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BRIEF PSYCHOSOCIAL ASSESSMENT OF A CLINICAL SAMPLE: AN EVALUATION OF THE PERSONAL PROBLEMS CHECKLIST FOR ADULTS

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In light of the requirements for managed health care organizations to use assessment instruments that are psychometrically sound, cost and time efficient, and theoretically useful, the present study examined the psychometric properties of one such potential instrument, the Personal Problems Checklist for Adults (PPCA). Designed to measure problems in 13 areas of everyday functioning, the PPCA along with the Brief Symptom Inventory were completed by 132 individuals in an outpatient drug rehabilitation program. Counselor ratings on the Adjective Check List were also obtained. Results clearly showed that personal problems as measured by the PPCA were related to self-reported psychological symptoms and to perceptions by their counselors. The PPCA proved to have good psychometric properties and warrants greater attention by testing psychologists given its potential to meet criteria set forth by managed health care.

Keywords: Personal Problems Checklist validity, brief assessment, clinical assessment, reliability, substance abuse

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The pressures of managed care present new and challenging obstacles to mental health professionals (Dana, Conner, & Allen, 1996; Power & Eisenberg, 1998), especially to psychologists engaged in testing. As the tenor of health care continues to grow and change, testing psychologists are often faced with a dilemma: Follow the guidelines and/or restrictions set forth by managed care organizations or deal with the assessment needs of their clients. Recent studies have revealed that psychologists are, in fact, reducing their testing services. *Psychotherapy Finances*, a monthly newsletter for behavioral healthcare providers, reported in a recent survey (Fee, Practice, and Managed Care Survey, 1995) that there was a 10% decline in the number of

psychologists utilizing testing services as a result of the managed care reimbursement structures. In a more recent survey, Piotrowski, Belter, and Keller (1998) reported that among their respondents (137 members of the National Register of Health Service Providers in Psychology) 72% indicated that their use of tests had changed in the past 5 years due to managed care. Most of these providers (75%) reported that they were doing less testing, using fewer tests, or both. In their summary, Piotrowski et al. stated:

> it seems clear that the majority of psychologists responding to this survey felt strongly that managed care constraints have negatively affected the use of psychological tests in clinical practice. Accordingly, the response of most of the respondents has been to (a) continue to use the same type of tests previously used, but to do less testing or (b) do less testing, but also discard more time-consuming tests such as projectives, IQ tests, and personality inventories, in favor of brief, easily scored, self-report measures and checklists. (p. 445)

Piotrowski et al. (1998) concluded that:

> evaluation of patients, in the near future, will focus more on testing rather than comprehensive assessment. That is, a clinician's selection of tests or assessment instruments will, most probably, focus on targeted symptoms or psychological states (e.g., anxiety, depression, hostility), as opposed to personality dynamics or intrapsychic processes. (pp. 445-446)

Cost effectiveness analysis also is being applied increasingly to decision-making at all levels of health care delivery (Power & Eisenberg, 1998). In order to be best prepared for these changes and to influence their direction, testing psychologists must demonstrate in a convincing manner the value (economic and quality) of assessment. In addition, they must be familiar with key expectations of case management. According to Anderson and Berlant (1994), there are four factors which should be noted: (a) The need for correct diagnosis and effective treatment; (b) The case manager's function of fostering the most efficient use of resources; (c) Decreasing costly procedures; and, (d) Avoiding poor quality services. One way in which testing psychologists can address the issues of cost and quality, which do not have to be mutually exclusive, is by utilizing assessment instruments that are psychometrically sound, cost and time efficient, and theoretically useful. One such instrument is the Personal Problems Checklist for Adults (PPCA; Schinka, 1985). This assessment instrument efficiently meets the presented needs (cost: $40.00 per 50). It is a 208-item checklist designed to measure problems in everyday functioning. The checklist is divided into 13 areas of functioning: social, emotions, appearance, vocational, school, finances, religion, sex, legal, attitude, crisis, family/home, and health/habit. The PPCA is a brief yet comprehensive tool which provides quick and easy access to areas of struggle in the client's life. Despite the minimal research done on *this* scale (e.g., Perry, McDougal, & Viglione, 1995), according to the test Publisher (Psychological Assessment Resources), it is one of the best selling instruments of the checklist series (B. VanAntwerp, personal communication, January, 1999).

