Abstract. To achieve a therapeutic design, we should examine three main information sources: clinical history, Rorschach test, and the subject's communication style during the diagnostic interviews. We should study people from the perspective of their individuality and always consider groups of data, not isolated elements. Professionals should do this task by examining five basic areas: explicit symptoms, strong and weak points, motivation level, definition of short-term and long-term objectives, and available therapeutic approaches. Clinical vignettes from two different Rorschach protocols, Case 1, a 25-year-old man, and Case 2, a 30-year-old woman, are included in this article.

Keywords: Rorschach Test, treatment planning, comprehensive system, psychological assessment

Introduction

Up until only two decades ago, an imprecise approach to treatment decisions prevailed within clinical circles. A set of ambiguous ideas was accepted with almost no criticism, such as the necessity to reach the optimal goals, without any greater degree of preciseness effort. When you put these theoretical notions into practice, what was required became equated with what was the best-known to each professional, which was not necessarily the equivalent of what was most appropriate for the patient.

In this way, even in those situations in which a more sophisticated intervention plan was made, treatment suggestions tended to be simplistic, based only on present symptoms or only on part of the clinical history. Therapeutic approaches were very similar in every case, and they
happened to match the professional’s theoretical schemes. In other words, there was a marked tendency to fit clinical pictures into the known therapeutic techniques, instead of creating individualized designs.

On some occasions, this procedure was adequate, but in most cases it involved serious risks, such as routinely using inadequate therapeutic approaches and/or provoking a premature interruption of treatment.

Those risks were attached to a procedure that paid attention neither to individual differences nor to the fact that identical symptoms may have a diverse psychological origin – indeed they may correspond to various personality structures.

More recently, due to the evolution of diagnosis and therapeutic concepts toward a wider variety and complexity, we have obtained more precise models for treatment planning. There is also an increasing tendency to draw up an elaborate cost-benefit analysis, taking into account not only the optimal therapeutic goals, but also the more adequate intervention strategies to reach them with the minimal cost to the patient.

Nowadays, we know that a change process (and every therapeutic approach, independent of its theoretical references, is a process oriented to producing significant changes) goes hand in hand with a set of various costs for the patient: time, financial costs, and social, interpersonal, or subjective costs. Among them, the latter ones are the most difficult to evaluate in advance, because they can belong to a broad spectrum: having disorganization episodes, disturbing a previous relationship balance, taking too much time and money, etc.

Despite these difficulties, most of these costs can be evaluated during the treatment planning task, and by focusing on them, we can facilitate their acceptance by the patient and also reduce their negative impact on therapeutic work.

A more integrative conceptualization is now the basis for psychological diagnosis. It offers a data synthesis derived from several sources of information. Diagnosis is no longer conceived of as a test score accumulation – and it would be very incomplete if it limits itself to a descriptive list of the person’s psychological characteristics, even if this were an exhaustive list.

Every psychological assessment process requires providing a context for each observed datum that gives different meaning to the same quantitative element, depending on the companion variables and on the relational styles showed by the subject during the diagnostic interviews (Sendín, 2000). In other words, the interpersonal space where diagnosis...
takes place is a privileged context for observing the patient’s resources and vulnerabilities in communication styles, interchange fluidity, cooperation-motivation level, and adaptive responses to external demands.

All these elements have direct links with the predictable attitudes that persons tend to manifest during their therapeutic process (Exner & Sanglade, 1992). Therefore, the identification of personality characteristics with a significant impact on treatment strategies becomes an essential aspect of the diagnostic task. It provides basic information and guides the selection of a suitable intervention, highlighting at the same time therapeutic goals and potential obstacles. When it is correctly achieved, it reduces many costs (e.g., time, financial), and it increases the intervention’s effectiveness.

A psychological diagnosis must include an integrative, sophisticated, and individualized design to take into account (as indicated) the context in which each datum appears and to incorporate prognostic and therapeutic suggestions. It helps to have a broad comprehension of people’s ideographic functioning; it stimulates their cooperation in the change process and it facilitates selecting the intervention strategies that would seem most suitable.

