The Utility of Projective Tests in Child and Adolescent Mental Health Services

by

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Abstract

The purpose of this professional portfolio is to demonstrate the clinical utility of projective personality assessment in a child and adolescent mental health service (CAMHS). It is argued that projective techniques may be used with this client group within the confines of evidenced based practice, following rigorous recommendations of best practice as determined by past research. Specifically, it is argued that evidence demonstrates reliability and validity of using the Rorschach using the Exner’s Comprehensive System for specific purposes as dictated by the literature and recommendations for best practice. It is further argued that there is a place for the use of projective drawing assessments in working with young people, not for the purpose of assessing and interpreting intricate details of the drawings, but to establish engagement, build rapport, observe problem behaviour, to facilitate spontaneous verbal responses, and to obtain direct information relating to the young person’s sense of self within their environment. Four cases are presented to demonstrate best practice with regard to using these assessments with this complex client group. Chapter four presents a case for which the projective assessment was used during the therapeutic process in order to obtain clarification of her personality characteristics and emotional functioning of a 16 year old female presenting with a long history of school refusal and low mood. Chapters five through to seven presents three cases for which the projective drawing assessments were integral to the assessment process. The assessments complimented traditional CAMHS assessments to obtain important insights into the client’s personality and view of the world. These insights were then used to inform the young person’s formulation and subsequently the treatment plan.
Chapter One: The Utility of Projective Assessments in Working with Young People at CAMHS

Overview

The purpose of this clinical portfolio is to highlight the clinical utility of projective assessments in working within a child and adolescent mental health setting. Despite controversy surrounding the use of projective assessments, they continue to remain popular among practicing clinicians (Hojnoski, Morrison, Brown, & Matthews, 2006; Merrell, 2008; Watkins, Campbell, Nieberding, & Hallmark, 2000) and are considered by some to be an integral element of a comprehensive assessment (Groth-Marnat & Hoboken, 2009; Merrell, 2008). Indeed, projective assessments are frequently used within Child and Adolescent Mental Health Services (CAMHS) to compliment a highly comprehensive assessment process using four session model (Luk, Robinson, Birleson, & Cooper, 1999). Specifically, the drawing assessments and the Rorschach are some of the most widely used projective techniques utilised by clinical psychologists, particularly when working with children and adolescents (Hojnoski, et al., 2006; Watkins, et al., 2000). The utility of these assessments in working within the CAMHS model will be discussed.

The follow review will argue for the clinical utility of projective assessment within a child and adolescent mental health setting due to the benefits to the assessment and formulation of the young person’s situation. However, such techniques must be used following rigorous recommendations of best practice (e.g., Cummings, 1986; Merrell, 2008; Thomas & Jolley, 1998). The following review will highlight the importance of employing these assessments in the
context of a thorough clinical interview, objective outcome measures, and collateral reports from observers including teachers and paediatricians. Specifically, it will be argued that there is evidence for the reliability and validity for the use of the Rorschach using Exner’s Comprehensive System (ECS) with adolescents (Exner, Thomas, & Mason, 1985; Exner & Weiner, 1994a) should it be used following recommendations for best practice (e.g., Weiner, 2000). It will also be argued that although there is a place for the use of projective drawing assessments in working with young people (Tibon & Rothschild, 2007), the traditional method of interpretations are not recommended (Wenck, 1977). Rather, it is indicated from research findings that drawing assessments are best used as a tool to develop engagement, build rapport, observe behaviour, facilitate spontaneous verbal responses, as well as obtain information regarding the client’s sense of self and others through information contained in the drawings in conjunction with collateral information (Cummings, 1986; Malchiodi, 1998; Matto, 2007; Oster & Crone, 2004; Tharinger & Stark, 1990). A particular focus of the following review is the discussion of best practice recommendations in using these assessments in an appropriate manner.

Following a review of the literature pertaining to the utility of the Rorschach and projective drawing assessments in assessing young people, the proceeding chapters will demonstrate the utility of these tools with four clients from a CAMHS in Melbourne. All cases were assessed by the author while working as a provisional psychologist within the services community team under close supervision by senior CAMHS staff. Chapter one presents a case for which the projective assessment was used during the therapeutic process in order to obtain clarification of her personality characteristics and emotional functioning.
As can be seen in this case, the projective assessment provided great insights that an objective measure could not due to significant defensiveness. Chapters five through seven presents three cases for which the drawing assessments were integral to the assessment process. The assessments were part of a battery of CAMHS assessment techniques used to obtain important insights into the client’s personalities and world views. The following cases will also demonstrate how this information was then used in conjunction with collateral material to inform a formulation of the young person’s presentation and the subsequent treatment plan. The following section will introduce the projectives and discuss some of the contentious issues associated with their use.

**Psychological Assessment; an Introduction to the Projectives**

Psychological assessment is core to the professional training of psychologists and is what distinguishes psychologists from other helping professions (Merrell, 2008). Assessment can assist in the formulation of diagnoses and treatment plans, is a means to measure therapeutic outcomes, and can be therapeutic in their own right (Matto, 2007; Musewicza, Marczyka, Knaussa, & Yorka, 2009). Within the realm of psychological assessment, projective tests have elicited more controversy from within the psychological community than any other assessment tool. Some proponents of their use consider projective assessments to be consonant with personality assessment and describe their use as providing a rich source of clinical information (Hughes, Gacono, & Owen, 2007; Weiner, 1999; Weiner, 2000). Criticism regarding projective measures relate to its psychometric properties, while some go so far as to argue that they taint the image of psychological assessment in eyes of the general public (Dawes, 1994; Lilienfeld, 1999; Lilienfeld, Wood, & Garb, 2000).
Although there is controversy regarding their use, there is no doubt that projective assessments remain highly popular among practicing clinicians (Hojnoski, et al., 2006; Merrell, 2008; Watkins, et al., 2000) and are considered to be a valuable element of a comprehensive assessment (Groth-Marnat & Hoboken, 2009; Merrell, 2008) thus warrant further scrutiny.

Contrary to methodology used when administering objective tests which require respondents to indicate their preferences to particular stimuli such as a question (e.g., “I never lie”) in a dictated way (e.g., true/false), projective tests require the respondent to respond to ambiguous stimuli (e.g., an inkblot or a broad request for a drawing) and queries are made regarding the client’s sense of the stimuli (Lilienfeld, 1999). In completing the task, the respondent is said to project aspects of their personality onto the stimulus in the absence of clear instruction from their environment. It is thought that this process taps into people’s natural tendency to interpret ambiguous or new stimuli through a lens which is coloured by their past experiences and present desires or wants (Murray, 1943). As questions are not directly asked of the individual’s experiences and preferences as in objective personality assessments, projective tests are thought to evade the respondent’s defences and provide information about underlying internal conflicts (Lilienfeld, 1999; Murray, 1943).

Of the projective tests, drawing techniques and the Rorschach are some of the most widely used by clinical psychologists, particularly when working with children and adolescents (Hojnoski, et al., 2006; Watkins, et al., 2000). Moreover, they are the most common assessments deemed to be integral to the training of clinical psychologists by their fully registered counterparts (Watkins,
et al., 2000). Given this, the following review will focus upon the utility of these projective tests in a child and adolescent mental health setting.

**Typical Uses for Projective Personality Assessment in Child and Adolescent Mental Health Services (CAMHS)**

CAMHS is a service which specialises in the assessment, diagnosis and treatment of children and adolescents with moderate to severe mental health concerns (Roongpraiwan, Efron, Sewell, & Mathai, 2007). The process of assessing child and adolescent mental health is a complex one which must consider systemic issues (Bearsley-Smith, Sellick, Chesters, & Francis, 2008) including complex family dynamics, the effects of prenatal and neonatal substance use, parent mental health, and intergenerational trauma (Perez, 2009). Given the complexity of the cases presenting to CAMHS, assessments conducted in Victoria are typically performed across four sessions (Luk, et al., 1999).

Should further information be required, specialist assessments such as personality, cognitive, and speech and language assessments may be conducted to facilitate a greater understanding of a client or to clarify diagnoses.

Projective assessments are commonly used within the CAMHS model to facilitate engagement, rapport and to establish an understanding of the young person and their perspectives of themselves and their often complex environments. Such assessments are typically utilised during the initial assessment phase of intervention by means of drawing assessment, in conjunction with clinical interviews, behavioural observation, and teacher/paediatric reports and any other relevant information. Should further information regarding the young person’s personality be required during treatment, a specialist assessment can be scheduled and more complex and time onerous assessments such as the
Rorschach, in conjunction with objective measures such as the Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A; Butcher, et al., 1992), can be administered.

In one case discussed below, a specialist assessment which included a Rorschach (Exner, 2003) provided information integral to understanding the young person’s worldview. In this case, the data derived from the Rorschach provided insights which facilitated movement in her therapeutic intervention. In the other three cases, drawing assessments were used during their assessment and they provided an opportunity to understand the young person’s perspective of themselves, their families, and their complex environments. These projective assessments will be discussed in greater detail below.
Chapter Two: The Rorschach and the Exner Comprehensive System

Introduction to the Rorschach

The Rorschach is a task which utilises projection, perceptual-association, and problem solving (Exner, 2003) which can be used to understand the rich and often complex nature of personality frequently seen in young people in mental health settings (McDougall, Worrall-Davies, Hewson, Richardson, & Cotgrove, 2008).

The Rorschach elicits widely discrepant sentiments among the psychological community with regard to the tool’s utility. Some have described it as “shoddy”, “not a valid test of anything”, even going so far as to suggest that individuals presented with the Rorschach in an assessment would be wise to leave the room (Dawes, 1994, p. 7). Some have concluded that “projective techniques present a curious discrepancy between research and practice” (Anastasi, 1982, p. 564).” To counter these criticisms a standardised system for administration, scoring and drawing normative comparisons was introduced (e.g., Exner, 1974;1978;2003). Based on these developments, proponents of the use of the Rorschach highlight that the tool shows reliability and validity and argue that clinically useful material can be obtained when the tool is used in a manner demonstrated to be reliable and valid in the literature (e.g., McCann, 1998; Weiner, 1999; Weiner, 2000). The psychometric properties and best practice recommendations of the Rorschach ECS will be discussed below.

Reliability, Validity, and Clinical Utility of the Rorschach ECS

As mentioned, the Exner Comprehensive System (ECS) (Exner, 1974;1978;1986;1993;2003; Exner, et al., 1985; Exner & Weiner, 1982;1994a)
was introduced to counter criticism of the use of the Rorschach due to poor psychometric properties. The ECS subscribes explicit and standardised administration and scoring procedures, tailored to increase this tool’s inter-rater and test-retest reliability (Hiller, Rosenthal, Bornstein, Berry, & Brunell-Neuleib, 1999). There have been a number of revisions of this system since it was originally developed in 1974 which have evaluated this system in a variety of populations including in groups of children and adolescents (Exner, 1974; 1978; 1993; Exner & Weiner, 1982; 1994b).

One of the reasons the Rorschach is so widely used with young people is because of its large and representative normative base (Kamphouse & Frick, 2005). The largest normative sample using the ECS comes from a population of young people between the ages of 5 and 16 (Exner & Weiner, 1994a). This sample comprised a minimum of at least 105 children for each age from within this 12 year range (N=1870) of equal gender distribution and varied cultural backgrounds. The only criticism that has been made of this normative group is that there is an overrepresentation of children from a high socioeconomic status (Kamphouse & Frick, 2005). From this sample, Exner and Weiner (1994a) developed age trends relating to the unique way in which younger children respond to the Rorschach stimuli (see Frick, Barry, & Kamphouse, 2009 for a review); for example, younger children are more inclined to provide popular responses to the blots (one third more likely <8 years), give fewer responses (less than 17 responses to the 10 blots is not uncommon prior to age 15 years) and tend to give responses that include the whole blot rather than a specific area (<11 years).
The reliability of this assessment in assessing personality in young people has been extensively tested (e.g., Exner, 2003; Exner & Weiner, 1982; Exner & Weiner, 1994a) demonstrating high inter-rater and test-retest reliabilities (see Hiller, et al., 1999 for a review). One striking example of the reliability data drawn from this sample involved 25 eight year old children who were tested on two occasions one week apart. Test re-test coefficients in this sample ranged from $r=.49$ to $r=.95$, with a mean of $r=.84$. The reliability coefficient for Inanimate Movement ($r=.49$) was the only one to lie below $r=.70$ (Exner & Weiner, 1994a). However, the stability of these scores over longer time periods has been found to be lower in children and adolescents than in adults. For example, Exner, Thomas & Mason (1985) investigated the consistency of reliability coefficients in an eight year longitudinal study involving 57 participants tested at 24 month intervals when they were between the ages of 8 to 16 years. Results indicated that only one variable was consistent between this age frame with results becoming more consistent between the ages of 14 to 16 years.

The moderate level of stability found in the ECS scores (Exner, et al., 1985) over a time delay is typical of tests administered to young people and is thought to be attributed to the fast pace at which children are developing through childhood into early adolescence then adulthood (Erdberg, 2007; Leichtman, 1996; Roberts & DelVecchio, 2000). Throughout childhood, personality is thought to develop through a number of stages as temperament slowly solidifies into more consistent adult like personality traits (Roberts & DelVecchio, 2000). Although it has been suggested that the Rorschach can be reliably administered to early school aged children (Erdberg, 2007; Leichtman, 1996), results of the Exner et al. (1985) study suggest that the Rorschach is unlikely to produce consistent
outcomes if administered to children under 14 years. Thus, it has been recommended that no definitive statements regarding a child’s disposition should be derived based upon a Rorschach ECS profile (Kamphause & Frick, 2005).