Given the need for brief, broad-based assessment instruments and the widespread use of the PPCA, this study provides basic clinical data to demonstrate the psychometric properties and utility of the PPCA and to stimulate further development. Using a sample of outpatient substance abusers, this study assessed the scale's sensitivity to changes in psychosocial status, and its relation to Axis I issues.

Method

Participants

Participants consisted of 82 men and 50 women, ages 23 to 52 years (M = 35 years) who were consecutive admissions to a 6-week, outpatient drug rehabilitation program between October, 1993 and July, 1995. Most had a high school diploma and 84% were African American. These individuals constituted a lower socio-economic group and many carried dual diagnoses (most secondary diagnoses were related to affective disorders or

were characterological). Most were alcohol (65%), heroin (42%), and cocaine abusers (73%), with an average of 15 years of substance involvement (range 1-35 years). All members of the program were volunteers, having been recommended by local shelters and social agencies. To be accepted to the program, an individual had to be drug free for *at least* 30 days. Any usage of substances during the program was grounds for immediate dismissal. On average, participants had been unemployed for 19 months prior to enrollment (range 1 month to over 8 years) and had their last rehab experience 4 months previous to entering the current program. On average individuals had two previous detox experiences. Almost one third (31%) were on probation at the time of entering.

Of the 132 participants who were accepted into the program, only 99 successfully completed the program (40 women and 59 men). These individuals served to evaluate the test-retest reliability of the PPCA. Of the 33 individuals who dropped out of the program, 8 relapsed, 9 lost interest, 1 had legal difficulties, 10 violated program rules (e.g., missed several sessions, did not comply with regimen), and the reason 5 left is unknown. Given the variety of reasons individuals had for leaving the program as well as the relatively small sample size in each category, any comparisons between these individuals who terminated the program and those individuals who completed the program are tenuous at best.

Measures

Brief Symptom Inventory (BSI)

Developed by Derogatis (1993), this 53-item, self-report inventory is designed to capture psychological symptom patterns over nine primary clinically relevant dimensions and three global indices. Each item is responded to on a 5-point Likert scale from 0 (*not at all*) to 4 (*extremely*). The symptom scales include: *Somatization* (distress arising from perceptions of bodily dysfunction), *Obsessive-Compulsive* (thoughts, feelings, and actions that are experienced as unremitting and irresistible), *Interpersonal Sensitivity* (feelings of personal inadequacy), *Depression* (dysphoric mood and affect), *Anxiety* (nervousness, tension, panic attacks, and feelings of terror), *Hostility* (thoughts, feelings, and actions characteristic of anger), *Phobic Anxiety* (persistent fear response that is irrational and disproportionate to the stimulus that leads to avoidance behavior), *Paranoid Ideation* (disordered thinking, including projective thought, hostility, suspiciousness, and grandiosity), and *Psychoticism* (withdrawal and isolation). There are 3 global scales, but only 1 was used in this study, the *Global Severity Index*, which is the sum of the nine symptom clusters divided by the total number of responses. Alpha reliabilities range from .71 for Psychoticism to .85 for Depression. Derogatis, Rickels, and Rock (1976) have shown the BSI to converge well with scores on the MMPI. Other research has shown the BSI to be useful in detecting symptomological distress in clients in a drug treatment context (Buckner & Mandell, 1990; Royse & Drude, 1984). Following guidelines provided in the manual, the scores from participants in this study were evaluated relative to norms provided for the Adult Nonpatient Sample.

