PSYCHOTHERAPY OR ACTIVE FOCUSED PROBLEM SOLVING FOR PERSONS IN CRISIS

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ABSTRACT

PSYCHOTHERAPY OR ACTIVE FOCUSED PROBLEM SOLVING FOR PERSONS IN CRISIS

By

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Interest in studying the various effects of crisis intervention with a public mental health clinic population was born out of the great demand for public services, coupled with a shrinking availability of public funds to support such services; by a burgeoning literature in crisis intervention theory, coupled with a dirth of research data on outcome; and by a recognition of the national problem of treatment dropouts (50%) and their concentration in the lower socioeconomic classes. The project examined the appropriateness of offering either supportive psychotherapy services or active goal focused crisis intervention services to persons of lower socio-economic levels. All patients had asked for a mental health service from the Livingston County Community Mental Health Center, within 30 days of an identified precipitating event.

Forty clients were selected, 20 of whom were seen in traditional supportive psychotherapy for 10 sessions, and 20 of whom were seen in 6 session problem solving focused crisis intervention.

Of principle concern were the frequency of patients failing to complete the treatment contract (dropout) and the relative degree of change in, and satisfaction with, each of the two treatment offerings, as rated by both patient and therapist.

Twenty-one of the original 40 subjects finished their treatment contracts, 14 experimental (crisis intervention) and 7 control (supportive) while 7 experimental and 13 control subjects dropped out prior to completion. The result (.124) while not significant was biased by a nonrandom distribution of patients by marital status. Single persons dropped out far more regularly than did persons of any other marital status. When services are offered only to married, or once married subjects, crisis intervention is found to be completed significantly more frequently (>.05) than the supportive method.

While change occurred in both groups, there was no evidence that either group changed more or differently from the other. There were, however, strong indications that patients who initially saw themselves in relatively better control of their lives, and thus felt less overwhelmed, were rated as better treatment candidates (both groups) and rated the therapy as having resulted in

greater positive change than those who felt less in control. Therapists' ratings of similar issues correlated highly with patient ratings.

A significant finding, not originally expected, was that the greater the liking of the therapist for the patient, the greater the patient's reporting of significant positive change, and the more likely was the patient to finish the treatment contract.

There are strong indications for needed further investigation in the area of therapist's liking or disliking of patient as strongly influencing outcome. Similar findings confirming previous research indicate that treatment outcomes, and particularly dropouts, are related to factors which are not only clinical but are in many areas also demographic and actuarial, i.e., differing social classes between therapist and patient-socioeconomic levels, etc. Further research on case assignment procedures as they affect outcome is advisable.

While further research is indicated, the most critical issue for public agency practice is clear. The crisis intervention group changed and was as satisfied with their experience as was the supportive treatment group, but achieved these results utilizing 40% fewer resources. The demands for public service forces the clinician to address this conservation of staff resources--even if those resources are expended on

persons who, rather than dropping out, complete a treatment contract having achieved more limited short-term goals. The implications for changing professional practice are clear. Crisis intervention is a legitimate alternative to short-term supportive therapy for persons who seek mental health services in a period of acute psychological upheaval.

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PREFACE

As society continues to undergo the technical-evolutionary process which began with the industrial revolution, individuals have found it increasingly difficult to successfully ply a course of adequate socialization and integration with the larger group. The increased difficulty (stress) is the likely result of the interplay between two factors. The first is the increase in the quantity and variability of social roles and expectations with which the individual must contend. Change itself has become a value. Second, western society has participated in the devaluation of the extended family, the church, and the community; institutions which have historically functioned as agents of emotional support and social control.

The result of greater stress and fewer resources has been an increased number of social casualties, countable in almost every item in the social disorganization index. Histories of individual casualties are replete with typically stressful life events, which were resolved in manners which functioned to the adaptational detriment of the individual.

> Theorists such as Erikson regard the developmental process as a hierarchy of challenge whose mastery generates an increasingly complex repertoire of coping skills. These are reflected in a more differentiated sense of identity and a growing sense of self-worth. . . . . A fluid expansive adaptational system is well suited for mastering adversity, novelty or even monotony, when it becomes burdensome. (Barten, p. 13)

During transitional periods, " . . . problem solving strategies must be developed or reactivated" (Barten, p. 13).

> An adequate level of self-esteem and a varied repertoire of coping techniques, greatly enhance the individual's capacity to accept and master new challenges. The less well equipped individual is more likely to be temporarily overwhelmed. . . . (Barten, pp. 14-15)

We have known for some time through clinical work that adaptational dysfunction often occurs in response to a crisis. Occasionally, however, a person emerges from a crisis in a clearly superior mental state than had been the case prior to the crisis (Caplan, 1967, pp. 337-338). A crisis

> . . . may be dealt with in an adaptive way by realistic modification of the environment and by intrapsychic readjustments. On the other hand, the solution may be (1) postponed, (2) maladaptive, or (3) (result in the) development of psychiatric symptoms. (Caplan, p. 337)

Thus crisis theory holds that the individual in a crisis state is at a crucial point of vulnerability to change and to therapeutic intervention.

> The present gap between the number of people needing help, and the professional manpower available to provide it will become greater in the next few years. Hence, our manpower resources must be conserved and the efficiency of the services now rendered increased. (Strupp, Fox, & Lessler, p. XVII)

A rethinking of service delivery is in order. A short-term psychotherapy approach to persons in acute psychological distress which aims to facilitate the resolution of the distress can increase future adaptability and prevent psychological deterioration. It is toward such a service delivery method that the following proposal for research in crisis intervention is directed.

CHAPTER I

INTRODUCTION AND REVIEW OF LITERATURE

Introduction

Since 1965, a burgeoning system of mental health centers has appeared on the national scene; the result in large part of an unparalleled availability of federal funds channeled to state governments. The objective of this vast expenditure is and has been the provision of preventative as well as remedial mental health care to all persons. This bright promise quickly dimmed with the nationwide realization that the greater the proliferation of mental health centers, the greater the incidence of identified emotional dysfunction.

Coleman observes,

> Soon after the clinic is established, a familiar pattern asserts itself: the overwhelming demand for service quickly gluts up the lines which feed into the clinic from the community. With the subsequent 6-12 month waiting list and the need for precise scheduling of patients, the clinic loses any ability to deal with the earliest manifestations of mental illness, at the time when we can probably be most helpful, i.e., during the crisis situation before the psychiatric illness has been incorporated deeply into the personality. (p. 980)

Paralleling the increased demand for mental health services was the general lengthening of the treatment process in both the private and public sectors. Stierlin asks,

> What factors account for this lengthening process? (1) the passivity and therapeutic perfectionism of the therapist; (2) the sense of timelessness inbuilt into the psychoanalytic situation; (3) the notion of the over-determination and rootedness of neurosis in early childhood; and (4) the development of a lengthy transference neurosis with a concomitant regression and dependence of the patient on the analyst. (p. 357)

The need-demand-waiting list syndrome has forced the realization that "Psychological maldevelopment, maladaption, and illness are so prevalent that treatment of established cases can never be expected to deal adequately with more than a fraction of the cases which occur" (Caplan, 1967, p. 331). Although the demand for services has been the driving force behind the re-emergent interest in short-term treatment, several other factors deserve mention. "The emphasis on ego psychology of how the individual's or family's coping repertoire can be mobilized to improve social functioning with respect to specific and limited treatment goals" (Parad & Parad, p. 347) has provided a needed theoretical framework; they are: The realization that "psychosocial disequilibrium or 'crisis' is by its very nature time-limited; dissementation of numerous papers advocating

the use of crisis techniques; and the existential thrust which demands solutions in the here and now" (L. Parad, p. 119).

Thesis Statement

It is the belief of this author that persons in crisis who are seeking assistance from a mental health facility are not at that moment appropriate candidates for traditional psychotherapeutic intervention, but appear to be seeking primarily a rapid stabilization of their psychic and social equilibrium.

The following research design is intended to demonstrate that this stabilization is more apt to occur more rapidly and more thoroughly by applying the method detailed in the following pages.

Review of the Literature: History

Most sources indicate only a recent interest in brief treatment and crisis intervention, beginning with Erik Lindeman's landmark 1944 paper, "Symptomatology and Management of Acute Grief." Freud, however, addressed himself to brief therapy with the statement, "The best way to shorten psychoanalysis is to do it right" (Socarides, p. 345). "It is very probable . . . that the application of our therapy to numbers will compel us to alloy the pure gold of analysis plentifully

with the copper of direct suggestion" (L. Parad, p. 130). Freud also practiced brief psychotherapy, as with Bruno Walter (Mayerson, p. 77).

The practice of shortening the treatment process preceded descriptive and theoretical presentations of technique. The Parads note,

> Interest in applying psychoanalytic principles to brief psychotherapy, generated by such leaders as Franz Alexander and Feliz Deutsch, was intensified by the tremendous need for immediate therapeutic services for servicemen and their families during World War II. (p. 347)

> During the forties most of the articles and books on short term therapy stressed the following factors: (1) use of a controlled relationship and modification of the use of the transference, with emphasis on positive transference; (2) focus upon carefully delineated presenting or central problems; (3) focusing on the ego and mobilization of its capacities to deal with stress; (4) the linking of present conflicts to past unresolved conflicts; and (5) the therapeutic goal of restoration of functioning. (L. Parad, p. 132)

Those clinical behaviors recommended by Fern Lowry were (1) relevant history-taking; (2) the need to distinguish between those cases in which the request was precipitated by a crisis, whether "immediate" or a result of slowly accumulating pressures, and cases of chronic crisis; and (3) the use of a direct approach (Parad & Parad, p. 124).

The historical statistical view of treatment services in agencies would seem to indicate that in reality most casework practice has always been short-term and most frequently environmentally oriented. A major

reason for the aforementioned finding has been the problem of treatment dropouts which statistically shorten the average number of visits or duration of contact at a particular agency. Treatment dropouts, or those who receive unplanned brief service, are defined as those persons who attend six or fewer sessions (Rosenthal & Frank, p. 342; Katz, p. 86; Rogers, p. 89; Errora, p. 456; McCleod, p. 193; Brown, p. 431). Between 38% and 50% of all applicants for psychological assistance fit within the dropout definition. Only 25% to 33% of all applicants appearing for one interview appear for more than five (Roger, p. 89). "Regardless of what type of treatment . . . over half of all patients 'dropout' prior to the seventh session" (Brandt, p. 81). "By the eighth interview, not one single agency reported as many as half their cases still in treatment" (Rogers, p. 89) and "one-third of all patients came only once, one-third less than five times and one-third continue for more than five interviews" (Katz, p. 86). Treatment dropout rates are generally higher for the acutely disturbed, and for all persons of the lower socioeconomic classes (Mayerson, p. 94). In short, the more disorganized and disadvantaged the patient, the greater the likelihood that he will drop out of, and thus fail to benefit from, psychotherapy. It is this patient population and

treatment problem (the dropout) that the following proposal is most specifically directed.

The growing body of literature on the subject of outpatient brief psychotherapy with acutely disturbed, disorganized and agitated patients is found to include almost exclusively theoretical material, opinions and reports of crude studies which invariably recommend replication with a well-controlled study. No clearly delineated definitions, parameters, variables or criteria for outcome or description of a method which might legitimately be termed brief or crisis psychotherapy can be found. It is widely accepted that insight based psychotherapies seem to be less effective with public psychiatric clinic outpatients than with patients in some other (private) settings (Rosenthal, p. 342).

Bellack (1967a, p. 128) finds there (is) great divergence in conception and definition of variables among authorities in the field. How long is "brief" psychotherapy? Bellack's answers range in length of time from a single interview to a total of 65 interviews extending over a period of 17 months (Alexander, p. 145). Sifneos defines short-term therapy as lasting anywhere from two months to one year, with an average of four months, and crisis intervention at lasting up to two months (1971, p. 83). Whittington limits brief therapy to 20 hours (p. 503), Cartwright to 12 (1955a, p. 362),

Errara to six hours (p. 456) and many to only one or two contacts.

Other conceptions of brief or crisis psychotherapy do not address themselves to duration of contract. Barten states,

> Brief therapy is characteristically a technique which is active, focused, goal-oriented, circumscribed, warmly supportive, action-oriented, and concerned with present adaptation. Brief therapy deals with a specific problem constellation. It may aim for the resolution of a present conflict or discomfort, and its objectives indeed may be of an emergency or stop-gap nature. (p. 9)

Effectiveness of Brief Treatment

Rapoport crystallizes the principle concerns about briefer therapies stating,

> Discussion about briefer forms of treatment always elicit questions concerning whether any changes brought about are lasting. This question reveals another erroneous assumption, namely, that if change is going to be long lasting it can be achieved only by a long process. There is another, more important assumption embedded in the question of the lasting nature of change. It presupposes a static life-model; that life-circumstances and experience are predictable and stable, and that, once conflicts have been resolved, no major problems in adaptation will arise. (1967, p. 32)

Cartwright feels,

> . . . in regard to the two therapies, (long vs. short) that they differ in kind of problems brought in by the client. It is possible that short case clients had mainly situational problems. (1955a, p. 362)

This statement is characteristic of the skepticism voiced regarding the psychic impact of brief therapy.