When used for diagnostic purposes the Rorschach has shown to have poor predictive validity when working with young people (Jorgensen, Andersen, & Dam, 2000). For example, in one study (Ball, Archer, Gordon, & French, 1991) researchers investigated two versions of the ECS Depression Indices (DEPI; Exner, 1983; Exner, 1990) in two samples, one comprising adolescents in an inpatient setting (N=99) and one involving community outpatients (N=67). Results found no significant relationships between the Personality Inventory for Children depression scale (Wirt, Lachar, Klinedinst, & Seat, 1984), an objective measure of depression, and the ECS DEPI in the outpatient group. Nor were there relationships between the ECS depression indices and clinical diagnoses for the inpatients.

Similarly, Archer and Krishnamurthy (1997) tested the predictive validity of subscales of the MMPI-A (Butcher, et al., 1992) and Rorschach ECS indices relating to depression and conduct disorder. Participants comprised 152 adolescents who were referred for assessment to inpatient, outpatient, and day patient settings. They were independently tested and diagnosed according to the DSM-III-R (APA, 1987). MANOVA analysis compared scores on the identified scales on the Rorschach and MMPI-A across three groups; 1) those identified as having depression, 2) conduct disorder, and 3) “other” psychological conditions. Results indicated that whilst there were significant differences across the groups for the MMPI-A, the same was not found for the Rorschach ECS with only one variable significantly differing across groups. Results suggest that while the
MMPI-A is largely able to identify diagnostic group membership, the Rorschach was less able to perform this function.

Additionally, Exner and Weiner (1982) assessed 20 young people ranging in age from 9-16 years with a diagnosis of Schizophrenia and 23 controls with no such diagnosis. They inspected indices identified by Exner and Weiner for detecting perceptual disturbance and found that they accurately distinguished young people with a diagnosis of Schizophrenia from controls with 91% accuracy. However, there has been no research to examine whether young people who display high scores on these indices are more inclined to go on and develop a psychotic disorder later in life (Kamphouse & Frick, 2005). In addition, Rorschach profiles indicative of perceptual disturbance have not reliably been demonstrated to be associated with other behavioural indicators of psychosis and disordered thought (Smith, Baity, Knowles, & Hilsenroth, 2001). Further, research of young people (aged 11-16 years) with intelligence quotients (IQ) greater than 135 (Gallucci, 1989) has found elevated scores on indices associated with Schizophrenia when compared with age appropriate norms despite no other evidence for a psychotic disorder. Results suggest that young people with superior intelligence may process the Rorschach in an unusual manner to their peers but do not display psychopathology thought to be attributed to psychosis. Finally, data derived from a small group of children and adolescents (N=35) with a diagnosis of PTSD (Holaday, 2000) found that they too had higher scores on the ECS Schizophrenia subscale. It was highlighted that young people with PTSD view the world in an “irrational, illogical and confusing” manner as a consequence of having their safety and view of the world shifted due to trauma (pp. 143). They highlighted that this scale should be renamed “the Perception and
"Thinking Index" (pp. 143) to reflect its function rather than any possible diagnostic classification.

Indeed, in a meta-analysis comparing the criterion validity of the MMPI and Rorschach (Hiller, et al., 1999) data indicated that overall there was no difference between these tests in their predictive validity across a variety of outcome variables (e.g., ability to delay gratification, the Beck’s depression inventory, couples presenting for marital counselling, behavioural ratings provided by spouses, clinical diagnoses). However in accordance with the aforementioned research (e.g., Archer & Krishnamurthy, 1997; Holaday, 2000), the MMPI had higher validity ratings for outcome variables which comprised clinical diagnoses whereas the Rorschach produced higher coefficients when objective criterion variables were used. Results were consistent with two prior meta-analyses conducted using different methodological approaches to assessing the data (Atkinson, 1986; Parker, Hanson, & Hunsley, 1988).

Despite these findings, some clinicians have been reported to base clinical decision making such as forming diagnoses purely on the basis of the Rorschach profile (Exner & Weiner, 1994a). However, the Rorschach was not designed for this purpose nor was it developed to be a diagnostic tool. As Weiner attested, [the Rorschach] “...is not a diagnostic test, if diagnosis means DSM classification... [it] is a personality-assessment instrument designed and intended to measure aspects of personality structure and dynamics” (Weiner, 2000, p. 1). Thus, it is not surprising that the MMPI-A, an empirically developed measure designed to assess diagnostic symptoms and classify people according to diagnostic groups, is typically found to be superior than the Rorschach in performing this task (see Hiller, et al., 1999 for a review; Weiner, 2000). The interpretative reports derived
by scoring the Rorschach with the ECS provide provisional diagnoses for the
clinician to consider when working with the related individual. This information
can be then used to inform further thorough assessment if necessary. However,
clearly the strength of the Rorschach is not its diagnostic utility, rather its ability
to provide rich data regarding the young person and their perspective of
themselves and their environment (Weiner, 2000).

The clinical utility of the Rorschach using the ECS with adolescents has
also been demonstrated in a number of published case studies (e.g., Şar, Ozturk,
& Turgut, 2002; Tibon & Rothschild, 2007; Weiner, 1986). For example, Şar,
Ozturk & Turgut (2002) reported on a case study regarding a young woman who
was assessed with the Rorschach before and after extensive psychodynamic
therapy for Dissociative Identity Disorder (DID). In conjunction with the
Rorschach and clinical interview, a Structured Clinical Interview for DSM
(SCID) Dissociative Disorders (SCID-D; Steinberg, 1994), a Structured Clinical
Interview for Structured Clinical Interview for DSM-III-R (Spitzer, Williams, &
Gibbon, 1987) a Structured Clinical interview for DSM-III-R Axis II Personality
Disorders (SCID-III), the Dissociative Experiences Scale (Bernstein & Putnam,
1986), and a measure of child/adolescent intellectual assessment (Cattell &
Cattell, 1963) were also administered. This client was assessed using standardised
measures and the Rorschach on two occasions with one year intervals pre and
post therapy (Şar, et al., 2002). Upon first assessment, results on the SCID-D
were indicative of DID, the client scoring the highest scores on amnesia,
depersonalisation, identity confusion, and identity alteration (total score of 20).
After one year of therapy this had significantly dropped to a score of eight, in line
with the client's new diagnosis of DID in remission. Her results on the
Dissociative Experiences Scale of the Rorschach was reflective of the amount of such experiences typically reported in normative groups by individuals with DID (Bernstein & Putnam, 1986); however this too significantly reduced post therapy. Finally her IQ was assessed pre and post therapy and was found to significantly improve following treatment (90-124) a factor attributed to disassociation in the initial assessment. These changes were not only evident in the integrative interpretation of Rorschach results but also indicated in themes noted in response to Rorschach stimuli. Pre-treatment, the client projected aggressive/pessimistic themes of blood, aliens smoking, and dead objects onto the inkbloths. However, this changed substantially during the post treatment Rorschach assessment which reflected themes of optimism and positive social interactions and images typically seen in daily life (e.g., two people conversing as opposed to aliens, cherries, rather than blood as previously seen).

This case is a good example of the utility of using the Rorschach in conjunction with objective assessments to form an in-depth understanding of an individual pre and post therapy. In both instances of administration of the Rorschach, findings were congruent with subjective measures, clinical interview, and behavioural observation. This assessment was also conducted with two separate assessors to maintain the integrity of results. Furthermore, the Rorschach was not used diagnostically, but as a method to inform the understanding of this client’s self and worldviews and to determine pre and post therapeutic changes.

**Summary**

In sum, the Rorschach demonstrates good reliability, particularly for adolescents and adults (Exner & Weiner, 1994a; Hiller, et al., 1999). Performance comparisons can be made as a result of the Rorschach’s large
normative groups, and the measure also has good predictive validity for objective criterion not relating to clinical diagnoses (Atkinson, 1986; Exner, et al., 1985; Exner & Weiner, 1994a; Hiller, et al., 1999; Parker, et al., 1988). According to the research, data must be considered with caution in young people below and between the ages of 14-16 (Exner, et al., 1985), information should be used in the context of collateral information including a clinical interview, and diagnostic suggestions derived from the ECS output should be prompts for further investigation as the research clearly indicates that the Rorschach should not be used as a diagnostic tool in young people (e.g., Butcher, et al., 1992; Gallucci, 1989). As was demonstrated in the aforementioned case study (Șar, et al., 2002), the Rorschach provides rich information regarding a young person’s personality which can be vital in informing effective formulation and treatment planning in mental health settings if used appropriately. This will also be demonstrated in the case of Annie, a 16 year old CAMHS patient, who will be discussed in chapter four.
Chapter Three: Projective Drawing Techniques: Clinical Utility and Statistical Validity

Another projective technique frequently utilised in CAMHS is the drawing assessments. Drawing is said to be a natural form of expression for children, providing them with a method through which they can express their desires, fears, and attitudes (Cummings, 1986). Drawings have also been described as a form of non-verbal communication that has historically been analysed for factors including structure, content, and quality (Koppitz, 1983). Koppitz’s statements reflect the position of many advocates for projective drawings:

“...Long before youngsters can put their feelings and thoughts into words they can express conscious attitudes, wishes, and concerns in drawings. Drawing is a non-verbal language, a means of communication (pp 283-284).”

Antagonists refute the suggested utility of projective drawing assessments due to the lack of explicit scoring and interpretative guidelines and due to reports of mixed to poor reliability and discriminant validity (Forrest & Thomas, 1991; Hibbard & Hartman, 1990; Joiner Jr, Schmidt, & Barnett, 1996). For the assessments which have demonstrated high reliabilities, such as the Family Kinetic Drawings (Handler & Habenicht, 1994; Mostkoff & Lazarus, 1983), correlations between drawings and behavioural outcomes have not been consistently found (Joiner Jr, et al., 1996). Additionally, most norms have not been reviewed for many years or decades and are considered to be insensitive to culture, gender and other factors (Oster & Crone, 2004). Some argue that hypotheses derived from projective drawings are highly suppositional and
questionable (Palmer, 1983) and consider the practice to be “best avoided” (Thomas & Jolley, 1998, pp 136).

However, these criticisms are based on very different methodology than is recommended in the current literature (e.g., Malchiodi, 2008; Matto, 2007; Merrell, 2008). The traditional approach to interpreting drawing assessments involves analysing the absence or presence of discrete features within the drawing and making inferences based on these factors (e.g., thickness of lines, size of hands, and/or presence/absence of a chimney on a house) (Cummings, 1986). Incongruently, the contemporary view highlights the use of drawing assessments as a mechanism for communication via projection of experiences, concerns, fantasies, and worldviews into their pictures in a more explicit manner or through verbal means as a consequence of prompting by the drawings. By using these techniques, the young person makes meaning from ambiguity drawing on personal experiences or feelings (Oster & Crone, 2004). The processes of conducting drawing assessments is seen as an opportunity to observe this problem solving process, and a method for emotional expression that provides insights of the young person that may not otherwise be made (Malchiodi, 1998; Oster & Crone, 2004).

In a review of the literature of the utilisation of projective assessments with children, Cummings (1986) lists four main purposes for the use of projective drawings. Firstly, they are said to provide an avenue for communication via symbolic representation for the child to express themselves to the adult clinician despite less developed language skills; they serve to develop an understanding of the client’s view of the world and inner fears, conflicts and experience of the family; they provide a method through which the child can be understood via a
psychodynamic perspective; and finally, they assist to develop hypotheses to inform further assessment.

Others have demonstrated that drawing assessments can assist in recalling information without compromising accuracy (Butler, Gross, & Hayne, 1995; Gross & Hayne, 1999). They have been demonstrated to facilitate information regarding traumatic events which is non-confrontational and less threatening than through verbalising their experiences (Burgess & Hartman, 1993). This was evidenced by Butler et al.'s (1995) study which found drawing assessments to increase the interview time and amount of content disclosed by a child; potentially as the drawing provides a focal point that is an alternative to an adult assessor. Drawing has also been demonstrated to create cues which the young person leverages to remember information at a later date by potentially enhancing memory recall (Butler, et al., 1995).

Indeed, projective drawings serve a core function in the assessment of young people by psychologists at some CAMHS settings. Further, they remain popular in the broader child and adolescent assessment process (Hojnoski, et al., 2006; Watkins, et al., 2000). Thus, it is important to understand best practice recommendations for how these assessments can be used in an ethical and useful manner.

**Best Practice Recommendations and Appropriate Uses for Projective Drawing Assessments**

The aforementioned discussion has highlighted two facts; firstly, projective drawing assessments continue to be a popular and widely used method of obtaining information from young people (Hojnoski, et al., 2006; Watkins, et
al., 2000), and secondly, there continues to be controversy regarding their use as research fails to demonstrate that the enthusiasm held by many clinicians is warranted due to very mixed psychometric properties (Forrest & Thomas, 1991; Hibbard & Hartman, 1990; Joiner Jr, et al., 1996). However, it is argued that the problem is not with the assessments themselves, rather it is with the method in which some clinicians continue to utilise these tools. To counter this problem, authors have offered recommendations for best practice in the use of the projective drawings which encapsulate the benefits gained from using these techniques by highlighting methods to avoid working in an inappropriate and unethical manner (Cummings, 1986; Merrell, 2008; Thomas & Jolley, 1998); these will be briefly discussed below.

Firstly, the drawing assessments offer an opportunity to develop rapport with the young person (Matto, 2007; Merrell, 2008). Typically, young people find these techniques to be safe and auspicious (Matto, 2007; Oster & Crone, 2004). Thus, they may serve to promote the therapeutic alliance between the assessor and young person and make them feel comfortable during the process of psychological assessment (Burgess & Hartman, 1993; Cummings, 1986). For an individual who has experienced a traumatic event, tumultuous family life, or who is exhibiting oppositional behaviour, projective drawings allow an avenue for emotional expression to give voice to internalised secrets, pain, and anger (Malchiodi, 2008). This process is therapeutic in its own right, and is used to commence and inform art therapy with some children (Malchiodi, 2008).