Personal Problems Checklist for Adults (PPCA)

Developed by Schinka (1985), this 208-item checklist was designed for adults aged 18 to 60 years. Respondents simply check those items that represent an area of distress currently being faced. Items are grouped into 13 areas: *Social* (e.g., being shy, not having close friends), *Appearance* (e.g., being overweight, having scars), *Vocational* (e.g., not having a job, job having no future), *Family/Home* (e.g., children misbehaving, not getting along with neighbors), *School* (e.g., getting bad grades, not having good study habits), *Financial* (e.g., wasting money, depending on others for financial support), *Religion* (e.g., feeling guilty about religion, failing to support church), *Emotional* (e.g., feeling anxious or uptight, being unhappy all the time), *Sexual* (e.g., not knowing enough about sex, disliking sex), *Legal* (e.g., being sued, facing criminal charges), *Health/Habits* (e.g., losing temper and hurting someone, having poor eating habits), *Attitude* (e.g., not having any interest in things, having a poor attitude toward self), and *Crises* (e.g., pet dying, being robbed). This instrument was not constructed to be a multi-scale

inventory, rather items were selected for content coverage on the basis of expert judge panels. As such, no item or scale analyses were conducted. This measure serves as a true clinical checklist designed to provide an actuarial index of the number and types of problems and/or stressors being encountered by clients in their current life. There are no current reliability or validity evidence for the measure. However, we examined the dimensional nature of this scale by scoring each item dichotomously and summing within each of the 13 content areas. The number of items in each content area is indicated in Table 1.

Adjective Check List (ACL)

Developed by Gough and Heilbrun (1983), this measure consists of 300 adjectives from which individuals select those which are viewed as self-descriptive. This instrument was completed by the counselors after meeting with clients for a 20- to 40-minute pre-program interview. Although the ACL can be scored for 35 different content scales, for the purposes of this study, only the single items ratings were used. These items provide a portrait of how the client is perceived by others, in this case professional counselors. The ACL has been shown to be quite valid (Piedmont, McCrae, & Costa, 1991) and the use of single item ratings from the ACL for establishing the personological qualities of a scale is not uncommon (Costa & McCrae, 1992; Piedmont & Weinstein, 1993).

Procedure

Prior to beginning the treatment program, all clients met with a counselor for a 20- to 40-minute interview which was designed to evaluate the suitability and level of impairment of each client. Within 1 week of this initial contact, counselors completed the ACL for each participant. Each client was rated by only one counselor.

After the interview, clients completed the BSI and PPCA, in random order. This was accomplished in one sitting either after their interview with a counselor or on the first day of the program. Counselors did not have access to clients' responses to these instruments before making their own assessments. Clients were told the purpose of the assessments was for program evaluation purposes only.

The program lasted for 6 weeks. Clients were to report 5 days a week for 6 hours a day. The program itself provided a broad-based, multimodal intervention. The major focus of the program was to develop useful vocational skills, and participants worked toward finding gainful employment by the end of treatment. In addition, participants received individual and group counseling, attended Alcoholics Anonymous (AA) or Chemical Dependence Anonymous (CDA) groups, and engaged in a number of therapeutic activities centering on personal and spiritual growth and development. During the last week of the program, clients were again asked to complete the battery of materials. PPCAs collected at this point served in the test-retest analyses.

Results

Table 1 presents descriptive statistics, both overall and within gender, for all of the PPCA domains as well as for an overall endorsement rate. As can be seen, the participants endorsed, on average, 38 (SD = 22.0 for overall Total) specific problems they were encountering in their lives at the time of entry into the treatment program. This represents an 18% endorsement rate. The Emotional and Social categories had the highest number of endorsements while Legal and School had the fewest number of endorsements. Overall, only two significant gender differences emerged, for the Sexual and Attitude scales (mean effect size was .25, suggesting a small effect), indicating that the instrument, at least in the current sample, captures issues equally relevant for both genders. These values may serve as useful initial reference points for evaluating other outpatient, substance abuse samples.

