavioral functional assessment, but rather to highlight that a client may not offer enough information to help create an effective conceptualization. Assessment tools allow for a multitude of questions to be pursued by the clinician. Further, reliance on a client’s self-report alone or the clinician’s own observation is just not enough data, nor is it always good data.

Good assessment and conceptualizations integrate data from various sources. People are inherently biased and how a person interprets his own behavior or how one interprets another’s behavior is not a good sample of information. Integrating data from tests, observation, self-report, and other collateral sources allow for a deeper, and more informed analysis of the individual (Cohen, 1996). Also, testing allows the clinician to follow-up with the client about information observed or reported during the interview. I am not advocating for the clinician to mistrust the client or to reject his reports, but rather to understand the reporting behavior itself as subject to contingencies in the environment in which it occurs (Karson, 2006). It also provides the clinician with the opportunity to increase the client’s awareness of his behaviors, which may lead down the road to effective change.
One additional advantage of the use of traditional assessment is it is cost-effective. A good comprehensive assessment battery can provide a wide breadth of data points to create a well-informed and individualized conceptualization of the client.

Thus, traditional, empirical assessment instruments can be useful in providing idiographic understanding of the client. The use of traditional assessment data, along with other information (e.g. client self-report, functional analysis of history, clinical observations, medical records, employment records, friends and family accounts, etc.) provides a rich and broad overview of the client and his functioning that gives rise to a more individualized analysis and guidance to an effective treatment plan.

It is important to understand that assessment data are useful in their ability to predict behavior and it is the behaviors that are of concern, not the overall test score. Thus when an assessment score suggest borderline characteristics, it is the clinician’s responsibility to interpret those behavioral patterns that are relevant and contributing to an individual’s distress, and to predict when those behavioral patterns occur through understanding the function of them in relation to their situational contexts.

The first assessment instrument to be discussed is often referred to as a projective or performance test, the Rorschach. Projective tests are usually described as assessing the unconscious processes of the individual. However, from a behavioral perspective, the Rorschach, like other projective tests, is more useful as a method to understand how an individual responds to ambiguous stimuli. While some argue against the validity of using arbitrary stimuli for this purpose, Skinner (1953) who created a projective test called the Verbal Summator, asserted that the variables that control behavior during testing are likely the same variables that control behavior in other ambiguous situations. This is especially important as direct observation of behavior in the environment is difficult (especially since observation changes that environment), and a client’s report
of his behavior in varying situations is not always reliable either to due impression management or lack of sensitivity to one’s own behaviors.

**Rorschach**

The Rorschach inkblot method was created in 1921 by Hermann Rorschach. It is most often used to analyze personality and emotional functioning. It is the second most commonly used assessment tool in forensic settings (Gacano & Reid, 1994). Although the Exner Scoring System (developed in the 1960s) claims to have addressed many criticisms of the original testing system with an extensive body of research, some researchers continue to raise questions about its validity. Some of these issues include the objectivity of testers, inter-rater reliability, the verifiability and general validity of the test, bias of the test's pathology scales towards greater numbers of responses, the limited number of psychological conditions which it accurately diagnoses, the inability to replicate the test's norms, its use in court-ordered evaluations, and the proliferation of the ten inkblot images, potentially invalidating the test for those who have been exposed to them (Lilienfeld, Wood, & Garb, 2001). It is still the most widely used system in scoring the Rorschach. In the system, responses are scored with reference to their level of vagueness or synthesis of multiple images in the blot, the location of the response, which of a variety of determinants is used to produce the response, the form quality of the response, the contents of the response, the degree of mental organizing activity that is involved in producing the response, and any illogical, incongruous, or incoherent aspects of responses. Using the scores for these categories, the examiner then performs a series of calculations producing a structural summary of the test data (Exner, 2001). For the purpose of this paper, the focus will be limited to a select few indices.

**Lambda**

Lambda is the number of responses using only form (and not color, shading, or movement) divided by the responses that included color, shading, or movement (Exner, 2001). Within the Exner
system, it is commonly interpreted as the amount of energy one puts into responses. It is an index of one’s responsiveness to stimuli and psychological willingness to become involved with ambiguous stimuli. Someone who scores what is considered to be a high Lambda is likely to be described as over-controlled, conservative, insecure, and/or fearful of involvement. It is likely that in emotionally evocative or threatening situations, he sticks to the facts, screening out relevant information.

By responding simplistically, he is engaging in a control strategy, either to make the task easier or to avoid color, shading, and movement. Rorschachers generally think that color on the Rorschach is treated as emotions are treated in life, shading as stressors, and movement as imagination. It is likely that due to the individual’s history, he may have created a narrative of the self that is so critical and condemning that coming into contact with that may be too aversive for him to willingly experience. Thus, he attempts to distance himself by approaching threats in a simplistic and constricted manner. Constriction of course is also associated with eventual impulsivity, and Lambda predicts impulsivity in many domains (Rose, Boyd, & Maloney, 2001). It is probable that this same approach is used within the individual’s world, and suggests a deficit of effective coping skills to handle perceived threats to self.

Behaviorally, an elevated Lambda suggests that emotional, imaginal, and stressful stimuli are unusually aversive. If impulsive behavior is observed, then exposure to unpleasant thoughts and feelings would be recommended. Efficient functioning should be suspected of fragility, since it may depend on simple situations. Very low Lambda suggests that the person is more responsive to emotional, stressful, and imaginal stimuli than most people. Acceptance and Commitment Therapy’s (ACT) interventions related to meditation—noting thoughts and feelings, accepting them, and moving on—would be relevant.
Processing Efficiency - Zd

Before explaining the Processing Efficiency Index, one should first understand Organizational (Z) Activity since the Zd is derived from the Z score. A Z score is assigned when the person organizes the inkblots, either by using the whole thing, relating perceived objects to each other, or integrating a blot area with white space. It has positive correlations to components of intelligence testing, “.43 and .52 between Wechsler I.Q.” (Exner, 1974, p. 112).

The Processing Efficiency (Zd) score provides an index of intensity versus laxity of organizing. The size of the Z score (ranging from 1.0 to 6.5) assigned to any response is determined by a scoring table; the scores were developed through a combination of statistics and judgment about how much organizational activity was required. For examples, using the whole inkblot on an easy-to-organize card like V earns a Z score of 1.0; integrating white space with ink on VI, where it rarely happens and is hard to do, earns a Z score of 6.5. The Zd is the total score minus the score you would normatively expect given the number of answers with Z scores. The difference is recorded with the appropriate sign.

The individual who scores a high Zd is described as having an overincorporative approach to problem-solving, investing more effort in organizing stimuli. This individual is described as being perfectionistic, but in the extreme, obsessive. He can lose sight of the forest for the trees. Studies have shown patients with high organizational activity are prone to “project conflicts” (Exner, 1974, p. 112). It may be that the thought of unaccounted details is aversive and attempting to control for ambiguity is satisfying. For some people, living in the space of unpredictability and uncontrollability is extremely uncomfortable, and this can easily lead to aversive control. An in-patient study showed that people diagnosed as compulsive, hypomanic, and psychopathic tended to yield higher Zd scores (Exner, 1974).
On the opposite end of the spectrum, a person who scores a low Zd is described as having an *underincorporative* style, which means that he processes information in a less organized style with less effort. Studies show that depressed patients tend to provide lower levels of organizational activity (Hertz, 1948). When navigating everyday situations or approaching a conflict, it is likely that the individual will neglect to consider relevant details. Low scorers are often described as impressionistic, having a trial-and-error approach to problem-solving, and often relying on his gut reactions to situations (Groth-Marnat, 2009). This can thus lead to seemingly impulsive or erratic behaviors. Diagnostically this may resemble someone who has histrionic tendencies.

