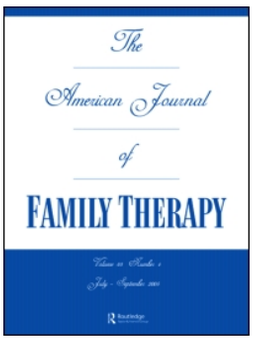

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Using Symbolic-Experiential Family Therapy to Treat Adjustment Disorder: A Case Study

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ABSTRACT

Despite studies claiming Adjustment Disorders (AD) affect up to 10% of the general population, research is severely lacking for effective treatment recommendations and screening tools. This article presents the treatment of a 30-year old Caucasian male diagnosed with AD - mixed anxiety and depression subtype. After 12 standard 60-minute sessions, treatment using a Symbolic-Experiential Family Therapy (SEFT) approach resulted in the alleviation of depression and anxiety symptoms. This case study provides preliminary evidence for the effectiveness of SEFT using a mixed methods case study. Implications for further study, and the usefulness of SEFT for the treatment of AD, is presented.

Research regarding Adjustment Disorder (AD) is sparse both in primary care and mental health settings despite a recent study by Ponizovsky and colleagues (2011) stating approximately 10% of the general population and up to 50% of patients in psychiatric hospitals meet the qualifications for this diagnosis. AD has been recognized as a disorder for decades, but severely lacks epidemiological research (Casey & Doherty, 2012). Patria Casey (2014) hypothesizes that the lack of research may be attributed to the subjective interpretation of "normal" stress reactions, the lack of specific diagnostic symptom criteria, and the overlap of criteria indicating adjustment disorders, major depressive disorder and generalized anxiety disorder. AD experts urge for an increase of studies regarding adjustment disorders after finding rates of suicidal ideation almost identical to those of patients with major depressive disorder, between 10% and 48% (Casey et al., 2015; Chung et al., 2014). Others stress that the lack of a standardized assessment instrument is to blame for the deficit in research (Strain & Friedman, 2011).

Adjustment Disorder is one of the most common working diagnoses in mental health settings and 7th most popular diagnostic category in psychiatric inpatient settings (Glaesmer et al., 2015). According to The Diagnostic and Statistical

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Manual (DSM-5; American Psychiatric Association, 2013), AD requires the development of emotional or behavioral symptoms in response to an identifiable psychosocial stressor, either chronic or acute, within three months of the onset of the stressor. The symptoms must be clinically significant and represent distress out of proportion to the severity or intensity of the stressor causing significant impairment in social, occupational, or other areas of functioning (Strain & Friedman, 2011). The symptoms must not meet criteria for any other disorder or indicate normal bereavement, and must not persist for longer than six months after the termination of the stressor. AD may present with symptoms of depression, anxiety and impulse control (Pelkonen, 2005; Glaesmer, Romppel, Brähler, Hinz, & Maercker, 2015).

Concerns and advances in diagnosing Adjustment Disorder

Due to the growing usage of the AD diagnosis, there has been recent peaked interest in the topic, thus shining light on the severity of deficit in research. With the overlap of symptoms - and lack of specific diagnostic criteria—AD is often misdiagnosed as Major Depressive Disorder (MDD) or Generalized Anxiety Disorder (GAD) and treated as such, adding to the difficulty of studying the disorder. Casey and Doherty (2012), conducted a study they believe illustrates the trend of misdiagnosis. Rates of AD declined from 28% to 14% between 1988 and 1997 while diagnoses of MDD rose from 6.4% to 14.7% over the same period. One characteristic of AD helping clinicians to distinguish it from MDD is that the removal of the client from the stressor or stressful situation will result in a reduction of symptoms that would otherwise persist from MDD (Casey & Doherty, 2013).

Strain and Friedman (2011) state that the non-specificity of diagnostic criteria has also hindered the development of assessment instruments. Because symptoms of AD are often open to subjective interpretation, critics pose that the only distinction between AD and ordinary life problems may be that the diagnosis itself implies the severity of the disturbance is sufficient to justify clinical attention or treatment (Carta, Balestrieri, Murru, & Hardoy, 2009).