Paired t-test analyses were conducted to determine whether PPCA scores changed significantly over the course of treatment. These analyses were based on only those individuals who completed the program (n = 96). Results of these analyses are presented in Table 2. As can be seen, there were significant declines on all but two of the

Table 1
Descriptive Statistics for the PPCA Scales Overall and Separately by Gender at Admission

PPCA scale	Score range	Men[a]		Women[b]				Overall[c]		
		M	*SD*	*M*	*SD*	*t*	Cohen's *d*	*M*	*SD*	Alpha
Social	0 - 18	4.99	3.4	5.25	4.3	0.37	.08	5.09	3.7	.79
Appearance	0 - 12	1.49	1.3	1.98	1.8	1.71	.39	1.68	1.5	.27
Vocational	0 - 18	4.09	3.0	3.73	3.5	-0.60	.14	3.95	3.2	.79
Family	0 - 34	4.09	4.2	4.92	4.2	1.12	.26	4.42	4.2	.80
School	0 - 12	1.85	2.1	1.25	1.8	-1.73	.40	1.61	2.0	.71
Financial	0 - 12	4.60	2.4	5.00	2.4	0.95	.22	4.76	2.4	.61
Religious	0 - 14	2.04	2.2	1.81	1.9	-0.64	.15	1.95	2.1	.62
Emotional	0 - 20	4.60	3.7	5.63	4.1	1.46	.33	5.00	3.9	.81
Sexual	0 - 14	2.41	2.0	1.55	1.5	-2.84**	.65	2.08	1.9	.57
Legal	0 - 10	0.99	1.2	0.75	1.0	-1.28	.29	0.89	1.1	.43
Health	0 - 20	3.46	2.7	3.61	2.7	0.30	.07	3.52	2.7	.68
Attitude	0 - 12	2.33	2.1	1.57	1.6	-2.32*	.53	2.03	2.0	.64
Crisis	0 - 12	1.61	1.8	1.61	1.9	-0.01	.00	1.61	1.9	.69
Total	0 - 208	38.54	22.8	38.37	20.8	-0.04	.01	38.47	22.0	.95

Note. PPCA = Personal Problems Checklist for Adults.
[a]$n = 80$. [b]$n = 52$. [c]$N = 132$.
*$p < .05$. **$p < .01$ two-tailed.

Table 2
t Test for the Difference Between Pre- and Posttreatment Means on the PPCA

PPCA scale	Pretreatment		Posttreatment			Cohen's *d*	Test-Retest reliability
	M	*SD*	*M*	*SD*	*t*		
Social	5.25	3.9	3.66	3.9	4.15***	.41	.52***
Appearance	1.70	1.6	1.51	2.0	1.10	.10	.57***
Vocational	3.99	3.4	2.50	2.7	4.77***	.48	.52***
Family	4.41	4.5	3.51	4.3	2.26*	.20	.61***
School	1.70	2.2	1.00	1.8	3.39***	.35	.49***
Financial	4.70	2.4	3.59	2.5	4.17***	.46	.43***
Religious	1.93	2.0	1.34	2.0	3.15**	.29	.59***
Emotional	4.80	4.1	3.22	3.6	4.52***	.41	.61***
Sexual	2.09	1.9	1.71	1.8	2.08*	.21	.52***
Legal	0.78	1.1	0.65	1.0	1.15	.12	.46***
Health	3.62	2.7	2.80	2.8	2.79**	.29	.47***
Attitude	2.06	2.0	1.16	1.6	4.10***	.51	.28**
Crisis	1.68	2.0	1.32	1.9	1.99*	.19	.56***
Total	38.56	22.9	28.61	26.0	4.42***	.40	.60***

Note. $N = 96$. PPCA = Personal Problems Checklist for Adults.
*$p < .05$. **$p < .01$. ***$p < .001$, two-tailed.

measured domains (Appearance and Legal). Overall, the number of personal problems decreased from approximately 39 at pretreatment to 29 at posttreatment, t (95) = 4.42, $p < .001$, Cohen's $d = .40$. These data suggest that the PPCA may be useful for documenting both the extent and types of changes an individual experienced over the course of treatment. However, the lack of a formal control group preempts our ability to conclusively determine whether these observed changes were due to the treatment itself or were merely the result of participants being retested. Nonetheless, the pattern of results observed here is consistent with changes noted in this sample in terms of both personality and symptom experience (see Piedmont, 1999; Piedmont & Ciarrocchi, 1999).