This conceptual evolution in clinical diagnosis means that one of the main goals in every psychological assessment is to construct an individualized treatment design to guarantee its effectiveness. The intervention plan is now the last phase of the diagnostic process, where the professional tries to get a deeper and more complex understanding of the subject’s personality features, in order to transmit to the therapist these unique characteristics and the appropriate strategies to reach reasonable objectives. Because of the increasing importance of treatment planning as part of the diagnostic process, we will outline in this article the main aspects of carrying out this task.

But first we should define it as the selection of intervention strategies with greater probability for:

- Increasing patients’ welfare
- Solving – as much as possible – their problems
- Facilitating access to their resources
- With the minimal cost possible – for all of these goals.

To reach these goals, treatment planning has to rely upon groups of elements and not upon single data. Up to now, researchers often defined several basic aspects to optimize the evaluation of therapeutic procedures, such as:
Rorschach Usefulness in Treatment Planning

– An understanding of disorder etiology
– A study of patients from an ideographic perspective
– A broad consideration of therapeutic strategies (not only of those well known to the professional).

To this end, it is necessary to conceptualize the psychological diagnosis as a *diachronic process with several phases*, where data coming from different information sources have to be integrated, contrasted, and synthetically handled (Sendín, 2000). Among these sources, research data points to a *detailed clinical history*, to the *Rorschach test*, and to an *analysis of subject’s communication styles* during the interviews, as the most useful tools for:

– Describing personality traits, especially those related to self-perception and interpersonal relationships
– Identifying etiologic factors
– Linking biographical elements with symptoms
– Connecting symptoms with manifest and implicit motives for requesting psychological help.

These are basic aspects that help us to understand each case and allow the intervention to be adapted according to individual features.

Numerous studies have looked at this topic with respect to the *Rorschach test* in the last few years (Elfhag, Rössner, Lindgren, Andersson, & Carlsson, 2004; Exner, 2002, 2003; Nygren, 2004). Some authors undertook a meta-analysis of published works about the use of Rorschach in treatment planning (Gronnerod, 2004; Weiner, 2004).

Most of these works point out that Rorschach clusters are good predictors of therapeutic success: control and stress tolerance, information processing, ideation, mediation, affects, self-perception, and interpersonal relationships. Curiously, several authors (Nygren, 2004; Weiner, 2004) consider all Rorschach clusters as valuable informative sources, which indicates its usefulness in this area. Nevertheless, research data from the Rorschach must be integrated with those from therapeutic strategies (Meyer & Archer, 2001).
1. Explicit symptoms: complaints expressed by the patient and an evaluation of disorder acute-chronic dimension.

2. Individual personality description, with special attention paid to the strong and weak points, in other words, to the available resources and vulnerabilities.

3. Motivation level to initiate significant changes, that is, to treatment commitment.


5. Consideration of available therapeutic approaches, in relation with proposed goals and individual characteristics. This should include an estimation of all costs: time, psychological, social, and financial.

This scheme for treatment planning is now set out in detail and, in order to better illustrate its practical use, brief clinical commentaries about two different Rorschach protocols are provided:

- **Case 1**: a 25-year-old man;
- **Case 2**: a 30-year-old woman.

It is important to remember that, in current clinical practice, we must always consider each and every quantitative and qualitative element present in the subject’s Rorschach protocol and in the clinical history. However, the comments included in this article refer only to some of the quantitative Rorschach (Comprehensive System) variables, because a qualitative analysis would necessarily require insert the full clinical histories and the Rorschach protocols of both cases.

**Explicit Symptoms**

We have to carefully examine the subject’s expressed complaints, although we could also infer other implicit and even more severe problems, because the stated motives for demanding psychological help constitute the core of the subjective concern that increases motivation toward change.

The expressed symptoms also provide good predictors of the seriousness of the disorder by revising several symptom aspects such as: Are they widespread (affecting many functioning areas) or specific (affecting only one area)? Are they acute (having appeared recently) or chronic (present for a long time)?

It is also very important to remember that symptoms are not equivalent to personality structure; thus, the same symptoms in different persons do not
necessarily match the same functioning basis nor the same etiology. Two patients with identical symptoms may require different approaches, depending on other personal and contextual data. The most important source for collecting information about symptoms is a detailed clinical history.