Mental health professionals are becoming increasingly aware of the impossibility of affording traditional remedial psychotherapy to all persons in need. The Community Mental Health movement is committed to the reduction of the incidence of emotional and social dysfunction. Psychoanalysis and psychotherapy are forms of therapy designed to heal the psychological casualities already identified as being in significant on-going distress. Primary prevention focuses upon reducing the incidence of new cases in a population. Efforts are directed at both modifying the environment and strengthening the individual's capacity to cope with situations. Bloom writes,

> Many believe that good mental health is in large measure the result of a life history of successful crisis resolutions; and, therefore, by providing therapeutic intervention to people while they are in crisis, the incidence of subsequent mental disorder in these persons may be significantly reduced. (p. 498)

Regarding short-term therapy, Sarvis states,

> It will be seen that this concept of therapy presupposes that much working through and consolidation may occur outside therapy, during a planned interruption, or a termination based on the understanding that the patient may return as needed for further clarification of the problem or with new problems which may have come up. (p. 366)

Further, regarding the trauma-neurosis model,

> There is no logic in assuming that only a misfortune can have a permanent effect on one's personality. A single, equally intensive, beneficient experience can also leave its mark.

If a treatment can provide such a restorative experience to counter-balance the misfortune, the effect of the trauma may be undone. (Alexander, p. 164)

Wolberg optimistically states,

There are those who, once introduced to a new way of thinking about themselves, and recognizing that their current upset is rooted in their past history, challenge the fundamental conceptions which have ruled their existence. Having achieved a state in this new logic during a few sessions of psychotherapy, improvement then becomes self-perpetuating. Sometimes through forces that we cannot divine, a chain reaction occurs in the absence of any apparent conscious deliberation. Follow-up studies may reveal extensive shifts that were scarcely discernable at the time of termination, and that justify the optimistic pronouncement of successful achievement equivalent to what we might have expected had the patient remained in therapy over a period of years. (1965, p. 190)

In psychoanalysis, the goal is the systematic elaboration, understanding, and interpretation of the patient's total psychic structure, insofar as this is possible. This is achieved by the induction and systematic working through of a regressive transference neurosis by the use of, or in conjunction with, techniques which result in a focus on irrational, repressed, warded-off, unconscious processes. These techniques are free association, frequent visits, relative anonymity and invisibility of the analyst, and so on. (Sarvis, p. 278)

Intensive analytically oriented psychotherapy has a similar, although perhaps more limited goal--limited either in the extensiveness of character-ological exploration, or by the introduction of some unanalyzed perimeters. In some situations, the frequency of interviews is less than in classical analysis, and within this limitation, the patient's motivation and tolerance for anxiety do not permit essentially analytic goals. (Sarvis, p. 278)

Clearly, the goal in both therapies is a significant impact upon the patient's personality which leads to change. "A meaningful personality change, though mostly deriving from an enduring future-bound relationship, may also emerge from significant short term encounters" (Sterlin, p. 366).

With ego supportive treatment, the goals are more exclusively restorative, with unconscious derivitives and characterologic manifestations left uninterpreted. Rather, those processes identified may be clarified, defensive alignments may be strengthened, and super ego constraints eased in the context of the treatment relationship.

Definitions

Crisis Intervention

While it is recognized that crisis intervention and other modalities can be therapeutic, for the purposes of this study, crisis intervention is distinguished from psychotherapy in that the former is characterized as a technique which is exclusively active, problem focused, time limited, and principally clarificative. Psychotherapy is herein considered to focus upon transference, and the elaboration of unconscious material through the gathering of patient associations, and their subsequent interpretation.

Published reports of the use of brief psychotherapy and crisis intervention are quite general in their description, and quite vague concerning their outcome criteria and the methods employed. For instance, with regard to duration and frequency of contact, Alexander recommends from one to 60 sessions (p. 163); Bellack between one and six (1967, p. 70); Socarides two or three (p. 344); six sessions by Paul (1966b, p. 49); a maximum of 12 sessions by both Shaw (p. 411) and Haskill (p. 546); 15 sessions by Campbell (p. 146); and from four to five months by Sifneos (1960, p. 169). Frequency varies from once every two weeks (Haskill, p. 546) to as many as two or three sessions per week (Morley, p. 487), and length of the session ranges from 15 minutes (Haskill, p. 546) to over one hour (Frontiers, p. 42). No standard or even most common practice exists in research material and clinical practice. Clinical work in crisis intervention has been conducted by practitioners from psychiatric nursing, social work, psychology-psychiatry, guidance and counseling, vocational rehabilitation, physical therapy, unpaid volunteers, and others. All agree, however, on one dimension,

> We have failed to realize that by the time a client is seen for diagnosis, after a waiting period, or for treatment after an even longer wait, he is no longer the same person as when he first applied for help. We have failed to note that the symptomatology may have shifted and that something has

> probably happened to his defensive system, namely, that he is more guarded and better defended against his initial anxiety, and, most important of all, that something may have happened to his accessibility which may make it more difficult to work with him effectively and economically. (Rapoport, 1967, p. 34)

It is assumed that the person who applies for service in a state of crisis is experiencing a highly stressful situation.

"A stressful situation is one which elicits painful emotions in an individual" (Sifneos, 1960, p. 176). "Stress is defined as the anticipation of an inability to respond adequately (or at reasonable cost) to perceived demand, accompanied by anticipation of negative consequences for inadequate response" (McGrath, p. 23). Stress is generally experienced as an intensification of the previous level of anxiety, which also signals the person that some initial perception of threat is at hand (McGrath, p. 23). "When these stresses are acute, unexpected, not susceptible to ready solution, or beyond the individual's coping ability, the resulting situation may be a crisis" (Beeker, pp. 296-297).

Research concerned with the scientific measurement of stress and crisis phenomena is still in a state of infancy, and no adequate models appear to be applicable.

It is herein presumed that while crises occur to persons who are in need of psychotherapy, and to

persons who are not, and the crisis itself occurring with an individual does not of itself dictate a psychotherapy intervention. The individual stress is presumed to be of a normative or typical nature, rather than of a psychopathologic one.

"Another useful notion is that a crisis is not an illness, nor is it to be equated with psychopathology. It may be superimposed on psychopathology" (Beeker, 1967, p. 36). Stresses are of differing types and are perceived differentially.

Stress

According to Cath,

> What may be stress for one person is merely a challenge for another. It is generally acknowledged that at any point of crisis the ability to adapt or integrate is related to the maturity of certain ego functions, that is, the capacity to tolerate tension, endure anxiety, postpone pleasures for reality demands, and synthesize the past and present within the current situation. The human ego can tolerate tremendous shock and loss and still expand, grow, and create. (p. 175)

Stress may result from too much or too little stimulus input. There are particular limits, upper and lower, or tolerances for each individual human being, and they are idiosyncratic (McGrath, p. 18). Stressful conditions may be of relatively long or short duration (McGrath, p. 23). Stress involves a series of at least four classes of events, or stages. The first of these is external, and takes place in the environment--the

psychosocial system in which the individual is living. This class of events can be called demand for response, or load of input, or stressor, or environmental force. Second, there is the perception of that objective demand for response which can be labeled objective demand, or strain, or personal definition. Third, there is the organism's response or responses to the then subjective demand at all levels, physiological, psychobiological, behavioral, and social-interactive. Fourth, there are the consequences of the response both for the person and for the larger system or environment in which he is imbedded (McGrath, pp. 15-16).

Betz states,

> The anxieties signaling such distress are responded to in a range of patterns. They may be coped with effectively from a repertoire of conscious and unconscious defense mechanisms, when the individual is relatively mature for his age. Or, the patterns for responding to anxiety may be so narrow in scope, or rigid, as to constitute a problem in themselves--as in withdrawal patterns, or depressions, or in severe obsessive or other neurotic patterns. Or the defensive repertoire may be inadequate to contain the distress, and the individual decompensates into a state of social incompetency as in the psychosis. (p. 478)

He continues,

> It should be emphasized further that a crisis presents a problem in the current life situation. Nevertheless, the current problem may be linked with old conflicts which may or may not have been satisfactorily resolved in the past but which in any case are to some extent reactivated by the current stress. This reactivation of old conflicts is likely to arise because the stresses leading to

> a crisis very often serve as a threat to the gratification of instinctual needs. It is in this manner that "Stress is assumed to have a pathogenic potential." (1962, p. 211)

When under great stress, persons often find that their memories of situations which are analogous to the stress situation, suddenly and unpredictably, come into consciousness, or labeled "surge of unmanageable impulses" the result appears to be an "unrepression" of impulses idiosyncratically determined which are threatening to the particular individual (Janis, p. 179). It is presumed, thus, that psychological stress is that salient factor the management of which utilizes psychological energy which disturbs the person's homeostatic balance.

Duhl (p. 297) and others simply refer to crisis as a significant upset in a steady psychological state. For the purpose of this proposal, this latter definition will be accepted. It must be noted that crisis only refers to the idiosyncratic psychological state of the reacting individual (Rapoport, 1967, p. 35) where reaction is synonymous with defensive psychological mechanism (Sifneos, 1960, p. 176). Reactions are typically acute with specific identifiable onsets and a relatively brief period of duration, regardless of whether the outcome is adaptive or maladaptive (Kaplan, p. 400).

There is no disagreement as to the fact that crisis states are limited in time, lasting four to six weeks, and that they constitute a transitional period which represents both danger of increased psychological vulnerability and at the same time opportunity for personality growth (G. F. Jacobson, p. 210).

Crisis, then, is viewed as an environmentally precipitated painful emotional reaction to which the individual is compelled to react, wherein it is the individual's idiosyncratic perception of the precipitant situation, within his own subjective framework, which determines both the nature and the intensity of the crisis.

Concerning the significance of crises, Rapoport states,

> Although studies have been conducted by people with different approaches and different topics, with no single set of theoretical and clinical interests, there is a common factor among them in that the crises being considered are viewed as turning points--as points of no return. If the crisis is handled advantageously, it is assumed the result for the individual is some kind of maturation or development.
>
> If the stresses engendered by the crisis are not well coped with, it is assumed that old psychological conflicts may be evoked or new conflicts may arise and a state of poorer mental health may be the result. (1965, p. 75)

Most theorists agree that several elements must be present for an individual to experience a crisis. Initially, there must be a hazardous emotional or environmental situation. A situation that is experienced

as difficult or dangerous to the individual as he idiosyncratically defines danger or difficulty is a hazard (Sifneos, 1960, p. 175). Maladaptive psychological reactions to these situations may lead to painful feelings. The painful state is simply defined as an unpleasant emotional state of being (anxiety, anger, or fear) (Sifneos, p. 176). These feelings in turn may develop into an emotional crisis in one individual, or in members of his immediate family if the feelings are experienced as overwhelming to the ego. Such emotional crises usually appear before the onset of psychiatric symptoms (Sifneos, p. 176). The painful state involved in both change and in the anticipation of the unknown provokes the crisis when relief or resolution is not imminent.

The crisis state has been defined as a further intensification or aggravation of a painful state because of a failure of the reactions to cope with the situation. It is a turning point for better or worse (Sifneos, p. 176). Caplan finds the state provoked when a person faces an obstacle to important life goals that is insurmountable through the utilization of the person's typical methods of problem solving (G. F. Jacobson, p. 209). Paul states that,

> Crisis is a term reserved for the actue and often prolonged disturbance to an individual or to a social orbit as the result of an emotionally hazardous situation (crisis is not the same as emergency). (Sifneos, 1966a, p. 141)

Erikson describes what are essentially normal or normative crisis points which result from physiologic, social, and psychological maturational stresses. Each precipitant becomes the focal point for the crisis experience because of what it borrows from other subjective experiential definitions of the patient (Erikson, p. 274).

> The basic functions of "personality" are: perceptual taking in of cues to events within and outside the self; processing such perceptions (coordinating them with previous experiences and current aims); and producing action (behavior). (Betz, p. 481)

When studying the effectiveness of techniques indicated for intervention in these situations, a precondition is a clear assessment of the existence and characteristics of the crisis state (Cath, p. 300). In practice,

> A crisis is defined primarily in terms of a precipitating event and, secondly, in terms of a slow resolution. Known precipitating events are generally judged to lead to crises if (a) there is no reaction or if (b) there is a reaction of any kind and resolution requires more than a month. (Bloom, p. 502)

> Review of the relevant literature suggests that the crucial elements in the identification of the crisis state appear to be (a) a stressful precipitating event of which the individual is aware; (b) significant subsequent rapid cognitive and affective disruption unusual for that particular individual; and (c) duration of the disruption of at least several days. (Bloom, p. 449)

Schenberg and Sheldon observed,

> (1) The greater the objective severity of the situation, the greater the probability of a crisis experience; (2) The greater the number and variety of difficult situations which the person

> has encountered and resolved, the lower the probability of a crisis experience in a given environmental situation; (3) The fewer or less adequate are one's real or perceived abilities to resolve a confrontation, the more threateningly it will be interpreted and the greater the probability of a crisis experience; (4) the more intense the crisis which is being experienced, the more potentially amenable is the individual to suggestion or environmental influence. (p. 553)

Six classes of crisis precipitants have been identified by Rapoport (1967, pp. 36-37) and others. They are: (1) loss or the threat of loss of a significant object; (2) developmental crisis such as adolescence or menopause; (3) external or situational disorder such as a disaster, war, fire, trauma, and the like; (4) role transition, such as adjustment after a divorce, school graduation, or retirement; (5) identification or fear of identification with another person, as in the homosexual panic; and (6) poorly managed or repressed instinctual needs or impulses. This list resembles the causes of neurosis delineated by Freud who mentioned frustration due to loss of an object, inability to adapt to a challenge such as marriage, inhibition in development, and biologic maturation (Caplan, 1967, p. 337).

