A PILOT INVESTIGATION INTO THE EFFECTS OF AN INTERPERSONAL THERAPY APPROACH UPON MENTAL PATIENTS IN A GENERAL HOSPITAL SHORT-TERM PSYCHIATRIC SETTING

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John Richard Levee

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AN ABSTRACT OF A THESIS

Submitted to
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This study was concerned with investigating whether positive gains could be made by patients in a short-term psychiatric setting, by adding interpersonal therapy sessions to the regular hospital regimen. Differences were assessed by: (a) contrasting experimental- and control-group scores of each of the MMPI sub-scales using mean scale and profile analysis, and (b) sorting experimental- and control-group individual profiles into normal and abnormal categories according to Meehl's criteria and computing chi-square.

The study sample was composed of sixty-four patients in a general hospital psychiatric setting, randomly divided into an experimental group of fifteen male and sixteen female patients, and a control group of fifteen male and eighteen female patients. Experimental patients received two to three hours of interpersonal therapy a week administered by the investigator. Therapy was based on the triadic dimensions of Rhona Rapoport. Average period of hospitalization for all groups was from 17.2 to 25.5 days. One to two days before discharge individual MMPI's were administered to each patient of the study.

The t-test analysis of the MMPI sub-scales yielded no significant difference for experimental patients receiving

interpersonal therapy over control patients. Mean profiles of the experimental and control groups showed typical psychiatric patterns with primary elevations on the D, Sc, Pt, and Pd scales. A post hoc analysis of variance of the anxiety index (Ai) showed significantly higher male than female means, but independent of experimental effects.

Brief periods of hospitalization most likely limited the effectiveness of the interpersonal approach. Therapy with significant intimates of patients might enhance the effectiveness of this design.

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CHAPTER I

THE PROBLEM

In recent years there has been an increase in the number of theoretical approaches to psychotherapy. At the same time, little attempt has been made to measure patient "change" or modification empirically in relation to a particular therapeutic approach.

Statement of the Problem

It was the problem of this investigation to assess experimentally the influence of individual interpersonal therapy given to patients in a general hospital short-term psychiatric setting.

An attempt was made to determine whether gain could be brought about in experimental patients with the use of interpersonal therapy two to three hours a week during the period of hospitalization. The two to three interpersonal therapy sessions a week were added to the normal regimen of treatment by a psychiatrist several times a week.

Theory

A need exists for a theoretical approach to therapy which gives recognition of the patient as a personality

in conflict with the social environment from which he comes, and to which, hopefully, therapy will return him as a more adequate individual. Conceivably the more quickly therapy can be used before maladjustment becomes strongly reinforced and generalized, the less the need for extensive or intensified treatment. In like manner, if keeping the patient in close proximity to his community during early treatment can be of value, the anguish experienced by patient and family will be less. Perhaps wasted man-hours and private or community costs for treatment can be reduced also.

For this study a basic assumption was that the approach of therapy given to the patient while in the hospital should be such that it best meets the needs of his interpersonal and community relationships. Throughout the study the theoretical approaches of interpersonal therapy based upon Sullivan,[1] Ackerman,[2] and Rapoport[3] are used because it appears that their approaches are consistent and complementary to the patient's needs in a social context. A basic assumption was made that Rapoport's interpersonal approach to therapy would be most consistent with the philosophy and context of the psychiatric setting, and would best meet the general needs of most patients admitted to a general hospital

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[1]Harry S. Sullivan, The Interpersonal Theory of Psychiatry (New York: W. W. Norton & Co., 1953).

[2]Nathan W. Ackerman, "The Development of Family Psychotherapy," International Mental Health Research Newsletter, Postgraduate Center for Psychotherapy, Vol. 3, June 1961, pp. 1-16.

[3]Rhona Rapoport, "The Family and Psychiatric Treatment," Psychiatry, Vol. 23, 1960, pp. 53-62.

psychiatric unit for short-term hospitalization.

It was further assumed that the sub-scale scores of the Minnesota Multiphasic Personality Inventory would serve as a measure of the influence of the interpersonal therapy on patient gain.

Definitions

Two important concepts need definition for purposes of clarifying and communicating the research procedures.

Therapy

The present study was built upon Rapoport's conceptual framework of analysis of family-patient conflicts and adjustment.[1] Within this conceptual framework, Rapoport proposes that the total relationship between patient and significant intimates determines role performances and failures. Three major dimensions of role strength and strain are postulated by Rapoport as important areas of study:

1. The degree of compatibility between the norms of the family and patient concerning the nature and importance of roles gives clues to disagreements that exist within a family system.

2. The degree of compatibility of interacting systems of each family member reflects the psychological and personality needs that exist for each person within that family.

3. The emotional tone which is established by the interaction of people living together suggests the type of

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[1] Ibid.

interaction which gradually dominates the life of each member.

The degree to which norms are compatible between patient and family, Rapoport proposes, determines the amount of harmony or strain in assuming roles. Personality systems, likewise, may be so structured that the way one family member seeks gratification or handles tensions and frustrations may affect adversely how another member attempts to do so. Emotional tones in any relationship may have many variations, and be complex. Thus compatibility of norms and structures of personality systems are changed in response to sustained interaction.

Improvement and Recovery

Improvement and recovery were predetermined in this study. Improvement may be considered to be on a continuum between the extremes of sickness and recovery. Psychiatrically, improvement is considered a sufficient base line to determine patient discharge. For the general purposes of this study then, improvement is best defined as the psychiatric judgment that a patient has attained sufficient reality orientation, emotional stability and insight to allow him a suitable degree of self-direction in adjusting outside the immediate hospital setting and relating adequately in interpersonal and community relationships.

It was hoped that for the experimental patients used in the present study, improvement in part, would consist in the patient's gaining insight into major difficulties of role performance. The psychiatrist's judgment of the degree

of recovery was, in the last analysis, the main criterion of discharge. The decision was based on: (1) the progress of the psychiatrist's own treatment and interviews with patient and family or friends, (2) perusal of progress notes and nurses' reports, and (3) consultation with the interpersonal therapist. MMPI's were not used in making discharge decisions.

The Hypothesis

It was hypothesized that the experimental patients who received interpersonal therapy during hospitalization, as a group, would score closer to the "normal" on the MMPI scales than would control patients who did not receive interpersonal therapy. In particular it was assumed that for this hospital population the F (response conformity), D (Depression), Pt (Psychasthenia), Sc (Schizophrenia), Si (Social Introversion), and Ai (Anxiety Index) scales of the MMPI would be the most sensitive to change influenced by interpersonal therapy.

Statement of the Research Hypothesis

> Greater improvement and adjustment in mental patients in short-term psychiatric treatment is expected from those who receive individual therapy, based upon interpersonal theory, than in those patients who do not receive such therapy, as measured by scores on the MMPI scales.

The overall plan of the dissertation is as follows: In Chapter II studies on assessment of the effects of therapy are reviewed; in Chapter III the methodology and sample selection procedure of the design are presented; in Chapter IV the analysis of the data was given, while in Chapter V, an interpretation and discussion of results are presented. In Chapter VI a summary, conclusions, and implications for further research are found.

CHAPTER II

REVIEW OF THE LITERATURE

Most schools of therapy have as a goal the bringing of some amount of insight to a client concerning his problems, and modifying his behavior directly or indirectly for more adequate social adjustment. Needless to say, it is the hope that any treatment procedure will assist patients to make dynamic gains in a positive direction. Difficulties in effectuating this positive gain are often made complex by a multiplicity of variables that handicap any assessment of progress in therapy. Perhaps influenced by these difficulties, there are those who have claimed that psychotherapy has no effects on patient gain or may even have negative results.

Controversy on the Effects of Therapy

Eysenck, in an extensive study of psychotherapy effects with psychoneurotics, reports on the ". . . results of nineteen studies reported in the literature, covering over seven thousand cases, and dealing with both psychoanalytic and eclectic types of treatment."[1] Patients receiving therapy were compared with patients presumably recovered

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[1]H. J. Eysenck, "The Effects of Psychotherapy: An Evaluation," Journal of Consulting Psychology, Vol. 16, 1952, p. 320.

without benefit of such therapy. Eysenck's conclusion was that the figures fail to support the hypothesis that psychotherapy aids in the recovery of psychoneurotic patients to any significant degree. He states:

> Patients treated by means of psychoanalysis improve to the extent of 44 per cent; patients treated eclectically improve to the extent of 64 per cent; patients treated only custodially or by general practitioners improve on the extent of 72 per cent. There thus appears to be an inverse correlation between recovery and psychotherapy; the more psychotherapy the smaller the recovery rate.[1]

Eysenck built his research and findings upon previous studies done by Landis and Denker.[2] Denker's earlier research was upon the outcome and related effect of therapy of several different disciplines. He studied 500 consecutive psychoneurotic disability cases treated by general practitioners and a comparable group of patients treated by psychiatrists or psychoanalysts. Denker's conclusions were that no significant differences of therapeutic success were found among patients treated by general practitioner, psychiatrist, and psychoanalyst.

Wheeler, White, et al., did a twenty-year follow-up study of 173 patients diagnosed as being neurocirculatory asthenics (anxiety neurosis, effort syndrome, and neurasthenia).[3] These patients were compared for like

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[1] Ibid., p. 322.

[2] Ibid.

[3] N. S. Lehrman, "The Potency of Psychotherapy," Journal of Clinical and Experimental Psychopathology, Vol. 22, June 1961, pp. 106-111.

periods of time to groups of similarly diagnosed patients treated by psychotherapists and psychoanalysts. Wheeler's conclusion was that no significantly better results were obtained by psychotherapy than were obtained by a practitioner's giving simple reassurance and allowing for the passage of time.

Wheeler emphasizes that even if significant differences were found among the studied groups, an evaluation that one treatment is better than another is not warranted because treatment procedures were not identical. One might question also the differences in clientele which would lead them to choose psychotherapist, psychoanalyst, or practitioner. The use of chemotherapy in medical treatment of patients may also be considered an important variable influencing outcomes.