Most widely utilized structured interview tools fail to include AD. Until 2014 there were no questionnaire type instruments in existence for the screening or diagnosis of AD. Clinicians commonly diagnose the disorder utilizing unstructured interviews and client descriptions of symptoms. Because symptomology commonly mimics MDD, GAD or impulse control disorders, clinicians may assess symptoms utilizing questionnaires for such disorders (Carta et al., 2009).

Treatment

Research has shown prognosis for patients with AD is good, but because of the lack of research regarding treatment, recommendations are limited (Srivastava, Talukdar, & Lahan, 2011). Most research regarding the treatment of AD has focused on

the use of pharmacology to relieve depressive and anxious symptoms. Although research suggests that psychotherapy is the treatment of choice for AD, little research has focused on the efficacy of specific psychotherapy approaches. Critics often undermine the necessity of treatment due to the brevity of symptoms despite evidence that AD is associated with suicide risk and may result in severe symptoms impacting functioning (Casey & Doherty, 2013). A five-year follow-up study demonstrated that 71% of participants no longer met criteria for any mental disorder after the treatment of AD with psychotherapy in general (Carta, 2009). Other researchers have documented successful symptom reduction utilizing a combination of medication and psychotherapy (Sundquist et al., 2015).

Symbolic-Experiential Family Therapy

Symbolic-Experiential Family Therapy (SEFT) was developed by Carl Whitaker and is a growth-oriented psychotherapy approach that is not based on intellectual logic, but rather on interactive processes, metaphorical language and personal interaction (Mitten & Connell, 2004). SEFT proposes that the facts of life are unchangeable, but a person's attitude or feelings can be altered to produce a more positive response to stressful situations. Kaye and his colleagues (1986) argue that people are not motivated to change unless they are pushed into a crisis state as a result of interrupting dysfunctional patterns through heightened awareness and emotion. One goal for experiential therapists is to help the client re-interpret the current dilemma to reveal the positive function for their dysfunction and leave with a vision of immediate possibilities for change (Napier, 1987; Mitten & Connell, 2004).

Because some populations may have an underlying predisposition to stress-related disorders, SEFT may be effective in the treatment of AD due to learned maladaptive coping strategies challenged by the therapist in session. Research by Smith (1998) may indicate SEFT as a useful treatment for AD with anxiety because the increasing of anxiety during session allows clients to adapt new coping mechanisms to combat further symptoms. Kaye (1986) summarized the well-balanced role of the SEFT therapist as a coach, a Zen master, a combatant in war and a surrogate grandfather.

SEFT therapists connect with clients through the use of humor and self-disclosure. Whitaker argued that success of SEFT relied heavily on the true self of the therapist and a heavy emphasis of personal intuition (Smith, 1998). Whitaker coined SEFT as the "therapy of the absurd" because of his use of playfulness with families meant to shake up the system and interrupt dysfunctional cycles, thus inducing change. His positive therapeutic relationship with clients allowed him the ability to use paradox and absurd statements to illuminate dysfunction in the system. Myriads of research has indicated the most important factor indicating success in therapy is the development and maintenance of an open, trusting, and collaborative therapeutic relationship (Rait, 2000). In fact, Lambert's common

factors model attributes 30% of client change to the development of a therapeutic relationship (Lambert, 2006). SEFT proposes that the process of therapy, after the development of a therapeutic alliance, becomes a mutually shared experience of inevitable change on the part of the therapist and the client (Kaye et al., 1986).

To date there is very little empirical research on SEFT. Critics of the theory argue that the techniques utilized in symbolic-experiential therapy are too subjective to objectively measure and call for the creation of manualized training. However, SEFT experts declare that developing such treatment protocol may interfere with the therapy itself (Mitten & Connell, 2004).