Forrer has dichotomized crisis in terms of narcissism. A crisis of primary narcissism indicates a weakening of integration and autonomy within the ego itself. "Crises of secondary narcissism require the ego to disavow important aspects of the self which

are continually being reactivated by relationships with other persons" (p. 279).

> At the most descriptive levels, crises involve one or more of the following internal psychological changes: (1) an unusual increase in anxiety or other affect or symptom; (2) the break-through to threshold level of intensity of some counteracted need or attitude of the self or identity fragment; (3) loss or weakening of a psychological defense or external support for a defense; (4) the qualitative change through loss or otherwise, of a complementary relationship which forces the ego to assume new responsibilities; (5) the internalization of a new standard of activity which is at variance with former capacities and inclinations or role change. . . . (Forrer, p. 278)

In the initial phase, there is a rise in tension in response to the initial impact of stress. During this period habitual problem-solving mechanisms are called forth. If the first effort fails, there will be an increase in the level of tension with an increase in feeling upset and ineffective. This state may then call forth emergency problem-solving mechanisms (Rapoport, 1962, p. 214). When the emergency measures fail, the state of crisis ensues. It is likely that the initial rise in tension will be perceived as a problem with which the individual must deal.

> Lindeman's study of bereavement reactions suggests that in the course of everyday living, there occur a wide variety of events which precipitate acute dislocations for the individual. These dislocations are reflected in lowered levels of social functioning and higher levels of anxiety and personal distress. (Kaplan, 1962, p. 18)

A crisis calls for new action; the challenge it provokes may bring forth new coping techniques which may serve to strengthen the individual's adaptive capacity and thereby in general to raise his level of mental health (Rapoport, 1962, p. 212).

Other reactions to crisis are also possible.

> The individual may deal with the hazardous event and his feelings about it with magical thinking or with excessive fantasy; he may respond with regressive forms of behavior, with somatization, or in extreme situations, with withdrawal from reality. (Rapoport, 1962, p. 215)

The person in crisis verbalizes a number of extremely uncomfortable feelings. He feels anxious, and thought processes are often confused and ineffective. He is preoccupied with the problem which precipitated the upset, and memories of similar situations from the past. Feelings of frustration and helplessness characterize the crisis in varying degrees for the duration of the crisis which usually lasts from four to six weeks (Caplan, 1967, p. 339). Rapoport suggests concerning helplessness that

> In part this may be a state of cognitive confusion wherein the individual literally does not know how to think of his problem, how to evaluate reality, and how to formulate and evaluate the outcome of the crisis and the possibilities for problem-solving. In extreme states, there may also be perceptual confusion such as in the temporal or spatial sense. (Rapoport, 1962, p. 215)

Clinical-Theoretical Considerations

Homeostasis

According to Kalis, the crisis intervention approach is based in large part upon a concept of psychosocial homeostasis.

> Psychiatric theory pictures the mental apparatus of an individual continuously maintaining and re-establishing its stability after disturbances by external and internal stimuli.
>
> Whenever this stabilizing process fails, a type of emergency state arises. Anxiety which represents repetitions of early traumatic states appears. The continuation of such unresolved tensions eventuates into overt psychopathology. (pp. 27-28)

Caplan believes that effective intervention in the emergency state can avert the formation of pathological coping patterns and enhance the functioning of the individual.

> We try all kinds of things which we did not try before in order to see if we can handle this situation; and eventually, and this is the particular thing about it, I think it has something to do with the homeostatic mechanisms of life--eventually we will find some way. That is why the crisis does not last longer than about four to six weeks. (1961, p. 41)

Precipitating Events

Crisis theory assumes the existence of a specific precipitating event, which creates a state of disequilibrium in the usual manner of functioning (Parad & Parad, p. 420; Jacobson, p. 1177; Caplan, 1961, p. 40; Kaplan, 1962, p. 19; Kalis, p. 28).

Kaplan has observed that,

> Acute situational problems occur when three conditions have been met. The first condition is the existence of the relevant nonpathological characteristic(s) in an individual without which the problem cannot occur; fertility, for birth problems; racial traits, for problems of discrimination; appropriate age for retirement; and so on. The second condition consists of those values inherent in the individual by virtue of which an event is perceived as a personal threat; thus premature birth is a problem for a mother when she values carrying the pregnancy through to term; retirement constitutes a threat to an individual when he places a high value on his position as an active, productive person and perceives retirement as involving a loss of this position. The internalized individual values generally reflect the values of the culture and the subculture to which he belongs. The third condition consists of the occurrence of events that constitute a threat to the individual: premature birth, death in the family, diagnosis of a chronic illness, and so on. (1962, p. 19)

The third condition need not occur if the second is sufficiently invested that the fear of the event is as threatening as the event itself.

A crisis occurs when an individual is unable to solve an important problem through customary methods and when alternatives are not readily apparent. Numerous authors and agencies have surveyed the precipitating events and presenting complaints of patients or clients making application for service to psychiatric outpatient clinics and social agencies. Many of the presenting complaints are not the result of symptomatology or psychiatric illness, but rather are the result of the individual experiencing everyday events typically

experienced by everyone in the course of a lifetime. McCleod, in a study of 100 applicants for psychiatric services, found the following distribution of precipitating events:

Table 1

Distribution of Precipitating Events

Separation	27
Death	16
Pregnancy	12
New Role for Patient	11
Illness or Injury to Patient	10
Divorce	4
Marked Change in Children	4
Job Loss	3
Marital Discord	3
Role Change in Other	3
Illness of Other	3
Unclassified	4
	100

Source: McCleod, p. 193

Gary Jacobson (p. 720), surveying the precipitants of distress in persons applying to a mental hygiene clinic, found that " . . . about one quarter of the patients (26%) reported the loss of an important friend or relative in the month prior to their contacting the clinic."

In family service agencies clients tended to apply most frequently for marital difficulties (21.9%), maturational and transitional events (14.3%), school and family problems (10% each), and all categories of loss or threatened loss of object (41%) (Parad & Parad, p. 420).

Anxiety and depression were found by Sifneos (1960, pp. 170-171) to be the most frequently mentioned affects associated with presenting complaints. The Parads (p. 421) in a comparative survey of psychiatric clinics and family service agencies found that over 20% of the family service applicants requested help within four days of the precipitating event. In the psychiatric clinic population the corresponding figure was under 10%. Similar data are reported at 7, 10, and 14 days. These data tend to suggest that people will wait slightly longer before calling for psychiatric assistance than they will for a service which is perhaps perceived as less threatening, such as family counseling. Approximately half of the applicant population from both groups, however, applied for service within 30 days of the precipitating event. Regardless of agency, orientation of the clinical staff, or type of patient, it is apparent that for at least half of all applicants, in the recent past, an event has taken place which as a precipitating factor, seemed to bring anxiety into the open, thus motivating the individual to seek assistance (Sifneos, 1960, p. 171).

> Fenichel points out that "there are precipitating factors for psychoneurosis or non-neurotic acute upset states which can be compared with traumata. A person may have evolved from old infantile conflicts into a state of relative equilibrium between repressed and repressing forces. An external alteration may mean a disturbance of

> this equilibrium, and thus make a hitherto attained adjustment more difficult." The anxiety indicates the re-emergence of conflict which recapitulates early traumatic states, and a new equilibrium must be sought. (Harris, p. 466)

Restoration of Homeostasis

One of the two major techniques for restoration of balance is reducing the severity of the crisis. This is accomplished primarily through clarification of the situation and separation of the external event from its internal definition. The second technique is stabilizing the individual by restoring defenses that had, prior to his crisis, enabled him to function more satisfactorily (Wolberg, 1967, p. 922). This is accomplished by encouraging the use of the previously effective defenses in gradually more difficult areas.

Rapoport attends to finding new adaptive patterns as ways of handling conflict or finding solutions to problems before they become heavily conflicted.

> The enhancement of coping patterns is achieved by a process that has decided educational components, such as anticipatory guidance, rehearsal for future reality, learning new social and interpersonal skills, and enlarging the capacity for anticipatory thinking and prediction. The educational process may be less verbal and more based upon identification. Here the therapist consciously offers himself as a model for identification and encourages rehearsal of behavior and attitudes in regard to new roles. (1967, p. 48)

This intrapsychic process is described by Brockbank as follows:

> Adaptation or fitting together as Hartman refers to it, is a highly complex process involving all three components of the human psyche and is not merely a function of the ego. It involves particularly the integrative and synthetic functions of the ego, and the relationship of the id and the superego to these ego activities. (p. 322)
>
> Adaptation, therefore, refers to ego defenses, whereas coping mechanisms refer more to the adaptive capacity of the ego to take appropriate and rational action in response to the perception of stimuli. (p. 323)

When the individual feels need to find new resolution of a felt difficulty, if his coping mechanisms are still open and fluid, he will likely achieve mastery of the difficulty without personality constriction. If coping methods are not fluid and available, he may compromise with the difficulty and find some less adequate adjustment, or may even use regressive devices, detrimental to his future mental health (Porter, p. 14). Progressive adaptations are those which occur in the direction of development. Regressive adaptations hinder the normal developmental process (Brockbank, p. 323).

Post-crisis readaptations will vary with many factors, including the previous level of psychic equilibrium, the severity of the disruption, the availability of coping mechanisms and environmental supports, and the speed and appropriateness of intervention (Harris, p. 467).

Goals

When an individual or organization attempts to provide an intervention system for a person or persons in acute stress or in psychological crisis, central is the need for a genuine acceptance of the concept of limited goals (Rapoport, 1967, p. 37). Preoccupation with the grand strategy of comprehensive concepts frequently blinds the therapist to the impact and significance of immediate issues (Regan & Small, p. 84).

Four short-term goals can be identified, any or all of which may be appropriate. These are (1) the restoration of the individual's previous balance; (2) the resolution of the stress-producing event; (3) simple symptom removal; and (4) the resolution of the psychic derivatives which facilitated the precipitation of the crisis state.

Restoration of the previous balance is the minimum goal. The thesis here is that if the previous level can be sufficiently strengthened, the individual is not likely to experience a succession of crises, eventuating in a lower adaptational level (Gary Jacobson, p. 1180; Wolberg, 1967, p. 921).

Many believe that with short-term work, the only goal is the removal or amelioration of specific symptoms. Typical is the view of Bellack,

> In its symptom-directed orientation, brief psychotherapy seeks to improve the individual psychodynamic situation sufficiently to permit the person to continue functioning, to allow "nature" to continue the healing process, and where indicated, to increase the self-supporting ability of the individual sufficiently so that he may be enabled to continue with more extensive psychotherapy. (1965, p. 9)

Mayerson (pp. 94-95) is in essential agreement that through removal of debilitating symptomatology the patient can be more easily returned to premorbid levels of functioning. This is primarily accomplished with the additional exploration and clarification of the reasons for, and gain involved in, the symptom's existence.

For Harris (pp. 466-467) and McGuire (p. 84) the aim is the resolution of that portion of the patient's difficulty which causes his internal stress. The resolution of any difficulty, regardless of at what level, necessarily alters the structure as a whole. "Indeed, long-term psychotherapy is frequently described as the working through of a succession of derivations" (Harris, p. 467). There is further a deliberate avoidance of conflict areas which are not a part of the current crisis situation, as in the case of character problems.

In addition Harris advocates clarification and resolution of the precipitating stress. Precipitating stress is resolved through exploration of the conflict derivatives involved in that stress (p. 465). Gerald Jacobson (p. 209) and Rapoport (1967, p. 40) are clear

that while conflict derivatives are explored, one would not expect him (the patient) to work through all of his problems, but rather only those that the material indicates are necessary to handle the acute situation.

Objectives of Crisis Intervention

Objectives at termination are the patient's being able to utilize his own adaptive reactions and environmental resources, and to return to a state where there is little or no pain (Sifneos, 1960, p. 178). The patient is seen as being able to anticipate impending crises prior to their evolving (Rapoport, 1967, p. 43). His sense of autonomy and mastery is enhanced, and he has learned to utilize his assets to best interest to minimize his liabilities, to avoid crises, in relationships to people to organize his activities around his character, and to discover and release some positive qualities within himself (Wolberg, 1967, p. 85). Bellack suggests that later life crises are more easily avoided or worked through because of structural changes which are begun during the therapeutic contact (Bellack, 1967a, p. 131).

Wolberg argues that the patient in short-term or crisis psychotherapy should be acquainted with other personality problems that inhibit a more productive life adjustment; educated to the availability of other forms

of therapy such as long-term; and learn remedial measures that can be applied to environmental difficulties (Wolberg, 1965, pp. 129-130).