Individual Personality Description: Strong and Weak Points

The strong aspects of a subject’s functioning represent available resources to initiate problem-solving behaviors, and the weak ones mark the more vulnerable or troubled features. The therapeutic approach relies upon both types of elements, so we have to identify them through the study of several functioning areas, mainly:

- Perceptual-thinking accuracy: XA%, WDA%, X%, FQnone, P, Sun6, MQ, PTI, adaptation to evaluation setting.
- Affects: C, S, eb, SH, DEPI, CDI, AG, CP, PER, 2AB + Art + AY, Afr, emotional expressions.
- Interpersonal relationships: M, H, T, a:p, Ma:Mp, GHR:PHR, COP, AG, Isolate Index, communication styles.
- Self-perception: An + Xy, 3r + (2)/R, Fr + rF, HVI, MOR, V, Content analysis.

The Rorschach test and an analysis of the subject’s communication along the diagnosis process are the best informative sources for this study. Tables 1–4 show a summary of significant data for both cases.

Case 1

Strong points:
- His cognitive level seems to be good (DQ+, Zf), and presently he is a young person who does not yet suffer from a cognitive deterioration.
- The affective field does not show too much maladjusted coping strategies (CP, PER, 2AB + Art + AY).
- When he establishes interpersonal relationships, he apparently maintains an active attitude (a:p, Ma:Mp).
- He presents neither an hypervigilant style (HVI) nor a pessimistic view of the environment (MOR).
- Apparently, there is no suicidal risk (S-Con).
Table 1. Strong and weak points

<table>
<thead>
<tr>
<th>Strong and weak points</th>
<th>Rorschach Variables</th>
<th>Case 1</th>
<th>Case 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cognitive potential</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DQ +</td>
<td>5</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Bl/R</td>
<td>0:20</td>
<td>7:26</td>
<td></td>
</tr>
<tr>
<td>Zf</td>
<td>13</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>WM</td>
<td>7:2</td>
<td>8:4</td>
<td></td>
</tr>
<tr>
<td><strong>Perceptual and thinking accuracy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XA%</td>
<td>.50</td>
<td>.82</td>
<td></td>
</tr>
<tr>
<td>WDA%</td>
<td>.45</td>
<td>.85</td>
<td></td>
</tr>
<tr>
<td>X%</td>
<td>.45</td>
<td>.10</td>
<td></td>
</tr>
<tr>
<td>FQ none</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Popular</td>
<td>1</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Sum6/WgtdSum6</td>
<td>13/42</td>
<td>4/7</td>
<td></td>
</tr>
<tr>
<td>MQq/MQq/MQ</td>
<td>1/1/0</td>
<td>4/0/0</td>
<td></td>
</tr>
<tr>
<td>PTI</td>
<td>5</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Affects</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pure C</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>S</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>eb</td>
<td>10</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Sum SH</td>
<td>3</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>DEPI</td>
<td>2</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>CDI</td>
<td>3</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>AG</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CP</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>PER</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2AB + Art + AY</td>
<td>1</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Afi</td>
<td>1</td>
<td>.37</td>
<td></td>
</tr>
<tr>
<td><strong>Interpersonal relationships</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>H/(H)Hdd/(Hdd)</td>
<td>0/1/0/0</td>
<td>1/0/2/1</td>
<td></td>
</tr>
<tr>
<td>Sum T</td>
<td>0</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>a:H</td>
<td>6:2</td>
<td>4:8</td>
<td></td>
</tr>
<tr>
<td>Ma:Mp</td>
<td>2:0</td>
<td>2:5</td>
<td></td>
</tr>
<tr>
<td>GHR:PHR</td>
<td>0:3</td>
<td>2:5</td>
<td></td>
</tr>
<tr>
<td>COP</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>AG</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Isolate Index</td>
<td>.35</td>
<td>.25</td>
<td></td>
</tr>
<tr>
<td><strong>Self-perception</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An + Xy</td>
<td>3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>3y + (2)/R</td>
<td>.35</td>
<td>.23</td>
<td></td>
</tr>
<tr>
<td>Fy + rF</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>HVI</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>MOR</td>
<td>0</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Sum V</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Weak points:
- The most worrisome data are those that point toward a combination of significant perceptual-cognitive distortions, indicating a high probability that this disorder fits the psychotic spectrum. We can see:
  - A very poor perceptual adjustment (XA%, WDA%, P, FQ none) with a clear tendency toward severe distortions (X-%)
  - A serious thinking disorder (Sum6, WgtdSum6, MQ, PTI)
  - Little complexity in his cognitive processing (Bl:R)
  - Some indicators of affective difficulties (S, Sum SH, AG)
  - Relational world seems to be very impoverished (H, Sum T, GHR:PHR, COP, Isolate)
  - Self-perception indicates both low self-centeredness and low self-esteem (3r + (2)/R)
  - There is a stable overload; this discomfort is not situationally provoked (D, AdjD).