Change mechanisms

The goal of SEFT is to provide experiences for the client that will reshape dysfunctional symbols and interactions resulting in positive, lasting change (Mitten & Connell, 2004). Experts in SEFT identified emotion as the primary element in the therapeutic process. Emotional expression promotes maturation, opportunities for ongoing growth and serves as a historical point of reference and context through which a "corrective emotional experience" occurs (Suarez Pace & Sandberg, 2012).

According to Mitten & Connell (2004), Symbolic-Experiential Family Therapy follows six core values or goals:

1. Generating an interpersonal set through the expansion of the symptom and introspection by each member of the system regarding their contribution to the problem and maintenance of dysfunctional processes.
2. Creation of a suprasystem through the therapist's successful joining of the family system. The therapist creates a therapeutic relationship with each member of the system through utilization of self-disclosure to present alternate perspectives to the problem.
3. Simulating the symbolic context to allow for symbolic experiences to occur in session. The therapist shifts from reality-based to symbolic listening allowing the creation and understanding of client's meaning of the problem.
4. Activation of stress within the system by increasing emotional intensity in the therapy room. Whitaker believed anxiety fostered growth and clients would not be motivated to change in the absence of such discomfort. Increase in emotional intensity combats therapeutic impasse from systems not desperate enough to change.
5. Symbolic experiences are created during interactions in therapy that are beyond the client or therapist's scope of conscious awareness. If meaningful change is to be maintained after therapy, a symbolic experience must be created and assigned meaning.
6. Therapists move out of the system through distancing once termination is imminent. Therapy is an experience of mutual growth and the therapist should acknowledge self-growth as a result of working with a client.

Therapeutic intervention

Although SEFT does not adhere to manualized treatment protocol, the approach does include the use of specific therapeutic intervention techniques. These techniques, proposed by Carl Whitaker are viewed as an extension of the self of the therapist and continually contribute to the genuineness of the therapeutic relationship. SEFT theorists stress that intervention techniques should not be universally applied to every case in the same manner as this could detract from the "here and now" of the therapy experience. Whitaker believed that interventions ought to be spontaneous rather than pre-planned to aide in the authentic flow of the session. When techniques are properly implemented in the presence of a healthy therapeutic relationship, they can determine the difference between "good" or merely "adequate" therapy (Connell & Russell, 1987).

Confrontation

Symbolic-Experiential Family Therapy utilizes confrontation to point out, and interrupt dysfunctional patterns and interactions. SEFT stresses genuine caring for clients is critical to the success of therapy. However, confrontation is viewed as a necessity in the process. It is out of care for clients that confrontation is used to jolt the system out of homeostasis resulting in the consideration of alternate patterns of interaction (Mitten & Piercy, 1993). Confrontation may provide clients with the opportunity to share non-verbal cues regarding unspoken feelings. Use of confrontation implies the message that the system's dysfunctions are visible and require immediate attention. Through confrontation the therapist takes the lead and pressures the client to make changes in dysfunctions (Connell & Russell, 1987).

Metaphors

Many of the recognized major family therapy theories involve the implementation of metaphors to help clients visualize or express ideas, emotions and concepts that cannot be said more clearly. They may also be utilized for decorative effect in session, and have the power to define reality. Metaphors embrace a postmodern approach in which multiple truths can coexist without one having privilege over another (Davies, 2013).

Use of self

Self-disclosure is a hallmark of SEFT. Therapists use their own experiences with the client in the room as the 'heart of therapy' (Rober, 2011). Symbolic-Experiential therapists utilize self-disclosure to create a healthy, genuine therapeutic relationship. Critics of the approach stress that SEFT utilizes an amount of self-disclosure and 'realism' that would be unacceptable with other theories. Encounters with clients cannot help but induce strong feelings in the therapist. Therapy without such involvement would not produce authenticity and growth, but it also

creates complex challenges for the therapist in every session. Genuine self of the therapist is employed to appropriately handle such intense feelings toward the system (Rait, 2000).