In both extremes, the individual is mis-appraising the costs of situations. The overincorporator may see trivial events as having severe risks. Further, the ambiguity in everyday events may be extremely aversive to the individual, especially if he is cognitively fused to the idea of ambiguity meaning danger. This may lead to apprehension and desperately attempting to control loose ends in work and life in an effort to minimize threat, or avoid danger stimulus cues. Further, by engaging in these behavioral strategies the private behaviors are strengthened, such as the thought, “I avoid disaster when I can account for every detail.” In treatment, consider behavioral interventions focusing on experiential exposure to his sense of apprehension through direct contact with loose ends in life and cognitive defusion around the idea of what safety and danger means to the individual.

The underincorporator approaches the world more carelessly. He may discount the severity of the consequences of his actions. In treatment with this individual, it often would be beneficial to work with the client in slowing down his processes before acting. Using the ACT and Dialectical Behavioral Therapy (DBT) model, this means staying in contact with himself in the present moment before impulsively acting. Work would also include learning how to describe his emotions and the occasioning events to allow for more purposeful action and intervention. This would afford him
more time to appreciate the situation more fully (using his “wise mind”), and to regulate his emotions if he is dysregulated. Treatment also includes working with the client in making more effective decisions. This would entail assessing the workability of his approach and discriminating between the long-term and short-term consequences of his actions, leading to more informed, and hopefully more successful, behaviors.

It is also worth noting that when working with these clients, their style of engagement tends to evoke and shape a style of behavior from the therapist that is somewhat common for others who are interpersonally related. Therapists who work with a client who have obsessive tendencies can be shaped to respond to the client in a relatively more emotional manner, the reason being that a client whose strategy is to be rational and controlled can evoke the opposite response from others, like the therapist. In contrast, the client who tends to be more emotionally impulsive can shape others to act more prudently. The therapist should avoid maintaining underincorporative or overincorporative behaviors by responding complementarily to them.

**Experience Balance (Erlebnistypus) - EB**

The Experience Balance (EB) is the relationship between two major variables, human movement and the weighted sum of the chromatic color responses (Sum M: WSumC). The weighted sum color is obtained by multiplying each type of color response by a weight. The manner in which color is handled reflects the style in which a person deals with his emotions. Pure color responses (C, with a weight of 1.5) are based exclusively on the chromatic features of the blot (“blood,” for example, without reference to the shape). These responses are less frequent compared to the other types of color responses. Pure C responses are often seen as an indicator of acting very impulsively, since they imply emotional responding without input from executive functions. Color-Form responses (CF, with a weight of 1.0) primarily use color features of the blot but includes reference to form in creating the percept (“blood spatter,” for example, or “a grass patch”). They are understood
to suggest reduced impulse control, or excessive emotionality. Form-Color responses (FC, with a weight of 0.5) represent the most controlled use of color (“red bowtie” or “blue crab”). They involve responses where form features are primarily used in the percept and color is also used for purpose of elaboration (Exner, 1974).

When interpreted, if color dominates (C, CF), then affect is likely to be poorly controlled and disorganized. In such cases, affect is disruptive and the person could be expected to be emotional, labile, and over-reactive. Individuals who could effectively delay their responses in a problem-solving task had a higher number of FC responses in their protocols, whereas those who had difficulty delaying their responses had more CF and C responses (Rose, Boyd, & Maloney, 2001). However, when CF and C are absent, there may be over-control of emotions (Groth-Marnat, 2009).

Human movement responses are probably one of the most interesting types of responses given, because they are responses in which a person sees activity in a still-life picture. The individual makes meaning out of ambiguity and interprets an agenda in the picture that is so compelling that it overrides the fact that the stimulus is static. It is seen as a major indicator of empathy, because the response strength must be great to see humanity in the inkblots to produce an M. Also, it is often understood as the ability to reflect on oneself and one’s situation, and respond appropriately. Research has documented longer delay in response time and has correlated higher M responses with productivity (Exner, 1974).

The Experience Balance ratio (EB) is described as the individual’s problem-solving style. Researchers view the EB ratio as the extent to which a person is internally oriented as opposed to being more externally directed and behaviorally responsive to outside stimuli (Groth-Marnat, 2009). While in general people tend to be externally oriented, someone who is relatively more internally oriented than most is described as being *introversive* and this is indicated by a higher value on the left
(M) side of the EB. In contrast, having a higher value on the right (sumC) side is described as *extratensive*, and is someone who is more directed by outside stimuli than most. Neither style is considered to be necessarily pathological, but rather more of a pattern of problem-solving. When the two styles are roughly equal, the Rorschach term is *ambitent* (Exner, 1974).

The introversive individual is thought to be more oriented toward using his inner experiences in problem-solving. He is often seen as cautious and deliberate in decision making. He tends to be thoughtful in reviewing information and engages in few public behaviors before approaching a solution. This individual is less driven by emotions, and attempts to exert more control over his feelings while pondering a solution. This leads to the ability to delay gratification. The delay in gratification may be satisfying for the individual especially if the product of doing so results in successful decision making or alleviation of distress. In the extreme cases, when this style creates problems for the individual, it is likely because the individual excessively avoids emotionality or impulsivity. He may believe that the best way to “remove” these aversive experiences is by engaging in fixed behaviors to alleviate the stress or anxiety caused by having these thoughts or feelings. Diagnostically, this may be an individual who presents with obsessive-compulsive traits. In treating an individual who has an ineffective behavioral pattern such as this, one would want to explore his fused ideas (“mistakes are dangerous,” for example, or “emotions are messy”) and use experiential exercises to move towards defusing from these thoughts. This will also help the individual evaluate whether his behaviors are effective in moving him toward his goals or if his behaviors are a method of control to avoid aversive thoughts and feelings. Again, by using experiential exercises he can move towards acceptance of aversive experiences and reduce the control these experiences has over his life.

In contrast, the extratensive individual defines situations according to external stimuli even more than most people do. This person is likely intuitive and inclined to use his feelings in problem-
solving. He is likely to approach decision-making by experimentation and trial-and-error. He is spontaneous and can be seen as assertive, but has trouble with delaying gratification (Groth-Marnat, 2009). This pattern of problem-solving can become problematic, especially if the individual’s judgment is poor. There are many reasons as to why a person would develop this pattern of behaving, such as the reward of immediate responding, receiving an outcome/feedback quickly, indulging in positive feelings, or being praised as “assertive.” However, in the extreme cases, when the individual tends to be more emotionally reacting, he may find himself in conflicts or engaging in ineffective behaviors. Using behavioral techniques to identify the effectiveness of the individual’s behavior in moving towards values can be beneficial, because the technique emphasizes deferred consequences. Exploring if the individual is satisfying short-term desires at the expense of long-term goals and values may help him make more effective decisions with more positive consequences.

Order and predictability may be aversive for this individual; therapists should thus expose the extratensive client to order by maintaining a solid therapeutic frame with respect to time limits, self-disclosure, and subjects discussed.