Case 2

Strong points:
- Her cognitive potential is good (DQ, Zf, Bl:R)
- There are no serious disturbances of perceptual and thinking functioning (XA%, WDA%, X-%, FQ none, P, Sum6, WgtdSum6, PTI)
- The affective field does not show aggressive tendencies (AG)
- She maintains a genuine interest in people (H, COP)
- Her self-perception shows neither narcissistic traits (Fr + rF) nor a hypervigilant style (HVI)

Weak points:
- Her more serious difficulties are in the affective area, where data points toward a deficit in coping style (CDI), which has also created a depressive clinical picture (DEPI)
The interpersonal relationship cluster shows a passive-dependent style \((T, p > a + 1, Fd, P)\)

Her self-perception indicates both low self-centeredness and low self-esteem \(3r + (2)/R\), including a very negative view of herself and the environment \((V, MOR)\)

She is very overloaded, for the most part by situationally provoked discomfort \((D, AdjD)\)

A serious risk to consider for this woman regards the inner irritative stimuli she is experiencing \((S, eb, Col-SH Bl, Sum SH)\), which are increasing her suicidal potential \((S-Con)\)

**Motivation Level**

Several Rorschach variables also seem to be useful signs concerning motivation toward change, in other words, concerning potential of treatment commitment, especially those related with:

- Expectancy level: \(W:M; ZF; Contents and Verbalizations analysis\).
- Rigidity-flexibility: \(a:p; Ma:Mp; PSV; EBPer\).
- Passivity-dependency: \(p > a + 1; T > 1; Fd > 0; high Popular\).

In general, a low expectancy level, high rigidity, and/or high passivity are negative prognostic factors, because they point toward more resilience toward change.

**Case 1**

- He shows a high expectancy level and invests considerable energy in organizing the stimulus field \((W:M, Zf)\)
- His thinking patterns tend to be rigid \((a:p; Ma:Mp; PSV, EBPer)\)
- He does not show a passive or dependent attitude

**Case 2**

- She also shows a high expectancy level and invests considerable energy in organizing the stimulus field \((W:M, Zf)\)
- Her thinking patterns are more flexible, which is a better prognostic indicator \((a:p, Ma:Mp, PSV, EBPer)\)
She shows a clear tendency toward a passive-dependent attitude (\(p > a + 1, T > 1, Fd > 0\), high Popular), which represents an obstacle for creating adjusted patterns for both self-perception and interpersonal relationships.

**Definition of Short-Term and Long-Term Objectives**

We have to integrate all previously collected data to define, in the clearest way possible, the objectives that seem attainable, taking the following into account:

- Subject’s strong and weak points
- Type of disorder and its possibility of being modified
- Motivation level.

The therapeutic aims must be always adapted to the subject’s psychological features.

**Case 1**

- Due to the chronic and severe disorder that he is suffering from (psychotic spectrum), the main short-term objective for this young man is to avoid a disorganization episode.
- It may be necessary to introduce psychopharmacological help – as a short-term objective – into the treatment design, to reduce his perceptual and thinking distortions.

---

**Table 2. Motivation level**

<table>
<thead>
<tr>
<th>Motivation level</th>
<th>Rorschach variables</th>
<th>Case 1</th>
<th>Case 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectancy level</td>
<td>(WM)</td>
<td>7:2</td>
<td>8:4</td>
</tr>
<tr>
<td></td>
<td>(Zj)</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Rigidity-flexibility</td>
<td>(a:p)</td>
<td>6:2</td>
<td>4:8</td>
</tr>
<tr>
<td></td>
<td>(MaMp)</td>
<td>2:0</td>
<td>2:3</td>
</tr>
<tr>
<td></td>
<td>(PSV)</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(EBPer)</td>
<td>3</td>
<td>2:1</td>
</tr>
<tr>
<td>Passivity-dependency</td>
<td>(p &gt; a + 1)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>(T &gt; 1)</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(Fd &gt; 0)</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Popular</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>
This disorder is not easily modifiable, so if we take into account the environment resources, we need to select, as long-term objective, the improvement of his welfare by increasing his self-esteem and by reducing his interpersonal isolation, using multiple strategies (group tasks, occupational therapy and/or social support).