Critics of studies that question the values of therapy have been many.

Rosenzweig's criticism of Eysenck's research is probably among the most pointed.[1] Among Rosenzweig's allegations are: (1) misuse of population figures and overgeneralization of statistical results, (2) insufficient comparability of clientele, and (3) lack of definitions of what constitutes psychoneurosis, psychotherapy, and recovery for patients treated in different professional settings. About the psychoanalytic or eclectic approach used in Eysenck's study, Rosenzweig comments that 80 per cent of the experimental groups

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[1]Saul Rosenzweig, "A Transvaluation of Psychotherapy: A Reply to Hans Eysenck," Journal of Abnormal Social Psychology, Vol. 49, 1954, pp. 298-304.

were treated by methods which vary between the eclectic psychiatrist and general practitioner only in degree of expertise, and not in kind.

> To undertake an evaluation of the effects of psychotherapy by tallying outcomes at second hand, without even introducing the problem of dynamic change in various forms of illness and in varying therapeutic procedures, and, in default of such considerations, to reassign diagnoses and prognoses is to invite . . . inconsistencies and non sequiturs.[1]

Importance of Objectivity and Comparability

Notwithstanding some of the inadequacies, Eysenck took a knowledgeable stand upon the necessity for actuarial studies by first initiating what Landis called a base line and common unit of study. Too often the base line has been the physician's subjective judgment of patient progress, led on quite unempirically by the patient's report of how he is "feeling." Patient introspection, used in the best tradition of general medical practice, is allowed to contaminate what otherwise might be a more objective personality assessment.

Lehrman[2] offers the suggestion that therapy may in fact accentuate the extremes of patient population, and while some patients may be helped by therapy, others may in fact be harmed by it. This line of reasoning is

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[1] Ibid., p. 303.

[2] N. S. Lehrman, "The Potency of Psychotherapy," Journal of Clinical and Experimental Psychopathology, Vol. 22, June, 1961, pp. 106-111.

consistent with Cartwright's[1] comment on the studies done by Barron[2] at the Kaiser Foundation Hospital, Oakland, California, with patients in both group and individual therapy using waiting-list patient control groups. Cartwright concludes that the S D's of MMPI scales used to assess change suggest that some of the therapy-group patients had more deterioration during therapy than waiting-list controls. If this be the case, therapeutic failure must be reckoned with as a potential hazard, and ways of predetermining this possibility are a professional responsibility not lightly to be dismissed.

Need to Assess Systematic Change

Too often change in psychotherapy is estimated in an unsystematic or haphazard way. Barron comments upon the unempirical attitude often present in biased evaluations of change in psychotherapy:

> To say that a remission is spontaneous, . . . is generally to make a confession of ignorance; what we mean is that a change occurred for reasons we do not understand. When a change in a psychic state of a patient has occurred concurrently with the application of psychotherapy, we usually feel that we do understand the causes of the change. Unless, however, we are certain that there is a significant increment in the recovery rate when psychotherapy is applied, we may be deceived in attributing the changes we have observed to the psychotherapeutic forces we think we have applied. Hence the

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[1]D. S. Cartwright, "Note on 'Changes in Psychoneurotic Patients with and without Psychotherapy,'" Journal of Consulting Psychology, Vol. 20, 1956, pp. 403-404.

[2]Frank Barron and Timothy F. Leary, "Changes in Psychoneurotic Patients with and without Psychotherapy," Journal of Consulting Psychology, Vol. 19, 1955, pp. 239-245.

importance of research into psychological change under systematically varied conditions.[1]

Schofield and Briggs[2] suggest that a large part of the inadequacies of therapy evaluation may be related to the circumstances that many studies are done on out-patients not available for consistent and frequent evaluation observation. In contrast, one might hope that in-patient studies should supply the adequacy of observation that these out-patient group studies lack. But the literature reveals such a hope to be short-lived, again because of employment of a loose-knit and inconsistent base line of improvement judgments, and the lack of vigorous comparability between experimental and control group patients (if control groups are used at all).

Criteria of Improvement

Schofield and Briggs[3] investigated the problem of patient improvement resulting from hospitalization. Three sets of data were used in assessing a patient's immediate response in a therapy situation, and one measure of long-term response. Immediate response was assessed by: (1) changes in the MMPI during hospitalization, (2) daily ratings by nurses during hospitalization period, and (3)

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[1] Ibid., p. 239.

[2] William Schofield and Peter F. Briggs, "Criteria of Therapeutic Response in Hospitalized Psychiatric Patients," Journal of Clinical Psychology, Vol. 14, 1958, pp. 227-232.

[3] Ibid.

psychiatrists' clinical evaluation of condition on discharge. The long term criterion was rehospitalization with the follow-up median per patient 5.3 years.

In a sample of 100 heterogeneous hospitalized psychiatric patients treated at the University of Minnesota hospitals for a period of not less than 30, nor more than 75 days, 31 per cent of the total samplewere rehospitalized. With rehospitalization or non-rehospitalization as a criterion, post-therapy clinical judgments had an overall "hit" rate of 72 per cent as against a judgment of 62 per cent on the basis of MMPI change. Psychiatrists' ratings were concluded to give better prediction than the MMPI.

Goals of Therapy and Patient Attitudes

Among the variables that may well influence comparability of results between different psychotherapy approaches are frequency of therapy and goals of therapists. Michaux and Lorr[1] attempted to study these two factors as they interrelate. They used a sample of 133 male outpatients who had completed four months of therapy at seven Veterans Administration Mental Hygiene Clinics. Sixty-nine therapists were involved: 20 psychiatrists, 27 clinical psychologists, and 22 social workers. After initial interviews with patients, each therapist was asked to state treatment goals for the next four months. Goals were fitted to a schema of Reconstructive, Supportive, and Relationship therapies.

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[1]William W. Michaux and Maurice Lorr, "Psychotherapists' Treatment Goals," Journal of Counseling Psychology, Vol. 8, 1961, pp. 250-254.

Reconstructive therapy was defined as "personality change or modification with insight"; Supportive therapy was defined as "maintaining or strengthening current adjustment"; Relationship therapy was defined as "facilitating patient's adjustment within the therapeutic relationship by focusing on his involvement in treatment." A fourth category was formulated to which was assigned "mixed, deferred, or vaguely formulated goals."[1] The results showed that reconstructive goals were not as frequent as might be expected for twice-weekly patients, but more frequent for bi-weekly patients. Therapists rated patients after their first interview on the basis of severity of illness with scales measuring symptom distress, suspiciousness, resentment of authority, withdrawal, reality distortion, lack of impulse control, and self-preoccupation. Conclusions were that the kind of treatment did not appear to have any significant or systematic effect in changes occurring in patients.

Hecht and Kroeber[2] attempted to assess patients' attitudes toward treatment in a short-term therapy situation and suggest that personality attributes established by patients over an extended time before therapy may well interfere with goals of therapy set up by therapists, so that evaluation of change as the result of therapy is quite difficult.

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[1]Ibid., p. 250.

[2]Shirley Hecht and T. C. Kroeber, "A Study in Prediction of Attitudes of Patients Towards Brief Psychotherapy," American Psychologist, Vol. 10, 1955, p. 340.

Varied Treatment and Measures of Change

Simon et al.[1] did an ambitious and extensive study upon the short-term differential treatment of schizophrenics. They took schizophrenics admitted to the Minneapolis V. A. Hospital and matched the patients into four treatment groups, randomized, with 20 patients to each group, as follows: clinicial judgment group, chlorpromazine group, reserpine group, and hospital routine group. The clinical judgment group was made up of patients receiving any therapy approach that was judged appropriate for the individual case, and used EST, insulin coma therapy, psychotherapy, and a variety and combination of drugs.

The hospital group was given no treatment other than hospitalization. Other groups were given only chlorpromazine and reserpine. All groups participated in all other daily routines and special servicing provided by the hospital. For all groups extended use was made of social history, occupational adjustment ratings, and psychometrics, which included the MMPI. Improvement scales were used for assessment of each patient.

As indicated by the clinical improvement scale, behavior ratings, and the MMPI, Simon et al. found that the clinical judgment group was the most improved after 30 days. On the MMPI change was indicated by a lowering in elevation on the F scale, Hs, D, Hy, Pa, Pt, Sc, and Si

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[1]Werner Simon et al., "A Controlled Study of the Short-Term Differential Treatment of Schizophrenia," American Journal of Psychiatry, Vol. 144, 1958, pp. 1077-1085.

scales, while no significant difference was found on Pd, Mf, or Ma scales. The average elevations of profiles were not considered schizophrenic in type. The chlorpromazine groups showed some improvement on the MMPI, but not as much as did the clinical judgment group. The only major change was on the Pa scale, although the average profile was still schizophrenic. The reserpine group showed little change over admission profile. A decreased Si scale on the MMPI indicated improved social comfort, but with the average profile still schizophrenic. The hospital routine group showed no significant change on behavior ratings of MMPI profiles.

The authors feel that future extensions of their study will determine the longer range responses of patients to the treatment procedures used.

> Our findings suggest that regardless of the type of treatment given, some factors are more indicative of prognosis than others. These confirm earlier reports that rapid onset with short duration is prognostically favorable, as is a good former occupational adjustment, and that those patients with sufficient ego strength to act out in their environment appear to have a better treatment probability than those who react with withdrawal and conformity. Furthermore, in our study, those patients whose early life was beset by hostile and rejecting fathers are least likely to recover, while those with mothers who, though inconsistent in their training methods, were nonetheless sources of protection and strength, have favorable prognoses. However, for this short period of time, many factors long believed to be prognostic do not have value.
>
> Finally, we find some consistency in our data. The patients who improve show the improvement in many aspects; in psychometric tests, in ward behavior, and in clinical interview; while those who remain most schizophrenic fail to show demonstrable improvement in any of these areas.[1]

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[1] Ibid., p. 1084.