Correlations between the PPCA and BSI scores are presented in Table 3. There are numerous significant associations between the types of personal problems individuals were encountering at pretreatment and larger types of psychological distress. Overall, the total number of problems experienced correlated significantly with all of the BSI symptom dimensions. This suggests that problems experienced in daily living are related to larger psychological difficulties. Multiple regression analyses were done using each of the PPCA scales as the dependent variables and the 10 BSI scales as the predictors. Adjusted R^2s (which adjust for sample size and number of predictors) are presented in the last column of Table 3 and indicate the amount of shared variance each PPCA scale has with all of the symptom dimensions. The Social and Emotional domains overlapped significantly with symptom experience as well as correlated with all of the BSI scales. The Health, Attitude, and Crisis domains also broadly correlated with the symptom scales, although their overall level of association was lower. Other PPCA domains, such as the Financial, Religious, Sexual, and Family, had a more circumscribed pattern of association with the BSI scales. Nonetheless, these data affirm the reality that the types and extent of personal problems are meaningfully related to the extent and types of larger psychological difficulties individuals may be experiencing.

A joint principal components analysis of the BSI and PPCA scales was conducted to examine how these scales load on underlying factors. Such an analysis also helps to control for the redundancy which exists among the scales within each instrument. A principal components analysis was performed on these 22 scales and a scree test indicated that three factors should be retained and they were orthogonally rotated. However, the two-factor solution provided the most interpretable findings, accounting for 54% of the total variance. The first factor had all the BSI scales loading on it (range was .60 to .85) along with the Emotional and Social scales (loadings > .40) from the PPCA. These results parallel the regression findings in Table 3, where these two scales shared the highest proportion of variance with the BSI. The second factor contained all the PPCA scales (range .55 to .74) with the BSI scales all loading less than .18. These findings suggest that there are many reasons why individuals experience problems in living, psychological distress being only one component. The PPCA scales appear to capture aspects of psychosocial functioning non-redundant with measures of affective distress.

In order to provide some additional construct validity to the PPCA scales, the number of difficulties experienced in each domain were correlated with counselor ratings on the ACL. These associations reflect the kinds of impressions individuals with different problems generate in observers. These correlations also provide some discriminant validity for the various PPCA scales by showing that scores on the different domains are associated with different counselor impressions of clients' personal styles and dispositions. These results are presented in Table 4. Although there were numerous, significant correlations between the PPCA scales and the ACL, only the five most positive and five most negative correlations are presented in Table 4.

Looking across all domains, there are certainly some consistencies in counselor impressions. We noted that being seen as worrying, anxious, confused, and pessimistic seem to characterize individuals having problems in a number of categories.

Table 3
Correlations Between PPCA Scales and Self-Ratings on the Brief Symptom Inventory (BSI) at Pretreatment

	BSI scales										
PPCA scale	SOM	O-C	I-S	DEP	ANX	HOS	PHOB	PAR	PSY	Total	Adj R^2
Social	.26**	.28***	.50***	.33***	.40***	.37***	.29***	.43***	.34***	.43***	.26***
Appearance	.06	.08	.11	−.06	.05	.05	−.06	.05	−.04	.04	.07*
Vocational	.07	.01	.11	.01	.03	.05	.10	.07	.04	.07	.00
Family	.22*	.14	.17*	.14	.16	.22**	.11	.16	.06	.19*	.04
School	.17*	.13	.11	.04	.13	.12	.13	.11	.14	.15	.00
Financial	.20*	.20*	.20*	.16	.25**	.27**	.18*	.20*	.16	.25**	.03
Religious	.17*	.13	.10	.09	.19*	.19*	.21*	.09	.13	.18*	.03
Emotional	.25**	.48***	.40***	.33***	.49***	.37***	.42***	.24**	.40***	.46***	.29***
Sexual	.01	.19*	.24**	.11	.17*	.16	.07	.22*	.26**	.20*	.05
Legal	.29***	.13	−.01	.04	.07	.17*	.10	.04	.02	.12	.08*
Health	.17*	.24**	.19*	.11	.21*	.28***	.17*	.19*	.20*	.25**	.06*
Attitude	.07	.30***	.32***	.23**	.36***	.31***	.28***	.28***	.29***	.34***	.12**
Crisis	.17*	.11	.11	.04	.24**	.23**	.20*	.18*	.07	.18*	.06*
Total	.25**	.30***	.34***	.22*	.35***	.35***	.28***	.29***	.27**	.36***	.14***