**Case 2**

- In the short term, it is important to reduce her suicidal risk as primary priority. This must be the first point to keep in mind because her low

### Table 3. Definition of short-term and long-term objectives

<table>
<thead>
<tr>
<th>Definition of objectives</th>
<th>Case 1</th>
<th>Case 2</th>
</tr>
</thead>
</table>
| Subject’s strong and weak points | - He is a young person who does not suffer from a cognitive deterioration.  
- He shows severe perceptual-cognitive distortions. | - Her more serious difficulties are at the affective field. Data point to a deficient coping style (CDI) that, secondarily, has created a depressive clinical picture (DEPI). |
| Type of disorder and possibility to be modified | - It seems to be a chronic and generalized disorder (psychotic spectrum), not easily modifiable. | - A serious risk to consider is the severe discomfort experience (eh, ColSH Bl, Sum SH), which is increasing suicidal potential (SCon). However, it does not seem to be a chronic disorder (D, AdjD) |
| Motivation level | - It is acceptable and may permit the patient to commit to treatment | - It is acceptable, but her tendency toward a passive-dependent attitude represents an obstacle for creating adjusted relational patterns |
| Short-term objectives | - To avoid a disorganization episode  
- To reduce perceptual and cognitive distortions by including medication help | - To reduce suicidal risk  
- To reduce intense affective discomfort  
- Medication help is not advisable for this woman |
| Long-term objectives | - To increase his welfare by improving his self-esteem  
- To include him in a variety of activities in order to reduce his interpersonal isolation | - To work on problems-solving strategies to increase the effectiveness of her social and interpersonal behaviors because her coping deficit has generated most of the difficulties  
- To reach a better understanding of her inadequate relational patterns |
self-esteem, emotional pain, and need for closeness are dangerously increasing her self-destructive potential.
– The disorder presented by this young woman is a depressive set of symptoms that require intervention to reduce her intense affective discomfort.
– Since we know that her defective coping style has generated the depressive situation, *medication is not advisable* for this woman: Research data (Exner, 2002, 2003) prove that medication may facilitate the chronicity of the disorder in such cases.
– Her deficit in coping strategies forms the basis of her difficulties and has secondarily provoked her depressive situation. As a long-term objective, we need to emphasize the necessity of increasing the effectiveness of her social and interpersonal behaviors.
– At the same way, in the long term she needs to reach a better understanding (and a subsequent change) of her passive-dependent relational style.

**Consideration of the Available Therapeutic Approaches**

In the selection of therapeutic strategies, professionals must consider not only the ones they know best, but also take into account the wide range of possibilities at hand. No single therapeutic approach has proved its effectiveness in *all* cases and for *all* disorders, and the intervention design should take the following into account:
– The subject’s characteristics and motivation level.
– Type of disorder.
– Available therapeutic strategies for proposed objectives.
– Predictable costs.

**Case 1**

– Because of the seriousness and extent of this man’s problems, we need to think of a long-term and multidimensional therapeutic design that would combine several professional approaches. This would include supportive therapy, medication help, occupational therapy, social and family interventions, and, probably, the arrangement of brief hospital admission periods if he becomes highly disorganized.
– The predictable financial costs are very high, and multimodal inter-
vention may prove to be very time consuming. On a psychological level, it would also be necessary to initiate psychoeducational work with this patient to contribute to his acceptance of the seriousness of his disorder.