When neither the value on the left (M) side or on the right (SumC) side of the EB is significantly different, then the person is described as having an ambitent style with no distinctive pattern of responding. However, ambitent may be more of a misnomer than an actual type of approach. It is erroneous to assume that a lack of significant difference between the scores means that there is a third option. The research does not support an ambitent group, and rather it would be more appropriate to consider these individuals who fall in between introversive and extratensive as unknown at the time of testing. Even if there are a group of ambitent people, the Rorschach is not sensitive enough to identify them (Karson, 2004). It is possible that these individuals who fail at the time to fit either style may be less constrained to a specific style of approach or that the inkblot
stimuli did not evoke a consistent response style. They may have been unsure of how to respond to the ambiguity.

**Stress Tolerance Index (D) and Adjusted D (adjD)**

All of the determinants in the Comprehensive System, except dimensionality (FD) and reflection (Fr/rF), are combined in the Stress Tolerance Index (D). Its main factors are the Experience Actual (EA) and Experienced Stimulation (es) indices. EA is interpreted as an index of available coping resources for experienced stressors (Weiner, 1998). The two variables composing EA are M and WSumC. As mentioned above, M represents an ideational style, which could be also be interpreted as beliefs about control. Subjects who give more M responses have been described as being prone to more socially effective behaviors (Exner, 1974). In contrast, WSumC is thought to be an emotionally expressive style, which could be interpreted as not being as influenced by cognitive beliefs as by affect. The second component in D, es, contains all the following variables: SumFM (all animal movement responses) plus m (inanimate movement) and the sum of the achromatic variables: C’ (achromatic color: black, white, grey responses), T (shading used as texture), Y (use of shading), and V (shading used to see three-dimensionality) (Exner, 2001). The variable es is interpreted to measure the degree of a person's disorganization and helplessness. The individual scoring high on es has a low frustration tolerance, and it is difficult for him to be persistent, even in meaningful tasks. So essentially, when combined, D is a means of evaluating the degree of available resources the person has (EA) versus the amount of disorganized psychological events that are occurring beyond the person's control (es) (Groth-Marnat, 2009).

An individual who has a high D is thought to be able to adequately deal with his current level of stress. Even if he is experiencing stress (high es), the relatively higher EA indicates that he has adequate resources to cope effectively with this stress. An extremely high D may reflect over-
concern with practical, concrete interests, and preoccupation with the obvious. He may have the
tendency to back away from effort (Groth-Marnat, 2009).

A low D score indicates that es characteristics have relatively more weight than EA, so the
person is experiencing more stress than he can handle. The person is likely to feel overwhelmed and
unable to deal with complex or ambiguous situations. His thoughts, affects, and public behaviors
might be impulsive and ineffective. He likely feels tense and irritable, has a limited tolerance for
frustration, and a tendency to act impulsively. An individual may present with a sense of being
overloaded, easily distracted, and having limited psychological resources to deal with stress most
commonly in response to a loss or stressful event. As described, much of the factors incorporated
into es are non-human movement, shading, and achromatic responses which tend to represent
feelings of inferiority, depressed affect, a painful self-appraisal and an extent to which a person is
experiencing life events that are beyond his ability to control (Groth-Marnat, 2009).

Adjusted D (adjD) on the other hand reflects an individual's general stress tolerance when
indicators of current stressors are removed from the record. Since the D Score includes measures of
one’s current capacity to deal with stress, it may not provide a measure of the person's usual ability
to modulate and control his behavior. This issue is particularly likely to be present for clients
referred for evaluation, because the events surrounding a referral usually involve psychosocial
difficulties. These situational uncontrollable stressful events are expressed in the D Score by the
presence of m and Y responses, which become more numerous in response to current stressors
(Rose, Boyd, & Maloney, 2001). Adj es has m and Y subtracted from it, so it theoretically removes
the influence of current environmental stressors. What remains in the Adjusted D score is a measure
of the person's general capacity to tolerate stress and to control behaviors (Groth-Marnat, 2009).
Despite the removal of most of the m’s and Y’s, what is left is still the sense of inferiority, depressed
affect, negative self-appraisal, uncertainty, confusion, and even ambivalence about one's own feelings.

It may be hard to believe that the way one treats color or any of these factors is a reflection of one's approach to the world, but the research strongly support that what has been suggested above. For instance, using empirical guidelines for interpreting assessment effect sizes, 13 Rorschach variables were found to have excellent support, and 17 had good support — one being the Adj D score (Mihura, Meyer, Dumitrascu, & Bombel, 2013). Therefore it is possible for a clinician to treat individuals’ responses as a reflection of the subject's learning history and approach to the world. It is unlikely that low scorers have learned how to effectively manage stress. It may be that they never had, or had very few and less severe, encounters with stressful events. It is possible that these individuals were negatively reinforced in some way which keeps them in this narrow way of responding to stress. Individuals who struggle with experiential stress to this extent are likely trying to retreat from reality. In these cases, there is a lack of willingness to accept the way things are. Commonly these individuals engage in strategies to avoid or control these experiences. However, despite their efforts, once they become stuck in these beliefs and affects, everything they attempt to do to rid themselves of these aversive feelings only intensifies them. What was once an uncomfortable affect response to stress is now a terrorizing state that they are desperately attempting to escape. Once low scorers are able to willingly accept whatever stressful event has occurred, they will be freed from the struggle of hopeless pain. Learning to take a willing and accepting stance in life will help loosen up the rigidity they experience in times of stress. One way to do this is through practicing mindfulness and radical acceptance. Nonjudgmental defusion exercises will help individuals to move away from “should” beliefs about the world and move towards the direction of willing acceptance of the way things are, instead of the way they wish or fear they are.
Form Quality

Protocol responses can be differentiated into two basic categories, those with good form (the inkblot looks like the response), and those with poor form (the response strength is great enough to overcome the demands of the environment). The symbol “+” is used for good form answers, and the symbol “–” for poor form answers. This refers to the “goodness of fit” of the responses given the area of the blot used. In the Exner system, the use of either symbol is based on the statistical frequency with which any given type of response occur to specific location areas. In a system (Mayman, 1970) that ought to appeal more to behaviorists, the response is coded as right or wrong depending on what the inkblot looks like to people who are very familiar with them. Exner constructed elaborate tables to determine scoring by card, location areas, and content. Plus (+) responses indicate a successful combination of imagination that is reality congruent because the response conforms to the structural properties of the blot areas used. The reader can see from this interpretation that Mayman’s system of expert judgment is superior to Exner’s system of putting it up to a vote. If a response is common in the general population, it almost certainly looks like the inkblot, but many uncommon responses also look like the inkblot (Karson & Kline, 2004). Minus (-) responses represent a gross disregard for the structural properties of the blot areas used, thus suggesting (Exner, 1974) or indicating (Mayman, 1970) poor reality testing. To the extent that perception is a respondent, mistakes indicate interference with accuracy, and inaccuracy must reduce response efficiency. To the extent that perception is an operant, mistakes mean that the response strength of the percept was great enough to overcome the demands of the situation, also a sure indicator of disadvantageousness.