Kaufmann[1] has done notable research in studying MMPI changes as a function of therapy. Fifty-one students in the neuropsychiatric service of the University of Wisconsin were studied; 34 of the students were diagnosed as "anxiety tension state," with the remaining distributed among various diagnostic groupings. The students studied, all rated by their therapists as improved, were given pre- and post-therapy MMPI's, along with a comparable group of non-therapy students. The results show that the therapy students obtained higher mean scores on every scale except the K scale. For female students the Mf scale also was elevated. The D, Pt, and Sc scales were found to be the most sensitive to and discriminative of change. The Pt scale correlated highly with the Sc scale as effective in differentiating psychiatric patients. The Hs scale, and the Mf scale with females, showed the same discriminating tendency, but to a lesser extent than D, Pt, and Sc. The F scale showed some modification as a function of therapy and was able to discriminate effectively between control and patient groups; whereas, the Hy and Pd scales showed differences of groups from pre- to post-test. Kaufmann concludes that both the Pa and Ma scales served no value in this study. There were no significant changes of pre- to post-test scores in the control group, with the exception of the K scale.

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[1]Peter Kaufmann, "Changes in the Minnesota Multiphasic Personality Inventory as a Function of Psychiatric Therapy," Journal of Consulting Psychology, Vol. 14, 1950, pp. 458-464.

Taulbee and Sisson[1] employed a technique of configurational analysis similar to Sullivan and Welsh,[2] applying the technique to 210 MMPI profiles for the purpose of testing the usefulness of this method in differentiating, diagnostically and psychodynamically, schizophrenic and psychoneurotic patients. The profiles were obtained from two groups of schizophrenics and three groups of neurotics. Interpreting in terms of psychodynamics the authors explain:

> The Sc and Pa scales reflect the greater disturbance in thought processes, more of a tendency to distort and, in general, the more precarious reality contact of the schizophrenic patients. These patients are attempting to alleviate their anxiety by such defenses as projection (Pa) and hyperactivity (Ma), as contrasted to the neurotics' greater use of vague somatic complaints, repression and obsessive-compulsive behavior (Hs, Hy, and Pt) is consistent with the generally accepted view that they tend to be more hostile, asocial, suspicious, impulsive, and less bothered by feelings of anxiety, self-doubt, and less able to show guilt or regret than neurotics. Also, the schizophrenics have stronger feelings of family and social alienation and rejection. The neurotics conflict usually takes place with himself whereas the schizophrenic, because of ego's weaker ties with the external world, is more rebellious against conventional practices and expresses many of the emotions, especially hostility, more openly than does the neurotic. The significance of the Mf and Pd scales in the scale pairs may be the schizophrenic's relatively less adequate identification with the cultural norm of masculinity and greater disregard for conventional behavior in general. . . . It is often very difficult to differentiate, on the basis of the MMPI, the acute paranoid schizophrenic from the hospitalized neurotic. This is true because a defensive patient may keep his Pa score well within normal limits and

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[1]Earl S. Taulbee and Boyd D. Sisson, "Configurational Analysis of MMPI Profiles of Psychiatric Groups," Journal of Consulting Psychology, Vol. 21, 1957, pp. 413-417.

[2]P. L. Sullivan and G. S. Welsh, "A Technique for Objective Configural Analysis of MMPI Profiles," Journal of Consulting Psychology, Vol. 16, 1952, pp. 383-388.

> also because undue sensitivity and feelings of persecution may be present in many neurotics.[1]

From the results Taulbee and Sisson conclude that the configurational analysis method yields an effective means of differentiating schizophrenic from psychoneurotic patients, of evaluating behavior processes of patients, and assisting in detailing for differential diagnosis.

Garfield and Sineps[2] applied this same configurational approach of Taulbee and Sisson to 129 patients in different diagnostic categories. Their results yielded many false positives occurring particularly with those scales pointed out by Taulbee and Sisson as discriminative of schizophrenia. They suggest, therefore, that the configurational method would yield more incorrect and indeterminate diagnoses than accurate ones. They state that the comparability of groups for both studies was difficult to control and so express the need for great caution in the use of the method diagnostically. When applied to unselected samples in a clinical situation Garfield and Sineps conclude that the configurational method holds little promise of discriminative power.

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[1]Earl L. Taulbee and Boyd D. Sisson, "Configurational Analysis of MMPI Profiles of Psychiatric Groups," Journal of Consulting Psychology, Vol. 21, 1957, pp. 413-417.

[2]S. L. Garfield and J. Sineps, "An Appraisal of Taulbee and Sisson's 'Configurational Analysis of MMPI Profiles of Psychiatric Groups,'" Journal of Consulting Psychology, Vol. 23, 1959, pp. 333-335.

Social Context as a Function of Therapy

If the type of therapy and treatment are important functions of patient improvement, so too is the social context from which the patient comes and to which he returns. Sullivan, and more recently Ackerman[1] have stressed the importance of family constellations and interaction as they relate to patient stress and recovery. Ackerman further urges the need to extend principles of diagnosis into diagnosis of families "analogous to the vocabulary standards for the description of individuals."[2] Ackerman comments that need exists to understand better the sources of both illness and health in the family unit. Important too, is the need to study verbal and non-verbal communication as it relates to the emotional health of the family group. Expectations of the family, particularly parents, have been shown to have important bearings upon levels of aspiration, and feelings of success or failure.[3] Current social work approaches attempt to study family problems as related to mutual adjustments when a patient is released from the hospital.[4,5]

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[1]Nathan W. Ackerman, "The Development of Family Psychotherapy," International Mental Health Research Newsletter, Postgraduate Center for Psychotherapy, Vol. 3, June 1961, pp. 1-16.

[2]Ibid., p. 16.

[3]D. McClelland, et al., The Achievement Motive (New York: Appleton-Century-Crofts, 1953).

[4]Howard E. Freeman and O. G. Simons, "Mental Patients in the Community: Family Settings and Performance Levels," American Sociological Review, Vol. 23, April, 1958, pp. 147-154.

[5]_____, "The Social Interpretation of Former Mental Patients," International Journal of Social Psychiatry, Vol. 6, Spring 1959, pp. 264-271.

Rapoport suggests that it may be increasingly appropriate to treat the entire family from which a patient comes, as a unit.[1] Disorders in a patient may be influenced by significant relationships which are continued in therapy by the patient. Such a conceptual framework has been studied in detail at the Social Rehabilitation Unit of Belmont Hospital, England. Therapy at Belmont Hospital is approached in terms of role failure difficulties which are examined in a context of familial position, personal and social norms, and personality resulting from an accumulation of life roles. Each role relationship is further analyzed into: (1) "fit" between norms of patient and intimates, (2) "fit" between personality systems of each family member interacting with the other, and (3) the emotional tone which is developed over a period of time in close relationships and which comes to characterize the major way of reaction to this relationship.

Kohn and Prestwood[2] report the results of group therapy sessions conducted with families of schizophrenic patients prior to release from hospitalization. Family therapy sessions were found useful in increasing family acceptance of patients returning home, and easing the strain of adjustment for patient and family members alike. Freeman

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[1]Rhona Rapoport, "The Family and Psychiatric Treatment," Psychiatry, Vol. 23, 1960, pp. 53-62.

[2]Shirley Kohn and A. R. Prestwood, "Group Therapy of Patients as an Adjunct to the Treatment of Schizophrenic Patients," Psychiatry, Vol. 17, 1954, pp. 177-185.

and Simmons[1] believe that a patient's position in the family and relatives' commitments to dominant values in the society, determine in large measure the amount of acceptance and tolerance of atypical behavior.

Summary

It has been suggested in this chapter that any effective therapy must contend with a multiplicity of variables if it is to make appropriate assessment of change. Efforts to make controlled studies have become more complex because of such variables as patient dynamics, population selection, clinical settings, ancillary treatment procedures, criteria of improvement, goals of therapy, and different measures of change, to mention but a few. Then too, variability exists from patient to patient because of the constantly unique and shifting needs of an individual coming from highly conditioned social settings with complex roles and expectations. An increasing awareness of the shaping influence upon a patient of societal "role expectations" have given greater dimensions to therapy, and greater burdens for research.

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[1]Howard E. Freeman and O. G. Simmons, "Mental Patients in the Community: Family Settings and Performance Levels," American Sociological Review, Vol. 23, April 1958, pp. 147-154.

CHAPTER III

DESIGN AND METHODOLOGY

In this chapter will be described the setting in which the study was done, the type of patients used, and the means by which change is measured.

Psychiatric Setting

First admission patients to the psychiatric unit of St. Lawrence Hospital, Lansing, Michigan, between November, 1961, and March, 1962, were used in this experimental design. The unit had a 35-bed capacity and normally administers to both adult male and adult female patients. Although a sectarian hospital, there is no discrimination on the basis of religious preference.

Many patients are admitted to the psychiatric unit under crisis conditions, such as occur in metropolitan areas, e.g., police apprehension, suicides, overt psychotic episodes. Unlike the public or private mental hospital, the goals and approach of this hospital unit differ. The goal is to restore a degree of stability to the patient by means of "crisis-therapy." Essentially the philosophy of the unit is that patients have much to gain if hospitalization is given as soon as stress is incapacitating. The approach is predominately supportive, i.e., relief of stress, temporary gratification of passive-dependent needs, setting time limits to acting out, specific physiological helps such as rest, diet,

medication, and EST, and by environmental manipulation. Unlike traditional mental hospitals, the milieu is open-ward in make-up. Attempts are made to impart to the patient the attitude that he is still close to the community to which he is to return as soon as medically feasible. An atmosphere of locked doors and barred windows is almost non-existent. There is a continual striving to convey to the patient the attitude that being a patient in this unit has no stigma attached to it, and that he is treated with the same respect and consideration as is given to patients on the medical wards of the hospital.

In addition to ward activities, patients are encouraged to have visitors, take part in community activities, and have holiday and weekend leaves whenever such activity is judged to contribute to treatment and recovery.