These techniques are also useful for children who are reserved, shy, or lack the verbal expressive skills to communicate their experiences (Merrell, 2008). Indeed, young people often do not have the sophisticated verbal
expression abilities necessary to participate effectively in a clinical interview. Instead, clinicians frequently need to use creative methods to understand a child including observing their play, conducting drawing assessments, and using visual activities (Gil, 1991). Moreover, it is not uncommon for children with mental health concerns, such as those presenting to CAMHS, to have co-morbid speech and language delay (Benner, Nelson, & Epstein, 2002; Law & Garrett, 2004); further exhibiting the need for techniques which rely less heavily on verbal acuity (Matto, 2007).

One factor which elicits extreme criticism for the use of projective drawings is the overgeneralisation of particular elements of the drawings to form strong opinions about their behavioural outcomes (Cummings, 1986). It has been repeatedly recommended that judgements derived from drawings should not be made in isolation; rather information should be considered as one of many forms of assessment techniques (Cummings, 1986; Merrell, 2008; Thomas & Jolley, 1998). In forming judgements in isolation, assessors may miss significant contextual information such as verbal comments or associations, overt behaviours, or affective observations (Cummings, 1986). This process may provide insights to generate hypotheses for further investigation.

Some have suggested that the greatest value added by projective drawings is the process analysis conducted whilst undertaking this activity (Cummings, 1986). This includes comments made by the young person about themselves, their families and environment. Used in conjunction with other information, such comments may provide insights into the young person’s sense of self, their worldview and perspective of their environment. Additionally, these assessments provide an avenue to observe the young person problem solving and interacting.
They also allow an opportunity to observe the child completing a semi structured activity which can then be compared to others completing the same techniques (Cummings, 1986; Merrell, 2008).

A number of different drawing assessments are popular among clinicians; those which are particularly utilised within the CAMHS environment in which the author conducted a clinical psychology placement include House – Tree- Person, the Kinetic Family Drawing, Two Dreams, and the Island Drawing. These will be briefly discussed independently below.

**House – Tree – Person.** A very commonly utilised drawing technique is the House Tree Person drawings which draws on psychodynamic theory (HTP; Cummings, 1986). Initially published as measure of intelligence, the HTP has developed into a highly popular projective technique. It involves the young person drawing a house, a tree and a person in succession on separate sheets of paper. After the young person has completed the drawing, succession of questions are asked to provide an opportunity for the young person to describe the drawn items (Cummings, 1986).

According to psychoanalytic theory, the house is thought to represent feelings associated with the young person’s home life and familial relationships. The tree is said to elicit unconscious feelings about the self and his or her relationships with their environment (Matto, 2007) and the extent to which the young person can grow and establish supports in their environment. Whereas, the person is thought to represent a more conscious view of the self, fantasies of how they would like to see themselves, or a view of a significant other (Frick, et al., 2009).
Kinetic Family Drawing. Another commonly used technique is the Kinetic Family Drawing (KFD). This involves the assessor asking the young person to “draw a picture of everyone in your family, including you, doing something” (Burns & Kauphman, 1970, p 5). Initially, the young person is asked to name the members depicted in the picture and provide their age and relationship to the young person. After this the young person is prompted to consider what activity they are going, how they are feeling, and what they are thinking about. They are asked to tell a story about the content of the drawing and what happened after this scenario occurred (Cummings, 1986). The KFD provides an opportunity for the child to express their feelings and perceptions of their family in a safe and indirect manner (Burns & Kaufman, 1970). It also provides an opportunity for the young person to depict the family in an active way and allows them to reflect on their perception of the interactions between family members (Handler & Habenicht, 1994).

A deviation of the KFD is to ask the young person to draw their family as animals. In these drawings young people are thought to project commonly understood characteristics and associations of animals onto their family members and themselves. These drawings are then assessed for salient features, proximity to other „family members”, and behaviours being undertaken in the drawing (Leibowitz, 1999).

Two dreams. In this assessment, the young person is then asked to draw a dream (Saxe, 1997). Information regarding the dream is elicited with a particular focus upon how the young person is feeling in this dream. Should the child draw what is identified as a „bad dream” they are then asked to draw another
dream depicting a "good dream" and vice versa. Young people are thought to project their fears and desires into these dichotomous dreams.

**Island drawing.** This technique entails asking the young person to draw a picture of an island including all of the things or people that they would like to have on this island and what they need to survive (Riley, 1999). This technique is thought to elicit information regarding the child’s view who and what they consider important in their life. It often provides an opportunity to understand what the young person desires and what they perceive to be deficits in their life.

**Conclusion and Introduction to Case Studies**

The aforementioned review has argued for the clinical utility of the use of projective assessment within a child and adolescent mental health setting due to the benefits to the assessment and formulation of the child’s situation. It has highlighted the importance of employing these assessments in the context of a thorough clinical interview, objective outcome measures, and collateral reports from other observers including teachers and paediatricians.

The following chapters will examine the utility of the use of projective drawings and the Rorschach ECS in the assessment of four clients from a Child and Adolescent Mental Health Service in Melbourne. All cases were assessed by the author while working as a provisional psychologist within the serviced under close supervision by senior CAMHS staff.

Chapter four presents a case for which the projective assessment was used during the therapeutic process in order to obtain clarification of her personality characteristics and emotional functioning. As can be seen, in this case the
projective assessment provided great insights that an objective measure could not
due to significant defensiveness.

Chapter five through four presents seven cases for which the projective
drawing assessments were integral to the assessment process. The assessments
complemented traditional CAMHS assessments to obtain important
understandings of the client’s personality and view of the world. These insights
were then used to inform the young person’s formulation and subsequently the
treatment plan.

Within the following chapters, all identifying information has been
changed in order to preserve the privacy of the client’s assessed. Names, ages,
schools attended, number of siblings, all genograms, and other identifying
information has been omitted or altered. Furthermore, example drawings derived
from three of the four cases can be seen in Appendices A-C. Any identifying
information contained in these drawings has been obscured to ensure anonymity.
Chapter Four: Personality Assessment as an Aid for Formulation: the Case of Annie

This chapter will review the case of Annie, a 16 year old girl referred to the author for cognitive and personality assessment part way through her treatment with CAMHS. This client was referred after obtaining diagnoses of Generalised Anxiety Disorder (GAD) and Major Depressive Disorder (MDD, single episode) because her case manager felt that further assessment and observation from another clinician may offer some clarification regarding her cognitive and personality profile which may provide greater understanding of this client diagnostically. It was hoped that by obtaining another perspective of Annie, information derived may assist the therapeutic process. In this case, a Rorschach assessment provided significant insights which helped to explain this client’s school refusal, interpersonal difficulties, and difficulties formulating her identity.

Reason for Referral

Annie was initially referred to CAMHS due to a long history of school refusal, 3.5 years of absenteeism, and low mood. Annie felt that she was not able to manage her emotions and wanted to learn to communicate her feelings more. Throughout the course of therapy it became apparent that Annie had a highly developed fantasy life and significant social difficulties.

She was referred for specialist psychological evaluation as her case manager felt that there may be elements of Annie’s personality which may be contributing to her difficulties.
MSE at Assessment

The specialist assessment was conducted over three sessions. The following MSE was taken when first seen for a cognitive assessment.

**Appearance, attitude and activity.** Annie is a 16 year old girl who presented dressed in clean casual clothes. She is above average height and weight, and has very dark coloured hair. She maintained good eye contact, appeared tired, and was superficially happy. Annie was motivated to conduct the cognitive assessment to the best of her ability.

**Mood and affect.** Annie reported mood fluctuations however indicated that she was typically low in mood. Affect was incongruent with mood as she presented as superficially euthymic. Affect was stable and in a normal range.

**Speech.** Normal rate and volume. She was noted to revert to a less developed language style when placed under pressure. She also frequently gave reference to movies or characters in her responses to verbal questions.

**Thought process.** Annie appears to have normal stream of thought; however there appears to be a loose association between thoughts at times. Content focused on topics at hand however frequently diverged to movies or books loosely related to the relevant topics.

**Perception.** Perceptual disturbances were not observed or noted by Annie.

**Cognition.** Annie was alert and oriented to person, place and time. She demonstrated good attention and concentration. Cognitive assessment had not
been conducted; however her responses were indicative of at least average intelligence.

**Insight and judgment.** Annie is aware that she has difficulties but has no explanation for these. She is motivated to receive assistance with this. Judgment does not appear to be impaired.

**Imaginative play and use of fantasy.** Annie has a rich imagination and use of fantasy.

**Rapport.** Good rapport established however appears wary of difficult questions and avoidant of distressing topics.

**Risk assessment.** Nil evidence for risk to self or others.

**Background History and Personal Information**

**Genogram**

![Genogram Image]

**Developmental History**

Developmental milestones were all generally considered to be within normal limits. Annie was the result of a planned pregnancy and her mother
reported no difficulties during pregnancy. She was four weeks premature and born after an eight hour labour. Annie was breastfed until nine months of age. She had sleep difficulties as an infant however this was well managed and she settled. She was said to respond to voices in her first month, her first word was at the age of 11 months, and she made two word phrases before the age of 18 months. Gross and fine motor development were described as being within the normal range (e.g., crawling at eight months, walking alone by 12 months, able to draw and throw a ball before 28 months).

Annie’s mother returned to work when Annie was eight months old. She was initially cared for by her maternal grandmother before transitioning to family day care; she was said to manage this transition with minimal disruption.

Annie exhibited severe separation anxiety from her mother when she initially went to primary school; however this was managed by arranging for another family member to drop her off. After school Annie would not want to leave at the end of the day. Her primary school was described as small and caring and she was said to fit into the curriculum well. She had significant difficulty managing the transition from primary to secondary school, indicating that she has difficulty relating to her “friends”, indicating that she is not interested in what most people her age like. Annie does not have any friends outside of her immediate family. She likes activities such as watching movies, reading, playing on the internet.

**Family Background**

Annie’s father Fred has been told that he is impolite; however he stated that he values honesty. He indicated that he is very open and direct about his
feelings and does not understand why people become upset. Fred did not wish to
discuss his family of origin (FOO) except to state that his father suffered from
Schizophrenia and that he had a “difficult” upbringing. Fred has no association
with his FOO. Fred presents as very matter of fact and concrete in his thinking
style.

Annie’s mother Jamie is the eldest of four girls and described her
experiences growing up in her family as “fairly typical”. Jamie is bubbly in her
personality but reports that she hides her emotions. Jamie indicated that she has
always suffered from heightened anxiety but has never felt that it was significant
enough to seek professional assistance.

Fred and Jamie met at work, dated for 18 months before getting married
one year later. Jamie fell pregnant with Annie two years later. They reported that
they had a harmonious marriage, indicating that they feel “ill” when they have
fought in the past.

**Family Dynamics**

Jamie and Fred live busy and independent lives. Jamie is close to her
sisters whom she sees regularly. Annie and her 12 year old brother Jim are said to
fight occasionally. Jamie is highly stressed about Annie’s school refusal and
indicated that it is a source of conflict between her and Annie and her and her
husband.

**Premorbid Personality**

Annie was described as anxious and socially withdrawn as a child.
Educational History

Currently, Annie is in year 10 of a public secondary college. She attended a public primary school and was said to excel academically. Annie was often invited to social events in primary school but often refused to attend. Upon the transition secondary college, Annie became increasingly withdrawn, she started to refuse to attend school, and her grades dropped. Jamie encouraged Annie to work or attend TAFE should she not want to continue her studies; however, Annie would like to finish her Victorian Certificate of Education.

Assessments

- Family and child clinical interview
- Outcome measures – HoNOSCA, FIHS, SDQ (parent version)
- Cognitive report
- MMPI-A
- Rorschach assessment (ECS)

Reason for Projective Assessment

Annie was originally diagnosed by her case manager with Generalised Anxiety Disorder (GAD) and Major Depressive Disorder (MDD) which was leading to frequent school refusal. However, throughout the course of therapy it became increasingly apparent that Annie was struggling with her identity formation and had a highly developed fantasy life; her case manager felt that there may be some personality characteristics that may be interfering with Annie’s ability to relate to others and attend school. A referral was made for a cognitive and personality assessment; given this, the Weschler Intelligence Scales for
Children (WISC-IV), the Multiphasic Personality Inventory- Adolescent (MMPI-A), and the Rorschach (ECS) were administered and will be discussed independently below.

**Results of the Cognitive Assessment**

WISC-IV results indicated that Annie has strong cognitive abilities which place her overall in the high average range. This high level of general intelligence is typically related to good aptitude for school based tasks and readiness to master the school curriculum. Her working memory was found to be well above most of those of a similar age. Moreover, her perceptual reasoning abilities were in the high average range. Her ability to reason with verbal tasks was found to be in the average range. A relative weakness for Annie was her processing speed.

The combination of Annie’s preference for non-verbal information, verbal reasoning skills which are lower than her other abilities, and low processing speed may indicate that she experienced difficulty in the transition from working within a curriculum which predominantly focuses on non-verbal learning, as is seen in the primary years, to working in a principally verbal environment which often requires that work be completed in a fast manner. Difficulties in these areas may be causing some of Annie’s distress regarding attending school. As Annie is an intelligent and contemplative person, she is likely to be aware of any relative weaknesses and may experience distress as a consequence of this rather than considering her relative weaknesses in the context of other strengths.

**Results of the Multiphasic Personality Inventory- Adolescent (MMPI-A)**

Following the completion of the cognitive assessment, an MMPI-A was conducted. However, her performance indicated that she was severely defensive
when completing the assessment, with scores indicative of someone with a marked tendency to portray a facade of adequacy and control, high moral values, and a tendency to admit no problems or weaknesses. She appeared to be highly inhibited, and denied any hostility towards others.

Her profile was indicative of someone who would go to great lengths to avoid unpleasant events, particularly those related to group and social activities. She has a tendency to rationalise and deny any negative emotionality. Instead it appears that she reports a variety of physical symptoms and views herself as in poor health.

Annie did not score highly on any of the content scales of the MMPI-A. This profile was considered to be an under representation of her symptoms and problems. Given little information was able to be derived from the MMPI-A results a projective assessment was conducted to provide more information.