**Case 2**

- The problems of this woman could be approached by a less complex intervention design, although it should take into account diverse ther-

<table>
<thead>
<tr>
<th>Therapeutic approaches</th>
<th>Case 1</th>
<th>Case 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject’s characteristics and motivation level</td>
<td>This young man does not suffer from a cognitive deterioration, and his motivation level is acceptable, but the presence of severe perceptual-cognitive distortions will make his acceptance of some intervention aspects difficult (i.e., medication).</td>
<td>A serious risk to consider is the difficult amount of experienced discomfort (eh, Col SH Bl, Sum SH), which increases suicidal potential. Her motivation level is acceptable.</td>
</tr>
<tr>
<td>Type of disorder</td>
<td>It seems to be a chronic and generalized disorder (<em>psychotic spectrum</em>)</td>
<td>Data point to a deficient coping style that, secondarily, has created a depressive clinical picture. However, it does not seem to be a chronic disorder.</td>
</tr>
<tr>
<td>Available therapeutic strategies for proposed objectives</td>
<td>He will need a long-term, multidimensional therapeutic design that combines several professional approaches: medication, supportive therapy, group tasks, occupational therapy, social and family interventions. Probably, he will also need brief hospital admission if suffering from disorganization episodes.</td>
<td>At first, she needs a supportive or cathartic strategy to reduce her intense affective pain and suicidal risk. Then she will need to work on problem-solving tasks to increase the effectiveness of her social and coping abilities. Finally, a reconstructive approach would be useful for a better understanding of her inadequate relational patterns.</td>
</tr>
<tr>
<td>Predictable costs</td>
<td>High financial and time investments necessary. On a psychological level, it will also be necessary to propose a psychoeducational type of work that could contribute to his accepting the seriousness of his disorder.</td>
<td>Time-consuming but reasonable financial cost, because the various therapeutic strategies can be arranged sequentially according to her needs. On a psychological level, the most difficult change for her will probably be to modify her passive-dependent relational style.</td>
</tr>
</tbody>
</table>
apeutic modalities in order to deal with the following different objectives:

- Initially, she probably would need a supportive or cathartic strategy to avoid suicidal risk and to reduce her intense affective pain.
- Then she would need a problem-solving solution to increase the effectiveness of her social and coping abilities.
- Finally, a reconstructive strategy based on the insight of her inner difficulties is necessary, in order to get a better understanding of her inadequate relational patterns.

- The predictable costs are elevated in terms of time, but only slightly in financial terms, because the different therapeutic strategies can be arranged sequentially, according to her needs. At the psychological level the most difficult change for her will probably be abandoning her passive-dependent relational style.

After considering the possible approaches in both of these cases, we can see that achieving a therapeutic design is complex but nevertheless possible. There is therefore no reason to avoid it despite the complexity of the task.

It is important to remember that it is good practice for mental health practitioners to communicate to their patients an overview of all possible and adequate treatment opportunities. This contributes to increasing their active attitudes and to strengthening their role as co-responsibles in the therapeutic intervention. Nevertheless, it is not necessary to explain to them all the technical aspects in detail, such as the reasons for selecting a specific plan or the specific sequences of the therapeutic process.

In order to better describe the different phases of treatment planning, we present Table 5*, which summarizes the stated concepts about:

a) Main areas for collecting relevant information.

b) Significant elements in each area.

In order to simplify this view, we show in brackets the Rorschach variables marked by research data as specifically being related with each dimension (Sendin, 2007).

Table 5. Summary of relevant aspects for treatment planning

<table>
<thead>
<tr>
<th>Symptoms (Clinical history)</th>
<th>Strong and weak points (Rorschach/subject’s attitude)</th>
<th>Motivation level (Rorschach)</th>
<th>Short- and long-term objectives</th>
<th>Therapeutic strategies and costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific:</td>
<td>b) Access to available resources (EA, EB, Lambda, M &amp; G qualitative data, Zd).</td>
<td>Rigidity/Flexibility (a, M, M, P, PS, EBPer).</td>
<td>With regard to acute-chronic disorder.</td>
<td>Intervention design should be adapted to subject’s characteristics and type of disorder.</td>
</tr>
<tr>
<td>Acute:</td>
<td>c) Affects (FC: CF = C, C &amp; SH qualitative data, S, eh, AG, CP, PER, DEPI, CDI, Afs. SumC, WSumC, ZAR + Art + Aq).</td>
<td>Passivity/Dependency (q &gt; a &lt; j, T &gt; I, P4, Popular).</td>
<td>With regard to motivation level.</td>
<td>We have to evaluate predictable costs: 1) Time requirements. 2) Financial costs. 3) Other predictable costs (psychological or interpersonal ones), such as a) Fragility of previous equilibrium. b) Disorganization risk c) Break-up of former relationships.</td>
</tr>
<tr>
<td>Symptoms # Personality structure:</td>
<td>1) Self-centeredness (Fr + rR, 3v + (2)/R, An + Aq).</td>
<td></td>
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<tr>
<td>Identical symptoms may point out at different disorders, and they may have a different origin.</td>
<td>2) Self-esteem (MOR, V, PQ, Movement and Verbal embellishment analysis, Subject’s attitude).</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>3) Acute/chronic overload (D &amp; Adj D, eb analysis, HVI, S Con, OBS, ColSHI BL).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4) Perceptual accuracy and thinking disorders (X%A, WDA %, X-%, MQ, PQnone, PQ, P, RausSum6, WSum6, PTT).</td>
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<td></td>
<td></td>
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</tbody>
</table>
Conclusions