Experimental and Control Groups

At the time of admission to the unit, intake patients of the study were assigned to experimental and control-group rosters made up on an odd-even number basis by use of a table of random numbers. All patients were given psychiatric examination immediately after admission. In the course of hospitalization experimental group patients were then given individual therapy sessions of from two to three hours per week within the functional limits of the hospital schedule.

Research Procedures

An interpersonal therapy approach, based upon the triadic dimensions of Rapoport, was used because it was considered to be consistent and complementary to the above philosophy

of treatment.[1] Interpersonal therapy[2] was done by the writer, who is a doctoral candidate in educational psychology at Michigan State University, with a master's degree in clinical psychology and approximately three years' supervised therapy experience in general hospital psychiatric settings. All therapy was given under the supervision of three psychiatrists. A number of clinical judgment treatments were administered routinely and include the use of EST, drug therapy, and periodic interviews by treating psychiatrists. Other servicing of the hospital, such as psychiatric social service and occupational therapy, were available equally to all patients. Control-group patients received the treatment and had services available to them as above, with the exception of the interpersonal therapy sessions of the design. At such time as the treating psychiatrist judged that each patient was sufficiently improved to be discharged (see definition of improvement and recovery, page 4), the booklet-form of the MMPI was administered to each patient of both the experimental and the control groups.

Instrumentation

MMPI scores for all scales were obtained for each patient by use of Friden scoring methods.[3] Profiles for each

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[1]Rhona Rapoport, "The Family and Psychiatric Treatment," Psychiatry, Vol. 23, 1960, pp. 53-62.

[2]A summary of an individual case used in the study is presented in Appendix B, p. 58.

[3]MMPI raw scores for total sample groups can be found in the Appendix A, pages 54-57.

patient tested were obtained. Group profiles, male and female, for both the experimental and control groups were obtained by averaging the individual profiles of patients of each group. Welsh's anxiety index[1] also was computed for all patients, using T-scores rather than raw scores. The formula from which the anxiety index was computed is:

$$\frac{(Hs + D + Hy)}{3} + ((D + Pt) - (Hs + Hy)).$$

This formula averages the dimensions of hypochondriasis (Hs), depression (D), psychasthenia (Pt), and hysteria (Hy), to yield a measure of anxiety.

MMPI scales were sorted into normal and abnormal groups on the basis of Meehl's criteria for abnormality.

> Profiles were called abnormal under the following four conditions: 1. Any of the eight components showed T equal to or greater than 90. 2. Any of the eight components showed T equal to or greater than 80, unless K was less than 40. 3. Any of the eight components showed T equal to or greater than 70, unless K was less than 50 and L less than 60. 4. Any of the eight components showed T equal to or greater than 65, unless K was less than 65 and L less than 60.[2]

The above criteria were used for the ten clinical scales of the present study. In Table 4.3 can be found the number of normal and abnormal profiles for each sample group.

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[1]George S. Welsh and W. G. Dahlstrom, Basic Readings on the MMPI in Psychology and Medicine (Minneapolis: University of Minnesota Press, 1956).

[2]Paul E. Meehl, "Profile Analysis of the MMPI in Differential Diagnosis," Journal of Applied Psychology, 30:5 (October, 1946), p. 518.

Chi-squares were computed on the normal-abnormal groups to test whether a greater number of normal profiles could be found in the experimental groups than in the control groups.

Samples

The sexes were analyzed separately for both experimental and control groups.

Male Experimental Group

The male experimental group was comprised of 15 male patients ranging in age from 17 to 60 years, with a mean age of 40.0 years, and an average educational level of 10.0 years. Of the male experimental group, three were single, nine married, and three divorced. Psychiatrists' diagnoses of the group were eight psychotics, five psychoneurotics, and two personality disorders (see Table 3.1, page 27, for diagnostic detailing). This group was hospitalized for an average of 23.0 days and seen in therapy two to three hours a week.

Male Control Group

The male control group was comprised of 15 male patients ranging in age from 18 to 60 years, with a mean age of 33.0 years, and an average educational level of 11.1 years. Of the male control group, five were single and ten were married. Psychiatrists' diagnoses of the group were five psychotics, five psychoneurotics, and five personality disorders (see Table 3.1, page 27, for diagnostic

TABLE 3.1

PSYCHIATRIC DIAGNOSTIC CATEGORY FREQUENCIES FOR EXPERIMENTAL AND CONTROL SAMPLES

Categories	Male		Female	
	Experimental	Control	Experimental	Control
Psychotic				
Depressive reaction			1	1
Schizophrenic reaction				
simple type	1			
paranoid type	1	1		
schizo-affective type	1			
undifferentiated (acute)	4	4	6	7
with alcoholism	1			
N	8	5	7	8
Psychoneurotic				
Anxiety reaction			1	2
Dissociative reaction			1	
Conversion reaction				1
Obsessive compulsive	1			
Depressive reaction	2	2	3	1
With alcoholism	1		1	
Other	1	3	2	3
N	5	5	8	7
Personality Disorder				
Inadequate		1		
Emotionally unstable			1	
Passive-aggressive		1		
Dissocial reaction		1		
Transient situational	1	1		
With alcoholism		1		
Undifferentiated	1			3
N	2	5	1	3
Group N	15	15	16	18

detailing). The male control group was hospitalized for an average of 17.2 days and had no interpersonal therapy.

TABLE 3.2

AVERAGE NUMBER OF DAYS OF HOSPITALIZATION FOR EXPERIMENTAL AND CONTROL GROUPS

Male		Female	
Experimental	Control	Experimental	Control
23.0	17.2	19.4	25.5

Female Experimental Group

The female experimental group was composed of 16 female patients ranging in age from 16 to 57 years, with a mean age of 35.0 years, and an average educational level of 11.2 years. Of the female experimental groups, two were single, ten were married, two divorced, and two widowed. Psychiatrists' diagnoses of the group were seven psychotics, eight psychoneurotics, and one personality disorder (see Table 3.1, page 27, for diagnostic detailing). The group was hospitalized for an average of 19.4 days and seen in interpersonal therapy two to three hours a week.

Female Control Group

The female control group was composed of 18 female patients ranging in age from 21 to 51 years of age with a mean age of 35.4 years and an average educational level of 11.5 years. Of the female control group, four were single, 11 were married, two divorced, and one widowed. Psychiatrists' diagnoses of the group were eight psychotics, seven psychoneurotics, and three personality disorders (see Table 3.1, page 27, for diagnostic detailing). The female group

TABLE 3.3

AGE, EDUCATIONAL, AND MARITAL DATA FOR EXPERIMENTAL AND CONTROL GROUPS

	Male		Female	
	Experimental	Control	Experimental	Control
Mean Age (years)	40.0	33.0	35.0	35.4
Mean Education Level (years)	10.0	11.1	11.2	11.5
Marital Status				
Single	3	5	2	4
Married	9	10	10	11
Divorced	3	0	2	2
Widowed	0	0	2	1

was hospitalized for an average of 25.5 days and had no interpersonal therapy.

Hypothesis

It was hypothesized that experimental raw-score means on the F, D, Pt, Sc, Si, and Ai scales would be significantly lower (.05 level) than control group raw-score means on these same scales. It was also hypothesized that chi-square for the normal-abnormal sorts of MMPI profiles would yield a significantly higher (.05 level) number of normals for the experimental groups as compared to control groups.

Design Limitations

Within the design of this study are incorporated randomization and control elements. However, because of functional limitations, replication was not included to complete the three basic elements of modern experimental design. For this reason, estimates of stability error could not be made and the study was designated as exploratory. The major compounding error was the use of only one therapist.

Summary

The sample used in this study was first admission patients to the psychiatric unit of St. Lawrence Hospital, Lansing, Michigan. Fifteen experimental male patients and 15 control male patients, 16 experimental female patients and 18 control female patients constituted the various subsamples of the study. Interpersonal therapy, based upon Rapoport's approach, was used with experimental patients because it appeared to be consistent with the philosophy of the hospital psychiatric treatment. MMPI's were given to all patients to assess whether differences in personality dimensions occurred in experimental patients influenced by the interpersonal therapy given them.

CHAPTER IV

ANALYSIS OF THE DATA

The criterion of gain in the present study was based upon MMPI evaluations. The analysis was conducted by: (a) contrasting the experimental- and control-group means of each of the MMPI sub-scales, and (b) classifying individual MMPI profiles of experimental and control patients into normal and abnormal categories.

Mean Scale Analysis

The research hypothesis, as stated previously, is:

> Greater improvement and adjustment in mental patients in short-term psychiatric treatment is expected from those who receive individual therapy, based upon interpersonal theory, than in those patients who do not receive such therapy, as measured by scores on the MMPI scales.

In particular, it was hypothesized that the experimental-group raw score means on the F, D, Pt, Sc, Si, and Ai scales would be significantly lower (.05 level) than the control-group raw score means on these same sub-scales. This lowering of experimental sub-scale means to approach "normal" means would thus reflect positive gain in therapy.

The means and standard deviations were computed for each scale of the MMPI for female control and experimental groups, and male control and experimental groups. Welsh's[1]

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[1]George S. Welsh and W. G. Dahlstrom, Basic Readings on the MMPI in Psychology and Medicine (Minneapolis: University of Minnesota Press, 1956).

TABLE 4.1

STUDENT "T" TESTS OF MEAN DIFFERENCES OF MMPI SUB-SCALES FOR THE MALE EXPERIMENTAL AND CONTROL GROUPS

Scale	Experimental N 15		Control N 15		S.E. of the Difference	d.f. 28 t
	Mean	S.D.	Mean	S.D.		
L	4.47	2.09	3.73	2.52	.267	2.77
F	8.00	5.09	8.00	4.26	--	--
K	11.60	4.03	11.20	6.16	1.902	.21
Hs	16.40	5.17	13.33	5.08	1.871	1.64
D	24.87	6.64	24.60	5.48	2.220	.12
Hy	23.67	5.05	21.87	4.76	1.797	1.01
Pd	26.53	3.83	23.87	5.48	1.726	1.54
Mf	25.20	4.24	24.13	2.90	1.328	.81
Pa	13.00	3.70	13.13	3.11	1.293	-.10
Pt	31.06	6.37	30.34	5.27	2.136	.34
Sc	31.13	9.33	30.53	6.34	3.015	.20
Ma	20.87	5.08	19.93	3.90	1.654	.57
Si	31.27	13.63	31.93	10.27	4.409	-.01
Ai*	74.76	27.21	77.60	17.62	7.367	-.34

* Based on Welsh's formula (T-scores).