**Information Provided by the Projective Assessment**

Annie’s performance on the Rorschach indicated that she is a unique girl who views the world differently to most others her age. She has a strong interest in fantasy, which is at times reflected in her speech content and thought processes. It seems as though Annie’s highly developed fantasy life is often at the forefront of her awareness.

Her profile also suggests that she has difficulty identifying with people her own age, instead tending to relate to fictional characters for comfort. This tendency may be counterproductive for Annie as it serves as an escape from the discomfort experienced in social situations rather than allowing her to establish a
level of comfort and confidence. Annie’s strong identification with fantasy may also be interfering with her ability to establish her own identity and peer relations.

Annie appears to be experiencing a great deal of emotional distress, however is concerned about recognising this herself and is also worried about others knowing that she is suffering. Annie also seems to go to great lengths to avoid emotional distress, such as that experienced in the school environment. Furthermore, both personality profiles are indicative of someone who views themselves in a negative light and in poor health. This is likely impacting upon Annie’s self confidence, ability to cope and manage adversity, and mood. These factors are also likely to impact upon Annie’s ability to navigate and cope with stress and adversity at school.

Her tendency to give tasks a great deal of thought and examine situations extensively indicates that she likes to be careful and thorough. However, this will only be appropriate when there is sufficient time to allow for this. Her tendency to seek out additional or complicated information may be impacting her ability to process new information quickly or make quick decisions, something which is often required in school activities such as tests/exams.

Results also indicated that she is experiencing anxiety about forming her own identity (e.g., who she is, what her place in this world is, what is the meaning of her life). Whilst this task is typical in adolescence, Annie appears to be placing a greater amount of time and importance on forming her identity than is typically seen in people her age. This may, in part, be related to her tendency to think a great deal and be over-inclusive when contemplating things. It may also be related to her preference to relate to mythical characters and movies which are often
complex and ominous in content. There is also ambivalence between who Annie is and who she thinks others want her to be. This discrepancy in conjunction with a preference for others to see her in a favourable light serves as a way for Annie to avoid looking at or sharing with others things about herself that she perceives to be personal slights or flaws.

Finally, it was noted that during both assessments which required verbal expression, Annie tended to revert to a less developmentally appropriate language style when feeling challenged or emotionally exposed. This method of problem solving may be ineffective in an educational environment and may also indicate that Annie feels as though she cannot cope with distressing emotions.

Formulation

Annie is a 16 year old girl who presented to CAMHS with a long history of school refusal and anxiety symptoms. Information obtained from the clinical interviews, specialist assessment and family interview indicates that Annie exhibits odd beliefs and magical thinking which is not developmentally appropriate, is socially isolated and demonstrates limited understanding of her peers, has no close relationships outside of her immediate family, demonstrates circumstantial speech which is frequently linked to unrelated thoughts of fantasy, exhibits affect that appears to be incongruent to her mood, and experiences significant social anxiety. Her difficulties appear to be predisposed by a biological predisposition for anxiety, schizophrenia in the paternal side of the family, and social difficulties as modelled by her father.

These appear to have been exacerbated by the transition from primary school to secondary college which was hindered by a poor sense of self,
difficulties with the formation of her identity, and underdeveloped social skills. Moreover, her preference for working with nonverbal information rather than verbal information, her slow processing speed in the context of above average general intelligence may have heightened the difficulty with the transition from working within a curriculum which predominantly focuses upon non-verbal learning, often seen in the primary years, to working in a principally verbal environment which often requires fast paced work as is increasingly expected in secondary college. She is likely to be aware of her difficulties with processing information quickly, and may have noticed that she is now at a similar level or not performing as well as her peers with verbal tasks. These factors may have led to some school refusal initially perpetuated her return to a scholastic environment after periods of non-attendance.

These symptoms may be perpetuated by her use of avoidance as a coping strategy and her trouble expressing and communicating her emotional state. Moreover, symptoms appear to be perpetuated by her family system whereby Annie receives conflicting messages regarding emotional expression.

Annie’s protective factors include intelligence, motivation to seek treatment, and willingness of her family to engage with CAMHS.

**Diagnoses**

**Axis I:**

Major Depressive Disorder, single episode (269.2)

Social Anxiety Disorder (300.23)

Identity Problem (313.82)
Axis II:

Provisional diagnosis:

Schizotypal Personality traits (301.22)

Differential diagnosis for further assessment/monitoring:

Pervasive Developmental Disorder (NOS) (299.80)

Axis III: Nil

Axis IV:

- **Problems with primary support group** – Annie’s difficulties individuating appear to be related to dynamics within the family of origin.

- **Problems related to the social environment** - Annie has not developed age appropriate peer relations.

- **Problems with educational environment** – Annie has missed a substantial amount of school which has left her behind or on par with her peers in some areas. Annie has typically been ahead of her peers and may find average performances on academic tasks quiet anxiety provoking.

**Axis V:** CGAS = 55

Recommendations

- Clinical case management

- Family therapy

- Further assessment recommended to further explore a possible Pervasive Developmental Disorder diagnosis
Further monitoring/assessment recommended to explore Schizotypal Personality Traits.

Using the Assessment Information in Therapy

Feedback regarding the information obtained from the three assessments conducted was provided to Annie. She was given the opportunity to decide whether she wanted anyone in attendance at feedback and she brought her mother. Annie and her mother were receptive to most of the feedback and Annie identified with most of what was relayed to her. She was said to have taken the reports derived from the assessment away and reflected on these in her own time, later bringing her thoughts into the therapeutic space over the following weeks. Having her experiences reflected back to her in a formal manner was a confronting process, yet it was a catalyst for change as it opened up areas for discussion that were previously avoided. Annie was no longer trying to hide herself from the therapist as she was previously, and was better able to discuss her identity and sense of self. When the author finished her placement with CAMHS, Annie was continuing to make gains in the therapeutic space and was considering attending another school next year which has more of a focus upon individuality and creative development than a mainstream school.

The family also engaged in family therapy whilst engaged with CAMHS. The focus of this therapy was to recognise differences in emotional expression and the impact of this on Annie’s emotional regulation, place the responsibility for attending school on Annie to facilitate her independence, and to obtain an understanding of Annie’s situation from within the family.
Conclusion

This case has demonstrated the utility of the Rorschach, using Exner’s Comprehensive System, in understanding an adolescent’s personality, her sense of the world and self. The Rorschach was particularly useful in this case as Annie’s defences were interfering with gaining an understanding of her situation, as demonstrated by guardedness during the clinical interview with her case manager, and by an invalid MMPI-A profile. This had resulted in axis one diagnoses which only encapsulated part of her experiences and difficulties. The projective assessment utilised in the context of collateral information provided an opportunity to understand Annie’s personality which was indeed unique for someone of her age. Whilst adolescents of superior intelligence have been demonstrated to have unique through processes typical of a thought disorder when completing the Rorschach assessment (Gallucci, 1989) these adolescents were observed to have no other behavioural indicators for disturbed thought. However, Annie’s presentation whilst performing a number of assessments, parent, teacher and self report at interview, and behaviour during therapy was consistently congruent with Schizotypal traits (e.g., odd beliefs, magical thinking, odd thinking and speech, inappropriate/constricted affect, lack of close friends, social anxiety that does not diminish with familiarity). In this instance it was her behaviour during assessment, speech content, and problem solving observations that informed this client’s diagnoses which happened to be congruent with the Rorschach profile, even though the ECS profile was not used for diagnostic purposes. The possibility of Annie having a PDD could not be ruled out; however, her odd behaviour, magical thinking and preoccupation with fantasy were more indicative of Schizotypal tendencies.
The information provided by the projective assessment was used to inform her formulation and treatment plan, and opened up avenues to discuss topics which were formally not broached. It stimulated reflections which lead Annie to make insights and gains in therapy and provided an avenue for her mother to better understand her situation. It also provided information that guided a more targeted approach for family therapy; following family therapy, Annie was said to have improved her school attendance.

Clearly the assessment in this case provided an opportunity to observe Annie performing different activities which varied in terms of how challenging Annie perceived them to be; this allowed the assessor to observe behaviours not previously seen during the clinical interview such as the regressed speech and avoidance through using fantasy. Information obtained via a number of sources indicated that Annie fulfilled some criteria for Schizotypal personality disorder indicating that she had Schizotypal traits. Indeed, observing Annie conducting a number of different tasks provided the assessment team with valuable insights to be able to notice these traits. Annie’s case manager is mindful of these insights when working with Annie and she is hopeful that with intensive and ongoing therapy, Annie can avoid a potential pathway to developing a personality disorder in adulthood.
Chapter Five: Projective Assessment as an Aid to Formulation: the Case of Aden

This chapter discusses the case of Aden, a nine year old boy referred to CAMHS for assessment and treatment of a number of externalising symptoms. In conjunction to a child and family clinical interview, cognitive and achievement assessments, and school observation, projective drawing assessments were utilised to develop an understanding of Aden’s sense of self and his view of the problems. As can be seen, the projective assessments in this case were integral to obtaining an understanding of this client’s presenting problems which then influenced the formulation and treatment plan.

Reason for Referral

Aden was referred to CAMHS by his mother at his school’s insistence. His school indicated that Aden was “unmanageable”, “violent”, and “aggressive”; stating that he recently tried to “cut himself” at school and was hyperactive and does not listen to teachers. Aden’s school welfare coordinator reported that she believed Aden to have Attention Deficit Hyperactive Disorder (ADHD) and would like him assessed.

Presenting Problems

Problems described include behavioural disturbances such as acting out at school, hurting peers, bullying others, truancy (two occasions fleeing the school grounds), climbing on „out of bounds‟ areas, loosing items, and hyperactivity at school only. Aden’s mother indicated that Aden has difficulty completing his school work. He becomes fatigued at lunch time and the school have started to
send him home after the morning classes. There is no disturbance to appetite and mood is described as “happy” but becomes easily agitated.

**MSE on Intake**

**Appearance, attitude and activity.** Aden presented to CAMHS in his school uniform. He was well groomed and average weight and height. He was cooperative and friendly with the assessors and displayed pleasant manners. He was alert and active throughout the assessment.

**Mood and affect.** Reported feeling “very angry” indicating that he has “always felt this way”. Affect congruent with mood, angry and irritable. Affect was stable and in a constricted range.

**Speech.** He exhibited clearly articulated speech. Some spontaneity observed. Aden was observed to redirect conversation if it broached a topic he did not wish to discuss (e.g., likes at school).

**Thought process.** Thoughts were well-connected and logical with no abnormalities detected. Content focused upon various toys in the room and what they were doing (e.g., the frog puppet swimming).

**Perception.** Nil perceptual distortions indicated/reported.

**Cognition.** Aden was alert and oriented to person, place and time. He largely maintained concentration on tasks which required a physical component. When unoccupied physically he became distracted by toys or other items in the room. Psychological testing conducted approximately 18 months ago reports average intelligence.
Insight and judgment. Judgement appeared impaired by impulsivity and emotional arousal. Aden appears to believe that he is justified for acts of aggression in the context of retaliation. He could not provide an explanation for his presentation however acknowledged that some of his behaviours got him into trouble at school. Aden reflected a desire to return to CAMHS and engage in treatment.

Imaginative play and use of fantasy. Aden demonstrates a good use of fantasy in his play however his drawings and fine motor skills were very underdeveloped for his age. Aden is highly animated when he plays and uses a variety of toys.

Rapport. Engagement was easily established and maintained with Aden throughout the session. Aden was reluctant to end the session.
Background History and Personal Information

Genogram

Developmental History

Aden is the youngest of five children born to Janice, conceived with three different partners. The pregnancy was not planned and Aden was born at full gestation. Prior to the birth of Aden, Janice had one miscarriage and one stillborn child. During her pregnancy with Aden, Janice smoked a significant amount of marijuana daily and drank alcohol regularly. Two months prior to Aden’s birth, the Department of Human Services (DHS, Child Protection) became involved and she consequently ceased her substance use. Aden was underweight at birth. He
was described as a good sleeper who rarely cried. He was breastfed for two weeks before being introduced to formula. Aden crawled at one year and walked at age two. He said his first words at one year and was saying sentences by the age of three or four. He was toilet trained by age four. He was described as active as a young person, but not hyperactive. He has attended day care or kindergarten four days per week since birth. He experienced no separation anxiety and was described by Janice as self-sufficient. Aden had difficulty settling into the routine of school for the first few months of prep, but settled with time. When Aden was six he was sexually abused by his stepsister, an incident that was interrupted by another family member. It was after this time that his mother reported that his attitude and mood changed significantly. He is reported to be less happy and reserved.

**Family Background**

Aden’s father, Phillip, was reported to be substance dependent, verbally abusive towards the children, and inflicted domestic violence Aden’s mother which was witnessed by the children. According to Janice, he was in and out of prison and was described as emotionally volatile. Little is known about Aden’s father’s family of origin as CAMHS never had any involvement with Aden’s father.

His mother, Janice, is the eldest of five sisters. Janice reported that she had a close relationship with her father who recently passed away from heart failure. Janice did not talk fondly of her mother who was said to engage in a number of extra marital affairs and was substance dependent. Her mother left the family after the birth of Janice’s youngest sister and started another family, having two more children. Janice was subsequently raised by her father and
indicated that she played a significant role in raising her sisters. She has suffered from depression for many years which was exacerbated by her father’s death. She has a low level of formal education (year eight) and has never upheld a stable job. Janice has a long history of poly-substance addiction; however reported that she no longer uses substances. During interviews with CAMHS, Janice appeared distant and exhibited poor short term memory function.

Janice and Phillip met through friends and became pregnant with Annie three weeks into their relationship. They were together for just under four years, Phillip leaving the family just prior to the birth of Aden.