Note. $N = 132$. PPCA = Personal Problems Checklist for Adults. BSI scale definitions: SOM-Somatization; O-C-Obsessive-Compulsive; I-S-Interpersonal Sensitivity; DEP-Depression; ANX-Anxiety; HOS-Hostility; PHOB-Phobic Anxiety; PAR-Paranoia; PSY-Psychosis; Total-Global Symptom Index, Adj R^2–Adjusted R^2.
*$p < .05$. **$p < .01$. ***$p < .001$.

Table 4
The 10 Most Correlated Counselor ACL Ratings Associated With Self-Reported Scores on Each PPCA Scale

PPCA scale	Characteristic	Uncharacteristic
Social	generous (.31), timid (.29), highstrung (.25), confused (.23), quitting (.23)	active (–.26), practical (–.24), interests wide (–.23), tactful (–.22), optimistic (–.22)
Appearance	worrying (.32), pessimistic (.28), high strung (.28), forgetful (.27), emotional (.25)	adaptable (–.28), charming (–.25), aloof (–.22), clever (–.22), careless (–.20)
Vocational	effeminate (.27), reserved (.22), cold (.22), self-pitying (.21), confused (.20)	considerate (–.28) appreciative (–.28) active (–.26) adaptable (–.25) versatile (–.22)
Family	effeminate (.33), self-pitying (.27), inhibited (.23), meek (.21), confused (.21)	reflective (–.22), cheerful (–.20), good-looking (–.18), interests-wide (–.17), witty (–.16)
School	effeminate (.28), pessimistic (.21), defensive (.19), dissatisfied (.19), mannerly (.18)	adaptable (–.39), attractive (–.31), capable (–.26), active (–.24), fair–minded (–.20)
Financial	fearful (.29), confused (.25), self-denying (.24), emotional (.24), anxious (.23)	aloof (–.38), polished (–.22), independent (–.21), capable (–.19), adaptable (–.19)
Religious	smug (.28), inhibited (.25), meek (.23), unstable (.22), forgetful (.22)	adaptable (–.21), attractive (–.21), capable (–.20), active (–.19), aloof (–.19)
Emotional	unstable (.36), confused (.32), dependent (.29), fearful (.28), complicated (.26)	helpful (–.29), considerate (–.27), charming (–.27), active (–.26), independent (–.24)
Sexual	tense (.30), masculine (.24), soft-hearted (.23), complicated (.22), unconventional (.213)	adaptable (–.29), poised (–.25), aloof (–.24), capable (–.21), versatile (–.20)
Legal	whiny (.30), despondent (.29), spineless (.24), self-pitying (.22), apathetic (.21)	thoughtful (–.27), energetic (–.25), courageous (–.23), reasonable (–.21), mannerly (–.19)
Health	spontaneous (.30), bitter (.28), unstable (.28), complicated (.23), talkative (.21)	charming (–.30), queer (–.19), reflective (–.19), independent (–.19), understanding (–.19)
Attitude	dissatisfied (.33), soft-hearted (.32), fearful (.31), complicated (.29), wary (.29)	versatile (–.23), aloof (–.22), adaptable (–.22), charming (–.21), independent (–.21)
Crisis	self-pitying (.25), resourceful (.21), dignified (.20), bossy (.19), rebellious (.18)	handsome (–.20), versatile (–.20), self-controlled (–.17), egotistical (–.16), considerate (–.16)

Note. $N = 132$. ACL = Adjective Check List. PPCA = Personal Problems.Checklist for Adults. All ACL items correlated with PPCA scale $p < .05$, two-tailed.