TABLE 4.2

STUDENT "T" TESTS OF MEAN DIFFERENCES OF MMPI SUB-SCALES FOR THE FEMALE EXPERIMENTAL AND CONTROL GROUPS

Scale	Experimental N 16		Control N 18		S. E. of the Difference	d.f. 28 t
	Mean	S.D.	Mean	S.D.		
L	4.63	2.47	4.78	2.71	.196	-.51
F	7.25	5.50	6.72	6.17	2.002	.26
K	13.50	6.04	13.44	4.89	1.915	.05
Hs	16.50	6.31	16.67	4.81	1.944	-.08
D	23.50	7.26	25.11	7.22	2.488	-.65
Hy	25.06	5.51	25.72	5.02	1.817	-.36
Pd	26.62	5.20	23.38	5.60	1.850	1.75
Mf	34.31	6.17	36.16	4.44	1.864	-.99
Pa	12.31	3.82	12.78	4.39	1.411	-.33
Pt	32.31	7.43	31.44	7.87	2.626	.33
Sc	33.94	11.20	31.33	9.80	3.631	.72
Ma	21.25	6.67	18.94	4.41	1.900	1.22
Si	29.25	7.35	30.83	8.22	2.671	-.59
Ai*	58.54	19.61	63.30	25.15	7.694	-.62

* Based on Welsh's formula (T-scores).

anxiety index (Ai) scale was also computed and analyzed in the same way as were the other clinical scales.

Presented in Table 4.1 and Table 4.2 are the means and standard deviations of the MMPI raw scores of the experimental (15 male and 16 female) groups who received interpersonal therapy, contrasted to the control (15 male and 18 female) groups who did not receive interpersonal therapy. Standard errors of the differences of the means and t-tests are also reproduced in these same tables.

In Table 4.1 are summarized the t-test levels for the male groups (28 degrees of freedom). Only the L scale is significant for the male groups beyond the .05 level, but in the direction of a larger mean for the experimental group than for the control group.

In Table 4.2 are found the t-test levels for female groups (32 degrees of freedom). The Pd scale is the only scale significant beyond the .05 level, but in the direction of a larger mean for the experimental group than for the control group.

Profile Analysis

It was further hypothesized that chi-square for the normal-abnormal sorts of the individual profiles, according to Meehl's criteria based on sub-scale ranges, would yield a significantly higher number (.05 level) of normal profiles for experimental groups than it would for control groups.

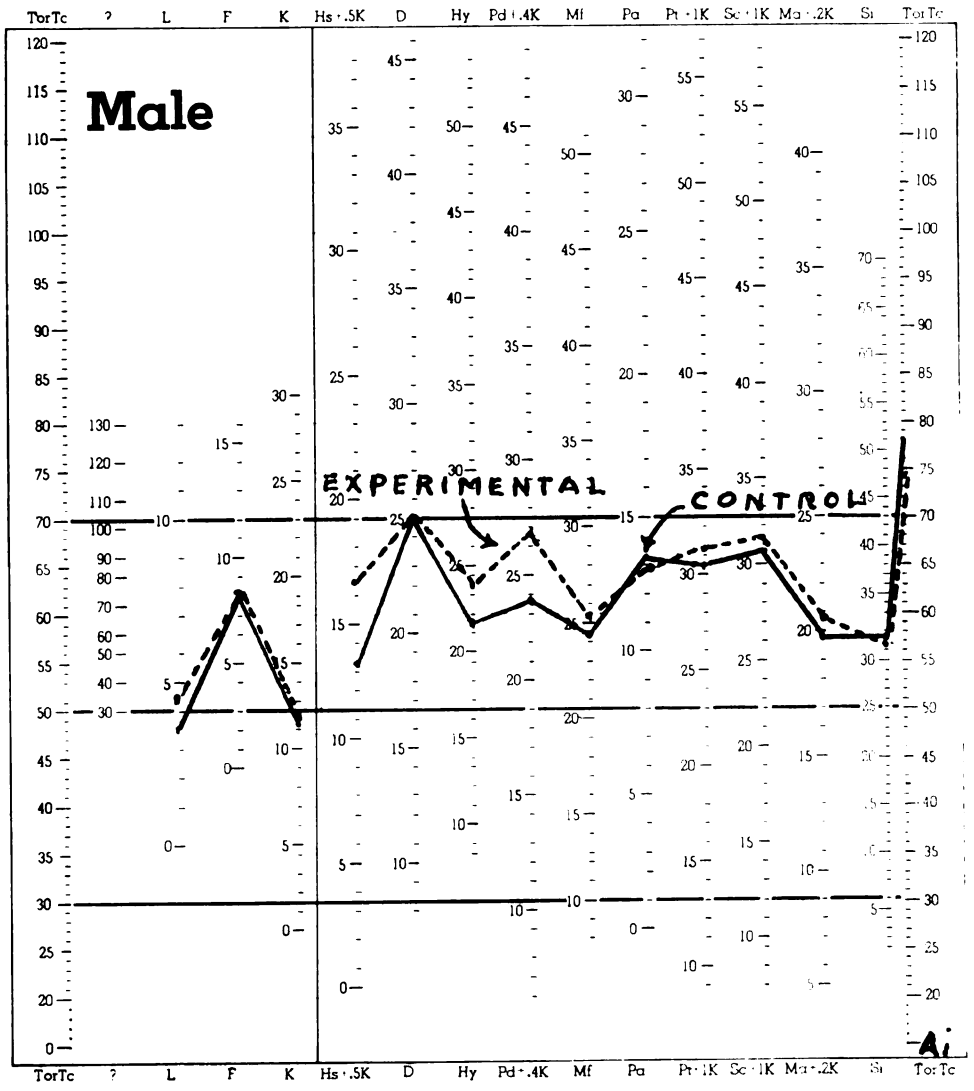
In Figure 4.1, the profiles for the raw-score means of the male experimental and control groups are presented graphically. Of the male experimental group, the plotted mean scores of seven clinical scales, Hs, D, Hy, Pd, Pa, Pt,

and Sc, lie between T-scores of 60 to 70. The Ai mean score is 74.76. Three scales, the Mf, Ma, and Si, are between T scores of 50 to 60. The most elevated scales for the male experimental group are Ai, D, Pd, and Sc, with Pt and Pa having approximately similar elevations. In contrast the male control group has five clinical scales, D, Pd, Pa, Pt, and Sc, with raw score means between T scores 60 to 70, and five scales, Hs, Hy, Mf, Ma, and Si between T scores of 50 to 60. The Ai mean score is 77.60. The most elevated scores for the male control group are D, and Sc with Pa and Pt having approximately similar elevations. Pd and Hs are more depressed than in the experimental sample. The L, F, and K scales appear to be essentially the same for the male experimental and the male control groups. with F elevated above T score of 60.

In Figure 4.2 the profiles for the raw-score means of the female experimental and control groups are illustrated. For the female experimental group, the plotted mean raw scores of six clinical scales, Hy, Pd, Pa, Pt. Sc, and Ma, lie between T scores of 60 to 70. Four scales, Hs, D, Mf, and Si, are between T scores of 50 to 60. The Ai mean score is 58.54. The most elevated scores for the female experimental group are Pd, Sc, and Pa , with secondary elevated scores being Ai, Pt, and Hy. Contrasted with the female experimental group, the female control group has six clinical scales, D, Hy, Pd, Pa, Pt, and Sc. between T scores of 60 to 70. The Ai mean score is 63.30. Four scales, Hs, Mf, Ma, and Si, are between T scores of 50 to 60. The most elevated