Communicating an integrated plan facilitates the patient’s understanding of the therapeutic process and increases their responsibility and active attitudes toward the intervention. It also permits sharing valuable information with the therapist and reduces many of the time and financial costs, as a careful treatment planning avoids numerous exploratory sessions and many intervention mistakes.

We should remember that the proposed goals cannot always be reached completely because of the level of difficulty of the respective case (low cooperation, lack of key data, too much complexity of disorders, etc.) and/or the professional’s difficulties (lack of training, problems with complex work management, etc.). Nevertheless, the ideal aim of any therapeutic design is to propose an intervention that is adapted, as far as possible, to the characteristics, type of disorder, and needs of each subject. Despite all obstacles, we insist on the fact that practitioners always have to deal with the treatment planning task as it will undoubtedly determine the outcome.

References


Summary

To achieve a therapeutic design, one should carefully examine three main sources of information: clinical history, Rorschach test, and the subject’s communication style during the diagnostic interviews.

We have to study people from the perspective of their individuality and consider groups of data, not isolated elements. Professionals must do this task examining, at least, five basic areas:

1. Explicit symptoms.
2. Strong and weak points (vulnerabilities and available resources).
3. Motivation level to initiate significant changes.
5. Available therapeutic approaches, taking into account the subject’s characteristics and needs, and including an estimate of costs (time, psychological, social, and financial).

In order to better illustrate the practical use of this scheme, we include in this article brief clinical vignettes from two different Rorschach protocols: Case 1, a 25-year-old man, and Case 2, a 30-year-old woman.

A detailed analysis and an integrative synthesis of these data should facilitate the following:

– Strengthening the patient’s attitude toward understand and assuming responsibility about psychological intervention.
– Sharing valuable information with other therapists.
– Reducing the time and financial costs, as treatment planning avoids numerous exploratory sessions and many intervention mistakes.

The ideal aims of this work cannot always be reached, because of case difficulties (low cooperation, lack of key data, complexity of situation,
etc.) and/or professional difficulties (lack of training, problems to complex work management, etc).

Despite these obstacles, we insist on the fact that assessors have to deal with the treatment planning work in every case.

**Resumen**

Para llevar a cabo un diseño terapéutico, debemos revisar cuidadosamente tres fuentes básicas de información: la historia clínica, el test de Rorschach y los estilos de comunicación del sujeto a lo largo de las distintas entrevistas diagnósticas.

Hay que estudiar a cada persona desde la perspectiva de su singularidad y considerar siempre grupos o constelaciones de datos, nunca elementos aislados. Esta tarea se puede realizar examinando, al menos, cinco áreas básicas:

1. Síntomas explícitos
2. Puntos fuertes y débiles: recursos disponibles y aspectos vulnerables.
3. Nivel de motivación para iniciar cambios significativos.
4. Definición de objetivos a corto y largo plazo.
5. Enfoques terapéuticos disponibles, teniendo en cuenta las características y necesidades de cada sujeto e incluyendo una estimación de costes: temporal, económico, psicológico y social.

A fin de ilustrar mejor la utilización práctica de este esquema de trabajo, se incluyen en este artículo breves comentarios clínicos sobre dos diferentes protocolos de Rorschach: **Caso 1**: un hombre de 25 años y **Caso 2**: una mujer de 30 años.

Un estudio integrador de estos datos favorece:
- Una mejora en la actitud del paciente para entender y aceptar su responsabilidad en la intervención psicológica.
- La posibilidad de compartir información relevante con el terapeuta.
- Un ahorro significativo de tiempo y dinero, porque una planificación detallada del tratamiento evita numerosas sesiones exploratorias y bastantes errores terapéuticos.