Distorted Form (X-%)

The X-% represents the proportion of responses misidentifying stimulus features. Responses with poor form reflect a personal response style of the individual that causes the stimulus field to be
disregarded and replaced by the private understanding of the person that becomes projected into the response. Minus responses represent a disregard for, or distortion of reality (especially using Mayman’s approach). Frequently, minus responses will have some continuity for location, determinants, or content which, in turn, can provide some insights into the antecedents of the perceptual dysfunction. The higher the X-%, the more likely the person will have a significant level of impairment. For example, moderately high percentages (X-% = 20%) are found for people with depression, and 37% is characteristic of an individual with schizophrenia. Any percentage above 20% suggests that the person will have difficulty with reality testing due to poor abstractions. In Mayman’s system, which does not penalize subjects for being creative, any minus response means a distortion unless it is offered as an afterthought or with the knowledge that it does not do justice to the blot area. If this score is 15% or greater, it is believed the individual has a significant tendency to distort reality (Groth-Marnat, 2009). The individual who responds in this manner is likely very insensitive to or avoids certain discriminative cues in the environment. It is plausible that for an individual who finds reality frightening and punishing that escaping into a world of his own could be reinforcing.

When working with a person with this presentation the clinician must first start with a functional analysis (as in any case) to understand which contexts and what stimulus cues the individual avoids being present with. Once one is able to understand the punishing contingencies in the environment, then one will be able to understand how escape from reality could be reinforcing. Then depending on how severe the poor reality testing, if necessary, with possible medication, the clinician can then work with the client on increasing sensitivity to both the reinforcing and punishing properties in his environment. It is possible that when the individual is sensitive to the reinforcing properties in his environment he will also be able to stay present with the punishing aspects of reality.
Poor form quality ought also to alert the therapist that the therapist and client may have very different views of what they are doing together. Therapy often starts with the client's generalization from benign authority figures, but the client who distorts reality may not have a trusting repertoire to draw on. The therapy may need to distinguish the therapy environment from punishing relationships, and it will have to do this in a way that does not so completely distinguish it as to ensure that behaviors learned in therapy will not generalize (Karson, 2008).

**Unusual Form (Xu%)**

In the Exner system, Xu% represents the proportion of unusual responses in the protocol. These are the responses reported by less than 2% of the norming sample but which are quickly and easily perceived by the psychologist. Why a response should be seen quickly and easily to count as good reality contact has never been explained (Karson & Kline, 2004). Why the psychologist's judgment should be deferred to in scoring “u” but not in scoring “+” or “-“ has also never been explained. The significance of these responses is they do not occur very frequently even though the responses are congruent with the structural properties of the blots. These responses are less conventional and more idiosyncratic, but they do not rise to the concern of poor reality testing. Likely what is being projected is the individual’s unique learning history. The issue is whether the proportion of these answers that appear in a record represents a tendency to disregard convention (Groth-Marnat, 2009). Unlike a retreat from reality, these individuals likely have been reinforced for their uniqueness. Often these individuals have been described as creative. However, this creativity can cross into problematic unconventionality if they push the limits of conformity, whether it is legally or socially. It is possible that individuals with a high percentage of unusual responses find some type of function in shocking others or pushing socially constructed boundaries. Similarly to those who have gross distortions of reality, this individual may find reality aversive, or more likely,
boring. He probably is insensitive to contingencies in the environment, and deliberately ignores or skews the verbal rules that mediate them.

Relational Frame Theory (RFT) principles can be applied here to explain this sort of idiosyncratic presentation. Individuals who show generalized pliance are very sensitive to social whim, which is also the case in counter-pliance. An example of that would be when an authority says, “I would like you to do that,” and then, the person does the opposite. Although the topography of the behavior is contrary to the generalized pliance rule, the controlling contingencies can still be the same (i.e., having social approval or avoiding/escaping socially mediated consequences). Thus, functionally speaking, counter-pliance is a case of pliance, and it will become a problem if generalized. Individuals who generalize pliance can’t learn to modify their behaviors because they are not responding to direct contingencies (Torneke, Luciano, & Salas, 2008). This would not necessarily mean that the person had a serious mental health or behavioral problem, but if the individual sought help, the work for this individual would not be much different from the person mentioned above. It would be recommended that the clinician help the client increase his sensitivity to the punishing aspects of pushing unconventionality. It could be helpful to focus more on values work, and clarifying what his values are, and how his unconventional behaviors get in the way of such values.

**Minnesota Multiphasic Personality Inventory (MMPI)**

The second assessment instrument to be discussed is the MMPI, which is the most widely used and researched standardized psychometric test (Camara, Nathan, & Puente, 2000). There have been many additions and changes to the measure since its inception in 1939, including the addition of supplemental, validity, and other content scales to help the interpretability of the original clinical scales (Nichols & Green, 1997). It is often referred to as a self-report measure, an objective measure, or a global measurement of personality. Self-report measures like the MMPI are often seen as more
difficult to interpret as they are not typically designed to assess a specific construct. It is suggested that the MMPI and any of its profiles are open to more than one interpretation (Greene, 1980).

From the behavioral approach, this is ideal, as no single data source should ever be considered the exclusive source for behavioral assessment. Any judgments gleaned from assessment data should be supported with additional data from other sources. For the purpose of this paper, the focus will be on the validity scales and the core clinical scales.

**Validity Scales – Lie, Infrequency, & Defensiveness (L, F, K)**

Part of the usefulness of the MMPI has been its indices that evaluate the examinee’s test-taking attitude. Self-report measures are susceptible to a variety of purposeful or self-deceptive manipulations and distortions. As many as seven strategies have been found (Nichols & Greene, 1997). The reasons behind these inaccurate responding styles vary depending on the individual. The focus of this section will be on the scales that assess for accuracy. The examinee may respond to the test items in a manner that may exaggerate distressful experiences and how negatively he portrays himself, or he may minimize or deny his experiences and enhance the view of himself. Such responding may be inadvertent, either a function of self-avoidance or misunderstanding. Conversely, it may be an act of purposeful impression management.

The MMPI-2 validity scales were designed to detect over-reporting or exaggerating the prevalence or severity of psychological symptoms (F), and to detect when test-takers are under-reporting or downplaying psychological symptoms (L, K). More specifically, the F (infrequency) scale items are those rarely endorsed by non-clinical populations (10% or less). Several of these items fall in a small statistical minority, so endorsements of these items suggest deviance or unconventionality. It is likely that if an individual has a significant elevation on the F scale, she intentionally was exaggerating her distress—either for secondary incentive or as a cry for help. The L (Lie) scale does not imply lying as much as it indicates denial of minor perceived flaws or personal
shortcomings that are common within the culture. An elevated L scale suggests that she is portraying herself as someone who is more virtuous than most people. The items of this scale are transparent and this scale is usually easily manipulated. The K scale is often considered one of the self-deception scales, but it too is susceptible to impression management. It was created to reduce the frequency of false negatives when individuals were producing a profile that did not indicate distress despite individuals’ severe presentation. The items on the K scale are more subtle than those on the L scale, thus less susceptible to effortful manipulation. However, the items are sensitive to response style. Theoretically K is responsive primarily to stable self-perception rather than situational incentives that may lead to over or underreporting as in some of the other scales (Nichols, 2011). There are several others, but these three are the most referred to of the validity scales.

A clinician can interpret these data as a pattern of responding that shows the way a person is either purposely presenting herself or sees herself—either as a function of misunderstanding or impression management. This information is therefore helpful because it is common a client engages in some sort of impression-management when she first seeks therapy. While it is important to attend to what a client does (i.e., clinically relevant behaviors or CRBs), rather than what she says, additional data helps to create a sound theory about the functions of her behavior.