Methods

There is a lack of published research on the treatment of adjustment disorder as a diagnosis—more specifically on treatment with Symbolic-Experiential therapy. A case study is presented to explore the efficacy of one person's successful completion of therapy after diagnosis of adjustment disorder. The client's name and significant identifying characteristics have been altered in order to protect their confidentiality.

Case presentation

Stephan, a 30-year-old Caucasian male contacted a student clinic for therapy to treat his recent onset of depressive and anxious symptoms after a divorce, stressful promotion at work, and the recent cancer diagnosis of a close family member. Stephan was raised in a small, conservative town in Northern Alabama and was the youngest of four children. His mother, father and three siblings were all successful lawyers and insisted Stephan follow family tradition. Stephan had close relationships with his mother and siblings, but a distant relationship with his father who left their family when Stephan was ten.

Stephan sought therapy after his wife of 18 months had divorced him approximately three months prior. She informed Stephan that she was bisexual and wanted to pursue dating women. They maintained very limited contact. Stephan had a complicated and unsuccessful history with past intimate relationships. Shortly after the divorce, Stephan's brother was diagnosed with stage 3 prostate cancer. Stephan moved in with his brother and assumed the role of primary caregiver; transporting him to doctor and chemotherapy appointments, cooking meals and contributing financially. In addition, Stephan was recently promoted at work, which came with many new responsibilities and stress. The recent promotion, accompanied by an increased workload and stress, occurred only weeks after assuming caregiver responsibilities and the leaving of his spouse.

Case study design

A single-holistic case study design was implemented to determine the efficacy of the approach for this one specific case; and to determine where and how interventions were useful for the client. For analysis, a Sequential Exploratory Mixed Methods design was used; privileging the quantitative and qualitative data equally. To determine a baseline for symptom severity, and application of a proper diagnosis, Stephan completed a variety of self-report measures. All sessions were video recorded, allowing the therapist to analyze each session and document observable

changes and responses to therapeutic interventions. It was determined that data collection would occur over the entire course of treatment, with no specified end dates – to allow for the natural progression of the case and to coincide with the theoretical underpinnings of the Symbolic-Experiential approach to treatment.

Screening tools and questionnaires

As previously discussed in the literature review there is currently a shortage of diagnostic screening tools in existence for use specifically for AD. Client diagnosis in this study was completed utilizing a variety of instruments to assess depressive and anxious symptoms along with client self-report.

OQ-45.2 (Outcome Questionnaire)

Created in 1996 by Lambert and his colleagues (Lambert, 2012), The OQ-45.2 is a 45-item self-report scale used to measure symptomatic distress in adult clients. The items address anxiety, depression, interpersonal interactions, and social role. The scale is designed to track client progress over time and to help clinicians better understand which areas of functioning are more problematic. The questionnaire has demonstrated high internal consistency and test-retest reliability with a Cronbach's Alpha of .84. Scoring ranges from 0 to 180 with scores of 63 or higher indicating clinical significance (Bringhurst et al., 2006).

Outcome Rating Scale (ORS)

The ORS was developed as a brief alternative to the OQ-45.2 (Miller et al., 2003). The ORS features four subscales to assess client functioning in the areas of individual, relational, social and overall well-being with scores ranging from 0 to 10 on each subscale. The ORS can be completed in less than one minute and is intended to track client progress over time. This scale is ideal to be completed prior to each therapy session. The measure has demonstrated high internal consistency and test-retest reliability with a Cronbach's Alpha of .97 (Bringhurst et al., 2006).

Session Rating Scale (SRS)

The SRS was developed to measure the health of the working therapeutic alliance, a long-standing predictor of successful therapy outcomes. The SRS, structured identically to the ORS, is an ultra-brief self-report measure that can be completed in less than one minute at the end of each therapy session. The scale consists of four subscales including the therapeutic relationship—ensuring the client felt heard, understood and respected, goals and topics—ensuring the session was focused on client-centered goals, therapeutic approach and method—ensuring the therapist's approach is a good fit for the client, and an overall client satisfaction score. Scores falling at 36 or below are cause for concern regarding the therapeutic relationship (Duncan et al., 2003).