Goal-Focused Technique

While agreement is common that a focused treatment technique is appropriate in crisis intervention, there is disagreement as to what are goals to be focused upon. Rapoport argues,

> Certain basic principles requisite to goal focused and time limited treatment may be delineated as follows. A little help, rationally directed and purposefully focused at a strategic time, is more effective than more extensive help given at a period of less emotional accessibility. This suggests that one should make use of anxiety when it is at its height. A corollary to this principle is that there needs to be continuity of contact, and a use of time, structured as to its limits and, within such limits, flexibly arranged. (1967, p. 21)

To capture anxiety, treatment must focus upon the immediate problem, the crisis, or stress-producing event, rather than upon long-standing pathology or well-established characterological problems (Gerald Jacobson, p. 210). The term "focus" or "focal problem" is a designation for the major problem, along with historically important dynamic relations, patterns of adaptation, external environmental difficulties, or physiologic imbalances--on which therapeutic work is concentrated (Gerald Jacobson, p. 894). The selection of one of the patient's "problems" as the "focal problem," and then

the selection of a critical area for treatment within that focus becomes an expression of the major concentration of the therapeutic effort (Regan & Small, pp. 292-294). Disagreement exists too on what, why, and how to focus the intervention plan. Kaplan (1968, p. 155) suggests focusing upon the client in the context of his family and community caretaking relationships. Kalis (p. 33) and Semrad (p. 594) both recommend focusing upon the precipitating event, but for differing reasons. Kalis would have the therapist understand the derivatives (unconscious) of the precipitant, while Semrad recommends an attempt to resolve the external factors in the stress-producing event. Harris (p. 467) quotes from Fenichel,

> Conflicts arise when new experiences occur that are connected with what had previously been repressed. Then there is a tendency on the part of the repressed to use the new events as an opportunity for an outlet; it tends to displace its energies to it, to turn the new event into a derivative.

Elsewhere he states,

> We must work not only at the point of actual instinctual conflicts, but at the point of the most important current instinctual conflicts. It is the point of the most important conflicts at the moment. (p. 468)

Caplan states,

> The short-term focus of this preventative model is on the pattern of adaptation to developmental and situational life crises.
>
> These crises represent transitional points, at each of which the person may move nearer or farther away from adaptive patterns of functioning. (1967, p. 332)

Whittington (p. 516), Kalis (p. 33), and Regan and Small (p. 896) expand upon Caplan's statement, feeling that the area of immediate focus should be selected by a process of enlightened guesswork, based upon a clinical judgment as to what defensive, resistive, repressive, and adaptational patterns existed in the past, and what the current presentation of the patient constitutes a more or less pathological or morbid process. Regan and Small warn of the seriousness of the selection process, stating,

> A well selected critical area is one in which the patient experiences considerable anxiety, an area where he may be reasonably expected to exert effort to alter the characteristic pattern, and where his chances of changing the pattern are good. The criterion of success is not necessarily insight, but change in the pattern. If the area in which the focal problem is explored is not sufficiently critical, only intellectual insight is achieved, because the experience is not sufficiently meaningful emotionally. If the critical area carries too heavy an emotional charge, the patient is not able to handle it and will retreat. Such a retreat may take the form of panic or suicide, withdrawal from treatment, increased symptomatology, or increased resistance in treatment. (p. 896)

The Technique of Crisis Intervention

Duration and Frequency

Considerable variability exists among practitioners in the structure, process, and content of crisis intervention techniques. Masserman (p. 78) believes that emergency psychotherapy is administered through no more than five or six interviews at intervals of no

longer than one week. The interview is to be no longer than one hour. McCleod (p. 195) prefers initial visits on a one-hour or longer basis, and follow-up visits of 15 minutes in duration with a frequency of one session every two weeks, ranging to three sessions per week. Levy (p. 40) limits the number of sessions to six, ranging three per week for two weeks to one visit every few weeks.

Paul, who favors six sessions states,

> The limit of six interviews tends to thwart the client from becoming too reliant on the therapist and thus lessen his own self-reliance, self-esteem, and functional competence. In turn, the time limit compels the therapist to mobilize both his and his client's resources for achieving their goal of social restoration, and also acts as to diminish any covert omnipotent strivings the therapist may have. (1966b, p. 50)

Barten (p. 87) recommends face-to-face interviews once, twice, or even three times weekly, lasting anywhere from a few minutes to an hour. He limits the contact to a period of two or three months. All theorists agree that crisis intervention should occur as quickly as possible after the perception of the difficulty is conscious. Practitioners disagree as to the length of time that may exist between the precipitant and the intervention, such that the therapy is still crisis intervention. The variability ranges from 24 hours to three months, and all are set arbitrarily.

Early Intervention

The argument for early intervention consists of the fact that since during crisis, the person's usual defenses are weakened, he is more apt to reveal more pertinent information more quickly. Further, it is felt that conflicts are more accessible since they are still active, and that secondary gain which is a frequent impediment to change, has not yet had much of a chance to solidify (H. Parad, p. 278). It is further argued by Kalis that the application for help means that something has happened which makes that patient unable to continue the successful adaptation which he had previously achieved (p. 28). The question of why a person comes at the time he does,

> . . . is broadly conceived as including not only what is going on that is distressing, but also what is it that is expected from the institution in the way of help for this distress. In answer to this question, the patient frequently cites long-standing difficulties, refers to the build-up of tension, or offers rationalized explanations. (Harris, p. 467)

This phenomenon occurs because the patient is typically not aware of the consequences of the precipitating stress and its relationship to the current distress (Rapoport, 1967, p. 216). It is also the case that even if the individual is aware of the precipitant and some relationship to the present functioning, that he

is unaware of the unconscious processes that caused the event to escalate into something of crisis proportions (Rapoport, 1962, p. 216).

Activity Level

Paul (1966b, pp. 49-50) and Stricker (p. 153) recommend a very high degree of activity on the part of the therapist to direct the patient away from his long-standing complaints (typically used to defend against the anxiety attendant to the crisis) and towards the present situation. Another approach recommended by Sifneos involves the therapist attempting to,

> . . . convince the patient that he (the therapist) is eager to help, and allow him to talk freely without interruption. He (the therapist) "lends himself" to the patient by taking over some of his decision making functions. He helps him to understand the ways in which he handled his feelings when faced with hazardous situations. He predicts the future behavior on the basis of past performances and thus, prepares him to avoid future difficulties. (1971, p. 87)

A high degree of therapist activity underscores the fact that a therapist is doing something. This process facilitates the development of hope and the expectation that the patient will be helped. Frank (p. 349) has observed, "If hopelessness can kill, it seems reasonable to suppose that activities designed to raise a sufferer's hopes can promote healing." It has further been demonstrated that mutual expectations of patient improvement by therapist as well as patient

are significantly correlated with patient improvement, regardless of the instrument or criteria for positive outcome.

The greater degree of therapeutic activity has one significant pitfall. Referring to the crisis interventionist, Townsend states,

> He can and must understand the person and his problem as fully as possible, but must never lose sight of the fact that the problem remains the client's and, if anything is to be done about it, the client himself must be the one ultimately to do it. (p. 378)

There is, then, a difference between doing with, and doing for, the patient. The former breeds autonomy while the latter breeds dependency. The goal is to enable the patient to "see" and contemplate "rationally" the alternative courses that are open to him to "resolve" his predicament, <u>not</u> to "resolve" it for him (Strickler, p. 150). Semrad (p. 578) argues that the therapist must remain watchful lest he stray from a strict problem-solving approach in crisis intervention. Strickler has found that this approach has much in common with what has been traditional social work professional practice.

> Social work is the most characteristically problem-solving oriented of all the mental health professions. In both casework and group work, treatment is focused on current problems related to emotional and social relationships, and pertinent areas of social dysfunction which are selected as the target for intervention; the importance of precipitating events is recognized; time limited goals are set; active focusing

> techniques are used; and treatment is geared to the level of conscious and near-conscious emotional conflict. This is equally true of crisis treatment. (p. 150)

Because they are offered to different kinds of patients and are technically dissimilar, psychotherapies of short duration may be divided into two groups: (1) anxiety provoking or dynamic and (2) anxiety suppressive or supportive. A certain degree of anxiety is necessary, even in supportive therapy, and too much anxiety provoked through confrontation will cause the patient to flee. The balance of a workable amount of anxiety and a supportive focusing of that anxiety on a workable problem is the hallmark of crisis intervention.

The therapist must maintain a high degree of flexibility, concentrating not only on the affective balance in his patient, but on environmental forces as well. An optimal blend of dynamic theory and common sense will inevitably lead the crisis therapist into numerous areas, and to a consciously more superficial coverage of those areas than would be the case with traditional psychotherapy.

For agitated patients for whom words come with great difficulty, Wolberg recommends the initial focus be upon the distressing symptoms.

> The patient is only too eager to talk about these. Their exploration may lead to a discovery of provocative anxieties and conflicts that initiate and sustain them. The importance of giving some meaning to disturbing or mysterious complaints

> cannot be overemphasized. So long as a symptom remains unidentified, it is autonomous and a frightening foreign body. To label it, to explain its significance gives the individual a measure of control by helping him to restore his sense of mastery. This enables him to function better, since in finding out some reasons for his symptoms, he can utilize his energies to correct their source. (1965, pp. 159-160)

The energies to which Wolberg refers are those that are freed up when the person no longer has to use them for worry or fear of the unknown--the strange--the dangerous that is happening "to him." This type of initial exploration and clarification is an example of the case wherein patients can make great use of just one or two interviews of primarily diagnostic work, and experience a great sense of relief (Gary Jacobson, p. 718). The simple act of focusing upon one thing at a time often places the problem segments in such bold relief, that possible solutions which may have been overlooked become readily apparent (Barten, p. 17). Understanding a number of segments may prove a catalyst for the discovery of broader solutions for the patient's difficulty (Gary Jacobson, p. 16).

Command of a Theoretical Reference

More than any other form of therapy, crisis intervention relies upon the therapist's thorough understanding of dynamic theory. The therapist is deliberately pressured to formulate case material during the

first interview into a dynamic diagnosis, and is urged to tentatively test these hypotheses in that initial hour (McCleod, p. 192).

Fenichel, referring to psychotherapeutic prophylaxis, states,

> An analyst is able to use the patient's symptoms, history, behavior, and utterances for the purpose of establishing a "dynamic diagnosis" about the patient's leading conflicts, the relative strength of the repressing and repressed forces respectively, of the defense system and its weak spots, of the patient's rigidity or elasticity, of his general accessibility. This dynamic diagnosis will enable him to predict with a certain degree of probability what the patient's reaction to certain measures will be. Combinations of limited interpretations, provocations of certain types of transferences, providing well-chosen substitute outlets, alteration of the environment, suggestions or prohibitions of unconsciously tempting or reassuring situations or activities, the verbalizing of actual conflicts, and advice about mental hygiene can very well be systematized. (p. 565)

Strategy of Crisis Intervention

Strategy in crisis intervention must be carefully but quickly conceived. What seems most parsimonious for one patient might be quiet inappropriate for the next. Since the crisis therapist should work toward the management of only that material needed to work through the acute disorder, the work plan must be as individualized as the idiosyncratic response to the original precipitant was for the individual patient (Strickler, p. 153). Awareness of dosage or pacing the experiencing of affect in the treatment is also

essential. Too little affect likely will mean relatively little improvement. Too much affect will risk an overwhelming of the patient's ego. This can lead to precipitous regression, to intensification of defenses, and quite possibly, to the patient dropping out of treatment (McCleod, p. 193).

Sifneos articulates five basic tenets of crisis intervention practice.

> The patient's motivation should be utilized in making the therapeutic work a joint venture. The patient should be helped to review and understand the steps that led to the development of the emotional crisis. The psychiatrist, on the other hand, must challenge and minimize the value of actions that he considers to be antitherapeutic and which may lead to further complications. The therapist must also try to teach the patient to anticipate situations likely to give rise to emotional difficulties similar to the ones he is experiencing. (He must) avoid by all means getting involved in the patient's characterological difficulties. (1966, pp. 125-126)

Such statements as "We had better find out how this thing happened," or "Let's take a look at your situation so we can figure a way out of it together," are examples of enlisting the patient in a "joint" venture with the therapist. Further, however, the open expression of the therapist's interest in the patient and concern for him as a person, is not only supportive, but causes the patient to want to help the therapist in their mutual task. This is one of the foundations of all elementary training in the mental health professions.

Most, if not all, clinical endeavors focus upon a dynamic etiology in the early phases of the therapy. Public agency practice forces the therapist to verbalize his interest in the area due to time considerations and the need for rapid diagnostic formulations. Questions of etiology are raised by intake forms and intake workers as a matter of agency policy as well as clinical practice. In crisis intervention, connections between the current time and recent events which may have been disruptive, or evocative of the current conflict, are fully explored. There should be a clarification linkage between current stresses and previous preconscious or unconscious conflicts that was not entirely successfully resolved (Rapoport, 1967, p. 38). According to Whitaker and Malone,

> In brief depth therapy, the emphasis shifts from an objective analysis of the historical determinants in the patient's behavior to a contemporary participation and response to the patient's behavior during the interview. The therapist accepts, as a point of departure, the notion that all of the patient's therapeutic participation is essentially symbolic in character. (p. 505)

Deeper issues may be explored, and yet not resolved in crisis intervention. They are only inadvertantly discussed as the patient may bring them up. If they become a major part of the therapy, short-term goals must be abandoned (McGuire, p. 85). One avoids picking up trends which are not directly related to the presenting

problems, and refrains from pushing certain aspects of the patient's problems which have roots too deep to probe in this type of therapy (Pumpian, p. 647). "Early dependent needs and problems with passivity, which create entanglements and lead to complications during treatment, are especially avoided" (Sifneos, 1961, p. 171).

In reviewing the suggested techniques of 10 of the most prolific author-practitioners of crisis intervention, one finds over 50 different descriptions of their own recommended techniques to be used in practice. They range in complexity from Beeker's single suggestion (p. 298) "The interviewer, if his intervention is to be truly preventative, should simply lend the kind of support which the person in crisis needs in order to work out the solutions himself," to a 15-point plan put forth by Wolberg. These numerous recommendations appear, however, to group under a few broad areas. The following table outlines that breakdown (p. 44).