Often the struggle with acceptance of self is a conflict between conceptualized sense of self and self as context. To fit this conceptualized view of herself, she engages in behaviors that are rule-governed and not moving in accordance with personal values. However, when she behaves in ways that violate the rules she has developed for herself, she becomes dissatisfied with herself. Confronted with these discrepancies she then attempts to escape the discomfort that occasions it through experiential avoidance. In an attempt to avoid those aversive feelings she may present herself to others in her idealized way, thus leading to this style of responding.
As stated by Torneke, Luciano, and Salas (2008) in their explanation of Rule-Governed Behavior as it relates to psychopathology:

Augmenting gets in the way when generalized pliance usually under the control of more abstract, verbally constructed and socially mediated consequences. For instance, the abstract consequences “being a good X” means always doing… This is the result of complex relational framing where (1) certain feelings or thoughts about oneself (i.e., “being a bad person”) are framed in opposition to acting towards particular goals, (2) these goals are framed in coordination to feeling well, and (3) feeling well is established as the necessary component (If-then framing) to reach what a person really values in her life […] When rules are established (given by others, or self-derived) which state the incompatibility between private events experienced as aversive and a fulfilling life, they will function as augmentals transforming private events into even more aversive contents, as long as having a fulfilling life is reinforcing for the individual. In this way they will enhance the reinforcing properties of the deliberate avoidance efforts. Experiential avoidance is now in effect. (p. 151)

This potential trap can be addressed if she is willing to be present with her private events in order to attain meaningful outcomes. This necessarily involves the ability to verbally discriminate between herself as the context for what is being experienced, and her experiences (thoughts, feelings, memories, etc.) are only experiences. Once she is able to discriminate her thoughts as aversive contents from just experience she will no longer attempt to control them. She will learn control efforts are futile in the long run because she does not have access to her private events, and secondly private events do not follow the rules she may want, which only puts her in direct contact and struggle with those aversive feelings. Further, she will be able to see how these efforts have become the central aspect of her life, while her other actions controlled by long term positive reinforcement are abandoned. That is the first key issue in undermining problematic rule-following,
recognizing how unsuccessful control efforts are in relation to her personal values. In order to accomplish that clarification of values is necessary. It will set the stage for acceptance of private events. This verbal discrimination can be done through experiential exercises that will set up the conditions for long-term tracking and appropriate augmenting. So that rule-following is where the private contents are no longer something to fight against, but are part of the process towards long-term and reinforcing consequences in moving in the direction of values.

While it may be argued that these tests are not ecologically valid, and thus not practical, it would be an unjustified argument. Tests like the MMPI appeal to the individual’s private thoughts and exemplify how language mediates the rules one develops for the self. Through the use of the data provided by the L, F, and K scales, the clinician will be better able to identify whether the client is engaging in some form of excessive impression-management and with this data and other observations proceed accordingly with intervention as described above.

**Clinical Scales**

The standard clinical scales were derived by the method of contrasted groups; their item content tends to be heterogeneous and their structures multidimensional. This is important because the basic clinical scales are often thought of as a way to diagnose, and indeed they were constructed for that purpose, but the scales individually reflect a cluster of experiences (Nichols, 2011). Thus it is important when using the data to understand that the scales should not be used diagnostically but rather to represent a variety of experiences that the person is endorsing.

**Scale 1: Hypochondriasis (Hs)**

The first basic scale to be developed focused on concern of bodily health absent a neurological or organic health illness. Those who score high on this scale tend to have a preoccupation about their health and a tendency to exaggerate physical symptoms. They have been described as demanding, with little psychological mindedness. Individuals with diagnosed illnesses
do tend to score higher, and score even higher when the illness is life-threatening (Nichols, 2011). The scale does not account for organic disease or age, but neither factor would explain the psychological need to exaggerate and complain. Clinicians should not confuse the intent of the scale, which is not to make a claim of the accuracy of experienced health distress, but rather how freely one communicates distress regarding health.

The individual elevated on this scale is often referred to treatment by a medical doctor due to the inability to explain somatic complaints. In general people want to avoid receiving information about bad health, yet this individual desires being diagnosed. Yet, she rarely feels satisfied once she is diagnosed. The complaints are maintained by reinforcers like a caretaking response from others. However, when the individual uses her ailment in an attempt to control others through heightened sense of obligation, obedience is a more likely reinforcer, shaped partly by anger towards others when expectations are not met. It is also possible that illness removes that individual from responsibilities in life that include work, relationships, and other expectations. The emphasis on illness could act as a CRB1 (avoidance move) to avoid other psychological distress. This may be more common in cultures not familiar or comfortable with mental health treatment, where stress is experienced somatically. A third major reason for higher scores on Scale 1 might be that the person grew up in a verbal community that taught her to represent emotions as physical manifestations rather than as functions of environmental contingencies. When frustrated, she might have been told that she had a stomach ache, for example.

Treatment for high scorers may be unconventional for the traditional behaviorist. For example, in ACT it is common to start with turning one’s awareness to her experience. However, for the individual with this pattern of behaving, it could be a way for her to focus more on her somatic complaints. The clinician should avoid reinforcing the client’s statements of somatic complaints if possible. Focus should be directed in developing the client’s affective vocabulary, especially in
relation to contingencies rather than affect alone. Indeed, this is how people learn an affective vocabulary in the first place: parents observe contingencies, infer emotion, and teach the child the name of the emotion. It has been noted that individuals with this presentation tend to have limited language for emotions (Nichols, 2011). Here the clinician may start by helping the client become more aware of the context in which she experiences the distress to help illustrate the pattern of responding and lack of appropriate factors to lead to experienced illness. Exploring the situational contexts in which she feels her somatic complaints may help her come into contact with her affective experience, which could be a sense of disappointment, fear, or helplessness. The result could be that the client stops thinking that something must be done about her body and instead thinks that something must be done about her environment and her reactions to it.

**Scale 2: Depression (D)**

Scale 2 was developed under the following criteria: “recognizable, general frame of mind characterized by poor morale, lack of hope in the future, and dissatisfaction with the patient’s own status generally” (Nichols, 2011, p. 101). The developers attempted to rule out those considered manic-depressive, and include only those who were depressed at the time of testing regardless of situational factors. It has been described as “the best single- and a remarkably efficient- index of immediate satisfaction, comfort, and security” (Carson, 1969). Being that Scale 2 reflects the individual’s general dissatisfaction, it is safe to treat this scale as secondary to or correlated with whatever else is concerning for the client, which can be varied.

Sometimes this score is elevated because reinforcers are unavailable. Life thus may be unsatisfying and causing a sense of massive extinction or anhedonia. This individual will likely express feeling “stuck,” not engaging in activities pursuing values. For instance, this would be the client who expresses finding once pleasurable activities less enjoyable.
A high score on Scale 2 can also indicate excessive avoidance, a different kind of depression. The person may isolate herself and withdraw from interpersonal relationships if they have been punishing. This may be perceived as a way to control her uncomfortable feelings. She will rather focus on her mood and use it to explain how it gets in the way of values-directed activities. The threat of failing and the immediate discomfort is aversive. When faced with those feelings she quickly engages in some type of escape behavior (i.e. quitting a job, ending a relationship, dropping out of school, etc.). However, she will see the reoccurrence of dissatisfaction caused by “others” (e.g., bosses, partners, finances) or her depression rather than her own ineffective behaviors or her punishment history.