Generalized Anxiety Disorder-7 (GAD-7)

The GAD-7 was developed as a short-form self-administered questionnaire version of the anxiety scale in the clinician administered primary care evaluation of mental disorders (PRIME-MD). Its purpose is to screen and measure severity of anxiety symptoms present over the past two weeks with scores ranging from 0 to 21. The scale has demonstrated acceptable internal validity and test-retest reliability with a Cronbach's Alpha score of .89 (Spitzer, Kroenke, Williams, & Lowe, 2006).

Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 is half the length of most other depression scales and can be completed in less than five minutes, but has comparable sensitivity and consists of the nine depression diagnosis criteria specified by the DSM-V. Upon completion, the scale is able to provide clinicians with evidence for a provisional diagnosis and rate symptom severity. The scale asks clients to answer the questions regarding depressive symptoms based on their experiences in the past two weeks and results in scores from 0 to 27, classifying symptoms from minimal to severe. The PHQ-9 has demonstrated acceptable internal validity (α of .89) and test-retest reliability (α of .84; Kroenke & Spitzer, 2002). In addition, the PHQ-9 has rapidly become one of the most frequently researched, translated, and used depression screening tool available (Moriarty, Res, Gilbody, McMillan, & Manea, 2015).

Client self-reports

Research investigating the diagnosis of AD suggests that because there is no standardized instrument in existence, client self-reports could be utilized to assist clinicians in making a descriptive diagnosis through questions assessing symptom severity and impairment of functioning (Carta et al., 2009). Research suggests that client self-report of symptoms and severity be utilized in addition to more standardized measures to enhance reliability.

Measuring change

Change will be measured through the comparison of client-completed measures from intake through termination. The scores from the OQ-45.2, ORS, SRS, PHQ-9, and GAD-7 will be analyzed in addition to client self-reports regarding symptom severity and impairment to track improvement over time and response to therapeutic intervention. Therapist will also document observable reductions in symptom severity and response to therapeutic interventions evident in session as further indication of change. In addition, sessions were recorded via video and audio in order to allow for the transcription, coding, and analysis of qualitative data. Qualitative data will be coded thematically and analyzed from a narrative analytical perspective, looking for specific instances of change identified by the client and therapist (Reissman, 2008).

The goal of analysis is to determine whether or not the overall approach to treatment is helpful in alleviating symptoms of adjustment disorder through the application of Symbolic-Experiential therapy. Both quantitative and qualitative data will be used in conjunction to determine the efficacy of the approach, and to highlight successful interventions. If the client exhibits reduction of symptom severity and impairment through descriptive self-report and self-report measures, the client will begin biweekly sessions and move toward termination. The termination of services will provide further evidence of change and positive improvement toward client goals.

Results and data analysis

Metaphors

Metaphors were utilized to help the client visualize and apply meaning to situations, symptoms and experiences that were otherwise difficult to comprehend or verbalize.

"The river"

The river is a metaphor utilized in session to help Stephan visualize how his discomfort with expressing emotion frequently allows him to become overpowered by them. Stephan was asked to visualize his emotion as a river and picture himself standing on the bank far away from the water. He named the riverbank 'logic' and viewed it as his comfort zone. Stephan's goal was to become comfortable enough with emotion that he could stick his toes in the water without increasing anxiety. Stephan professed that he felt if he "*touched the water he would be swept away by it"* because of his lack of experience around water. Stephan's dysfunctional pattern of emotional avoidance was a difficult subject for discussion, but the utilization of the river metaphor allowed him to discuss the topic more openly.