**Family Dynamics**

Janice and her four youngest children live in a three bedroom unit. Aden’s older brother Xavier visits the family home regularly however lives independently. Xavier is said to be Aden’s favourite sibling. Aden plays with his sister, Annie (the perpetrator of the sexual abuse), however his mother indicated that he is “always” supervised when around her. Aden has irregular contact with his father whom phones occasionally. Aden was reported to be close to his maternal grandfather. Aden sleeps in the bed with Janice.

**Premorbid Personality**

Aden was described by his mother as “happy and outgoing” before the sexual abuse allegation. She acknowledged that Aden was always quick to temper.

**Educational History**

Aden is in grade two at Bluevale Primary School where he has attended since prep. He repeated grade two this year as he was not meeting work
requirements. It was last year than the school started to report behavioural concerns to Aden’s mother. Aden is said to have always had difficulty reading and writing. He also has trouble focusing on mathematics.

Social Development

Aden is said to be a popular child however students sometimes do not want to play with him due to his disruptive behaviours at school.

Risk Assessment

Aden has a moderate risk of accidental harm to self. He appears to be at moderate to high risk of harm from others as it seems that at this time Janice does not have the resources to protect him from his elder sister. Due to the nature of the aforementioned information, a notification was made to the DHS Child Protection services. Aden’s mother was made aware of these risks and of the purpose of the notification.

Assessments

- Family and child clinical interview

- Projective drawings

- Outcome measures – HoNOSCA, FIHS, SDQ (parent version)

- School reports/observation

- Cognitive report (WISC-IV)

- Achievement assessment (WIAT-IV)
Results Derived from WISC-IV (Weschler, 2003) and WIAT-II (Weschler, 2001)

Prior Assessments

Aden has been previously diagnosed as having auditory processing disorder. He also performed a speech and language assessed at the age of 5 years, 4 months and was found to have low average core language skills; no further speech pathology intervention was deemed necessary at that time. He also underwent a cognitive assessment (WPPSI-III; Weschler, 2002) at age 6 years, 5 months which indicated that his full scale IQ was in the average range (specific indices not reported). His ability to reason and work with his hands (73rd percentile) appeared to be better than his ability to reason and understand language (25th percentile). His ability to process new information under time pressure was at the 37th percentile.

Current Assessment

Aden’s cognitive abilities are generally in the low average to average range with the exception of his processing speed which much slower than most others his age. His ability to perform on school based tasks is significantly lower than what is typically seen in someone of Aden’s age and what would be expected of someone with his level of intelligence.

A slower processing speed can be associated with poor handwriting, difficulty with mathematics and reading. This may in part explain why Aden’s reading, mathematics and written language skills are less developed than his ability to express himself orally. Interestingly, it seems that Aden’s processing speed has decreased substantially since he was assessed approximately two years
ago. Processing speed is known to be deflated by a number of factors including heightened anxiety. Aden has also missed a substantial amount of school as he has been attending half days; this is also likely to be attributing to his academic performance.

**Reason for Projective Assessment**

Information regarding the incident of sexual abuse was not offered initially by Janice. In fact, Janice was initially reluctant to engage with CAMHS and appeared to underreport Aden’s problems. However during the initial interview with the author, Aden’s case manager, his mother, and Aden present, Aden was observed to become increasingly anxious and climbed under a table when mention of his sister was made. This created concern and subsequently the sessions were separated and projective drawings were conducted with Aden whilst family history was taken with his mother. The assessments provided information regarding Aden’s view of the family home (e.g., as a fearful and scary place “haunted” by a girl) which then triggered targeted questioning during a later parent session which provided Janice an opportunity to disclose their family secret and subsequently reveal that Aden has nightmares and sleeps in the parental bed. In this case, the projective drawings allowed Aden a method through which he could share his concerns in a non-direct and nonverbal way. This was particularly important as he was avoidant of talking about this topic with the assessor.

**Information Provided by the Projective Assessments**

A number of drawing assessments were undertaken in order to obtain Aden’s view of his family, self, and members of his family. Some examples of his drawings can be found in Appendix A.
House-Tree-Person

Aden’s house drawing is very underdeveloped for a child of his age. There are no doors, windows, and the walls are described as “very very thick”. Aden described the house a “scary place” that is “very very cold, dark” and “haunted by a girl at night time”. It seems that Aden’s sense of his home as a closed off environment that people typically do not enter or see what is happening inside. It is not a pleasant place, rather one that he fears. It seems Aden has significant fears of “the girl” scaring or hurting him at night.

His tree has an elongated trunk, leaves with no branches and what appears to be roots. There are birds that live in the tree as do their eggs. It is described as a healthy tree as it has apples that “make people strong”. Aden indicated that it was summer in the drawing, his favourite season. There are elements of this drawing that indicate that Aden has internal strengths that he is drawing on. The presence of fruits, life in the tree, the season being a pleasant and desirable for Aden, and the statement regarding the tree being a living entity are a signs of nurturance. A lack of branches is said to represent feeling as though the child cannot reach out to his/her environment.

Aden’s person drawing included a picture of a large person/stick figure with a menacing face. Next to it was a much smaller stick figure with wavering lines; the latter person was standing in a bin. Aden indicated that the large person was “crazy” 23 year old boy and wants to “kick over the bin to see if there is a person inside” and the small one as “scared”. This picture may express a fantasy that he is older and can feel strong and powerful, perhaps being able to intimidate those who he once feared.
It should be noted that prior to completing this drawing, Aden became to sketch something on paper while the enquiry phase of the tree drawing was being undertaken. Aden drew a “crazy girl” who was very large in size with a very angry face and big hands. Next to this was a very small person who was “scared”. This may represent how Aden feels in the sibling relationship with Annie. It may have precipitated the feelings underpinning the aforementioned person drawing.

**Family Kinetic Drawing**

In the drawing, Aden is running around, Xavier is dancing, Kelly is watching television, Tailor is listening to music, and Annie is eating lollies that “she stole”. Notably Annie is farthest away from Aden. Janice is in bed sleeping because she “is sad”.

It seems Aden perceives himself as active. He appears to want to keep close to Xavier but far from Annie. Aden may perceive Annie to be deviant and untrustworthy as she steals. Also, Aden may be aware of his mother’s low mood and inactivity (associated with her depression).

**Integrative Summary**

These drawings raised significant concerns for Aden, who appeared to be sharing his fears and anxieties quite openly through the drawings and subsequent inquiry. It seems that Aden is fearful of a girl at night time and feels small, scared, and hurt. He may be aware of his mother’s low mood and may feel that he needs to stay close to his older brother for protection. In the context of other information obtained in the assessment it seems that Aden is afraid of his sister and does not trust her. He may have fantasies of being able to protect himself.
Formulation

Aden is a nine year old boy, the youngest in a sib-ship of five. He was referred to the service by Bluevale Primary School following increased behavioural disturbance characterised by aggression, bullying, destruction of school property, disrupting peers during class activities, and difficulty settling in class. The school noticed these changes in 2009; however his mother Janice indicated that these behaviours appear to be more prominent in the school environment. In the home environment Janice noticed behaviours such as agitation, hyperactivity (e.g., inability to sit still), and purposely irritating his siblings.

These behaviours were not observed on a school visit. At the time of assessment Aden appeared guarded about sensitive topics. He experiences nightmares (biweekly) and sleeps in his mother’s bed at night. Aden is startled by loud noises and is hypervigilant. He is reportedly fearful of his sister and does not like to be left alone in her presence. He does not discuss the incident of sexual abuse. As a consequence of his anxiety, avoidance, and behavioural difficulties at school objective tests indicate that he is significantly behind his peers in his level of mathematics and reading for his level of education and what would be expected of someone with his cognitive abilities.

Aden’s presentation is predisposed by a history of disturbed family dynamics including substance dependence, severe maternal depression, and a chaotic family life. He presents with symptoms associated with chronic post traumatic stress disorder in response to past sexual abuse. This is evidenced by symptoms including nightmares, avoidance of the perpetrator, symptoms of increased arousal including sleep difficulties, agitation, outbursts of anger, and
hypervigilance. This appears to be perpetrated by continued contact with his sister which appears to be triggering Aden’s fear responses. As Aden’s mother was severely depressed and substance dependent upon his birth, it is possible that he did not develop the resources necessary to regulate intense emotions such as anger and fear and as such seems to be externalising these through disruptive behaviour. His learning difficulties appear to be contributing to his anxiety in the school environment; these in conjunction with emotional dysregulation difficulties are likely compounding Aden’s behaviours in the school environment. Furthermore, Aden was said to be close to his maternal grandfather whom recently passed. This may be an additional perpetuating factor particularly as Aden has difficulty regulating his emotions and due to a limited support network. Whilst Aden presents with some features consistent with an ADHD diagnosis, he does not meet enough to warrant this diagnosis; particularly as symptoms do not seem to be pervasive across settings. Rather it seems the symptoms which may be attributed to ADHD are occurring in the context of post traumatic stress.

Aden is an enthusiastic and engaging young boy who demonstrates desire to engage in psychological work. His mother appears to be trying to act in a protective manner at this time and is willing to engage with CAMHS. These protective facts can facilitate the therapeutic process.

**Diagnoses**

**Axis I:**

Post Traumatic Stress Disorder (309.81)

Oppositional Defiant Disorder (313.81)
Reading Disorder (315.00)

Mathematics Disorder (314.1)

Axis II: Nil

Axis III: Nil

Axis IV:

- **Problems with primary support group** – Aden may be grieving the recent death of his maternal grandfather. The primary support network is chaotic and impacted by a history of substance dependence, mental health, sexual abuse, and domestic violence.

- **Other psychosocial and environmental problems** – Aden is living with the perpetrator of sexual abuse. There have also been allegations made by Aden’s sister that she was sexually abused by a visitor to the family home in the past. Aden appears at risk of ongoing abuse. This living arrangement is also causing Aden ongoing fear and anxiety which appears to be interfering with his ability to manage his emotions or process the trauma. Maternal depression and possible substance use may also be interfering with Janice’s ability to act in a protective manner, despite assurances otherwise.

- **Educational problems** – Aden has significant difficulty performing academic tasks (particularly reading and performing mathematical operations), and there appears to be discord between Aden’s mother and his school which is causing tension within the school.
- **Economic problems** – Aden’s mother is having significant problems managing on government payments.

- **Axis V: CGAS = 58**

**Differential Diagnosis**

ADHD (314.01)

**Recommendations**

- Clinical case management

- Child centred play therapy

- Family Support worker and respite (DHS)

- Secondary consultation with Centre Against Sexual Assault (CASA) as required

**Treatment Recommendations**

A number of interventions are recommended for Aden. Firstly, Aden’s mother Janice is not interested in child focused parent therapy and given the concerns raised in the risk assessment ongoing support for Janice and monitoring in the home would be ideal. A referral was made to child protection with the recommendation that Janice receive supports such as a family care worker and regular respite. Play therapy was recommended for Aden to provide him with an avenue to process and express the trauma(s) he has faced in his life. Finally, clinical case management was recommended to focused upon linking Janice and Aden with appropriate services (e.g., a tutor) and liaising with Aden’s school to ensure they were supporting him appropriately.
Conclusion

This case has demonstrated the utility of using projective assessments in conjunction with other information to inform a complex formulation. The projective assessments provided the therapists with insights that required further investigation, which facilitated the collection of information which was integral to understanding Aden’s situation, his view of the world and sense of self. In particular, Aden first drew and then verbalised information relating to being afraid in the night, being scared of a girl in his home, and expressed fantasies of wanting to be strong. This offered information which stimulated further direct assessment with Aden’s mother which prompted her to provide information regarding the sexual abuse of Aden. This information was then used to formulate an understanding of Aden’s anxiety in the context of a past trauma. His avoidance of certain topics was better understood, and treatment was tailored to process Aden’s trauma in addition to taking steps to provide some protection to Aden in his home by initiating connection with a family support worker.
Chapter Six: Projective Assessment as an Aid to Formulation: the Case of Katelyn

This chapter discusses the case of Katelyn, a 14 year old girl referred to CAMHS for assessment due to concerns that she may have an eating disorder. Assessment in this case included parent, child, and school interviews, cognitive assessment, and projective assessments. Katelyn gave valuable insights into her concerns via her drawings which could not be obtained through conversation or interview.

Reason for Referral

Katelyn was referred to CAMHS by her mother upon recommendation by her school coordinator. They expressed concern that Katelyn may have an eating disorder. This was based on behaviours such as refusing to eat at school, hiding food brought from home so that she does not have to eat it, headaches, and reports of feeling dizzy (6/12) and the appearance of weight loss.

Presenting Problems

Katelyn's mother indicated that she felt that Katelyn had low self esteem, is anxious, and vomits when anxious. Katelyn indicated that she has never felt that she is fat or consciously decided to lose weight. There is no evidence for excessive exercise or purging.

MSE on Intake

Appearance, attitude and activity. Katelyn is a 14 year old girl who presented in an oversized school uniform, a head band, and matching sneakers. She wore braces and was neatly presented. She appeared as above average in
height and below average in weight. Katelyn’s face often flushed when discussing her difficulties in front of her mother. Activity appeared normal.

**Mood and affect.** Mood is reported to be anxious, dysthymic at times, and angry. Affect largely congruent with mood, and she appears anxious and tearful at times.

**Speech.** Katelyn’s speech was at a normal volume and rate. Nil impediments observed.

**Thought process.** There was no evidence of a formal thought disorder. Thinking appeared to be quite concrete.

**Perception.** No current perceptual disturbance observed. Katelyn reported hypnagogic hallucinations many years ago.

**Cognition.** Katelyn was oriented to person, place and time. She maintained concentration for the period of the assessment without difficulty. She appears to have no disturbance of memory function and has an IQ of 69. Katelyn’s verbal reasoning is significantly better than her perceptual reasoning abilities.

**Insight and judgment.** Katelyn has poor insight into her presentation which is likely attributed to her cognitive functioning. She has a positive attitude to treatment and is open to engaging in treatment. Katelyn’s judgement appears to be age appropriate.