Matters of individual style and semantics account for a majority of the differing recommended interventative techniques. There appears, however, to be general agreement that the traditional analytic stance is less than optimal for crisis intervention. There also appears to be general agreement on the overall focus of therapeutic activity. Rapoport states,

Table 2

Recommended Techniques for Crisis Intervention

ACTIVITY LEVEL	Sterlin Active approach Involvement Enthusiasm	Semrad Active discussion Use of reason Confrontation Information	Garner Advise Suggest Persuade Command Forbid Exclaim Confront Reassure	Gutheil Active	
PLANNED PASSIVITY	Wolberg Ignore "deep" problems	Garner Passively ignore "deeper" problems			
INTELLECT	Sterlin Joint conscious Assessment of problems	Wolberg Identify immediate problems Rank symptoms History Connect the past and present Clarify Explain Foster intellectualization	Semrad Clarify	Bellack Foster catharsis Foster intellectualization Clarify	Masserman Foster intellectualization Identify Label Clarify

Table 2--Continued

INTELLECT	Garner Clarify	Gutheil Clarify	Pumpian Clarify	Rapoport Describe Define Reorder experience Clarify	
USE OF INTERPRETATION	Sterlin At termination	Semrad Inappropriate	Bellack Use in areas of drive repression super-ego control, and self-esteem	Masserman Traditional	Paul Not recommended
	Wolberg Preconscious material only	Garner Traditional	Gutheil Traditional	Pumpian Traditional	Rapoport Not recommended
USE OF TRANSFERENCE	Sterlin Ignore the positive "Tackle" the negative	Paul Equality of social power Confront Humanistic	Wolberg Discuss Reassure Clarify	Bellack Interpret Negative	Rapoport Clarify if necessary Ignore
REFERENCES	Sterlin, p. 358; Semrad, pp. 582-583; Bellack, 1937a, p. 131; Masserman, p. 79; Gutheil, p. 59; Pumpian, pp. 649-650; Rapoport, 1967, p. 39; Paul, 1966a, p. 143; Garner, p. 16				

> Communication should be addressed to certain aspects of the ego, such as the defensive system which needs to be strengthened; the cognitive system which needs help with intellectual mastery through explanation and clarification; the affective system, in order to lower tension, anxiety, or guilt; and the adaptive and coping parts of the ego, which need strengthening and enlargement. (1967, p. 38)

The greater engagement of the perceptual and cognitive functions of the ego by describing, defining, and reordering recent experience, Masserman states,

> . . . helps in two major ways. First it focuses the available energy of the personality on the problem, an initial step in mastery and second, the new definition of the problem keeps it from drawing it into affects from other conflictual areas. (p. 79)

This engagement (clarification) is the only technique which is consistently recommended in Table 2. He continues:

> Clarification is generally thought of as an explanation of the patient's situation in which material (generally conscious, sometimes preconscious) is brought together in what is for the patient, a novel arrangement. A casual clarification would undertake to link a precipitating event with its sequelae. A descriptive clarification, on the other hand, defines a situation more clearly. (p. 32)

Regarding interpretations, those advocating a prohibition argue that the very definition of psychoanalysis rests upon the systematic elaboration of the unconscious and transference through interpretation which is contrary to the goals of crisis intervention. Others argue that transference and interpretations are utilized to a limited extent in so far as they are

directly concerned with the conflict area. A third group feels that no differences should exist regarding technique. Pumpian states:

> Interpretations which are made, are couched in more general terms are not related necessarily to specific historical conflicts and difficulties in the patient. In addition, interpretations are usually made not in terms of the unconscious underlying impulses but in terms of the more readily available preconscious material. One works primarily with the reverberations of earlier conflicts as they are reflected in adult and adolescent behavior and attitudes rather than attempting to uncover the genetic childhood conflicts per se. (pp. 649-650)

Since the crisis itself is a manifestation of the actual or threatened break-through of repressed impulses, there must be at least a minimal understanding of the linkages between the behavioral/affective, and the causative areas, which may well still be at a level other than consciousness when the patient makes application for assistance. Such linkages can only be established through the use of interpretation. When defenses have become debilitating, or where temporary adaptations are dysfunctional, those elements of the symptom formation which are not conscious will require interpretation.

An area where interpretation would appear to be optional rather than mandatory is that of transference. Whittington defines transference as follows,

> The brevity of the process, active interaction between therapist and patient, focus on current reality problems, all tend to obscure and distort transference. Nevertheless, idiosyncratic emotional responses in the patient, directed

> toward the therapist, and relatively independent of the therapist's personality or activity in the hour, do occur; for want of a better word, the unconscious attitudes, feelings, and expectations, as they become evident in the therapeutic process, will be termed transference. (pp. 504-505)

He continues that interpretations need not be exclusively verbal,

> Rather the process is one of active interaction, in which the therapist thwarts the gratification of transference expectations by actively resisting being cast in the transference role assigned by the patient, so that the transference distortions become clearer until they are, perhaps directly interpretable. This is quite a different technique from the "blank screen" of psychoanalysis, in which the therapist frustrates gratification of transference wishes by his inactivity and neutrality with resultant regression. In short term therapy, an active role must be adopted and transference actively dealt with as it arises, thus minimizing regression. (p. 516)

Transference begins when the patient seeks assistance for even at that time he has some expectation of what he will receive or encounter. Expectation is a conscious or nearly conscious belief that something will happen which involves oneself (McGuire, p. 219). Most patients do not expect to become emotionally involved with the therapist, but rather expect specific answers to their questions, as in a problem-solving process (McGuire, p. 86).

A premise common to all authors surveyed is that in short or brief work, termination should be effected before the development of a transference neurosis. Sifneos, while observing that a positive transference

is the main tool of short-term psychotherapy, has speculated that there is an optimal period within which the aims of the therapy must be achieved. He states, "Aims are achievable as long as a positive transference exists, but must be achieved prior to the full development of the transference neurosis" (Sifneos, 1961, p. 173).

The most superficial positive transference may be termed the rapport of a positive therapeutic relationship. Semrad observes that,

> In this state, the patient thoroughly believes in the therapist and thinks he has the knowledge that may help him. He is willing to talk because someone in his environment wants him to talk or because he thinks that he is talking to a doctor, and it is a doctor's prerogative to expect his confidence and his duty or privilege to give it. He usually hopes to gain something. (p. 595)

Guthiel believes,

> We almost never interpret the so-called positive transference, unless it interferes with the treatment in some way. The negative transference, however, has to be interpreted at once. (p. 63)

It is presumed that long-term, or particularly intense, negative transference feelings will eventuate in premature termination by the patient. Paul states that

> Obstacles to therapy such as mistrust, despair, skepticism, scorn, contempt, sarcasm, cynicism, antagonism, or anger directed at the therapist . . . arising and interfering . . . must be investigated and reduced immediately. (1966b, p. 50)

In such cases, the therapist first clarifies the nature of the patient's feelings, and when more than clarification is necessary, he helps the patient to see

that the therapeutic relationship is a condensation of all transference relationships of the past (Whittington, p. 506) and, when necessary, develops the connections between past affective experiences and the patient's present emotions for the therapist. Whenever possible these feelings are related to the precipitant of the crisis situation and the reason for application for treatment. Whittington (p. 505) points out that while there is agreement that transference should be minimized, maneuvers such as ignoring, denying, or manipulating transference only serve to prolong rather than to minimize transference distortions.

Omnipotent fantasies about the therapist which might be counterproductive to long-term work can be a strong ally in crisis intervention. They serve to increase and enhance the credibility of the therapist and speed the process of therapeutic guidance (Masserman, p. 83; McGuire, p. 85). The therapist, however, must thwart gratification of this transference expectation to insure the patient taking a role in his own recovery (Whittington, p. 516).

The Process of Crisis Intervention

The process of crisis intervention can be described as follows: The initial interview with persons in crisis should occur as soon after the initial

contact (telephone or otherwise) as is possible, and certainly within seven days. The therapist focuses initially upon the patient's perception of "How can I be of service to you," and then "What brings you to the agency at this time." What the patient wants, and why he feels he needs it now, are the dual avenues leading the therapist to identify both the precipitating event and those defenses which have failed to maintain the integrity of the ego, as well as the defensive maneuvers employed against the responses to the precipitating stress event (Paul, 1966a, p. 142).

There must be an overt acceptance by the helping person of the disordered affect, irrational attitudes, or negative responses (Rapoport, 1962, p. 216). The therapist must also determine what the patient thinks of the meaning of his state, whether he has felt similarly in the past, how he felt prior to the onset of his upset, and what attempts he has made to correct his balance, this time and on previous occasions, if any (Wolberg, 1967, pp. 923-924).

While gathering these data with the patient, the therapist must be involved with two additional processes. Initially, the therapist must authoritatively inform the patient as to the normal nature of his reactions, stressing that many people feel like he does at similar times. Further, the patient should understand the fact

that it is only the intensity and perhaps the duration of the patient's feelings which are unusual. The patient must come to feel the therapist has a great capacity, interest, and willingness to "attack" the difficulty jointly with the patient. "You and I will have to learn a number of things about you, and how you got into this predicament so we can determine your best way out," is a statement which both stresses the "we-ness" of the task and instructs the patient as to the "rational" nature of the process.

The crisis therapist must be particularly in touch with his own feelings and psychic associations from the theory so that, shortly after beginning the initial interview, he can formulate an initial hypothesis as to the patient's current dynamic overlay and consider possibilities for returning the person to their pre-morbid state. Once the therapist has tentative formulations he asks for verifying data from the patient's history. Once the therapist feels confident of his theoretical postulations concerning this particular patient, he can begin to make connections between the patient's present complaint and previous episodes or residual personality difficulties (Wolberg, 1967, pp. 923-924). In a reasonable and uncomplicated fashion, the therapist makes these connections, including their relationship to the precipitating event and the impulses which are

being warded off. The discussion includes acquainting the patient with the primary (most powerful) defenses he is using against recognizing and feeling the impulses (Paul, 1966a, p. 142). When resistance appears, the therapist must be prepared to deal directly with why the patient is in such a state of fear of the warded off impulses as they relate to the history. Normalization of these impulses frequently allays the fears and melts away the resistance. A statement such as, "Anyone who had lived your life would likely feel as you do now," both makes the feeling somewhat more acceptable and suggests the focus and solution must be idiosyncratic, based upon that particular individual's experience in life.

Therapists involved in brief and crisis intervention find that the luxury of time for reflection and consideration of each intervention conspicuously lacking. Most staff members respond with anxiety about bypassing the "protective" screening of patients in the traditional intake interview (Frontiers, p. 2). A few staff members might remain too anxious, too passive, or too bound by their own carefully developed theoretical orientations to participate effectively in crisis intervention (Frontiers, p. 2). As with any clinical methodology, if after training the therapist's discomfort remains high, he should not be forced to remain involved. He should

be encouraged to continue with those methods with which he is comfortable (Townsend, pp. 392-393).

Variables in Crisis Intervention

Mutuality of Expectation

Strupp points out that "Heine and Trossman (1960) have shown that mutuality of expectation is an important factor in the continuation of a therapeutic relationship" (p. 8). Patients are most accustomed to the medical model for dealing with their internal difficulties. They have been told on a number of occasions something like, "Take these pills for 10 days, and then we'll see you again," or "We'll fix you up in just no time at all," or "We'll have to take some tests," or "It's your nerves." The expectation of being fixed or told what to do must be dealt with early in the sessions and can well be the therapist's greatest ally. Telling the patient that he will have to work with the therapist, and how that work will proceed, most frequently will satisfy this expectation, and the patient will generally readily "obey." With clear instructions, the patient can quickly begin using problem-solving techniques in the sessions and should be informed as to his progress periodically.

Social Class

Social class as determined by Hollingshead's and Redlich's criteria has proved a significant

psychotherapy outcome variable in numerous previous studies which find that the lower the socio-economic class, the greater the likelihood that a patient will self-terminate, and the shorter the agreed-upon treatment contract (Brown, p. 432; Mayerson, p. 93). Hunt has suggested that traditional psychotherapy may well be a middle-class therapy, and Lief and associates suggest that analytically oriented psychotherapy be offered to class II and III patients and that more appropriate treatment methods be devised for class IV and V patients (p. 730). The class levels referred to herein are as follows:

> Level III includes proprietors, the bulk of small business people, white-collar and skilled workers; this group consists predominantly of high school graduates. Level IV consists largely of semi-skilled workers and laborers, with an educational index below the secondary level. Level V includes unskilled and semi-skilled workers who have an elementary education or less, and live in the poorest areas of the community. (Redlich, et al., p. 729)

Sociological research demonstrates that neurosis shows a higher incidence in the higher social levels and a remarkably low incidence in social levels IV and V, and that the reverse is true for psychosis (Redlich, et al., p. 732).