"The tripod"

Therapy with Stephan often referred back to the metaphor of a tripod. As he described the reasons for initiating therapy (job stress, divorce, cancer diagnosis) I began to visualize a tripod with three legs that depended equally on each other for stability; if one leg were removed the tripod would fall. The same appeared to be true for Stephan. When he made prior attempts to manage stress at work to reduce symptomology, the anxiety and depression manifested further in the other two areas. Stephan responded well to the use of the metaphor as evidenced by self-reports. Stephan came to the conclusion that although he could better manage work stress, and care for his ill brother and maintain a close relationship, he felt helpless against his feelings of loneliness and depression resulting from the divorce. He reported, "*I feel like the cancer and the job stress are things I can't really control, but I do have control over my love life, so I beat myself up over it."* However, Stephan reported the metaphor of the tripod provided a positive visualization of the distribution of stress and symptomatology.

Stephan's response to the use of metaphor in session is reflected in client self-reports, therapist's documentation of client's openness and body language, and SRS scores (see Figure 1). Reduction of depressive and anxious symptoms as measured by the OQ-45.2, ORS, GAD-7, and PHQ-9 also provide additional support for the effectiveness of metaphor as a therapeutic intervention.

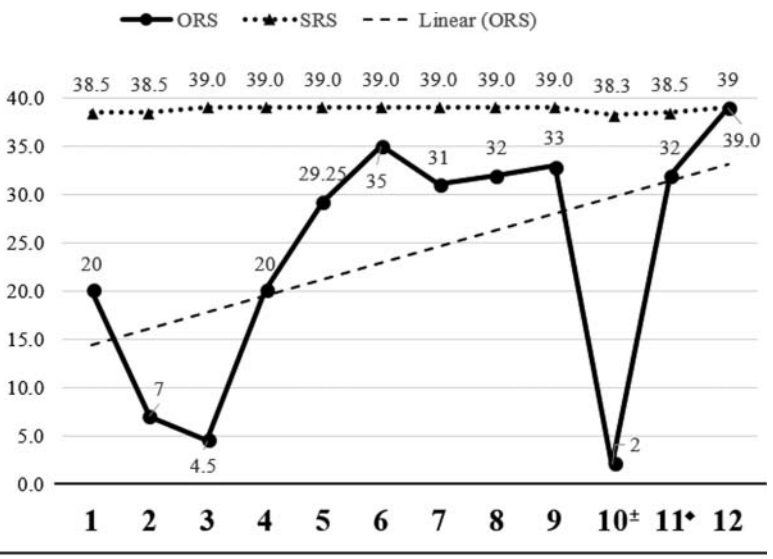
Confrontation and heightening of emotion

After the development of a healthy therapeutic relationship, as measured by client self-reports and the SRS, confrontation was utilized in session to confront dysfunctional cycles. Confrontation was also utilized to heighten emotion in session, a hallmark of the SEFT approach. Stephan described the cycle of interactions with his ex-wife since the divorce which resulted in significant increases of depressive and anxious symptoms immediately following by asking "What happened to change? I guess old habits die hard." Rather than continue to enable the cycle, the therapist used confrontation to highlight how Stephan was contributing to his own distress and exacerbation of symptomology. Session 10 occurred after a painful encounter for Stephan in which his ex-wife revealed that she was now dating a woman and wanted to cease all contact with him (notice the extreme difference in ORS scores in Figure 1). While discussing the conversation in session, the therapist utilized questions to access Stephan's underlying feelings regarding the situation resulting in an observable increase of anxiety symptoms. Stephan's respiration increased, he began to perspire and exhibited fidgeting behaviors. Stephan reported "*I'm sorry. These are all great, thought-provoking questions, but right now I can't even think straight. How could she do this to me?*" After unsuccessful attempts to manage anxiety in session, he opted to terminate the session early—a choice that was brought up at the start of the next session.

At session 11 Stephan reported that his reaction in the previous session was a "*wake up call*" and he "*felt embarrassed that someone else had that much power over*" his life. However, his ORS scores increased dramatically and depressive and anxious symptoms decreased as measured by the GAD-7 and PHQ-9. Although initially the increase in anxiety may indicate an adverse reaction to the use of confrontation and heightening of emotion, the ongoing decrease in distress and maintenance of the therapeutic relationship indicate a favorable reaction to the intervention (see Figure 1).