**Imaginative play and use of fantasy.** Not directly observed; however Katelyn was reported to be creative at school in classes such as woodwork and art.
Rapport. Katelyn appeared nervous however she was open with the assessor and was easily engaged.

Background History and Personal Information

Genogram

Developmental History

Katelyn was the result of an unplanned pregnancy. Her mother experienced extreme morning sickness throughout the pregnancy and Katelyn was two weeks late. Following a 30 hour labour, emergency caesarean was conducted. Katelyn is said to have not taken a breath for approximately nine minutes after the birth. She was described as a quiet baby who did not cry much. She was said to reach her developmental milestones in an age appropriate manner until the age of four. Katelyn reportedly exhibited difficulties dressing herself and became highly distressed after attending kindergarten.

Educational History

Katelyn experienced separation anxiety upon the commencement of kindergarten; she would vomit daily. She did not enjoy primary school, finding
many of the teachers “nasty”. In grade four Katelyn experienced significant anxiety and was referred to a psychologist who recognised her intellectual disability. She entered into a special school for secondary college and is said to enjoy woodwork and cooking, she reported that she does not like maths or music. Katelyn is described as an above average student typically; however her marks have slipped in the last six months.

Katelyn reported high levels of fatigue after coming home from school, often eating as soon as she gets home and napping. She frequently complains of headaches after school. Katelyn reports that she “doesn’t feel hungry” or thirsty at school, only becoming hungry at “3:45pm” once she is home.

Katelyn’s school teachers reported that they have made attempts to engage Jasmine in interventions to assist Katelyn (e.g., eating breakfast at school) however they have found that Jasmine does not appear to be as invested in facilitating this.

Social Relationships/Networks

Katelyn was said to have a big group of friends by her mother. However, school reports indicate that this has changed this year. Katelyn’s school teacher reported that she appears to only be socialising with one member of her group and Katelyn reported that she had experienced some bullying this year.

Family Background

Katelyn’s mother Jasmine is the third eldest in a sibship of three. The family have an Italian heritage. Jasmine’s father was a strict man who often made comments about his children’s weight and diet. Jasmine indicated that he continued to do this until the day he passed in 2009. Her mother was described as
a caring person whom had a long history of depression. Jasmine and Katelyn are very close to „nanna May“ whom was unwell with pneumonia at the time of assessment. Jasmine spoke openly about her mother’s health concerns and her concerns about her mortality in the presence of Katelyn who became highly upset and tearful.

Jasmine is a stay at home mother who has previously worked in hospitality. Jasmine has suffered from depression and bulimia nervosa for many years. She has been hospitalised for the latter on two occasions. Jasmine presented to the assessments in gym gear, frequently discussed the nutritional value of the foods Katelyn ate, and described herself as a “gym junkie”.

Katelyn’s father Phillip had no involvement with CAMHS and his history was obtained via Jasmine. Phillip is the youngest of three siblings. He was described as a “controlling man” who was verbally and physically abusive towards Jasmine. Katelyn has no contact with Phillip and is reportedly frightened of him.

Phillip and Jasmine were together for two years and were engaged. Jasmine left Phillip when Katelyn was 4/12 of age. Jasmine married Andy when Katelyn was two years of age and Phillip is said to have a long term girlfriend. Andy is said to be highly self aware and was on a diet at the time of the assessment. Jasmine indicated that last year Andy became highly unwell due to significant weight loss.

At the time of assessment, Katelyn’s sister Emily was on a diet due to weight gained whilst physically unwell. Jasmine indicated that what Emily was doing was not a diet, rather “changing her eating” so that she would lose weight.
Ethan is described as having an anxiety disorder and is receiving psychological intervention from his school psychologist. Jasmine indicated that she had to drop him at the school gate and be there again at the end of the day to pick him up. Jasmine was displeased that she was being asked to join his sessions for parent work.

**Family Dynamics**

Katelyn is reported to be very close to her stepsiblings; although is said to fight with her younger brother. Katelyn reported that she and Andy do not argue or fight as it “makes her feel sick”. There is high expressed emotion within the family unit, and information is readily shared among the family subsystems. Jasmine appears to have difficulty consoling Katelyn when she is distressed and becomes tearful. When Katelyn becomes upset, Jasmine tries to quickly cheer her up rather than listening to the problem at hand. Andy is said to be abrupt with Katelyn at times as he is said to have limited understanding of what her level of cognitive functioning means for her thinking and communicative style. Katelyn becomes very upset by this and retaliates in anger.

**Premorbid Personality**

Katelyn was described as always having been an anxious child. She was described as caring and sensitive.

**Current and Past Medical History**

Katelyn has suffered from Irritable Bowel Syndrome for many years (IBS) which is exacerbated by anxiety. She has also suffered from asthma since a young age. Katelyn’s mother reports that Katelyn has regular menstrual periods; no amenorrhea reported.
According to her treating doctor, Katelyn's bloods indicate that her blood sugar levels, thyroid function, blood pressure (128/84) and electrolytes are all normal. However, she is deficient in vitamin D.

Upon initial assessment, Katelyn's height was 174cm and her weight 55kgs thus her BMI was 18 (in the underweight range; however having a BMI two points below the normal range is not unusual for her age). She is said to require reading glasses which she does not wear and suffers daily headaches.

Risk Assessment

Katelyn and her mother reported no incidents of self harm, and Katelyn reports no suicidal ideation or intent, substance use, or homicidal ideation. There appears to be no harm from others. The greatest risk for Katelyn appears to be weight loss and the subsequent health concerns.

Assessments

- Family and child clinical interview
- Projective drawings
- Outcome measures – HoNOSCA, FIHS, SDQ (parent version)
- School reports/observation
- Report from mother's psychologist
- Cognitive report
- Food log
- Review by eating disorder nurse practitioner
Reason for Projective Assessment

Katelyn was unable to express why she was not eating at school and it was hoped that the projectives may stimulate discussion around this to help obtain a clearer understanding. Further, the assessors wanted to better understand Katelyn’s perspective of her family and her relationships with family members. Finally, it was hoped that these assessments would provide a greater understanding of the way Katelyn views herself to inform the assessment process. Examples of Katelyn’s projective drawings can be seen in Appendix B.

Information Provided by the Projective Assessments

House-Tree-Person

Katelyn’s drawing of a house is an a-frame with a chimney coming out of the side of the roof. She described it as a “happy house” in which five people live with their dogs. She reported that the family had lived in the home for “a long time”.

Her drawing of a tree is colourful, has birds flying above it, sunshine, and clouds with rain. There is an image of a girl smiling while watering the tree. Katelyn reported that the tree was two years old. She reported that she was the only person to care for the tree, and that it got enough food and water. No-one has tried to cut down the tree and there have been “no storms but rain”.

Her person drawing was of a girl with dark hair and a smiling face. The seven year old girl is reportedly happy because she is “going to see her nanna”. She plans to play with her nanna’s dogs when she goes to her house.
Family Kinetic Drawing

Katelyn’s FKD contains her siblings and dogs. During this activity Katelyn reflected that her siblings are playing with the dogs, but leaving her out. She reflected that she no longer joins in on this activity as her Ethan “fights with her”.

Two Dreams

Her “good dream” was of an androgynous figure (described as being a girl) having come home from school “angry, tired, and with a headache”. The girl in the drawing is making the girl”s favourite meal, spaghetti. She is reportedly feeling “good because she hasn’t eaten all day” and is about to eat the spaghetti. When asked why the girl has not eaten all day, Katelyn replied “because school makes her nervous”, but could not elaborate on this. After eating dinner Katelyn reported that the girl is going to play basketball by herself as she loves this activity.

Her “bad dream” consisted of a 24 year old girl pushing a baby into a volcano resulting in its death. Katelyn reported that the girl was feeling angry at the baby at first but was saddened when it died. She reported that the baby felt “sad”. Katelyn reflected that she used to have dreams of pushing people into volcanos when she was younger. She also had dreams of being persecuted by monsters and the like. She reported having no nightmares currently.

Island Drawing

Katelyn’s island is a bright and colourful place with the ocean, a smiling sun, and a coconut tree. The people Katelyn has decided to bring to the island
include her „nanna May” and her aunty Kate (Jasmine’s brother’s wife). Also on
the island are Katelyn’s two dogs.

Katelyn describes this place as a “happy” one. She is performing her
favourite activities, body boarding and swimming. She described how much she
loves to spend time with her grandmother on the island. Her aunty Kate is on the
island because “she listens to [her] problems”. It was during the completion of
this activity that Katelyn also reflected that her nanna often makes statements
about her impending mortality; “you remember me now” she often states, which
quickly brings Katelyn from a place where she is feeling happy about spending
time with her grandmother to remembering that she is unwell and might pass.
This then reminds Katelyn of her grandfathers passing and the associated sadness.

**Integrative Summary**

Katelyn’s drawings highlight some protective factors. For example, it
seems that she perceives the family home to be a relatively warm place which is
“happy”. However, Katelyn may feel ostracised from her stepsiblings and her
parents whom were not represented in any of the drawings. It seems that Katelyn
feels that she needs to be self sufficient in caring for herself. She may also have
feelings of hostility and anger which she does not know how to express
effectively. At this time in her life, Katelyn appears to want to spend time with
her maternal grandmother and aunt and she wants someone to listen to her.
Perhaps Katelyn feels as though she is not being heard in the home. Clearly a
trigger for Katelyn’s sadness is people mentioning death and illness in passing.
Formulation

Katelyn is a 14 year old girl who was referred to CAMHS by her mother Jasmine due to concerns from staff at Katelyn’s secondary college regarding her eating behaviour. Katelyn was referred for an urgent assessment and was followed up by the DCAMHS community team. She presents as a tall, slim girl (BMI 18) with braces. Of particular concern to the school was Katelyn’s refusal to eat breakfast and lunch (3/12). Also reported by Katelyn’s mother Jasmine was exacerbated anxiety levels (6/12), which has reportedly been present since age four. Katelyn also reports feeling tired, having frequent headaches, and never feeling hungry or thirsty during the day. She reports that she does not believe that she is overweight, and cannot explicitly give an explanation for her food refusal at school. Katelyn eats as soon as she arrives home from school and on weekends. She experienced separation anxiety at the commencement of kindergarten which was evidenced by crying and vomiting. The separation anxiety was also present upon commencement of primary school. The anxiety reportedly settled until grade four when Katelyn had difficulty with her classroom teacher; again experiencing elevated levels of anxiety and involuntary vomiting after which she remembers feeling “much better”. It was at this time Katelyn was initially referred to a psychologist and a cognitive assessment revealed that she has an intellectual disability (FSIQ 70). She went to Tailor’s secondary college (for children with intellectual disabilities) and established a group of friends. However this year she has been increasingly distracted and has disconnected from her group of friends, tending to spend time with one friend only.

Katelyn’s presentation is predisposed by a number of factors including a sensitive personality style, genetic vulnerability, and family dynamics.
Specifically, Katelyn’s maternal grandmother suffers from depression, her mother has obtained prior diagnoses of Bulimia Nervosa, depression and anxiety, and her brother has been diagnosed with an anxiety disorder. Food and dieting is a central concern within the family. Katelyn’s father and 10 year old sister are currently restricting their eating to lose weight, and Jasmine describes herself as a “gym junkie”. As Katelyn’s food intake has been restricted in the home environment she tends to choose large quantities of high fat foods in compensation when it is available (e.g., straight after school).

Katelyn’s presentation appears to be precipitated by a number of health concerns from within the family, all of which are openly shared between the parent – child subsystems. Katelyn is particularly distressed by the news that her grandmother, with whom she is very close, is highly unwell. Katelyn reports thinking of her grandmother and feeling distressed occasionally while at school. She also reports having difficulty with her classroom teacher and with one of her peers which appears to be causing her anxiety. Finally, Katelyn was recently told by her dentist that there was mouth old food in her braces. The combination of these factors appears to be causing her significant distress and anxiety and impacting her eating behaviours.

Whilst Katelyn does not fulfil criteria for an eating disorder at this time, she is highly susceptible to developing one in the future given the aforementioned risk factors. Her anxiety is generalised at this time and she appears to be suffering from some dysthymia; however does not fulfil criteria for a mood disorder as the periods of low mood are intermittent and are in response to grief/loss in her environment. Protective factors include a supportive school
environment, a willingness to engage with CAMHS, and good adaptive functioning.

**Diagnoses**

**Axis I:**

Generalised Anxiety Disorder (300.02)

Parent-Child relational problem (V61.20)

**Axis II:** Mild Mental Retardation (317)

**Axis III:** Irritable Bowel Syndrome, Asthma, vitamin D deficiency.

**Axis IV:**

- **Problems with primary support group** – There is a high level of expressed emotion (including anxiety and distress) within the family of origin. There is also a high level of focus upon eating behaviours and weight loss.

- **Problems with educational environment** – Katelyn is experiencing difficulty maintaining peer relations at school, she is also leaving the classroom and having difficulty concentrating on tasks at hand.

- **Educational problem** – Katelyn is reporting that she does not get along with her current class teacher. She is also experiencing bullying at school and is becoming distressed when considering her grandmother’s health.