When treating high scorers, the clinician needs to be cautious in analyzing the reinforcement contingencies. This client is likely to respond atypically to common reinforcers, such as reflective listening or other attempts of validation. Although validation often encourages the client to participate in collaborative functional analysis, collaboration may be a conditioned punisher through failures to obtain desired outcomes or letting the other person down. Instead, the clinician may have more success with undermining what the client sees as literal truth of her experience, which is the belief that “something” is happening to her or that she “has depression.” One way to do this is through turning the client’s awareness back to her experience and to prevent response avoidance. The client will likely engage in such control strategies as “reason-giving” of why she “can’t” do identified important activities, blaming external situational factors, and relying on cognitive rationales to justify her inactivity. Once the clinician is able to identify the underlying function, she can increase the client’s sensitivity to the direct contingencies in the environment (e.g., job lost, financial debt, socially isolated) to shift away from the verbal rule-governed behavior (e.g., I can’t work with other people) that keeps her stuck in these unhealthy patterns.
Scale 3: Hysteria (Hy)

The creation of Scale 3, like Scale 1, consisted of items that assessed for somatic complaints, but Scale 3 is sensitive to the individual who believes that she is psychologically healthy and denies the presence of any trouble in her life (Nichols, 2011). The individual who responds in a manner that elevates this scale tends to respond to life stresses by turning attention away from the stress to somatic complaints which acts as a way to experientially avoid the stresses in life. She tends to be described as “Pollyannish,” which is a tendency to impose a sense of prettiness on ugly things, leading the person to be overly optimistic, socially outgoing, gregarious, positive, and enthusiastic. However, despite being uncomfortable with her own emotional sensitivity, this individual may be comfortable with other people’s anger and sexuality. It is likely that as a child the individual was punished for expressing her emotional reactions to ugliness, and over time she has become fused with the inner experiences associated with the punishment (e.g., my response to event is “bad” and thus I am “bad”). She blurs the distinction between thought and thinker, feeling and feeler (Hayes, Wilson, Gifford, Follette, and Strosahl, 1996). She will engage in behaviors that attempt to avoid the aversive functions she identifies as aspects of herself.

One of the ways this client avoids the aversive experience of herself is by developing a limited affective expressive repertoire ineffective in many contexts. For instance, sexuality can be a way of engaging in interpersonal intimacy. It is not only reinforced physically, but it can also be reinforced because it provides her with a sense of being wanted and approved of. The intimacy she desires may not always be sexual, but since non-sexual affection scares her, she relies on sexual intimacy. Over the long term this can reinforce the verbal evaluative relation she has created of herself and is damaging to her ability to develop desired intimate relationships. She will likely present with trouble with relationships and feelings of rejection which can lead to feelings of hostility and anger. So while the client may claim that she is fully capable of handling these sexual relationships,
she struggles. In regards to other contexts, this individual is very likely to quickly “forget” her own feelings and stressors, and she will deny that anything is really a problem. This can be especially important for the clinician to be aware of, since the client’s report of therapy and the therapeutic relationship may not always be accurate if she says things are progressing well. For this client not having emotions other than those associated with lovability (experiential avoidance) is desired. For clients with other patterns of responding, they might have been punished for expressing negative affect, but learned to keep it private; for this individual, being punished has translated into not having the experience at all as a means to avoid the punishment.

The treatment for this individual will require increasing her behavioral repertoire of effective emotional responding, especially in the context of relationships with others. First the client will have to work on values clarification to identify whether her sexual and Pollyannish behaviors are functionally effective. For instance, it is possible for an individual to value sexual activity for the purpose of experiential freedom or liberation, but if this client views her behaviors as a method to reach emotional intimacy, work needs to be done to illustrate the ineffectiveness of her behaviors. Similarly, seeing the pretty or positive side of things can lead to short term harmonies, but it can also make it difficult to manage conflict and aggression effectively. This will entail increasing her sensitivity to discriminative factors, such as how her sexual and Pollyannish behaviors are actually hindering her opportunities to engage in intimate relationships, including especially with the therapist.

**Scale 4: Psychopathic Deviate (Pd)**

Scale 4 originally was developed using criterion cases that included a variety of complaints such as stealing, lying, truancy, sexual promiscuity, and similar delinquencies. The emphasis was on the persistence and consistency of the behavior pattern, rather than on the severity of any particular aspect of conduct. However, the scale was revised when it was cross-validated on men from a
federal prison who had been diagnosed with Psychopathic Personality. The scale was essentially designed to be able to detect asocial/amoral behaviors. However, there is limited support for its validity in doing so (Nichols, 2011).

When this scale is elevated, it is often by the individual who endorses a general durable and mostly maladaptive pattern of behaving disagreeably or unconventionally. The individual is usually emotionally expressive in the form of anger and hostility that seems impulsive, and usually in contexts involving authority figures. She will often blame the environment and see herself as only reacting to situations, unaware of herself as she engages in these patterns that contribute to the conflicts. She was probably punished for impulsive behaviors and associated authority with punishers. Authority now occasions hostility and potentiating injury to the authority figure is reinforced. Rebellion may evoke an aversive feeling in the authority, which may be pleasurable for the client. It may also serve as a way to distance herself from memories or other private events that may occur when in context with authority. By shifting her focus away from herself to others and what they are doing, she can avoid a sense of guilt/shame. Whom the individual sees as an authority can seem arbitrary, and it may include the clinician and the client herself when she is engaged in self-control.

For the clinician, taking a non-punitive stance with a client is beneficial, but especially so for this client. If the clinician acts authoritative, the client will rebel, and if the clinician is passive or lax, the client will either dismiss her, see her as a competitor, or see her as a source of reinforcers (e.g., sexual, injurious, and financial). This experience can be a chance to create a new narrative around what authority means to the individual and to extinguish expectations of punishment. Also, the clinician should help the client find less costly ways of expressing rebellion. To help decrease emotional impulsivity, the clinician can help the client to become more present with herself in times of conflict so that she can learn to slow down and make mindful choices in action.
Scale 5: Masculinity-Femininity (MF)

Scale 5 was originally designed to identify gay men. However, it has never performed well in doing so. The items of this scale better identify gender stereotypes than sexual orientation. Further, the scale is sensitive to dimensions of activity-passivity, with high-scoring men and low-scoring women acting toward behavioral control and nonaggression (Nichols, 2011). For both men and women, those who score high on this scale perceive themselves in a manner stereotypical of the opposite gender (as defined by 1940s Minnesotans) and alternately those who score low on this scale behave in ways that are consistent with their identified gender stereotype. Gender refers to behaviors reinforced or punished on account of the sex of person (Karson, 2008). A low-scoring male may have been punished for engaging in any activities that were traditionally feminine. These may include expression of emotions (other than anger), interest in art or artistic ability, showing tolerance or passivity, intellectual interests, sensitivity towards others, lack of interest in physical activity, non-aggression, etc., while other behaviors were reinforced that fit male gender stereotypes, such as aggression, promiscuity, limited intellectual interests, or actions that may be described as independent, callous, practical, etc. Conversely, for the high-scoring male, the contingencies of reinforcement and punishment were reversed, or it is possible they may have been less frequent or rigid, or that punishment for feminine behaviors proved ineffective once the man left home.

In regards to the low-scoring woman, she would have had a similar history of contingencies based on conforming behaviors to female gender stereotypes. Her behaviors and identified interests may include those that center upon home, family and community, social issues, showing compassion and nurturance, actions that are typically passive, submissive, constricted, and sensitive. Behaviors and interests that would have been punished include being physically active or adventurous, creative, loud, assertive, self-confidence, outgoing, etc. The female who scores high on this scale would have been reinforced and punished for the opposite set of behaviors, or less frequently.
Gender expectations have changed since the items were developed. Although norms have been updated, the feminine end of the scale has as much to do with education as with gendered behavior, since contemporary educated people share many interests with traditional women, such as cooking, literature, and art.