Use of self

The genuineness of the self of the therapist was utilized spontaneously in session as the catalyst for change. The therapist utilized genuine caring, humor and self-disclosure to facilitate the development of a healthy therapeutic relationship. The therapist would disclose an appropriate amount of inner-dialogue or personal information to form a genuine bond with the client. Client's reactivity to the intervention was measured via client self-reports of comfort in



GAD-7		16		15		*13**		*10**		15		**2***
PHQ-9		15		*13**		*11**		15		*9**		**2***
OQ - Symptom Distress	48		67		60		51		47		40	
OQ – Interpersonal Relations	43		37		**27**		**22**		**18**		**14***	
OQ – Social Role	21		23		14		11*		**6***		**5***	
OQ – Total Score	112		127		101		**84**		**71**		**59***	

* Indicates a score below clinical cut-off
Italicized Scores indicate moderate signs of depression/anxiety on PHQ-9/GAD-7.
Bold scores indicate a reliable change from initial test.
± Indicates when sessions moved to biweekly; ◆ Indicates when new relationship began.

Figure 1. Assessment scores by session.

session such as "*I appreciate your candidness and honesty… it makes me feel more comfortable.*" Stephan would often state during difficult therapeutic dialogue that "[he] *can trust you.*" As shown in Figure 1, SRS scores indicated a favorable reaction to therapy.

Assessments

OQ-45.2

Stephan completed the OQ-45.2 at intake and two session intervals until termination. Upon intake Stephan scored 112 overall with highest levels of impairment indicated on the symptom distress subscale. Scores peaked at session 3 assessment with an overall score of 127 indicating moderately high symptom distress. Stephan's OQ-45.2 scores on subsequent sessions continued to decline with session

11 resulting in scores falling under the clinical significance cut-off score of 63. Scores on the OQ-45.2 indicate successful reduction of depressive and anxious symptoms initiated by AD. The downward trend of scores indicates the client responded favorably to therapeutic interventions over time. Analysis of scores at session 11 indicate the client no longer has symptomology or distress deemed by the assessment as clinically significant.

Outcome Rating Scale (ORS)

Stephan completed the ORS prior to each session. Upon intake Stephan scored a 20 overall indicating mild symptom severity. Sessions 2 and 3 were some of his lowest scores, during which time he was re-visiting his problem-saturated historical perceptions, a typical pattern. After session three his scores steadily improved. After session 9 Stephan was contacted by his ex-wife resulting in a relapse of progress and significant increase in depressive and anxious symptoms which reflected his session 10 ORS scores. At session 12, termination, Stephan's scores indicated almost no symptom distress with a score of 39.

Session Rating Scale (SRS)

The SRS was completed weekly at the end of each session to determine the health of the working therapeutic relationship. Scores falling at or below 36 indicate areas of concern to be addressed by the therapist in session. Stephan's SRS scores, never dropping below 38 from intake through termination, indicate successful joining and a healthy therapeutic relationship. Consistently high SRS scores are also indicative of the client's positive response to therapeutic interventions.

Generalized Anxiety Disorder-7 (GAD-7)

Although the OQ-45.2 and ORS assess for symptom distress neither provide detailed descriptions of symptomology or specify to what extent the distress is rooted in depression or anxiety. The GAD-7 can indicate symptoms of anxiety disorder with a cut-off score of 8. At session 2 Stephan scored a 16 indicating moderately/severe anxiety and a probable anxiety disorder. Stephan completed the GAD-7 biweekly until termination. Although GAD-7 scores indicate an overall downward trend, Stephan experienced a peak in anxiety symptoms at session 10 corresponding with the traumatic contact with his ex-wife. However, upon termination (session 12) Stephan's GAD-7 scores fell below the cut-off score of clinical significance indicating the absence of symptomology for the probable diagnosis of an anxiety disorder. These scores provide further evidence for the support of SEFT to successfully achieve client goals of reduction of symptomology related to AD.

Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 was completed biweekly starting with session 2 through termination. Stephan's initial scores indicated moderately severe depression. Stephan's scores

indicate an overall downward trend in depression symptomology with a slight relapse in distress mid-way through the 12 session schedule. At termination Stephan's scores placed him below the cut-off for even mild depression indicating the successful treatment of depressive symptoms related to AD with Symbolic-Experiential Family Therapy.

Termination of services

The client's progress toward achievement of therapeutic goals was re-assessed at session 10 at which time the decision was made to commence biweekly sessions rather than weekly. Therapy was terminated after session 12 through a mutual decision by the client and therapist. Stephan entered the room, sat down and stated "*I think I'm ready to try things on my own.*" Termination of services through mutual decision was achieved after review of client goals, treatment plan, client self-reports of symptom distress and assessment tool scores. The client's self-reports indicated a drastic decrease in anxiety symptoms with no anxiety attacks since session 11. Self-reports also indicated a severe decrease in depressive symptoms and drastic improvement in social and occupational functioning. The client began dating, resumed exercise and playing music, and reported an improvement in sleep patterns with marked increase of pleasure in activities. Scores on all assessment measures including the ORS, OQ-45.2, GAD-7, and PHQ-9 revealed symptom distress below clinically significant cut-off scores indicating the absence of criterion for AD with anxiety and depressed mood.

Discussion of implications for family therapy and practice

This case study has provided an example of how Symbolic-Experiential Family Therapy (SEFT) can be used effectively to treat symptoms of Adjustment Disorder with anxiety and depressed mood, in situations and with clients similar to the one presented here. This study may also provide an illustration of how SEFT may be used successfully with individuals in addition to family systems when all members of a system are not physically present in the therapy room. The use of systems theory allows for the utilization of family therapy techniques when treating an individual through consideration of reference to absent members of the client's family system. There have been no prior documented cases of treating AD with SEFT as research on the disorder is severely limited. The original research statements are further supported by the results of this case study. After 12 sessions the client documented a significant decrease in anxiety and depression symptoms. The client no longer met diagnostic criteria for Adjustment Disorder with anxiety and depressed mood after treatment with SEFT.

Although the majority of research regarding the treatment of AD suggests the use of brief psychotherapy models such as Cognitive Behavioral Therapy or Solution Focused Brief Therapy (Carta et al., 2009), this study provides

introductory evidence of the effectiveness of SEFT for reduction of symptoms. SEFT focuses on underlying chronic emotional and interactional patterns, reducing recurrence of AD through the creation of lasting change. This study further illustrates the effectiveness of SEFT techniques for the creation of a healthy therapeutic relationship through the use of genuineness and authentic self of the therapist.

Limitations and future research

The current study is not without limitations. The use of case studies, although capable of showing change and effect, cannot be generalized due to the sample size. Future research could aim to recreate this study with a larger sample size. However, because of the spontaneity of therapeutic intervention and emphasis of SEFT on self of the therapist, controlling for extraneous variables would prove difficult. Past research has supported the claim that AD symptoms rarely extend beyond six months, and symptoms have been known to cease spontaneously (Carta et al., 2009). Because the client had been in therapy for six months, there is some possibility the symptoms dissolved as a result of other extraneous variables. Common factors research has indicated that 60% of therapeutic change is attributed to the therapeutic relationship, model and technique, and client's hope and belief in the process. However, 40% of change is attributed to other client factors that cannot be controlled (Sprenkle & Blow, 2004). For example, the client began dating someone new after session 10 which may have contributed to the decrease in depressive symptoms as a result of increased social interactions and outings, and decreased feelings of loneliness. This new relationship may have skewed the results of the study.

Because of the lack of standardized assessment and screening tools for use with AD, the clinician was obligated to utilize assessments normed for use with depression and anxiety to measure symptom severity. Future research should focus on the development and use of tools specifically for AD to ensure correct diagnosis and understanding of impairment as AD symptoms may mimic other disorders, but may result in different manifestations and consequences.

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