However, there are some distinct characterizations. For example, someone with more Social problems was seen as being confused, timid, and high-strung while someone with fewer Social problems appeared more active, tactful, and optimistic. Individuals with more Vocation-related issues were seen by counselors as being confused, evasive, and with narrow interests, while someone with fewer such difficulties appeared as being active, versatile, and adaptable. Finally, individuals with many emotional problems were seen as being unstable, confused, and dependent, while those with few such problems were seen as being independent, charming, and considerate. What the correlations with the ACL and BSI show is that scores on the PPCA have something to say about a client's larger psychosocial realities. Thus an examination of a client's status in these different areas can provide information about his/her personal style as well as his/her larger psychological issues.

Discussion

Overall, these data provide some encouraging initial support for the use of the PPCA as more than just an intake questionnaire. The presence of few gender differences in this sample suggests that the PPCA may have few adverse impact qualities (i.e., identifying one gender as having more psychological difficulties than the other) if used in employment-related settings (e.g., Employee Assistance Programs). However, some of the gender effect sizes (e.g., for the Sexual and Attitude scales) were quite robust suggesting that additional studies need to be conducted to establish the reliability of these gender differences, or lack thereof. The PPCA also showed itself quite sensitive to possible treatment changes; scores on most scales significantly changed, with an overall moderately strong effect size. Correlations with the BSI also indicated that personal problems were differentially related to symptomological experiences. In conjunction with the counselor ACL ratings, these data suggest that the information contained on the PPCA may allow one to draw wider, clinically relevant inferences about respondents. Future research may want to more closely examine how different patterns of responses on the PPCA may indicate specific clinical patterns relevant to both presenting problems and treatment selection. No doubt the PPCA is a brief, efficient, and clinically informative instrument that can help clinicians understand their clients and document the efficacy of their interventions.

Although the PPCA can be an important tool for client evaluation, there is no substitute for a comprehensive clinical assessment of a client. A multimodal, multidimensional assessment provides a thorough picture of a client's needs and motivations. There are three major areas that are measured in any comprehensive assessment plan: symptoms, personality, and psychosocial context. One of the first things to be addressed among persons presenting for treatment is the specific problem(s) they are confronting. Usually this takes the form of some array of presenting symptoms. It is important to know both the type and severity of these problems. Instruments such as the BSI are useful in garnering such information. Then it becomes necessary to learn more about the client themselves. What are their motivations? What psychological strengths do they possess that can be accessed during treatment and relied upon as therapeutic resources? What are their potential weaknesses and liabilities? Personality assessment can be useful for anticipating not only the course of treatment, but also the kinds of interventions that may be useful (see Miller, 1991; Piedmont, 1998). Finally, there is the psychosocial context. This aspect of assessment focuses on the quality of the the client's environment by identifying the specific problems in living that are operating as a result of the client's temperamental inclinations and symptomological distress. Psychosocial assessment, like that provided by the PPCA, can help the therapist to pinpoint the specific aspects of living that may need immediate clinical attention.

As noted earlier, the current health-care environment is restricting the frequency of such comprehensive assessments. Clinicians are now being forced to either reduce the scope of their measurement or find more efficient methods for gathering the information. The results of this report should provide some encouragement for the latter. Although initially intended as an intake device,

the PPCA seems to have some value beyond providing a mere description of a client's problems of living. These data show that an evaluation of an individual's psychosocial context carries with it larger potential psychological repercussions. As was shown here, the number and type of problems are very much linked to symptom experience. The descriptive data provided here can serve as a beginning foundation for constructing a useful normative sample for evaluating presenting complaints on the PPCA by outpatient clients. This information can potentially assist in diagnostic formulations.

Another potential value for the PPCA is as a treatment outcome measure. Clinicians are facing increasing pressure for providing greater accountability of the efficacy of their services. This pressure is coming from not only managed care, but from the growing consumer movement in this country (see Consumer Reports, 1995). Potential clients are now seeking reasonable guarantees that the treatments provided by their therapists will provide some relief of their symptoms. After all, it is their personal resources of time and money that are being invested in therapy, and they need to know that the product they are purchasing will do for them what it claims. As such, the need for practitioners to document therapeutic efficacy is growing. The medium through which such documentation can be compiled is clinical assessment. Through assessment clinicians can show in what ways and to what degree their interventions impact clients. The PPCA can be one such useful instrument to accomplish this. As was shown, the PPCA appears to be very sensitive to change experienced over the course of treatment. Significant declines in specific, personal problems were evidenced over the majority of content domains.