The work for the clinician would be to expose these individuals to interests or behaviors that are inconsistent with their pattern of behaving, which may also mean the very expectations the individuals have of treatment. A female who endorsed stereotypical interests and behaviors may view therapy as a setting to be emotionally supported. The approach of change may be foreign or aversive for this female client. Alternatively, the male client with stereotyped views may expect just this, solutions and action. Therapy thus for these clients will entail exposure just by the clinician’s approach to treatment and it is important for the clinician to be aware of this stimulus factor to make good use of it and to prepare for frustration. Further work will include exposure to stimuli that are a-stereotypical. This means for the low-scoring male having him express his private experiences without allowing him to engage in avoidance behaviors, which might include dismissing them or resorting to anger, and exposing him to whatever he is avoiding, while defusing rules about what a man ought to be like, and how he perceives himself in contrast. This will create more flexibility in not only in his outward behaviors, but in how he experiences himself and private events. Similarly, for the low-scoring woman, the clinician can highlight ways she behaves that are a-stereotypical, such as expressing assertiveness, anger, and resentment. High scorers can also be exposed to avoided gendered behavior.

**Scale 6: Paranoia (Pa)**

Scale 6 was originally designed to identify paranoia, largely successfully. The scale is able to detect one’s sense of vulnerability and belief that others are conspiring against the individual (Nichols, 2011). The high-scoring individual often has been described as someone who feels
inadequate about herself especially in regards to her gender (Wolowitz, 1971). The individual fused to shame finds it so aversive that she avoids feeling disappointed with herself and looks to external factors to blame. She then becomes fused with ideas of persecution and anger. This allows her to feel justified in taking action which is reinforced by distancing herself from shame.

Thus, this individual will likely present to therapy for problems with others that led to angry conflicts. She will attribute these to others not liking her, respecting her, or conspiring against her, her strategy of handling setbacks in life. However, her fused beliefs and actions entangle her. Her thoughts that people are out to get her can influence her to engage in behaviors in an attempt to control situations and injure others; these behaviors include accusations, verbal attacks, or physical aggression that lead others to act similarly towards her, which only strengthen her beliefs that not only are people out to get her, but there is something wrong with her. Further, the individual in another attempt to avoid feeling shame and inadequacy may sexualize pleasant relationships she has with others. Since she is very sensitive to verbal rules she has around herself and gender, she will likely view interactions with others in a sexualized and gender-stereotyped way. Again, however, because she is so fused with these verbal rules and beliefs, she is insensitive to other contingencies in the environment which may run counter to what she believes, such as messages that communicate the person is unavailable or not interested. This too can lead to interactions that leave her feeling wounded and shamed, only to perpetuate the suffering she experiences.

The clinician when working with this individual ought to be wary of how the client is likely to view him. It is likely that she will treat him with the same mistrust, heightened by his position of perceived authority and “abilities.” It would be advisable for the clinician to be aware of how the client may shape the clinician into engaging in battle with her. For instance, the clinician may hear the client expressing a need to change, but when approached with ideas of change, she can become guarded and interpret the clinician’s approach as being confrontational. She may think the clinician
is blaming her and feel shamed, which, unless the clinician can metacommmunicate about the conflict, can ensnarl the clinician in the client’s pattern of conflict. Further this individual will find deference and smallness in other people reinforcing. The therapist faces a dilemma, having to be powerful enough to evoke change from the client but powerless enough to avoid threatening her.

Conversely, if the clinician and client are able to establish a therapeutic relationship, the client may perceive the intimacy as being sexual (or, depending on the sexes of the parties, sexually competitive), again setting up a possible condition in which the client feels wounded and angry. This may occur when a clinician expresses understanding and acceptance of the client’s identified struggles. If acceptance is tender, the client may react with fear; if it is an act of superiority, the client may react with anger. These reactions will likely be private, which is why traditional assessment can be helpful in conjunction to functional analysis to avoid damaging the relationship before it begins.

Work with this client will include exposing the client to natural setbacks and asking her to be present with disappointment, and more importantly, the associated feelings of shame. The clinician should set up conditions that prevent avoidance responses which may include blaming the clinician or some other external variable, then turn the client’s awareness to herself as she engages in those avoidance behaviors. However, direct efforts to control the situation may backfire.

**Scale 7: Psychasthenia (Pt)**

Although the design of this scale was to detect experienced obsessions and compulsions, Scale 7 is more sensitive to experiences of worry, anxiety, apprehension, dread, fearfulness, tension, discomfort, and distress (Nichols, 2011). Further, the significance of this scale to the clinician is whether it is elevated along with another scale. Since this scale is generally sensitive to one’s experience of anxiety, its elevation in addition to another scale suggests that the individual is experiencing distress (and to what degree) regarding the other indicated psychological problem. However, if Scale 7 is elevated in isolation, it suggests that the individual is experiencing stress and
anxiety as a primary concern. This scale is similar to the Stress Tolerance (D) and Adjusted D (adjD) indices on the Rorschach in that it measures one’s general experience of stress or in relation to stressors, although in a face valid and therefore easier to manipulate manner. The difference between Scale 7 and the Rorschach indices is that Scale 7 is the verbal report of one’s experience. It is important for the clinician to note that when the individual denies or fails to report experienced distress in person, it is possible that she is attempting to present as agreeable or avoid what she believes is burdening another. The reinforcing contingencies for this pattern of behaving are again to avoid, control, or ward off anticipated failures or aversive events. The individual’s problem-solving strategy for anticipated misfortune is to plan and account for every possible thing that can go wrong. For her, by predicting everything that can go awry, she avoids (in the short term) the aversive private events of failure or catastrophe. Therefore, as mentioned with D and adjD, treatment would be to expose the individual to the possibility of failure and misfortune, whether it is external or internal, and the clinician would work with the client to increase flexibility and acceptance around possible failure or psychological distress.

**Scale 8: Schizophrenia (Sc)**

Scale 8 was designed to identify those who had schizophrenia, as defined at the time, whose symptoms include bizarre perceptual experiences and the classic negative symptoms. It is therefore sensitive to endorsed feelings of isolation and alienation from others, and from oneself. It provides good information about how one may experience oneself and one’s “sense of identity,” pattern of relating to others, and quality of everyday experiences (Nichols, 2011). So at a milder level, these individuals too report feeling as though something is “off” or “isn’t right” with them, which is not elevated to the level of psychosis. It can be argued that this scale is more useful at measuring moderate-level psychological distress and ineffective interpersonal patterns than for identifying psychosis, which is likely to be apparent and rare.
High scorers have trouble with distinguishing the self as a discriminative stimulus. She struggles differentiating what is occurring within her and what is not her, which can contribute to an aversive experience of self, described often as a lack of sense of self/identity, which can be problematic in being aware of the self as context. This is likely to arise from a history in which abuse or intense frustration occurred in an intimate relationship which disrupted the experience of stability in the environment and/or in her.

Typically those with a troubled intimacy history have difficulty integrating her affects in an effective manner, which can contribute to engaging in impulsive behaviors both damaging to the self and to interpersonal relationships. These behaviors are reinforced because they decrease her private sense of disorientation as they increase chaos within the environment. For instance, when she feels angry or frustrated with herself she may lash out at or send mixed messages to others, which is likely to lead another person to feel angry and create conflict, which in the short-term creates a distraction and avoidance of her own feelings of self anger. Another likely control strategy is the individual will engage in self-harm behaviors, such as cutting, in times of stress which also avoids aversive private events.