- **Problems related to the social environment** – Katelyn has lost friends recently and reported experiencing problems with one member of her social group. Katelyn rarely sees her friends out of school.
**Axis V:** CGAS = 60

**Recommendations**

- Clinical case management
- Family therapy
- School liaison
- Short term individual therapy to build anxiety management strategies and perform grief counselling
- General Practitioner (GP) monitoring of general health in consultation with ED nurse practitioner

**Treatment Recommendations**

Once the feedback and formulation took place, Jasmine became more aware of the impact some of the family dynamics were having on Katelyn’s presentation and the risk of her developing an eating disorder in the future. She exhibited genuine interest in engaging with family therapy, also indicating that she felt that it may assist her husband to understand Katelyn better. This was scheduled with a family therapist and while the family were on wait list Katelyn engaged in individual work to assist her to develop anxiety management tools. Katelyn’s medical health was monitored by her G.P and the therapist continued to liaise with the ED nurse practitioner as required. Improvements in mood, eating behaviour and social inclusion were observed throughout the course of the assessment and therapeutic process.
Conclusion

As can be seen in this case, the projective assessment provided a method through which Katelyn expressed her view of her situation and her feelings about her family. Information obtained through the drawing assessments provided an avenue for Katelyn to describe how she was feeling in an indirect manner. By talking about “the girl” instead of her own situation, it offered enough distance for Katelyn to put words to her emotional experiences. Additionally, due to Katelyn’s concrete thinking style she had less capacity to express herself through a clinical interview than others her age. The projective drawings offered an alternative non-threatening approach to collating information. It was thought that the drawing assessments might offer an avenue for Katelyn to share information regarding her appearance or concerns regarding gaining weight. However, to the contrary they offered an avenue to understand that for Katelyn, anxiety, loneliness, and grief were contributing to her eating behaviours. Given Katelyn’s low level of cognitive functioning, the drawings offered a technique that was fun and non-threatening for her to share her concerns with the assessor which a traditional assessment was unable to achieve.
Chapter Seven: Personality Assessment as an Aid to Formulation: the Case of James

This chapter reviews the case of James, a nine year old boy referred to CAMHS for assessment and treatment of a number of externalising symptoms including aggression. Projective drawing assessments were used in conjunction to child and family interviews, school reports, and a school observation. Information from these sources were used to inform James’s formulation.

Reason for Referral

James was referred to CAMHS by his mother’s psychologist due to reports by James’s mother that he was engaging in violent and aggressive acts such as wielding an axe in anger, making threats towards his mother with a knife, asking her to kill him, threatening to cut off his penis, and swearing. There were also reports that James was “deteriorating” in school.

Presenting Problem

James mother’s concerns are largely behavioural and related to his conduct. Namely, she is concerned with his aggressive behaviours including physical aggression towards his brother and mother, anger outbursts, poor impulse control, and noncompliance with requests. She reported that his behaviours were impacting his academic functioning.

James’s attention and concentration is another concern (hyperactivity, overactive, fidgety, irritable), as is reports of poor frustration, irritability, and heightened anger.
James’s paediatrician and school teacher have not observed the aforementioned behavioural disturbances

**MSE at Intake Assessment**

**Appearance, attitude and activity.** James is a nine year old boy who presented in his school uniform. He sat on his father’s lap during the family assessment, slumped in posture. He appeared average height and weight, and was noted to wear an orthodontic plate in his mouth. He was guarded when talking in front of other assessors and parents however was somewhat more cooperative when alone.

**Mood and affect.** He reported feeling “very angry” indicating that he has “always felt this way”. Affect was congruent with mood, angry and irritable. Affect was stable and in a constricted range.

**Speech.** James mumbled at times and statements occasionally required repetition or clarification. Some spontaneous speech was observed.

**Thought process.** Thoughts were well-connected and logical with no abnormalities detected. Content contained themes of anger, aggression, and homicidal ideation (largely directed at his younger brother).

**Perception.** Nil perceptual distortions observed or reported.

**Cognition.** James was alert and oriented to person, place and time. He largely maintained concentration for approximately 45 minutes however became distracted by extraneous objects in the room when not physically active. Past psychological testing reports average intelligence (67th percentile) with deficits in working memory.
Insight and judgment. Judgement appears to be impaired by impulsivity and emotional arousal. He is remorseful and tearful following impulsive/aggressive instances. He has some insight as he acknowledges that some of his behaviours are a problem and recognises consequences of his actions when calm. However, he blames much of his concerns on his brother.

Imaginative play and use of fantasy. James demonstrates a good use of fantasy in his drawings however his play is underdeveloped for his age. James appears unable to use toys to their full capacity and does not appear to be using them as an outlet for emotional expression.

Rapport. James is highly guarded. This is exacerbated when in the presence of his parents.

Background History and Personal Information

Genogram
Developmental History

James is the eldest of a sibship of two. He was the result of an unplanned pregnancy. When Penelope became pregnant with James, Agnus was enraged and threatened suicide. Agnus was concerned about repeating the difficult childhood he himself endured. James was born 36 weeks gestation and weighed eight pounds. He was born after a 13 hour labour and required oxygen. He then spent one day in a humidicrib, two weeks in hospital during which time James had difficulty breastfeeding. Once home, this resolved and James breastfed until nine months of age. James was described as an unsettled baby, suffering from gastric reflux and colic. He was diagnosed with sleep apnoea which has resolved recently. James was described as an “active child” often climbing, wriggling, and moving about as a young child.

Family Background

Penelope is the younger of two children born to Narni and Sig. Sig left Narni when Penelope was approximately three months old and Narni subsequently relinquished care of Penelope and her sister to her adopted parents Will and Maggie. Penelope was raised to believe that Narni was her sister, only to discover the truth at the age of 15 years. She sought contact with her mother in recent years however Penelope feels that it is too late to establish a close relationship and blames her sister for causing conflict with their mother. Penelope describes her family of origin (FOO) as “emotionally void” and regiment.

Agnus is the eldest of four siblings, none of whom he keeps in contact with. Agnus’s parents separated when he was seven years old. He mother suffered from Schizophrenia and had multiple psychiatric admissions. He described his
upbringing as “horrible”, indicating that he was often responsible for his mother’s wellbeing and for the care of his younger siblings. He indicated that he had to be independent as there was no one available to care for him.

**Family Dynamics**

Penelope and Agnus were on the brink of separation from their marriage. Agnus indicated that he did not care for Penelope and stays in their marriage for the children’s sake. He associates marriage separation with his own “terrible” upbringing.

Penelope was distraught by Agnus’s reports of unhappiness, and presented for assessment as depressed, passive, and overwhelmed. Agnus spends much of his time interstate on “business trips”; often spending much of the family money on business ventures that do not produce income. Agnus appears to have periods of hyper activity during which he spends the family’s money, has grandiose ideas, and becomes agitated. Agnus has difficulty regulating his emotions, frequently becoming angry and aggressive. At times he has punched walls and other objects in anger. Despite these behaviours, he does not report a history of mental illness.

The marital couple are socially isolated from friends and have limited contact with their FOOS. Both parties have denied any form of domestic violence, or physical violence directed at the children.

James and Robert are said to fight a great deal in the home environment and do not play together. Robert reported that he does not wish to play with James as he is “too naughty” and is “always doing wrong things.”
Premorbid Personality

According to representatives at James’s school he was said to become defiant and difficult to manage in grade one; however was described as compliant, pleasant, and respectful prior to this and in recent times. James’s parents describe him as having always been a challenging to manage and Penelope strongly feels that he has undiagnosed inherent psychiatric problems.

Educational History

James’s parents indicated that he had difficulty settling into school and making friends. They also indicated that he has been “acting out” in class and is disobedient. Upon meeting with a representative from James’s school and obtaining his class reports, it appears that James is currently well mannered, cooperative, and performing well academically. James is said to have developed a small group of friends and plays with his younger brother on occasion in the school yard. They acknowledged that there were previously some concerns regarding James’s behaviour (in grade one) but that he had settled.

James’s parents indicated that he had made allegations of sexual abuse to a school teacher against a family friend in grade one. James’s parents indicated that this was investigated by police and found to be unsubstantiated; his parents felt that he had “made it up for attention and so that people feel sorry for him” however no longer allow James to see the alleged perpetrator. A representative from the school indicated that they felt that this case was mishandled.

Risk Assessment

James has expressed suicidal ideation but no plan, intent, or past attempts; given this, his level of risk was considered low. He has also verbalised homicidal
ideation towards his brother; as he has emotional dysregulation difficulties, impaired judgement when emotionally aroused, and has elevated level of impulsivity there was considered to be a low to moderate risk that James may harm his brother in an impulsive act of harm. James may also harm himself accidentally when in a state of rage. Finally, James’s parents are certain that he has no exposure to the man accused of sexually assaulting him in grade one; despite this, James revealed that he continues to spend time with this man and he lives in close proximity to the family home.

Due to the nature of the aforementioned information, a notification was made to the DHS Child Protection services. James’s parents were made aware of these risks and of the purpose of the notification. They continued to report that no misconduct had occurred.

**Assessments**

- Family and child clinical interview
- Projective drawings
- Outcome measures – HoNOSCA, FIHS, SDQ (parent version)
- School reports/observation
- Report from mother’s psychologist
- Cognitive report (WISC-IV)

**Reason for Projective Assessment**

As noted, James was highly guarded during the assessment sessions.

Moreover, there appeared to be incongruent information presented by James’s
school, his parents, and the referring psychologist. Given this, it was felt that projective assessments would provide a clearer understanding of James's sense of self and place within his family. It was also utilised as a method for rapport building.

**Information Provided by the Projective Assessments**

A number of drawing assessments were undertaken in order to obtain James's view of himself and the world (see Appendix C for an example). In general, the drawings obtained themes of anger and aggression; however this information was obtained during the clinical interview phase and his presentation changed throughout the course of therapy.

**House-Tree-Person**

James's house drawing indicates themes of aggression, chaos and turmoil. The robots that clean the house are said to be attacking the plane so that they can "kill the pilot". The person parachuting from the plane is on fire. James reportedly feels "good...because [he] is in the house and is not being burnt". The unnecessary detail not only represents anger and hostility in its content, as displayed by James's images and verbal content, but extraneous stimuli provided while discussing the home may also serve as a distraction from some of the sadness James feels about this environment.

James's description of his tree gives insight into his sense of self. He indicated that the tree is "1 second old" and "can kill...because it feels angry". Moreover, the tree has human features which are indicative of a person who is out of control. According to psychodynamic theory these factors connote regressed control over primal behaviours and affect (Leibowitz, 1999).
James indicated that in the drawing the tree was under attack, and that it needed to protect itself (with an umbrella). He also stated that “no one cares for the tree, just himself”. These statements reflect a feeling of threat from those around him and a sense of pseudo independence and/or that his emotional needs are not being met. James also reported that the tree was “drowning” due to a deviant action it undertook. As previously mentioned, according to psychodynamic theory the tree is a representation of feelings about the self and their environment (Matto, 2007). Again, James’s responses to this drawing indicate that the feels uncared for and under attack; however, James may blame himself, indicating that the tree is drowning because he “spat on the ground”.

James’s person drawing also displays themes of anger and aggression. His anger was largely directed at younger “kids” in the drawing, particularly at one in retaliation for feeling victimised for things that are outside of his control (for “having big teeth and glasses”). He is also shooting at the sun because it “gets in his eyes”. Whilst James reflected that the boy in the drawing gets nourishment in terms of food and water, he specified that he “takes care of himself” again reflecting a sense of pseudo independence. Interestingly, James chose to present himself with rabbit ears; he did this on one other occasion only when representing his mother in the Family Kinetic Drawing perhaps indicating a sense of similarity between the pair, despite James’s mother’s rejecting behaviour rewards him.

Family Kinetic Drawing

In this drawing respondents are asked to “draw their family doing something”. Following this, open ended questions are posed. James drew himself and his brother fighting; and Penelope taking her anger out on Robert (James’s
fantasy that he isn’t the one reprimanded). Whilst James feels that his mother is
angry, he indicated that he father is completely unaware of the commotion going
on outside. Instead, Angus is observed in the drawing to be facing away from the
family playing with his trinkets in the shed, facing towards what appears to be a
gallow.

Interestingly James is able to identify the strong emotions of all involved
in the family, including his younger brother’s sadness.

James drew his parents with animal ears, his father as a cat with ears and a
tail and his mother with rabbit ears. This may be indicative of the way James
views his parents. Rabbits are said to evoke a sense of non-assertiveness, whereas
cats often represent the feeling that the drawer wants a sense of normalcy or
conformity (Leibowitz, 1999).

Family as Animals

James drew his family in order of height and age. All were “snakes” with
round eyes; however, Robert was drawn with snake-like eyes. When asked why
he was different, James indicated that it was because “it is the baby”. Snakes can
be representative of a sense of hostile aggression (Leibowitz, 1999). It is
interesting that the youngest snake, representative of Robert, it perceived to be the
most hostile.

Integrative Summary

Firstly, the decision to represent achromatic drawings can represent
dissatisfaction and dysphoria (Leibowitz, 1999). He perceives himself as needing
to meet his own needs and is highly aware and perhaps fearful of his aggression.
James appears to find the home an unsettling, hostile and unstable place; however appears to feel that it has the potential to provide nourishment. James perceives his mother as non-assertive and his father as disconnected and preoccupied. James has fears for his father’s safety and may wish for a more “normal” domestic home-life. James has fantasies of his mother harming his brother; perhaps his younger brother is the safest outlet for his anger which appears to be actually directed at the whole family.

James’s drawings informed the assessment in a number of ways. Firstly, the Family Kinetic Drawing provided the first indication that his father was suicidal as James drew his father standing by a gallows (this was later raised with his parents and verified). It also allowed the assessors to see that the discontent aimed at his brother was one part of a larger picture which involved him feeling “under attack” and hostile towards all members of the family. It allowed the assessors to see that James feels isolated from the family. The assessments also provided an avenue for obtaining some understanding of James’s perceptions of his parent’s parenting style.

This information would not have been obtained via other means due to guardedness and reluctance to engage verbally with the assessor. Thus, the drawing assessments were an avenue that provided important information which was later integrated into the formulation and considered in the treatment plan.

**Formulation**

James is a nine year old boy (grade three) who was referred to CAMHS by his mother’s psychologist due to reports by his mother, Penelope, that he was engaging in violent and aggressive acts such as wielding an axe in anger, making
threats towards her with a knife, asking her to kill him, threatening to cut off his penis, and swearing. Aside from the swearing, all other acts were performed on one occasion. There were also reports that James was “deteriorating” in school from his parents which are incongruent with school reports. James has a prior diagnosis of ADHD and is prescribed 5ml of Ritalin daily; Penelope reporting that he is unmanageable without his medication. James’ parents feel that they are not coping with James’ behaviour and his father, Agnus, has made claims that he would put James up for adoption or suicide due to his behaviour. James is aware of Angus’ claims and appears to be holding onto worry or guilt as a consequence.