Mayerson finds in clinical practice that,

> . . . the more sophisticated, upper class patient often felt deprived by being offered psychotherapy for only six sessions and also tended to obscure his acute symptoms in a history of chronic conflicts, defended by much intellectualization and

> rationalization. In contrast, the lower class patient often regarded the psychiatrist's role as similar to his authoritarian concept of the general medical doctor. He was not so aware of or interested in his underlying neurotic or characterological conflicts. He experienced his psychic disturbance as an acute problem, often presented in a clear manner, and came to the psychiatrist expecting the illness to be cured in a few visits, much like a toothache or a respiratory infection. (p. 94)

The Use of Time

A second significant variable with crisis intervention treatment is the use of time. Shlien states,

> In essence, the theory is that time limits place the emphasis where it belongs; on quality and process, rather than upon quantity. Time does not heal, because it cannot. Only activity can heal, and the more activity, the shorter the time required. This theory holds that limits, in effect, increase energy, choice, wisdom, and courage, and so they heighten the essential process, while they reduce the largely unessential time. (p. 31)

Rapoport continues,

> Time needs to be used to provide structure and limits, which are reassuring to an ego that is decompensating. Time limits also operate as leverage and as pressure to get on with the problem-solving task. They also serve as relief to the client against anxiety about getting involved in a dependency situation and serve as counterforce against the client's self-concept of being emotionally sick. Time limits can also be used, along with other techniques, to prevent tendencies toward development of a regressive transference. (1967, p. 39)

McCleod feels,

> (a) that the treatment structure is more readily established; (b) that dependency and regression are discouraged if their development is counter to the treatment goal; and (c) that a focus on

> termination work is frequently possible, this focus often being very difficult to create with the usual treatment arrangements. (p. 196)

Kaplan (1962, p. 23) and Haskell (p. 546) echo the above, with the addition of the fact that knowledge of the specific time limits should be well known to both patient and therapist from the beginning of the treatment (Sarvis, p. 279). Rapoport (1967, p. 37) cautions against the belief that the time element alone is enough to distinguish brief treatment from other treatment modalities.

The duration and frequency of sessions have been dealt with elsewhere in this review, as has the number of sessions recommended for crisis work.

The Dropout

Dropouts present a problem for therapists regardless of which theoretical position they espouse in their practice. A dropout is defined as anyone who self-terminated therapy when the clinical recommendation is for continued work. Brandt found that regardless of what type of treatment is being offered (by a clinic) over one-half of all patients drop out prior to the seventh session in nearly all studies. Two classes of reasons for this phenomenon are apparent; external and patient determined. According to Rogers, the external factors are,

> (a) Many patients are referred for diagnosis, psychological evaluation and/or consultation, i.e., treatment was not the purpose of the referral; (b) Some patients are either hospitalized or committed to penal or reform institutions before they are able to start treatment; (c) Many clinics, knowing that they cannot treat everyone successfully try to select the patients they consider for treatment; (d) Some patients are referred who are not in need of psychiatric treatment; (e) Circumstances prevent some patients from continuing treatment, i.e., moving, illness, death, etc. (p. 91)

He believes some patient-determined reasons are:

> (a) Patients who are referred frequently are not interested in treatment or have relatives who do not want them to have psychiatric treatment; (b) Patients may come with erroneous ideas of treatment, i.e., magical cures, advice, or medication, and when the clinic fails to live up to their preconceived ideas, and the intake workers are not able to work through their feelings, they do not return. (pp. 90-91)

Rogers suggests further that such factors as low socioeconomic level, lack of education, and low intelligence account for the uniformly high dropout rate in all agencies (p. 91).

Mayerson finds that middle class patients are generally

> . . . considered better psychotherapy candidates than lower class patients who are often seen as less able to believe that talking can help, possess a different value system from the usually middle-class therapist, and are more concerned with the bread and butter necessities related to a harsh environment than with introspection into subtle psychological states. (p. 93)

Katz (p. 90), studying outcome variables, finds " . . . that patients of higher socioeconomic social status seek psychotherapy more frequently and continue

treatment longer . . . ," than patients of other classes. Kaegler observes that persons from lower socio-economic classes are more inclined to be seeking symptomatic relief, rather than insight (p. 107). And Jacobson reports,

> One of our basic findings from the extensive research data we are accumulating is that under conditions of high public availability, a brief-treatment, walk-in center attracts more persons of lower educational background and of older ages than are customarily found in traditional psychiatric facilities. (p. 209)

Crisis therapy appears to hold for members of this group (Jacobson, p. 209).

Other factors, too, suggest that a shorter term crisis approach would be appropriate for lower socio-economic patients.

1. Lower class individuals give a sparser history of constructive object relationships (Mayerson, p. 92; H. Parad, p. 83);

2. Lower class individuals report their difficulties in a somatic or externalized manner, as opposed to defining their problem as intrapsychic (Brown, p. 437; Katz, p. 87; Battle, p. 86);

3. The higher the intelligence and more extensive the education, the greater the likelihood of a treatment success (Brown, p. 437; Katz, p. 87; H. Parad, p. 83; McGuire, p. 84);

4. The greater the tolerance of and experience with the typical burdens of a clinic situation or bureaucracy, the greater the likelihood of the patient lasting in treatment (McGuire, p. 84).

It might be noted parenthetically that (a) men are more likely to drop out than women, that (b) persons 20 through 29 drop out less frequently, and that (c) married or single persons drop out less frequently than do persons who are separated or divorced. The above holds true for all socioeconomic classes.

Indications for Crisis Treatment

Those persons for whom brief or crisis intervention is recommended in theory are those who, facing an emotionally crucial situation in their lives, develop the appearance of psychiatric symptoms (Sifneos, 1961, p. 168). Although an essentially intact ego prior to the period of upset is preferred in brief treatment (Rapoport, 1967, p. 40; Visher, p. 342; McGuire, p. 84; Pumpian, p. 643), the presence of severe pathology is not a contraindication for short-term therapy (Pumpian, p. 643). The patient may be exhibiting chronic symptomatology or pathological patterns of behavior when the ego goes into a state of crisis (Rapoport, 1962, p. 212). These problems must, however, be peripheral to the specific precipitant and the current crisis (Visher, p. 338). According to Pumpian, it is essential that,

> The areas of disturbance, while in many cases profound, have not so pervaded the whole range of ego function as to impair the patient's ability to establish meaningful relationships with people with some degree of adequacy, and to translate stimuli and impulses into rational thought and effective action. (p. 643)

Sifneos has identified strength of character, and he and Howard Parad have postulated that motivation is the significant factor in brief psychotherapy outcomes (Sifneos, 1961, p. 168; H. Parad, p. 83).

Bellack, reporting a survey of a number of outpatient clinics, states,

> Usually the presenting problem is quite clear. The patient suffers from anxiety, depersonalization, depression, doubt, confusion, or some other identifiable state. As we shall see, the nature of the presenting problem very often, in itself, serves as a guide to the psychotherapist in his search through the life history and contemporary situation for contributing factors, and beyond that, begins at once to lay the groundwork for the formulations permitting hunches about etiology. (1965, p. 42)

Semrad (p. 589) states that acute depressions are the ideal case for crisis intervention. He feels that because

> Affective disorders manifest ego patterns of behavior that are designed to put objects in a position to support them and enable them to solve their problems in their current adaptation in living, loving, loss, frustration of object need, and organic and structural change. (p. 588)

In addition to acute onset and definable problem, the criteria proposed as indications for brief treatment are remarkably similar to those found to be significant for longer work.

Readiness for change, as with maturational crisis, awareness of differences between symptoms and emotions, and a stable life situation are Visher's additional factors for indicating brief therapy (p. 336). Sifneos (1967, p. 169) adds the ability to relate, emote, verbalize, be flexible, highly motivated, and see the problem as anxiety, mild depression, phobia, and conversion. Pumpian lists five criteria as follows:

> First, the "worthwhileness" of a patient. Second, the degree of discrepancy or accord between the patient's fantasies and his actual reality situation, between his aspirations and his achievements. Third, the ability of the individual to tolerate past and present frustrations. Fourth, the adequacy of the patient's past and present object relationships. Fifth, the more favorable the environmental circumstances are, the better the prospects for short term therapy. (pp. 645-646)

Finally, Sifneos (1971) suggests,

> Patients with character defects who give histories of recent and rapid decompensation from a precarious level of emotional functioning, and who complain of life-long psychological difficulties and poor interpersonal relationships, are selected for therapy according to the following criteria: one, ability to maintain a job; two, strong appeal for help; three, recognition that these symptoms are psychological in origin; and four, willingness to cooperate in therapy. (pp. 86-87)

According to McGuire, persons who present

> Difficulties which appear to have a partial origin in character, but are transient, such as marital problems, decision-making difficulty, and the like, are appropriate for brief work if it is felt that the current problem may be isolated and treated separately from the essential character make-up and its pathology. (p. 84)

Special Problems/Cases

Wolberg finds,

> There are patients who by themselves have already worked through a considerable bulk of their problems and who need the mere stimulation of a few sessions with a proficient therapist to enable them to proceed to astonishing development. (1967, p. 918)

Further,

> Problems which do not yield to short term measures are those that have persisted for a long time, and perhaps date back to early childhood. (Wolberg, 1967, p. 923)

There are also persons whose lives consist of a chronic state of crisis, or a rapid succession of sub-acute crises. For many of these people the crises are self-generated and serve the purpose of warding off deep unconscious impulses. These people generally suffer from character disorders (Rapoport, 1967, p. 41), and brief treatment might seek only to point up the long-standing characterologic nature of the problem. Longer term work is generally required for this group.

The other special group (diagnostically) around which there is significant controversy as to the use of brief treatment is that of the borderline state. While Rapoport observes from clinical experience that crisis intervention has been

> . . . surprisingly effective with the person of borderline character who may be on the verge of a psychotic episode with a breakthrough of primitive impulses. Here, active intervention can often quickly restore crumbling defenses and return the individual to a previous level of functioning. (Rapoport, 1967, p. 40)

Visher cautions that the borderline patient often became "worse" by even the mildest examination of underlying problems.

The issue would appear to be resolvable first by observing that both Rapoport and Visher are likely referring to a person who is not in a stable borderline state, but rather is in a process of decompensation to a psychotic state. The two clinical pictures, while appearing similar, are actually separate and distinct diagnostic pictures. Second, it must again be pointed out that the sensitive clinician will avoid uncovering underlying difficulties before the person can tolerate the revelation.

CHAPTER II

METHOD

Hypotheses

Ho 1:

Members of the experimental group will drop out significantly less frequently than those of the control group.

Ho 2:

Members of the experimental group will evidence significantly greater change than will those of the control group.

Ho 3a:

Members of the experimental group will self-rate a greater degree of positive change resulting from the therapy experience than will members of the control group.

Ho 3b:

Members of the experimental group will self-rate a greater degree of satisfaction with the therapy experience than will members of the control group.

Ho 4:

Therapists will rate members of the experimental group as significantly more changed than members of the control group.

Setting for the Study

Persons eligible for this study were drawn from the typical patient population of the Livingston County Community Mental Health Center. The Center, which has been in existence for nine years, will provide the clinical setting for this research.

The Center is the sole mental health facility in this semi-rural county of 75,000 residents. The staff of the agency consists of a Program Director (ACSW-MSW), a Chief Psychologist (Ph.D.), a Chief Social Worker (ACSW-MSW), three MSW social workers, and four MA psychologists all of whom are employed full time. Two psychiatrists, two MA psychologists, four social work interns, and one psychology intern are employed or assigned part time. While this author is among the staff of the Center, no involvement, direct or indirect in the selection, assignment or treatment occurred. During the time of the study, the author became the Director of the agency.

Eligibility for service at the Center is determined by residence, and fees are charged on an ability to pay basis (Appendix A) with no one being refused service because of their economic circumstances.

The Center operates on both an appointment and walk-in basis, with appointments given only to that person requesting the service for himself. The average waiting period for an initial appointment is five to

10 days, with a two- to three-week wait typical during peak service demand periods. Peak periods tend to occur regularly in September, October, January, and April. At other periods of time, i.e., when staff are ill or on vacation, staff shortages are created such that sufficient clinical coverage for new applicants is not available.

Evaluation of cases takes from one to three weeks, at the end of which a recommendation for treatment is offered to the patient if appropriate, and an appointment given to begin the work if the patient elects to utilize the service.

Case dispositions typically available are the following: individual psychotherapy of 10, 20, or more sessions; group psychotherapy, which is generally open-ended child therapy; marital therapy; and family therapy; in addition to chemotherapy for those patients deemed in need.

All persons requesting service were screened on the telephone by an intake secretary who was not directly involved in offering clinical services.

Criteria for Inclusion/Exclusion From the Study

The criteria for study selection were as follows: The patient must be (1) between the ages of 18 and 50 and legally as well as socially emancipated, i.e., not economically dependent upon parents; (2) belong to the

lower-middle socioeconomic class or below, that is Class III, IV, and V (the maximum income for the family is $2500 per year per family member, i.e., $10,000 for a family of four), and have no more than two years of post high school education; (3) show no evidence of neurological deterioration or dysfunction; (4) not be taking regularly, prescribed or otherwise, tranquilizers, barbituates, stimulants, and the like; (5) not have been seen in any form of psychotherapy or counseling within the previous year; (6) be free of psychosis at the time of the initial interview, as judged by the therapist; (7) identify, either voluntarily or upon investigation, an onset or intensification of the presenting complaint within the previous 30 days; and (8) relate the onset of the difficulty to external or externalized factors (precipitant).

All callers who appeared to fit the study criteria were assigned randomly to either the experimental or control groups by the intake secretary. The assignment of group was determined by a table of random numbers (Appendix A) taken serially, with all even numbers indicating assignment to the experimental group, and all odd numbers indicating the control group. Once the group assignment was known, the secretary selected a therapist. Each of the therapists involved in the study

was assigned a number prior to the beginning of the study and assignments were made serially.

Once the therapist and group assignment were known, the therapist made an appointment with the patient to meet at the Center within three days (generally 48 hours except when a weekend intervened).