We are not recommending that the PPCA can take the place of a comprehensive assessment battery. Rather, as a brief, easy to administer and interpret instrument, it can have a useful place in clinical practice and research. The information contained in this report shows the potential value of the instrument for use both in diagnosis and in tracking the impact of treatment on client progress. Future research can help to establish better normative values for use in examining the level of psychosocial distress and for charting the rate and extent of improvement over treatment.

References

Anderson, D. F., & Berlant, J. L. (1994). Managed mental health and substance abuse services. In P. R. Kongstvedt (Ed.), *The managed health care handbook* (pp. 130-140). Gaithersburg, MD: Aspen.

Buckner, C. J., & Mandell, W. (1990). Risk factors for depressive symptomatology in a drug-using population. *American Journal of Public Health, 80*, 580-585.

Consumer Reports. (1995, November). Mental health: Does therapy help? 734-739.

Costa, P. T., Jr., & McCrae, R. R. (1992). *Revised NEO Personality Inventory: Professional manual*. Odessa, FL: Psychological Assessment Resources.

Dana, R. H., Conner, M. G., & Allen, J. (1996). Quality of care and cost-containment in managed mental health: Policy, education, research, advocacy. *Psychological Reports, 79*, 1395-1422.

Derogatis, L. R. (1993). *Brief Symptom Inventory, manual*. Minneapolis, MN: National Computer Systems.

Derogatis, L. R., Rickels, K., & Rock, A. (1976). The SCL-90 and the MMPI: A step in the validation of a new self-report scale. *British Journal of Psychiatry, 128*, 280-289.

Fee, Practice, and Managed Care Survey. (1995, January). *Psychotherapy Finances, 21*, 1-8.

Gough, H. G., & Heilbrun, A. B. (1983). *The Adjective Check List manual*. Palo Alto, CA: Consulting Psychologists Press.

Miller, T. (1991). The psychotherapeutic utility of the five-factor model of personality: A clinician's experience. *Journal of Personality Assessment, 57*, 415-433.

Perry, W., McDougal, A., & Viglione, D., Jr. (1995). A five-year follow-up on the temporal stability of the ego impairment index. *Journal of Personality Assessment, 64*, 112-118.

Piedmont, R. L. (1998). *The Revised NEO Personality Inventory: Clinical and research applications*. NY: Plenum Press.

Piedmont, R. L. (1999). *Cracking the plaster cast: Big Five personality change due to intensive outpatient counseling*. Manuscript submitted for publication.

Piedmont, R. L., & Ciarrocchi, J. W. (1999). The utility of the NEO PI-R in an outpatient, drug rehabilitation context. *Psychology of Addictive Behaviors, 13*, 213-226.

Piedmont, R. L., McCrae, R. R., & Costa, P. T., Jr. (1991). Adjective check list scales and the five-factor model. *Journal of Personality and Social Psychology, 60*, 630-637.

Piedmont, R. L., & Weinstein, H. P. (1993). A psychometric evaluation of the new NEO PI-R facet scales for Agreeableness and Conscientiousness. *Journal of Personality Assessment, 60*, 302-318.

Piotrowski, C., Belter, R. W., & Keller, J. W. (1998). The impact of "managed care" on the practice of psychological testing: Preliminary findings. *Journal of Personality Assessment, 70*, 441-447.

Power, E. J., & Eisenberg, J. M. (1998). Are we ready to use cost-effectiveness analysis in health care decision-making?: A health services research challenge for clinicians, patients, health care systems, and public policy. *Medical Care, 36* (Suppl. 5), MS10-MS17.

Royse, D., & Drude, K. (1984). Screening drug abuse clients with the Brief Symptom Inventory. *International Journal of Addictions, 19*, 849-857.

Schinka, J. A. (1985). *Personal Problems Checklist for Adults*. Odessa, FL: Psychological Assessment Resources.