FIGURE 4.1

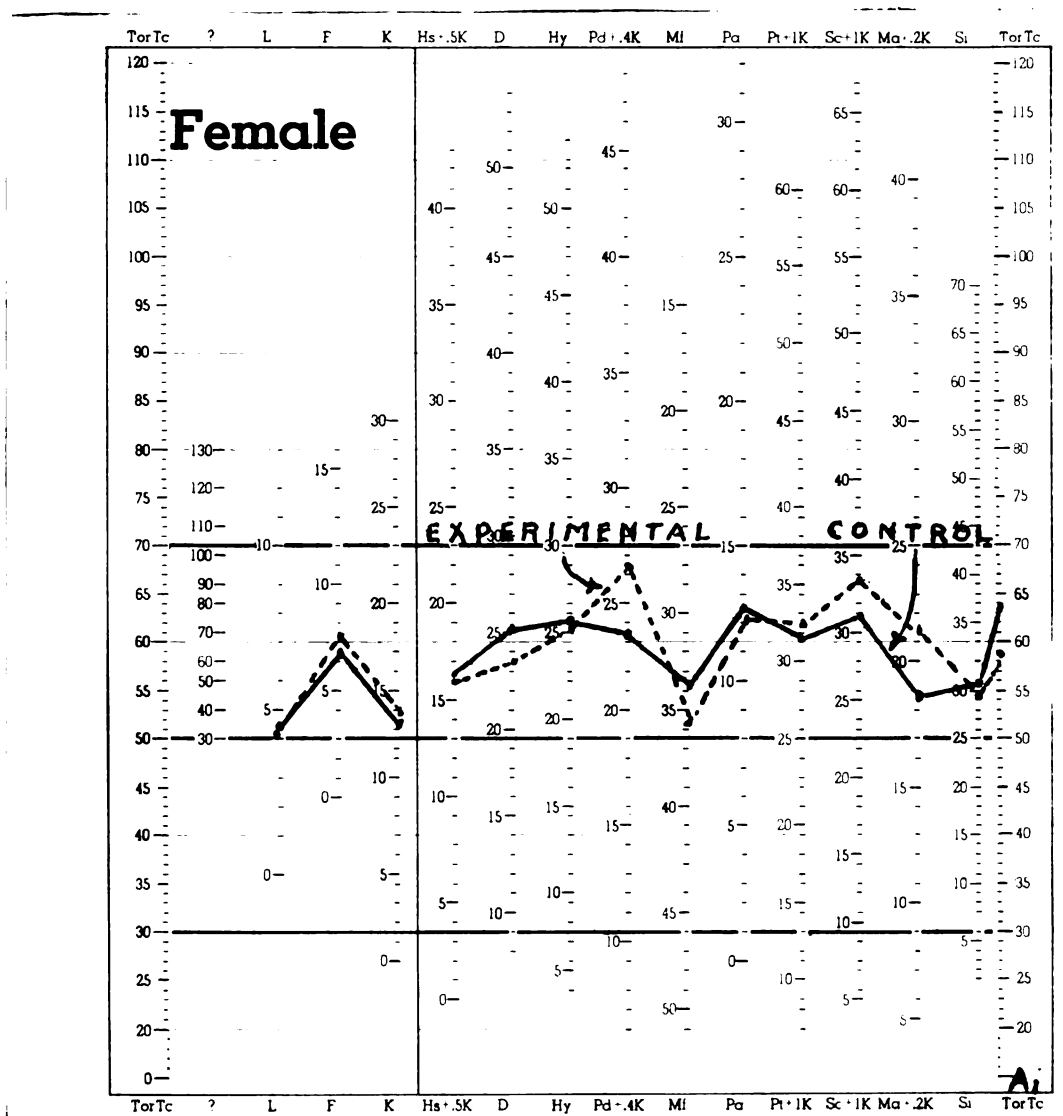
MEAN RAW SCORE PROFILE COMPARISON OF MALE EXPERIMENTAL AND MALE CONTROL GROUPS



Control $\bar{X}$		3.73	11.20	24.60	23.86	13.13	30.53	31.93						
N = 15		8.00	13.33	21.86	24.13	30.33	19.93	77.60						
Experimental $\bar{X}$		8.00	16.40	23.66	25.20	31.06	20.86	74.76						
N = 15		4.46	11.60	24.86	26.53	13.00	31.13	31.26						

FIGURE 4.2

MEAN RAW SCORE PROFILE COMPARISON OF FEMALE EXPERIMENTAL AND FEMALE CONTROL GROUPS



Control $\bar{X}$	4.77	13.44	25.11	23.38	12.77	31.33	30.83		
N = 18	6.72	16.67	25.72	36.16	31.44	18.94	63.30		
Experimental $\bar{X}$	7.25	16.50	25.06	34.31	32.31	21.25	58.54		
N = 16	4.63	13.50	23.50	26.62	12.31	33.93	29.25		

scales for the female control group are Pa and Sc, with approximately similar elevated scales being Hy, D, Pd and Pt.

Male and Female Anxiety Index (Ai) Mean Differences

In this study no hypothesis was made about differences between male and female Ai means. The Ai scale was considered to have an important bearing upon patient reaction to the interpersonal therapy given. The Ai means of the female groups (experimental 58.54, control 63.30) appear to be much lower than the Ai means of the male groups (experimental 74.76, control 77.00). As a post hoc investigation, a two-way analysis of variance was made for the Ai scales by sex and treatment grouping. Three individual scores were randomly dropped out of the female control group, and one score from the female experimental group in order to equalize group cell N's to 15 each. The F ratio for sex is 10.24 and is significant beyond the .05 level. Treatment and Interaction F's are .49 and .11, respectively, and not significant. Data for the analysis of variance for the Ai scales can be found in Table 4.3.

Normal-Abnormal Analysis

In Table 4.4 can be found the number of normal and abnormal profiles for all four groups of the study based on Meehl's criteria. The female experimental group (N = 16) is comprised of seven normal profiles, seven abnormal, and two invalid profiles. In the female control group (N = 18)

TABLE 4.3

ANALYSIS OF VARIANCE OF THE Ai SCALES FOR MALE AND FEMALE GROUPS

Source of Variation	S.S.	df	Mean Square	F
Between	4551.42	3	1517.14	3.62
Within	23482.88	56	419.34	
Total	28034.30	59		
Sex	4295.99	1	4295.99	10.23
Treatment	207.87	1	207.87	.49
Interaction	47.56	1	47.56	.11

there are six abnormal, ten normal, and two invalid profiles. The male experimental group (N = 15) contains ten abnormal, three normal profiles, one invalid, and one questionable profile. In the male control group (N = 15) are found five abnormal, nine normal profiles, and one invalid profile. Chi-square was computed for normality-abnormality of the male groups in a 2 x 2 contigency table, using Yates' correction factor. The X^2 value of the male group with one degree of freedom is 3.12 and is not significant. Chi-square was not computed for the female group because the observed to expected frequencies are sufficiently near each other to reveal their non-significance by inspection.

Summary

Gain was assessed in this study by the use of MMPI scales. The assessment of the MMPI scales for the

TABLE 4.4

SORTS OF MMPI PROFILES INTO NORMAL AND ABNORMAL CATEGORIES BASED ON MEEHL'S CRITERIA

Sorts	Male				Female			
	Experimental		Control		Experimental		Control	
	O	E	O	E	O	E	O	E
Normal	3	5.8	9	6.2	7	7.9	10	9.1
Abnormal	10	7.2	5	7.8	7	6.1	6	6.9
Invalid*	1		1		2		2	
?**	1							
Total N	15		15		16		18	
df = 1	$X^2 = 3.12$							

5% level, $X^2 > 3.84$
*Not used in calculating chi square

experimental groups (male and female), and control groups (male and female) was made by mean score analysis using t-tests and normal-abnormal sorts of profiles, based on Meehl's criteria. The t-test results revealed that there was no significant difference between experimental and control group means in the direction of making greater gain toward normality. The normal-abnormal sorts yielded typically psychiatric profiles with elevations on the D, Pt, Pd, and Sc scales for all four groups. There were no significant differences on sorts between experimental and control groups.

CHAPTER V

INTERPRETATION AND DISCUSSION OF RESULTS

In this chapter will be presented an interpretation and discussion of results as they relate to differences influenced by the interpersonal therapy approach of this study.

Discussion of Sub-scales and Profile Analysis

A number of researchers have found, in general, significant depressions of the D, Sc, Pt, and Hs scales[1] after various periods of therapy with psychiatric patients. For the present study it was hypothesized that any gain as a result of therapy would be most evident on F, D, Pt, Sc, Si, and Ai scales, with mean scores of the experimental groups being closer to T-scores of 50 than would be the mean scores of control groups. Other researchers have found differences to be significant on these dimensions as a result of psychotherapy.

The t-tests of MMPI sub-scale mean scores for both male and female groups of the study support the null hypothesis that there is no difference between experimental and control groups in the direction of therapeutic gain.

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[1]W. G. Dahlstrom and George S. Welsh, An MMPI Handbook (Minneapolis: University of Minnesota Press, 1960).

Group Differences

The four groups of this study similarly exhibit typical psychiatric profiles[1] with the MMPI scales D, Pd, Pt, and Sc being elevated. No differences were found as hypothesized between the sub-scale means for experimental and control groups at the time of discharge. Normal-abnormal sorts yielded much pathology consistent with psychiatric profiles, but no differences were found among or between the groups.

The male experimental group had a mean age of 40.0 years compared to a mean age of 33.0 years for the male control group, despite the randomized selection of patients. The experimental males were hospitalized an average of 23.0 days compared to an average of 17.2 days for the control group. Personality difficulties found in the male experimental group may be of longer duration and may have progressed further by reason of the greater age of this group as compared with the control group.

Contributing Factors

Independent of the hypotheses and research design of the study, several factors were noted which may have produced the negative findings.

Differences were found in the diagnostic category frequencies (Table 3.1, page 27), where there were approximately 20 per cent more psychotics in the male experimental group than were found in the male control group. The

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[1] Ibid.

diagnostic judgments suggest the findings of Schofield and Briggs[1] in which psychiatric ratings were concluded to give different (better) predictions of patient improvement than MMPI results.

A two-way analysis of variance of treatment by sex (Table 4.3, page 39) indicated that the male group means were significantly different from the female means on the Ai scale. The treatment and interaction effects were not significant. The male experimental and control groups had Ai scale means of 74.76 and 77.60, respectively. In contrast, the females of the study appeared to be less anxious than the males. The female experimental and control groups had means of 58.54 and 63.30, respectively.

It is possible that the concepts of male and female roles, and societal expectations according to sex, have much bearing upon differences of anxiety levels. Similarly, male and female role concepts are sampled heterogeneously by the items of masculine-feminine conventions. For this reason, more thorough testing of the relationship of Ai to Mf scales would be a worthwhile area of research. It might be hypothesized that longer-termed interpersonal therapy involving role concepts would be more difficult with males than females. Males in the present study seemed to have much more difficulty with acceptable patterns of conduct than did females.

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[1]William Schofield and Peter F. Briggs, "Criteria of Therapeutic Response in Hospitalized Psychiatric Patients," Journal of Clinical Psychology, Vol. 14, 1958.

Results

The results obtained from the comparison of experimental and control groups suggest several conclusions:

1. The addition of interpersonal therapy to the hospital setting of the study has no appreciable influence on patient improvement, as measured by MMPI scales within the limits of this design.
2. The finding of a lack of significant difference between the means of the various MMPI scales may be influenced by the nature of the diagnostic instrument, i.e., measurement may be (a) too molecular, or (b) validity may not assess short-term gains.
3. The theoretical approach may be too superficial in treating the essential conflicts of patients.
4. The term of hospitalization and thus the period of treatment may be too short for use of the interpersonal approach.
5. Several contributing factors outside the research design may have had some effect on group comparisons, e.g., a greater number of psychotics in the male experimental group, greater anxiety in males as shown in Ai scale differences. Such variables may have arisen from sample selection factors, or be influenced by treatment effects. The design of the study did not permit separating

these variables.