Upon initial interview, the therapist could elect to drop the patient from the study if further exploration revealed that the patient did not meet one or more of the study criteria. If dropped, a patient was replaced by the next appropriate case requesting service from the agency. Outside of criteria rulings in the initial session, the only reason for dropping a patient from the study was for reasons of death, illness, move from the area, etc.

Patients were asked to set aside two hours for the intake process (as opposed to the traditional hour and a half) at the first session. The added time was necessitated by the presentation of the extra evaluation instruments. The second through fifth sessions required no extra time at the Center, and the sixth required, again, two hours. The actual treatment time for all sessions, in both groups, was 45 minutes per session.

Upon appearing at the Center, the patient was greeted by a receptionist who provided him (her) with an intake form (Appendix C) and the shortened form of

the Minnesota Multiphasic Personality Inventory (MMPI, Appendix B), both of which were completed prior to the interview. Upon completion, the receptionist relayed only the intake form to the appropriate therapist. Therapists did not see the MMPI answer sheets or results until the completion of the entire study.

Sampling

The sample population consisted of 40 persons who by their own subjective evaluation have experienced a recent deterioration in their level of functioning, or an exacerbation of a painful affective state, or both. The following social, actuarial, and demographic data were collected for each of the 40 clients in the study population: age, sex, marital status, persons in family, source of support, income, education, occupation, type of residence and religion, previous therapy, years in the County. The 40 patients were separated at application into two groups of 20 each with the experimental group being offered a six session program of crisis intervention and the control group the shortest (10 session) traditional supportive psychotherapy regimen.

Experimental Technique

The basic objectives of the initial interview were to establish a relationship with the patient, such that the necessary work could be conducted; to gather

essential information such that a diagnostic formulation could be made with a degree of confidence; to give the patient in general terms, an idea of the nature and relative seriousness of his situation; to explain in simple terms what the patient could expect to be required of him (her) and what could be done in the therapy; to arrange for the necessary future interviews, impressing upon the patient the importance of not interrupting the treatment; and to terminate the initial interview (Wolberg, 1965, p. 143).

An understanding of the precipitating events and their meaning to the patient was sought in order to help him to restore the upset balance. Thus, the first technique in brief or crisis therapy was a preoccupation with the question, "Why now?" What had interfered with the patient's previous equilibrium that he now seeks help (Rosenbaum, p. 72)? Therapists began the initial interview by asking, "How can I be of service to you?" and follow soon with something like, "What made you decide to contact the Center at this time?" This type of question usually led into the life situation that is at risk. The question emphasized the cognitive and decision-making resources of the client, and the circumstances rather than the feelings involved in the situation. It also underlay the fact that the therapist and client focused their efforts on the current situation (Paul, 1966b, p. 49).

In the first session, the therapist accepted the patient's definition of his difficulty, and gently attempted to clarify its meaning so as to help the individual to see it in different, more realistic, terms. The therapist described what he saw as the differences between the processes extant within the patient, and the experience of patient defined symptoms, which were identified as the problem, and then described what he believed he and the patient could and could not accomplish in the allotted time. The exploration and/or elaboration of linkages and derivatives between the present and the past awaited the second and future sessions. Historical data, however, were gathered through brief explorations, primarily of the patient's interpersonal history. This was accomplished by requesting elaboration when the patient mentioned a significant object, and by direct questioning when such mention was not made.

The therapist remained watchful for the appearance of major preconscious patterns in material volunteered by the patient.

Once the therapist was reasonably certain of his diagnostic hypothesis, he began consideration of an appropriate treatment intervention. What supports could the environment offer, such as strength in the family, basic institutions, and others? Were his social statuses such that one or more options were closed or are open to

him (Rapoport, 1967, p. 37)? What attempts at coping were being made, and what attempts have been made in the past? An assessment of the degree to which those attempts were successful became the next conceptual process upon which the patient and therapist focused (Sifneos, 1966, p. 125).

The therapist then clarified for the patient how, together, they might view the problem differently, and how the situation might be affected by therapeutic intervention. Once this was accomplished, the patient was asked if he had any further questions, and once they were answered, the therapist determined the degree to which the patient was willing to make a commitment to undertake the future course of therapy. If they agreed upon a contract (session limit, focus, and fee), the first session was terminated with the second and future interviews planned for approximately one week apart.

While the demarcation between evaluation and therapy was not clear cut, the second through the fifth sessions were characterized by a more thorough exploration of a few selected critical areas on which the focus was actively maintained by the therapist. The datum from beyond the agreed upon focal area was not ignored by the therapist, but neither was it incorporated into the clinical process. From the earliest interaction, the

therapist encouraged, praised, gave narcissistic support for those ego functions in which defense was combined with adaptive gratifications.

The therapist focused upon the presenting problem and identified symptoms as symptoms, feelings as feelings, and confusion as confusion. He concentrated upon the mutual understanding of the relationships between the symptoms, the feelings, and the precipitating event. Here attention was directed towards the modification of the situation itself, through elaborating more clearly the relationship between the crisis situation and its relevant accentuated antecedents. A basic tenet for the crisis therapist was, "Neurotic and psychotic defenses, troublesome and hindering as they may be, have considerable value in maintaining some kind of stability, and the therapist should not attempt to blast them away without careful provision of other supportive measures and thoughtful consideration of the patient's alternative modes of adjustment" (Semrad, p. 581).

Since the psychic mechanisms of incorporation, identification, transference, and object substitution are most significant to the relief of symptoms, and all are affected by a strong desire for interpersonal relatedness, the crisis therapist had leverage with the patient through the pacing or dosage of the activity of the relationship (Rosenbaum, p. 74). The experimental

method required the therapist to feel free to structure the interview; to offer suggestions, opinions, and alternatives; and to "coerce" the patient into adherence to the current material.

The positive transference was nurtured and only dealt with when it interfered with the progress of the treatment. Negative transference was handled quickly through verbal confrontation and clarification of the displacement of the patient's feelings to the therapist, and an exploration, however brief, of the historical relationship to the derivative object.

Finally, the therapist utilized his own experience and his own concept of the patient's life to help the patient anticipate the emergence of disruptive affect in future situations. Anticipatory guidance provided the patient with tools which helped him avoid a future crisis situation.

The sixth session was reserved for a summing up, review, and evaluation of the patient's then new-current status. In the event the crisis was unresolved, did the patient wish to engage in further treatment? If so, it had to be carried out by a different therapist since for this study, therapists were not allowed to follow experimental patients for more than six sessions and control patients for more than 10. Direct and thorough evaluation of questions such as these had to be accomplished prior to termination.

If further service was indicated, the patient was referred to another (nonstudy) therapist. With resolution achieved, the patient was advised what he might encounter in the near future, i.e., separations, role changes, etc., which might prove especially stressful. He was reminded of the parallels between the recently resolved crisis, and those similar situations which appeared to be in his near future, and was assisted in seeing that the recently learned coping techniques might well serve to handle new situations.

At the conclusion of the sixth session for the experimental group, and at the conclusion of the tenth session for the control group, all patients were retested on the MMPI and the adjective-symptom checklist and, in addition, were asked to rate the outcome of their treatment experience.

Treatment for patients from the control group (10 sessions) was offered in the traditional supportive, ego-oriented style that the therapist learned in schooling. This was characterized typically by more of a passive relationship to the patient's presenting problem, a non-directive approach without clearly articulated goals, and a somewhat greater effort to explore unconscious derivatives.

For this research, the paridigmatic question was whether treatment X had a different effect from

treatment Y when offered to two groups of similar patients applying under similar conditions.

Change in, and resulting from, an experience in psychotherapy is at best an elusive concept. The question of whether any changes in patients were due to the therapy or to something else was accounted for by virtue of the fact that the original homogeneous patient group was exposed to differing stimuli in a consistent manner. All of the instrumentation had been utilized on numerous occasions for the purpose of measuring psychotherapy outcome, and had proved valid for that purpose. Measurable changes which might have been due to factors which were outside of this experimental design would be expected to occur randomly to either the individual or collective participants of both the experimental and control groups and, thus, were not at issue for this study. The crucial question remains, what were the differences between the two groups, and not necessarily the degree of change within either or within the total population.

The goal of crisis intervention in this proposal was specifically change in the areas of the individual's ability to cope or to function adequately, and in the overall affective state of the patient. Lessened affective intensity or disappearance of painful feeling was reported by patients and estimated by therapists.

Instrumentation

The following measures were applied to evaluate the pre-treatment and post-treatment differences between the two groups. The three validity scales from the Minnesota Multiphasic Personality Inventory (L, lie scale; F, conformity; and K, defensiveness) along with the Hs (hypochondriasis), D (Depression), Hy (Hysteria), Pt (Psychasthenia), and Ma (hypomania) were administered pre- and post-treatment.

The MMPI was selected because of its great frequency as an outcome measure in numerous previous psychotherapy effectiveness studies. Further, it has been found to be sensitive to changes in patient groups in pre- and post-therapy administrations. Cartwright (p. 403) found significant differences (pre- and post-) on the F, Hs, Pt, and Sc (schizophrenia) scales. The Sc scale will not be utilized since thought disorders were clinically screened out of the study during the first interview, and because of the wish to make the evaluation process as brief as possible for patients. Kaufman (p. 460) found similarly for the D and Pt scales. The consensus of opinion and research appears, therefore, to lend the most utility and significance to the seven scales mentioned above for studies of this nature.

The adjective-symptom checklist (ASCL) in this study was an extrapolation of the most frequently

selected descriptions of persons who have been in crisis and seeking treatment at the Livingston Community Mental Health Center over two years (June 1970-July 1972). A split half correlation was performed on this list of 32 adjectives (16 positive, 16 negative) and a correlation of .76 was achieved. (Product of positive on subtest one correlated to product of positive on subtest two, etc.) The scoring system for this instrument is patterned after the Zuckerman affect-anxiety checklist, wherein positive one through positive five are the values of the answers as follows:

Positive		Negative	
always	+5	always	+1
frequently	+4	frequently	+2
sometimes	+3	sometimes	+3
occasionally	+2	occasionally	+4
never	+1	never	+5

It can be predicted that at the time of application, this instrument will be completed with a lower positive rating and a higher negative rating, and that after therapy (both groups) the reverse will be the case.

The patient rating form (PRF) was an extrapolation of the more extensive form used in evaluating long-term psychotherapy by Strupp, Fox, and Lessler (p. 150). The 10 items selected for the PRF were those which related most specifically to an evaluation by the patient of the results of the therapy, relating to the presenting

complaint, coping ability, and overall satisfaction with the clinical intervention. The PRF was scored similarly to the ASCL, on a +1 through +5 basis, and total group scores were compared. Item analysis was also performed on an exploratory basis.

The therapist's rating form (TRF) (Appendix E) also from the work of Strupp, Fox, and Lessler (p. 163) consisted of 20 (of a total of 23) items from their original scale. Those items omitted (Nos. 21-23) relate to therapist-patient experiences in the treatment and were not relevant to this research. The first 10 items of the TRF were administered to the therapist after each initial interview, and the full 20 questions, immediately following the final session. Scoring was on a +1 through +5 and +5 through +1 basis, and was compared between both groups on total scores, with an exploratory comparison of individual items between groups.

Nature of the Data

Twenty-two outcome measures were used in testing the hypotheses. These measures were divided into two general classes, those which examined the pre- vs. post-test result differences between the experimental and control groups, and those measures which examined the absolute levels of post-treatment performance. The 10 measures which belonged to the pre-post-group were the

seven MMPI scales, two ASCL scales, and the first half of the TRF. Additionally, the MMPI, ASCL, PRF, and both halves of the TRF were examined at their absolute values.

All of the data produced by these instrument scores were either ordinal or ordinal like. Parametric statistics were used exclusively.

Statistical Procedures

A Pearson product moment correlation[1] was utilized to examine the relationship between all potential covariates (demographic, actuarial, and pre-treatment) and treatment outcome (post-treatment MMPI, ASCL, PRF, and TRF). Specifically, a correlation was run between pre- and post-subscale scores from the MMPI, ASCL, and the first half of the TRF. Additionally, all previously identified demographic and actuarial variables were each correlated with each of the 22 outcome measures mentioned previously, as well as with the differences between all pre- and post-subscale scores. For all of those variables where a significant correlation was found, correction was made, and an analysis of covariance was performed. For all of those factors found not significant no correction was made, and the analysis of variance was used.

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[1]As demonstrated by E. J. G. Pitman in "Problems in Validities," Bertram E. Karon in Projective Techniques in Personality Assessment, edited by E. I. Rabin (New York: Springs Publishing Co., 1968), pp. 85-111.

For statistical purposes whenever a particular variable occurred three or fewer times within a group, an effort was made when possible to collapse the smaller variable with another to make the data more meaningful (i.e., remarried plus married if either had three or fewer, but not married and divorced even if one had a cell of three or fewer). In all situations in this research, acceptable significance was considered to occur at the .05 level.

Study Sample

Over a 20-month period, March 1972 through October 1974, 40 clients, all of whom met all of the original criteria for the study, were selected. Ten clients, nine women and one man, originally selected for the study were removed and replaced. Four of the removals occurred for the following reasons: one client moved out of the state; one client refused the short-term contract in the initial interview and was offered long-term therapy instead of crisis intervention; and two clients upon further interview (second session) were found to be in need of medication or involved in a psychotic process which disqualified them from the study. Three other clients were removed from the study at the initial interview. One, the male, was found to be a chronic abuser of alcohol; two patients were unable to complete the required instrumentation prior to being seen. They

were found, upon interview, to evidence acute psychotic symptomatology and were, thus, not a part of the study. The three other removals did not show up for or cancel their initial appointments and were never seen.