James’ presentation may be predisposed by a number of factors including intergenerational parent-child relational problems in both the maternal and paternal sides of the family whereby James’ parents did not receive the kind of care that they can now pass on to him. Additionally, Penelope describes the pregnancy and birth of James as difficult indicating that he was subsequently an unsettled baby. He became quite a hyperactive child who was described as trying to “wriggle” from the pram at an early age. These factors seem to have interrupted the attachment process and contributed to Penelope establishing a view of James as a “problem” child. James has subsequently developed a sense of pseudo independence from others and difficulty recognising and regulating his emotions.

The escalation in James’ behaviour appears to coincide with a time in which he made sexual abuse allegations against a male neighbour to a school psychologist when he was in grade one. These were later investigated by police and found to be unsubstantiated. As a consequence, James is no longer allowed to spend time with this neighbour who reportedly gave him attention, lollies, and
allowed him to visit his work. Thus, James may be externalising due to
undisclosed trauma and/or the loss of this relationship.

Moreover, there has been increasing marital tension within the
relationship of his parents during this time, with James becoming the focal point
in the family script. James sleeps in the marital bedroom, thus appears to also be
physical barrier between his parents. James perceives his younger brother Robert
(age seven) as competition for his parent’s attention and subsequently directs
much of his anger towards him when his parents are present. Interestingly, they
are reported to get along well in the school ground, a place where the pressure of
competing for parental care is absent. Externalising behaviours are also being
modelled within the family home by James’s father, whom quickly escalates in
anger and becomes aggressive. This may be contributing to James’s fear of his
own anger. Additionally, James’s mother is depressed, and models ineffective
coping and emotional dysregulation.

James’s behaviour is congruent with a diagnosis of Oppositional Defiant
Disorder as he is described as often losing his temper, arguing with adults,
defying requests made by adults (his parents), he blames others for his behaviour,
is frequently angry, and is easily annoyed by others. In addition, his behaviour
appears to be best understood in the context of ADHD and parent-child and
parent-sibling relational problems.

James’s protective factors include average to above average academic
abilities, average intelligence, an enthusiasm for sports which aids him in
establishing friendships, a good network of friends at school, and engagement
with mental health services.
Diagnoses

Axis I:

Oppositional Defiant Disorder (313.82)

Parent-Child relational problem (V61.20)

Sibling relational problem (V61.8)

ADHD (previously diagnosed by paediatrician) (314.01)

Axis II: Nil

Axis III: Nil

Axis IV:

- **Problems with primary support group** – There is significant marital discord between James’’s parents. They do not provide a unified front in parenting James.

- **Other psychosocial and environmental problems** – James made allegations of sexual abuse against a male neighbour. This was investigated by police however James retracted his statements. James continues to live next door to this neighbour however is no longer allowed to spend time with him.

- **Economic problem** – Agnus’’s spending has left the family struggling financially. Consequently, Penelope began to have trouble paying the family bills which caused further marital discord.

- **Axis V: CGAS = 58**
Recommendations

- Clinical case management
- Child focused parent therapy
- Individual therapy for each parent (not provided by CAMHS)
- Working towards family therapy – child dyadic subsystem followed by all family members
- Family Support worker (DHS)

Treatment Recommendations

Treatment is likely to be a long process with this family due to complexity and intergenerational attachment issues. Given this, the recommended treatment plan included a number of interventions commenced in a graduated manner. These included (a) play therapy with James to help him develop his play skills and emotional expression/regulation through play; (b) co-occurring child focused parent therapy conducted by the case manager and family therapist; (c) aim to work toward utilising a family therapy approach to improve communication and system alliance. Another aim was to assist James to feel as though he was a worthwhile and loved member of the family so that he does not direct his frustration at others within the home; facilitating the attachment between he and his family members. The plan was to introduce family therapy in a gradual manner commencing with dyadic work with the sibling subsystem prior to introducing James’s parents. James’s ADHD will continue to be managed by his paediatrician.
Conclusion

This case has demonstrated the utility of using projective assessments in conjunction with other information to inform a complex formulation. The projective assessments provided the therapists with insights that required further investigation. They also served as a method to gain rapport with a child who was highly guarded and reluctant to talk with the assessor. It was clear during the assessment with James that he used the drawings as both an emotional outlet for his anger and frustrations, and a way in which to share information indirectly with the assessor. It also seemed as though James was using his brother as an outlet for his anger, perhaps due to fear of further rejection by his mother or due to fear of erratic behaviour by his father. As a consequence of spending time with James, some rapport was able to be built, and feedback provided to his parents regarding the way he views himself and his environment. This served two purposes; firstly, to aid James’s parents in trying to understand their son’s perspective and underpinnings of some of his behaviours, and secondly, to model to James that we were taking him seriously, listening to him, and trying to understand his point of view. Throughout individual play therapy with James, he became more comfortable in using play to express himself and built a trusting relationship with the therapist who modelled unconditional positive regard. His parents participated in dyadic couple work with a CAMHS family therapist. Despite these interventions, James’s parents demonstrated little changes in their view of him or his behaviour in the home and therapy was continuing when the author left the service.
Chapter Eight: Implications and Recommendations

Information contained in the literature review of this portfolio highlights the need for tools to be used in an evidenced based framework. Whilst projective tests are routinely used in the traditional approaches within the CAMHS framework, they are done so within the context of collateral information, multidisciplinary assessment, and an extensive four stage assessment model. As chapter two highlighted, there is evidence that demonstrates good reliability (Exner & Weiner, 1994a) and validity in providing information regarding personality traits when utilising the standardised administrative and interpretative guidelines outlined in the ECS (Şar, et al., 2002; Tibon & Rothschild, 2007; Weiner, 1986); however there is little evidence to support the use of the Rorschach ECS for diagnostic purposes (Archer & Krishnamurthy, 1997; Hiller, et al., 1999; Jorgensen, et al., 2000). Further, while high reliabilities have been demonstrated for some drawing assessments, such as the FKDs (Handler & Habenicht, 1994; Mostkoff & Lazarus, 1983), the link between interpretations derived using traditional interpretative guidelines (e.g., Wenck, 1977) and behavioural outcomes is not available (Joiner Jr, et al., 1996). Furthermore, unlike the Rorschach using the ECS (Exner & Weiner, 1994a) a large and representative normative base is not available for the projective drawings (Merrell, 2008; Oster & Crone, 2004; Thomas & Jolley, 1998). As the aforementioned case studies have demonstrated, there is very much a use for the projectives in working with young people if used within guidelines that have been formed on the basis of evidence derived from past research (Cummings, 1986).
Overwhelmingly, research suggests that psychologists are best to use projective assessments as an aid for facilitating exploration in psychotherapy (Garb, Wood, Lilienfeld, & Nezworski, 2002) and in conjunction with objective assessments and clinical interviews in the assessment and treatment formulation of children and adolescents (Lilienfeld, et al., 2000). It is evident that projective assessments should not be used independently to formulate diagnoses as this practice is contrary to the intended purpose of these assessments and is likely to lead to children and adolescents being over-pathologised (Garb, et al., 2002).

As can be seen in the case studies presented, interpretations made by the projective assessments discussed were conservative and validated by collateral information. Often, information obtained during the drawing assessments offered insights to further investigate in the clinical interview. No certainties were drawn from these assessments; rather, they offered suggestions for further assessment (Cummings, 1986) or alternatively assisted in confirming hypotheses developed based on other information.

Projective tests can facilitate understanding of the young person that is difficult to ascertain via alternative means (Handler & Habenicht, 1994). This is because projectives orbit the child’s defences, use a method that is familiar and largely unthreatening for them, and does not require a great deal of verbal output (Cummings, 1986). Moreover, as was demonstrated in the case of Aden, are some things that children do not have the language or desire to express directly to an adult; projective tests offer an alternative avenue to do this in a non-confronting manner. In a mental health settings, such as CAMHS, assessors also face defensiveness from parents of the children, in fear of being blamed or having family secrets aired; given this, some information which may be important to the
understanding of the young person’s presentation can be withheld. Projective
tests such as the drawing assessments provide an avenue for young people to
share their experiences in an indirect manner via the drawings, then potentially in
a more direct manner during the inquiry phase (Burns & Kaufman, 1970). Whilst
projective assessments can assist in providing corroborative information to
support the development of diagnoses as was seen in the case of James, they are
best used in understanding the child’s sense of self, understanding of their role
within the family, and to determine themes of thought content (Cummings, 1986;
Weiner, 2000).

In the case of Annie, the assessment itself stimulated therapeutic gains by
providing the adolescent with insights to contemplate and process. In the case of
Aden, his projective drawings allowed insight into a trauma which not only
stimulated further questions regarding this, prompting his mother to share
information regarding an incident of sexual abuse in the home, but also allowing
the assessor to understand that he was highly fearful and had this incident at the
forefront of his mind approximately 18 months after its occurrence. Katelyn’s
drawing provided some subtle information regarding her situation and some of
her concerns. This was important as due to concrete thinking, Katelyn’s ability to
express these verbally was limited. Finally, whilst it is easy to become distracted
by the violent and angry nature of James’s drawings, they also provided
information which was integral to understanding his perception of his place in his
family and his view of himself. This information was used in the formulation and
subsequent treatment plan.

Whilst it could be argued that some of this information could be provided
through alternative means, this can be a time consuming process for even the
most experienced clinicians due to barriers such as protective defences, a willingness to maintain family secrets, embarrassment, a lack of insight, guardedness or shyness around strangers, or a limited capacity for expression through language (Malchiodi, 2008; Oster & Crone, 2004). In each of the aforementioned cases, participating in the projective assessments appeared to be non-threatening and even fun (Matto, 2007). Whilst the author was concerned that Annie may find the Rorschach assessment confronting, particularly as she had responded in a defensive manner on the MMPI-A, she indicated that she quite enjoyed the process and the methodology used appeared to appeal to her creative cognitive style. Moreover, all of the young people who participated in the drawing assessments appeared to enjoy the process and their body language exhibited comfort, particularly in comparison to their behaviour during verbal assessments.

The types of projective assessments utilised in the cases discussed are representative of those used during my status as a provisional psychologist during a 10 month placement with CAMHS. They are also representative of the kinds of assessments frequently used by clinical psychologists in this CAMHS community team setting. As drawing assessments take a short amount of time to administer and serve as an engagement tool (Cummings, 1986), they are used in the assessment of most child cases and some adolescent cases. As the Rorschach is highly time consuming to administer, score, and produce a detailed report, they are used less frequently than the drawing techniques. Additionally, there are a number of limitations inhibiting psychologists working in the CAMHS environment from conducting specialist assessments including the Rorschach including heavy case loads, crises calls, and urgent assessments which require
immediate attention. Given this, longer assessments are reserved for cases the case manager feels are highly necessary and integral to service delivery.

In conclusion and as demonstrated in the four cases provided, projective personality assessment appear to have significant clinical utility in the assessment of children and adolescents with mental health concerns as an adjunct to clinical interviews, objective measures, and direct observation. This portfolio has highlighted the necessity of following best practice recommendations due to mixed psychometric properties of these assessments (Forrest & Thomas, 1991; Hibbard & Hartman, 1990; Jorgensen, et al., 2000). When done so, benefits include rapport building, personality insights, perceptions of others, and information gathering that can inform the young person’s formulation.
Appendix A: Sample of Projective Drawings Provided by Aden

Sample 1.1: Aden’s House Drawing (note, the following images are not to size)

James’s house representation - described as a “scary place” that is “very very cold, dark” and “haunted by a girl at night time”.

![House Drawing](image)
Sample 1.2: Aden’s Tree Drawing

Contains images of fruit that “make people strong”.
Sample 1.3: Aden’s Person Drawing

The larger figure is an older boy who wants to “kick over the bin to see if there is a person inside”. The smaller person is described as “scared”.

Sample 1.4: Aden’s Family Kinetic Drawing

Mum seen in bed while the children perform their activities.
Appendix B: Sample of Projective Drawings Provided by Katelyn

2.1: Katelyn’s Island Drawing

During the completion of this drawing Katelyn reflected on the happiness she feels when her aunt listens to her. It also reminded her of her grandmother who often reminds Katelyn of her mortality and the sadness she experienced when her grandfather passed last year.
2.2: Katelyn’s Dream Identified as a ‘Good Dream’

Katelyn provided information regarding her typical day during the completion of this activity. It highlighted Katelyn’s perception regarding the reason behind her eating behaviour (“because school makes her nervous”) and provided an insight into Katelyn’s loneliness.
2.3: Family Kinetic Drawing

Left to right – Ethan, Katelyn, and Emily. Katelyn’s stepsiblings are playing together with the dogs. Katelyn doesn’t play with them anymore because Ethan “fights with her”.

Appendix C: Sample of Projective Drawings Provided by James

3.1: James’s Family Kinetic Drawing

Left to right – James’s father working on his trinkets in the shed with what appears to be a gallow behind him (portrayed with cat like features), his mother looking dazed with rabbit ears, Robert holding his mother’s hand crying, younger brother mocking James (“haha”).
3.2 James’s House Drawing (HTP)

James depicted images of turmoil, anger and aggression in his house drawing.
3.3: James’s Tree Drawing (HTP)

The tree is described as needing to protect itself from attack. He reported that “no one cares for the tree, just himself”. The tree is described as “drowning”.
3.3: James’s Person Drawing (HTP)

James’s “person” drawing representing his perception of his sense of self. Themes of anger and aggression particularly in relating to harming the “other kid” described as younger than him. James is being laughed at and victimised by the person to his right. James also portrayed himself with rabbit ears, as he had for the drawing of his mother (image 3.1).
References