6. The use of only one therapist employing the interpersonal approach may have limited the findings. Possibly the interpersonal approach could be used more effectively by a more experienced or different therapist.

Summary

In this chapter are presented an interpretation and discussion of the results of the previous chapter. No difference was found between experimental and control groups in the direction of therapeutic gain. The use of interpersonal therapy appears to have no benefit to patients when added to the regular hospital regimen. All four groups appear to be typical of psychiatric populations on the MMPI, with elevations found on the D, Pt, Pd, and Sc scales. It was suggested that contributing factors not controlled in the research design may have influenced the findings, e.g., differences in group pathology.

CHAPTER VI

SUMMARY AND CONCLUSIONS

In this chapter will be presented a summary of the problem, design, and interpretation of results and, in addition, conclusions and implications for further research.

The Problem

The purpose of this study was to investigate what gain would take place in patients receiving interpersonal therapy in a short-term psychiatric setting. Gain was assessed by sub-scale scores of the MMPI.

Methodology and Procedure

The randomized samples for the study were composed of 15 male and 16 female experimental patients contrasted to 15 male and 18 female control patients. Experimental patients received two to three hours of interpersonal therapy a week added to the regular hospital regimen in which all patients were seen by their treating psychiatrists.

All patients were tested by the booklet form of the MMPI one to two days previous to discharge. The comparison of experimental and control groups was made by: (a) contrasting the means of each of the MMPI sub-scales using mean scale and profile analysis, and (b) sorting individual

profiles into normal and abnormal categories according to Meehl's criteria and computing chi-squares.

It was hypothesized that experimental raw score means would be significantly closer (.05 level) to "normal" means on the F, D, Pt, Sc, Si, and Ai sub-scales than would be control group raw score means on these same sub-scales. It was hypothesized that chi-square for the normal-abnormal sorts would yield significantly more (.05 level) normal profiles for experimental groups than it would for control groups.

The Findings

The analysis of MMPI data as criteria of gain revealed the following:

1. The t-tests of the sub-scale means for both male and female groups show no significant difference for the experimental groups, receiving inter personal therapy, compared to control groups.
2. Normal-abnormal sorts of profiles, according to Meehl's criteria, yielded no significant differences for experimental and control groups.
3. All four sample groups have typical psychiatric profiles with primary elevations on the D, Sc, Pt, and Pd scales.
4. Contributing factors outside the design of the study may have influenced the above results, e.g., imbalance of age and pathology in the randomized selection of the groups.

Conclusions

The results of this study appear to support the following conclusions within the limits of the design:

1. Adding interpersonal therapy to the present regimen of short-term treatment yields no differences in patients as measured by MMPI sub-scale means and normal-abnormal sorts of profiles.
2. The use of MMPI sub-scales may have limitations in assessing gain in short-term treatment, e.g., too molecular, and validity misses small differences.
3. Patients discharged from the hospital unit of the study show much pathology as revealed by MMPI profiles and Meehl's criteria of normal-abnormal profiles.

Implications for Further Research

1. While the interpersonal approach used in the study indicates no significant difference in patients, it is likely that the brief period of therapy was a limiting factor. Longer-termed therapy might have given more significant results.
2. Pre-therapy tests might be added to the design to measure differences, this adding a covariance model when analysis indicates lack of randomness in the sample division.

3. A more adequate equalization and randomization of sample groups might be made according to size, age, and pathology to yield clearer results.
4. Simultaneous interviews or therapy with significant intimates of experimental patients might enhance the effectiveness of the interpersonal approach used.
5. Anxieties tapped in the interpersonal approach were probably in evidence on the anxiety index scale (Ai). Larger samples of patients and more extensive research of male and female Ai scale relationships might yield more detailed information of differences between male and female groups. Anxieties are believed to have an important relationship with the norms, role concepts, and personality systems sampled in the theoretical approach of the study.
6. The MMPI was the only measuring device used in the study. A multiple criterion of tests pertinent to the interpersonal problems explored might be used for greater sensitivity in assessing differences. e.g., Taylor Anxiety Scale, Edwards Personal Preference Schedule. Shorter forms of the MMPI, selection of scales, or other more convenient tests might be used in future studies of this kind. Many patients expressed discomfort about the length of the MMPI form.

7. Possibly the interpersonal approach might yield more positive results when used by a more experienced therapist, or by several therapists.

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APPENDIX A

MMPI RAW SCORES FOR THE TOTAL SAMPLE GROUPS

MMPI RAW SCORES FOR THE TOTAL SAMPLE GROUPS

Male Experimental N 15

L	F	K	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si	Ai*
3	17	4	27	34	25	11	23	18	36	40	24	38	96
5	2	15	10	14	20	27	25	11	23	24	23	7	43
2	3	17	18	27	25	31	26	13	31	24	15	32	57
2	2	13	14	18	20	18	20	8	27	22	21	22	54
2	10	9	16	23	27	30	34	15	38	46	28	20	80
4	16	10	15	34	32	24	18	14	43	42	19	52	114
6	10	9	14	27	27	34	29	16	34	38	25	37	89
4	11	6	21	31	32	29	28	13	35	39	18	44	85
5	8	14	18	28	21	28	23	11	28	27	20	24	77
5	5	19	19	24	25	26	21	10	30	27	11	40	78
2	11	7	14	29	24	26	28	10	34	30	21	30	99
4	6	8	12	21	18	23	31	19	31	28	20	36	76
7	4	15	11	16	18	25	23	14	20	19	16	21	33
7	9	9	28	37	29	26	24	12	38	33	19	55	102
7	3	15	9	18	16	23	24	8	22	20	28	13	57

*Derived from T-score equivalents

MMPI RAW SCORES (continued)

Male Control N 15

L	F	K	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si	Ai*
4	6	9	11	28	18	30	22	9	25	24	18	40	84
1	11	5	13	18	22	25	16	14	36	41	25	35	72
1	4	7	10	21	17	21	24	19	21	17	11	40	59
4	7	8	16	24	24	21	25	13	35	28	20	45	82
4	7	7	20	28	21	21	22	12	32	29	12	35	85
1	5	17	11	20	21	22	29	14	24	25	22	16	58
8	6	9	20	32	32	23	25	10	32	30	17	41	85
5	12	18	13	23	18	23	24	9	34	36	24	25	89
2	2	8	10	21	12	19	24	11	28	30	23	29	81
5	19	8	22	26	21	28	24	21	32	47	29	36	76
2	10	8	13	24	22	25	24	15	33	28	20	36	86
4	8	21	13	21	27	33	25	15	27	34	17	24	56
10	2	25	18	24	23	24	26	10	27	28	19	13	63
3	14	11	19	34	26	31	26	16	39	37	21	43	114
4	9	11	13	17	20	21	27	12	26	31	19	17	51

*Derived from T-score equivalents

MMPI RAW SCORES (continued)

Female Experimental N 16

L	F	K	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si	Ai*
0	17	5	21	28	28	25	23	17	44	52	20	40	82
9	23	23	30	34	32	32	30	17	39	53	16	38	72
8	8	17	12	14	24	35	40	8	27	27	26	15	35
6	5	12	16	23	26	29	37	12	29	21	15	26	51
5	7	13	10	20	17	23	37	11	22	23	20	30	52
6	4	16	5	17	24	18	37	13	23	25	13	34	35
3	10	6	13	22	25	22	25	12	30	28	26	25	34
7	2	24	15	22	24	18	35	10	34	29	10	34	63
2	13	10	21	17	25	25	40	11	36	35	33	25	45
2	13	8	14	30	30	34	33	8	43	45	25	37	92
6	8	10	11	29	26	30	44	17	27	27	25	33	72
3	4	12	17	32	24	31	34	8	31	27	16	32	72
2	7	10	11	16	11	24	26	9	27	29	17	25	57
4	5	17	11	15	22	26	43	15	32	40	31	20	50
6	11	9	30	37	34	30	34	20	46	54	28	35	89
5	5	24	19	20	29	24	31	9	27	28	19	19	36

*Derived from T-score equivalents

MMPI RAW SCORES (continued)

Female Control N 18

L	F	K	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si	Ai*
2	19	6	24	40	30	31	38	19	45	49	27	48	108
1	25	9	23	39	34	32	34	23	51	61	24	46	112
2	6	10	14	19	28	30	40	13	31	30	25	29	46
9	6	11	18	29	23	26	25	15	30	28	20	25	83
2	9	10	13	25	22	18	35	14	37	39	10	27	81
7	2	18	13	26	22	16	37	8	28	23	13	32	67
4	2	13	11	17	17	19	34	13	29	33	22	34	50
2	7	11	14	19	21	20	42	10	25	26	15	37	45
7	1	21	22	28	31	22	41	9	24	24	17	24	43
6	6	12	19	30	28	18	41	8	36	27	16	41	77
7	2	10	17	20	26	18	32	11	23	22	15	29	33
6	2	19	15	20	28	23	36	12	27	25	16	25	41
4	5	17	13	17	22	17	40	12	32	34	21	23	54
1	6	11	14	30	30	30	36	11	40	31	19	18	71
8	7	16	26	20	35	27	29	11	32	27	23	30	25
7	2	16	8	21	21	17	40	7	21	26	19	24	52
3	9	8	19	33	24	31	36	22	30	31	21	37	73
8	5	24	17	19	21	24	35	12	25	26	18	26	52

*Derived from T-score equivalents

APPENDIX B

THE INTERPERSONAL THERAPY METHOD: A CASE SUMMARY

THE INTERPERSONAL THERAPY METHOD: A CASE SUMMARY

The interpersonal therapy used in this study represents an attempt to explore with the patient three important dimensions which reflect personal adjustment:

1. The norms by which the patient expects to function are examined within his predominate social setting. Patient norms are compared with the norms of significant individuals of the patient, and societal expectations in general.
2. An overview is made of the personality system of the patient as reflected in his interacting needs, demands, and means of gratification in relation to others.
3. Determination is made of the emotional tone which comes to characterize the patient's behavior because of his reaction to significant others over an extended period of time.