When working with this individual the clinician will need to be aware of this pervasive interpersonal pattern of engaging others in conflict as an avoidance move. Thus the approach that would normally be effective or reinforcing for the client may be aversive and fear provoking, such as being empathic and compassionate. This can be scary for the client as her history has taught her that intimacy is associated with pain and disruption to stability. To avoid that threat, she may reject the clinician’s attempts to empathize and build rapport through showing up late, angry outbursts, or dismissal. It would be advantageous for the clinician to take a different approach which is to identify what could show up between them, such as how the work on creating a flexible, self-as-context stance will be threatening and vulnerable. Secondly, the clinician will have likely experienced the
client’s expression of anger and dysregulation as her attempt to regain control, and the therapy will benefit if the clinician is able to demonstrate that she can withstand and be present with those aversive feelings. By continuing to be present with the client’s aversive behaviors, she will be able to work with her on integrating her emotions more effectively because it will serve as response prevention. When this does show up in the room, it will also be a good approach for the clinician to continually check in with the client in how she experiences her and ask her to review the evidence that she is there to help and compare it to the evidence that she is there to harm her.

**Scale 9: Hypomania (Ma)**

Research has supported the sensitivity of Scale 9 at identifying individuals who have manic-like symptoms, which include increased energy, accelerated physical and mental tempo, reduced need for sleep, irritable or euphoric mood, increased extroversion, and impulsivity (Nichols, 2011). Moderate high-scorers on this scale tend to be described as enthusiastic, emotionally immature, easily bored, grandiose, and callous. This individual is the person in search of the next thrill, which may include job hopping, risky sexual behaviors, ditching class, blowing off commitments, etc. She finds routine and stability (like most jobs, relationships, or school) boring and aversive. She avoids tasks or situations that consist of repetitive behaviors. For most individuals, stability and routine is comforting as it provides predictability and a sense of safety. However, she finds pleasure in contexts that provide thrilling, novel experiences.

The aversion this client has to monotony is likely to cause a multitude of problems. For instance, interpersonally she may be described as callous because she becomes so focused on finding excitement that she may disregard the impact her behaviors have on others, or she may lack consistent employment and be strained financially. Interestingly though, it is likely that this repertoire has been shaped to avoid distress. Functionally, by engaging in the next adventure she temporarily avoids or removes distress in her life. It is her way of controlling or “managing” stress.
The caveat here is that for the person always looking for the next thrill the last thrill is not exciting enough. She becomes desensitized to average stimuli of excitement and is forced to push the boundaries, becoming more rigid and narrow in her behaving despite believing she is engaging in more excitement. For this individual it is likely that she was raised in a home environment with rather severe punishment contingencies. It is imaginable that she was punished for engaging in any activities that were perceived as forbidden, and these activities were likely trivial or inconsequential to most. This of course only heightens the appeal of those acts to her when the punisher is out of sight.

When working with this client, the clinician should be aware of the limitations of standard therapeutic practice and structure. For instance, time constraints (50 minute sessions), regular weekly scheduled appointments, agendas, treatment plans, etc. are likely to be aversive to the client. She is likely to find the natural process of therapy boring, unchallenging, and see herself as “stuck.” It would be probable this client would begin to miss appointments to avoid not only this rut of therapy, but the threat of how structure prevents distractions from her distress. The clinician will want to work with the client in staying present in the here-and-now since she finds it boring and distressing. This will entail finding value in the present moment and learning how to appreciate everyday experiences, while also working towards recognizing and accepting the limitations of everyday living which tends to be at times mundane and routine. To add meaning to her life she can focus on clarifying her values and live each day committed to honoring them. Also, the clinician will want to work with the client to face the distress she is avoiding by her thrill-seeking behaviors. The clinician can also expect some efforts on her part to make the therapy itself thrilling, whether by telling exciting stories, sexualizing the relationship, or putting herself at risk. The clinician will have to navigate the space between punishing these behaviors and letting her avoid what seems boring to her but is actually the work of therapy.
Scale 0: Social Introversion-Extroversion (Si)

Scale 0 is intended to be a measure of introversion-extroversion, one’s sense of shyness, self-consciousness, and discomfort in group situations. However, it is not a true measure of introversion-extroversion as it is also sensitive to the reporter’s subjective distress, tension, mood, and confidence. High scorers on this scale report feeling timid and shy in group situations. Others would be likely to say high-scorers are generally hard to get to know, overly-sensitive, over-controlled, submissive, conventional, cautious, and rigid (Nichols, 2011). This individual is prone to find social reinforcers (approval, attention, and affection) to be aversive or ineffective (presumably because they were not consistently followed by biological reinforcers). The individual is likely to present for problems related to this (martial problems, social skills, unassertiveness, fearfulness, loneliness etc.). This aversion to social reinforcers would explain why so many would have trouble with intimacy, feeling unconfident with others as this individual would avoid the very behaviors and situations that provide social reinforcement.

The problem when working with this individual is that most clinicians tend to approach a client using social reinforcements often in attempts to validate the client’s experiences and build rapport, which will not work for the high-scorer. This approach will likely only punish the client from engaging in behaviors that move towards connection and openness. The clinical work will benefit more if the clinician is able to be more explicit when attempting to reinforce the client’s behaviors. For instance, stating something like, “So, when you do speak to your co-workers they invite you out for social gatherings,” will be more comfortable for the client to hear and thus more likely for her to repeat. Attention, approval, affection, and praise for this client are more likely to evoke behaviors to avoid and hide from the clinician. Once rapport and effective behaving begins to be shaped, others naturally in her social environment will expose her to those social reinforcers and she will become gradually more comfortable with them.
Low scorers on 0 are often described as socially outgoing, talkative, energetic, competitive, superficial, and manipulative (Nichols, 2011). This individual is likely to report that being alone is aversive. In contrast to high scorers, low scorers are strongly reinforced by social reinforcers. Most of their behaviors are controlled by attention, approval, affection, and praise, which can explain why they appear competitive, superficial, or manipulative. When working with these clients, be aware that they may be more interested in feeling that they are doing good work than actually doing effective work. Further, not providing social reinforcers may evoke feelings of inadequacy or lack of connection early in therapy. It is important then for the clinician to be sensitive to the client’s response to social reinforcement, and to be more focused on distinguishing between reinforcing the behavior versus reinforcing the individual. By doing so, the client will be able to defuse from ideas about self-worth connected to behaviors and social approval. Also, this individual might try to convert the therapy into the kind of social relating at which she is already proficient. The clinician can discuss the ways in which the pursuit of social reinforcers can be a way of avoiding various states, which are better accepted than avoided.

Conclusion

While there are plenty of benefits, the role of traditional assessment in behavioral practice is not devoid of possible problems. Clinicians should be wary of misinterpreting data outside the guidelines of the instruments, and as mentioned, formulating conceptualization solely from test data. It is important to remember that the test scores are not the behavior (or the person), but only a guide to the possible function of behaviors. This paper is not advocating that assessment data will ever replace a thorough functional analysis, only that they can enhance it. Good assessments use multiple sources of data, because all sources have advantages and disadvantages. Ultimately, the goal of clinical work, regardless of theory, is to create and implement an effective treatment plan based on evidence.
References