Hay que recordar que no siempre se pueden alcanzar los objetivos ideales de este trabajo, por las dificultades del caso (poca cooperación, escaso aporte de información relevante, excesiva complejidad de la situación, etc.) y/o por dificultades del propio profesional (falta de formación, problemas para manejar con series complejas de elementos, etc.).
A pesar de estos obstáculos, hay que insistir en la necesidad de que los evaluadores afronten la tarea de planificación del tratamiento en cada caso, aunque los resultados no siempre sean óptimos.

Resumé

Afin d’atteindre des objectifs thérapeutiques on doit prendre en compte trois sources d’information: l’histoire clinique, le test de Rorschach et l’analyse des styles de communication du sujet au long des différents entretiens diagnostiques.

Chaque individu doit être considéré dans sa singularité et les données obtenues doivent être analysées non pas séparément mais comme faisant partie d’une constellation. Cette démarche est possible lorsqu’on analyse, au moins, cinq champs essentiels:

1. Les symptômes explicites.
2. Les points forts et faibles du client: les ressources disponibles et aspects vulnérables.
3. Le niveau de motivation pour initier des changes significatifs.
4. La définition d’objectifs à court et long terme.
5. Tenir compte des modalités thérapeutiques disponibles, en considérant les caractéristiques et nécessités de chaque sujet et en incluant une estimation des coûts: en temps, financier, psychologique et social.

Afin d’illustrer l’utilisation pratique de cette approche, deux vignettes cliniques sont présentées: Cas 1 – un homme de 25 années, et Cas 2 – une femme de 30 années.

Un étude qui intègre toutes les données favorise:
– L’augmentation de la compréhension du patient des processus d’intervention psychologique et de l’acceptation de sa responsabilité dans le traitement.
– La possibilité d’informer le thérapeute sur les potentiels du patient.
– Un important gain de temps et d’argent étant donné que la meilleure approche peut être sélectionnée et éviter des erreurs de choix thérapeutiques.

Il est important de rappeler que l’on ne peut pas toujours atteindre des objectifs idéaux. Des difficultés cliniques (peu de coopération, manque d’information, complexité accrue de la situation, etc.) et profession-
nelles (manque de formation, manque de temps pour apprécier la complexité clinique) peuvent se présenter, mais il semble important que ce travail de planification du traitement reste une tâche primordiale pour l’évaluateur.

Rorschach Usefulness in Treatment Planning

治療計画を達成するために、私たちは3つの主な情報源：ケースヒストリー、ロールシャッハテスト、診断面接の間の対象者のコミュニケーションスタイルを注意深く検討しなければならない。

われわれは人々を彼らの個体性の観点から研究しなければいけないし、同時に独立した要素としてではなくデータの集合法と考えなくてはいけない。専門家は少なくとも5つの基本的な領域でこの吟味するという課題をなさなければならな

1. 明確な症状
2. 長所と短所（脆弱性と利用可能な資源）
3. 重要な変化に着手しようとする動機づけのレベル
4. 短期的および長期的目標を明確にすること
5. 対象者の特徴やニーズを考慮に入れ、コスト（時間的、社会的、財政的コスト）の評価も含んだ、有効な
治療的アプローチ

このスキーマの実践的な活用をよりよく例証するために、2つの異ったロールシャッハ・プロトコル（ケース1：25歳の男性とケース2：30歳の女性）から引き出された簡潔な臨床的な描写をわれわれはこの論文に含めた。

これらのデータの詳細な分析と統合的なまとめは以下のことを促進する。

・心理学の介入に関する責任性を理解し、それを引き受けるというもっともよい患者の態度。
・重要な情報を治療者と共有着すること。
・治療計画が膨大な探索的セッションと多くの介入の間違いを回避するので、時間と財政的コストを減らすこと。

われわれは、ケースの困難（低い協力性、疑問なるデータの欠如、状況の過度の複雑さ、など）および／あるいは専門家の問題（トレーニングの欠如、作業のメタマージメントを複雑にするという問題）によって、本研究の理想的な目標であるべきであり、これは達成できるわけではないことを覚えておくべきである。このような障害があるにもかかわらず、観察者は、すべての事例において治療計画をあつかうことができる必要はないと考えず、それが結果は最善とならないかもしれないが。