The patient is encouraged to recount past and present relationships and future expectations. He is also encouraged to display affect connected with the above dimensions, and to contrast his viewpoints with those of peers and significant others. An attempt is made to lead the patient to insightful conclusions about difficulties that may arise from conflicts within the context of interacting norms, personality systems and characteristic emotional tones.

A summary is presented in the following section of one individual who was in the male experimental group of the study. In brief, the case illustrates some of the difficulties which arise in interpersonal areas and how these difficulties can be focused upon in therapy to encourage insight and decision-making.

Patient: Bob C_____ Age: 18

Days Hospitalized: 84 Therapy Sessions: 21

Bob is an only child and lives with his parents in their Lansing home. The family is of middle social-economic background, the father having worked for the State of Michigan for a number of years. The patient was born to Mrs. C. when she was 35 years of age; Mr. C. was 45 at the time. The parents relate that because of the lateness of a child in their lives, they showered him with affection and gifts. He became the center of their lives.

During his early years in public school, Bob had been an average student who brought home average marks. He took piano lessons methodically, learned to play the saxaphone and clarinet, but seldom took part in activities with peers. Bob's time was always well planned for him by his parents, especially his mother. Bob's mother commented when he came into the hospital that she was always watchful lest he become involved with "worthless activities and the wrong crowd. . . . He has an IQ of 138, but doesn't take an interest in things."

In his later school years as a maturing teen-ager, Bob never held a job. His activities kept him at home or in supervised situations. Bob's mother constantly kept a check on his friends and activities, about which he commented, "She'd never leave me alone to think for myself!" Often his mother would take him to a doctor because of a fall, a bruise, or complaint of an ache.

In high school Bob became more lax about his studies and his music. He became the "class clown" in an attempt to amuse his schoolmates, and he defied teachers if they attempted to correct or control him. In Bob's second year of high school he was referred to the school's Psychological Clinic, but the case was closed after several interviews because the school psychologist found the parents to be "uncooperative and unwilling to face their responsibilities." Bob was expelled from school. About this his mother commented at the hospital that he was "expelled for a lot of little things, like talking in class . . . although he's a class clown, everyone likes him."

After being expelled from school, Bob was seen privately by a psychiatrist, but was terminated after several visits because the psychiatrist had "little support from the family . . . little insight from Bob."

Out of school, Bob became restless and increasingly resentful of his parents. He attempted to find several jobs. Another time he attempted to join the Air Force, but at the last minute on each occasion he would become extremely anxious and fail to follow through. He then refused to seek

employment, "grew a beard and became a beatnik . . . began to seek companionship with the 'wrong crowd' . . ." according to his mother. Activity with his new companions included "drag-stripping" on the city's main thoroughfare. Bob was repeatedly ticketed for speeding. Bob's father, in turn, paid all his traffic tickets dutifully, but at home he reacted with tirades about his son's never amounting to anything. Bob soon reacted to his father's tirades with physical violence which became increasingly serious. On one occasion he assaulted his father and broke one of his ribs. The parents, quite fearful of Bob's increasing rages, called the psychiatrist he had once visited. Under pretext of having him seen for a physical ailment, the parents brought him to the psychiatric unit of the hospital.

At the time Bob was admitted to the hospital his mother appeared to be quite anxious and depressed about having to bring him. Both parents were fearful of how Bob would react when he found himself in the psychiatric unit. Admission to the hospital was a crucial turning point, as the parents, especially Bob's mother, could finally admit that perhaps their son had some difficulties. As expected, Bob became enraged at being admitted to the unit, and was placed in isolation.

Therapy

The first hour of therapy was devoted mostly to allowing Bob to talk freely about his reactions to hospitalization and letting him expound on what a " dirty trick" his parents

played on him in bringing him to the hospital. He was encouraged to explore why his parents would resort to such tactics and what events he thought might have led up to this move on their part. Bob mumbled something about a strong temper and then reluctantly admitted that he had been abusive physically to his parents. He attempted to persuade the therapist that he saw the errors of his ways and that he would make amends if only he were allowed to go home. The therapist commented that he felt that Bob must be very uncomfortable with some of his difficulties and he would like to be of some help if Bob wanted to talk about them. It was pointed out to Bob that since he was to be hospitalized for an indefinite period it might be to his advantage to make use of these sessions; should he desire to continue these sessions, he should express how he felt and what he thought, and be as honest as possible about his difficulties. Bob was told that insincere attempts to win over the therapist would not help in understanding himself. Bob reacted to the first interview with reluctant sarcasm.

The second and following sessions were directed to a general understanding and then a detailed inquiry to explore more in detail the frictions that existed at home among family members in terms of the dimensions of norm conflicts, personality systems, and emotional toning. Bob was asked to express how he saw himself at home, and what he thought his parents expected of him, both in day-to-day activity and for the future. He was also asked to appraise what he expected of himself. Inquiry was made about his performance in

school, and how he felt about working.

Bob saw his father as very passive and uninterested in anything, a parent who only complained about what things cost him and never shared any activities with Bob. He saw his mother as picayune and picking on him, "highly nervous." When asked to explore his own personality, he described himself as likable by most people, talented, but picked on too much. Despite little self-direction and being out of school, his expectations for the future were quite high and unrealistic. He saw himself going on to law school or becoming a pianist.

The nature of parents' demands and their controls, and possible reasons for anxiety were explored. Because the term "picked-on" was used quite often by both Bob and his mother, this term was explored in more detail as it applied to controls at home and in school. Bob was asked to explore what he might consider to be reasonable roles for a teenager and maturing adult, as compared to what might be expected from him when he was much younger.

Over a number of sessions some of Bob's defenses broke down gradually and he was able to talk more easily and with increasing insight. He described inadequacies that he felt with peers, early dependency on his mother and her controls, and becoming a class clown in order to gain some sense of importance. His definite fears of increasing uselessness and inadequacy were shown as Bob contrasted himself with friends who were finishing school and going to college, good jobs, or the service. His rebellion appeared a strong

reaction to his desire for accomplishment on a footing with peers, and his strong feelings of dependency upon parents. In later therapy sessions Bob's insights led him to a confidence that he might be able to work out some of his difficulties more easily if he had a chance to go back to school and also get a job in order to be more self-sufficient.

Controls

Controls were considered essential to effective therapy. It was explained to Bob from the first week of hospitalization that he was expected to conform to the demands of the hospital routine. In conjunction with therapy, Bob was restricted from having any visitors, including his parents. By the restriction of visitors, the therapist intended to modify the intense emotional tone which was apparently dominating the interaction of Bob with his parents, and allow Bob to adjust to the norms imposed by the hospital. Privileges were defined, such as participation in group activities, TV viewing in the evenings, visits to the hospital store to buy sundries. At the outset Bob attempted to test controls by frequent abuse of privileges and the privacy of other patients. His privileges were consistently withdrawn so he soon modified his abuse.

When Bob appeared to be functioning well within the limits imposed, privileges were extended to include weekend visits home. Bob was asked to return to the hospital whenever he felt his emotions getting beyond his control. The therapist asked that during these weekend visits, Bob's

parents not discuss what progress he was making in the hospital, nor bring up the topics of school or future jobs. Bob cut short two of his weekend visits, returning to the hospital to avoid heated arguments with his parents or physical abuse. Difficulties that had arisen were talked out at length in therapy. Later home visits became less charged, although they were not entirely free from friction.

Follow-through

It was considered important that Bob be allowed to test out some of his insights and decisions. After several weekend visits, Bob asked that hospital privileges be extended to him so that he could go out several hours during the day to look for a job. He arranged for testing and interviewing with the Michigan Employment Security Commission, and explored various jobs to which he was referred. The therapist held several conferences with Lansing school administrators and they agreed to allow Bob to attend school two nights a week. Bob left for school from the hospital and returned directly after classes. Several weeks later he obtained a job painting the inside walls of a local grocery during his non-school evenings. Bob maintained an A average in his classes and stayed on the painting job to conclusion. This limited success gave him an increasing sense of self-direction and usefulness. The next job was a full-time one at a local discount store, at which time Bob was discharged from the hospital, to be seen by his psychiatrist on an out-patient basis.

Synopsis

Among the norms of the family members there were strong conflicts which worsened as Bob became a young adult. Bob's mother believed that complete supervising of all his activities was important if he was to achieve. The father felt it sufficient to provide only financial support, to leave management in the home to his wife. Because of the controls Bob failed to develop any ability to test social roles for himself, to make many of his own decisions. Although he later resented controls, he also expected that his parents should be a constant source of supply for his physical wants. In the personality systems that developed, Bob's mother learned to gratify herself by being the overseer of Bob's activities and thus the model mother of an achieving son. Bob learned early that his mother was pleased if he achieved. He learned to control situations outside the home by complaining often that he was picked on, to which his mother reacted with support. He learned to control at home by somatic complaints. The emotional tone of the relationship derived from the conflicts in norms between Bob, his mother and father. As Bob became a young adult, he found that the constant decision-making of his mother, and his failure to meet demands outside the home were stripping him of any ability, or worth in the eyes of peers. The control that his mother imposed on Bob became less effective as he became more aware of how poorly he was able to compete with peers. He attempted to rebel against control, but was unable to surrender his

dependency on parents and, in turn, rebelled the more strongly.

Therapy with Bob was directed to: (a) lessening the emotional tone that existed with family members by isolation, (b) encouraging him to explore his conflicts and abilities in terms of his own and others expectations of him, (c) encouraging him to come to insightful conclusions and decision-making about work, school, and the future in the context of a consistently controlled but supportive hospital setting.