The 40 eligible cases demographically and actuarially evidenced characteristics as in Table 3. Significant differences were found on only one of the 47 variables between the experimental and control groups as randomly assigned. All five single persons in the study were assigned to the experimental group. This difference was controlled for in the analysis of the outcome data. Although not significant, there is a tendency for the control group to have more children, more persons in the family, and more persons supported. This is a logical outcome of the biasing factor of no single persons in the control group.

Pre-treatment test results are presented in Table 4. No significant differences existed between groups, and none approached significance. It is important to note that the project was, in part, designed to focus on the dropout rate in middle class and poorer families. The group median income yields, for instance, a median income for a family of four of $6,700 (with the control group family of four earning an average of $7,100 and the experimental group $6,300). This places the population well within the range of the project.

Table 3

Pre-Treatment Data/Experimental Control

Variable Number	Combined	Experimental	Control
	N = 40	N = 20	N = 20
Age			
3) Age	$\bar{X}$ = 27.73	$\bar{X}$ = 27.05	$\bar{X}$ = 28.40
4) Age squared	$\bar{X}$ = 800.98	$\bar{X}$ = 761.05	$\bar{X}$ = 840.90
Sex			
5a) Female	31	15	16
5b) Male	9	5	4
Marital Status			
6) Married	21	7	14
7) Single	5	5	--
8) Divorced	8	6	2
9) Separated	6	2	4
Number of Persons			
12) Number of children	$\bar{X}$ = .63	$\bar{X}$ = .40	$\bar{X}$ = .85
13) Number of children supported	$\bar{X}$ = 1.03	$\bar{X}$ = .75	$\bar{X}$ = 1.30
14) Number of persons supported	$\bar{X}$ = 2.78	$\bar{X}$ = 2.45	$\bar{X}$ = 3.10
Source of Family Support			
15) Employed	24	8	16
16) Unemployed worker	3	1	2
17) Public assistance	9	7	2
18) Disabled	1	1	--
19) Otherwise supported	3	3	--
20) Income per person supported	$\bar{X}$ = $1,675.00	$\bar{X}$ = $1,575.00	$\bar{X}$ = $1,775.00
21) Previous therapy	2	2	--
22) No previous therapy	38	18	20
23) Years of education	$\bar{X}$ = 11.53	$\bar{X}$ = 11.30	$\bar{X}$ = 11.75
Occupation			
24) Occupation unknown	3	1	2
25) Disability	1	1	--
26) Housewife	26	15	11
27) Laborer	4	1	3
28) Semi-skilled	4	2	2
29) White collar	1	--	1
30) Skilled	1	--	1
Residential Characteristic			
31) Years in county	$\bar{X}$ = 11.70	$\bar{X}$ = 10.40	$\bar{X}$ = 13.00
32) Own home	21	11	10
33) Rent home	19	9	10
34) Urban	19	10	9
35) Rural	21	10	11
36) House	27	14	13
37) Farm	1	--	1
38) Apartment	8	3	5
39) Trailer	4	3	1

Table 3--Continued

Variable Number	Combined	Experimental	Control
	N = 40	N = 20	N = 20
Religion			
40) Catholic	6	3	3
41) Protestant	8	5	3
42) Baptist	3	1	2
43) Nazarene	1	1	--
44) Jehovah's Witness	2	--	2
45) Lutheran	4	1	3
46) Church of Christ	1	--	1
47) No religion	11	6	5
48) Methodist	4	3	1
MMPI			
49) L Scale	4.20	4.05	4.35
50) F Scale	13.30	11.85	14.75
51) K Scale	13.20	14.15	13.30
52) HsScale	15.45	14.40	16.50
53) D Scale	26.78	29.10	24.45
54) Hy Scale	28.55	29.65	27.40
55) Ma Scale	23.78	23.25	23.10
56) Pt Scale	19.88	20.10	19.65
Adjective Checklist			
57) Positive rating score	42.00	42.15	41.85
58) Negative rating score	51.75	49.15	51.65
Therapist Rating			
59) Number 1	3.73	3.60	3.75
60) Number 2	4.03	4.20	3.85
61) Number 3	3.30	3.15	3.55
62) Number 4	3.20	3.00	3.40
63) Number 5	3.83	3.95	3.70
64) Number 6	3.90	3.90	3.90
65) Number 7	3.43	3.30	3.55
66) Number 8	3.65	3.50	3.80
67) Number 9	3.63	3.50	3.85

Table 4

Pre-Treatment Testing/Finishers vs. Drops

Variable Number	Finishers N = 21	Drops N = 19
Age		
3) Age	$\bar{X}$ = 29.14	$\bar{X}$ = 26.16
4) Age squared	$\bar{X}$ = 873.43	$\bar{X}$ = 720.89
Sex		
5a) Female	19	12
5b) Male	2	7
Marital Status		
6) Married	9	12
7) Single	1	4
8) Divorced	7	1
9) Separated	4	2
Number of Persons		
12) Number of children	$\bar{X}$ = .61	$\bar{X}$ = .63
13) Number of children supported	$\bar{X}$ = 1.05	$\bar{X}$ = 1.00
14) Number of persons supported	$\bar{X}$ = 2.76	$\bar{X}$ = 2.79
Source of Family Support		
15) Employed	13	11
16) Unemployed worker	1	2
17) Public assistance	6	3
18) Disabled	--	1
19) Otherwise supported	1	2
20) Income per person supported	$\bar{X}$ = $1,786.00	$\bar{X}$ = $1,525.00
21) Previous therapy	1	1
22) No previous therapy	20	18
23) Years of education	$\bar{X}$ = 11.62	$\bar{X}$ = 11.42
Occupation		
24) Occupation unknown	--	3
25) Disabled	--	1
26) Housewife	17	9
27) Laborer	2	2
28) Semi-skilled	1	3
29) White collar	--	1
30) Skilled	1	--
Residential Characteristic		
31) Years in county	$\bar{X}$ = 12.33	$\bar{X}$ = 11.00
32) Own home	13	8
33) Rent home	8	11
34) Urban	10	9

Table 4--Continued

Variable Number	Finishers N = 21	Drops N = 19
Residential Characteristic (Continued)		
35) Rural	11	10
36) House	16	11
37) Farm	1	--
38) Apartment	2	6
39) Trailer	2	2
Religion		
40) Catholic	2	4
41) Protestant	5	3
42) Baptist	2	1
43) Nazarene	1	--
44) Jehovah's Witness	1	1
45) Lutheran	2	2
46) Church of Christ	--	1
47) No religion	7	4
48) Methodist	1	3
MMPI		
49) L Scale	4.29	4.11
50) F Scale	11.95	14.79
51) K Scale	13.00	13.42
52) Hs Scale	15.29	15.63
53) D Scale	27.67	25.79
54) Hy Scale	30.19	26.68
55) Ma Scale	25.57	21.79
56) Pt Scale	19.76	20.00
Adjective Checklist		
57) Positive rating score	44.95	38.74
58) Negative rating score	54.33	48.89
Therapist Rating		
59) Number 1	3.48	4.00
60) Number 2	4.24	3.79
61) Number 3	3.14	3.47
62) Number 4	3.24	3.16
63) Number 5	3.67	4.00
64) Number 6	3.76	4.05
65) Number 7	3.23	3.63
66) Number 8	3.33	4.00
67) Number 9	3.29	4.00

Slightly fewer males were in the study than are in the normal clinic population (and conversely slightly more females) but this was accounted for by the fact that few of the presenting crises dealt with children, and many "parents" are counted in the normal clinic population. The remainder of the descriptive data conforms remarkably well to the county-wide statistics and to "normal clinic populations."

CHAPTER III

RESULTS

Hypothesis 1

Members of the experimental group will drop out significantly less frequently than those of the control group.

Of those 40 persons in the study, 21 finished their contract and 19 dropped out of treatment. Table 5 depicts background variables as they existed between persons who dropped and persons who finished the study. None of these differences were significant.

Pre-treatment test results (Table 6) also showed no significance between drops and finishers. However, on therapist ratings, rating 8 and 9, therapists demonstrated a tendency to consistently rate drops higher (no. 8--P = .07, no. 9--P = .08) on lack of motivation and poorer prognosis respectively (Table 6).

The only "outcome" variable between the experimental group of 20 starters and the control group of 20 finishers is that of drop vs. finish (whether the client, experimental or control, did or did not complete the six- or 10-session treatment contract).

Table 5

Pre-Post-Treatment Testing Data for Finishers

Variables	Pre-Treatment $\bar{X}$	Post-Treatment Uncorrected $\bar{X}$	Post-Treatment Corrected $\bar{X}$	Experimental Finishes	Control Finishes
	N = 21			N = 14	N = 7
MMPI					
L Scale	4.28	3.86	4.16	4.540	3.394
F Scale	11.95	10.14	11.31	11.527	10.881
K Scale	13.00	12.81	9.73	9.567	10.081
Hs Scale	15.29	12.90	11.61	11.747	11.348
D Scale	27.67	23.19	21.56	21.241	22.192
Hy Scale	30.19	24.57	25.35	25.018	26.034
Ma Scale	25.57	21.29	19.67	20.009	18.996
Pt Scale	19.76	16.76	17.52	17.510	17.546
Adjective Check-list					
Positive rating	44.95	35.86	36.01	36.095	35.855
Negative rating	54.33	43.48	43.13	43.361	42.659
Therapist Rating Scale					
1	3.48	2.71	3.32	4.351	4.062
2	4.24	2.81	2.58	4.470	4.352
3	3.14	2.62	2.71	3.731	4.156
4	3.24	2.81	2.56	4.200	4.137
5	3.67	3.24	3.65	3.482	3.661
6	3.76	2.76	.80	4.279	4.184
7	3.24	2.43	2.67	3.810	3.740

Table 6

Analysis of Co-Variance Post-Treatment Outcome Variables

Variable Number	Experimental Finishes N = 14	Control Finishes N = 7	Significance
MMPI			
77) L Scale	4.540	3.394	.589
78) F Scale	11.527	10.881	.619
79) K Scale	9.567	10.081	.391
80) Hs Scale	11.747	11.348	.818
81) D Scale	21.241	22.192	.933
82) Hy Scale	25.018	26.034	.728
83) Ma Scale	20.009	18.996	.566
84) Pt Scale	17.510	17.546	.942
Adjective Checklist			
85) Positive rating score	36.095	35.855	.493
86) Negative rating score	43.361	42.659	.415
Patient Rating			
87)	4.351	4.062	.360
88)	4.470	4.352	.749
89)	3.731	4.156	.321
90)	4.200	4.137	.692
91)	3.482	3.661	.592
92)	4.279	4.184	.735
93)	3.810	3.740	.194
94)	3.357	3.900	.049
95)	3.621	3.575	.785
96)	3.464	3.653	.673
97) Total	39.994	39.252	.241
Therapist Rating			
98)	3.571	2.810	.460
99)	2.580	2.573	.986
100)	2.768	2.594	.580
101)	2.817	2.039	.634
102)	3.802	3.351	.663
103)	.875	.660	.500
104)	2.657	2.697	.988
107)	2.388	1.673	.051
108)	3.359	3.415	.954
109)	2.935	3.017	.395
110)	1.103	1.306	.339
111)	3.076	3.005	.950
112)	2.903	2.617	.693
113)	3.305	3.292	.897
114)	2.549	2.605	.844
115)	3.109	3.148	.838
116)	3.117	3.095	.902
117)	1.898	1.896	.991

Simple correlations were computed between the drop/finish variable and all other pre-treatment variables and it was determined that the following variables were significantly correlated: marital status; pre-MMPI scales F and Ma; and the pre-treatment positive A/C/L score. An analysis of covariance was computed with the aforementioned variables as covariates, and the result was not significant (.124 level).

Hypothesis 2

Members of the experimental group will evidence significantly greater change than will those of the control group.

The outcome variables germain to this question were those administered both before and after therapy, i.e., MMPI scales, adjective checklist, and therapist ratings 1-7 (TRF 1-7).

The covariate analysis of the MMPI, A/C/L, and TRF yielded nothing in the way of supporting evidence for the acceptance of the hypothesis. This was true for both individual scale scores, and total results for each instrument. While it was evident that change occurred, in no case was the difference between experimental and control therapy significant.

Hypothesis 3a

The experimental group will self-rate a greater degree of positive change resulting from the therapy experience than will members of the control group.

Questions 1, 4, 5, 6, 9, and 10 on the PRF speak to the issue of self-rated change (variables 87, 90, 91, 92, 95, and 96 respectively). The result of the computed analysis of covariance provided no evidence for the acceptance of this hypothesis (see Table 7).

Hypothesis 3b

The experimental group will self-rate a greater degree of satisfaction with the therapy experience than will members of the control group.

PRF items 2, 3, 7, and 8 (variables 88, 89, 93, and 94) were utilized. There was some minimal support for the notion that the patient felt better towards the experimental treatment than the control, but only one of the four variables designed address Ho 3b was significant (variables 94, .049). This was not sufficient evidence to warrant the acceptance of the hypothesis.

Hypothesis 4

Therapists will rate the experimental group as significantly more changed than the control group.

There was no evidence to support the acceptance of this hypothesis from the TRF. Only question 10 on

Table 7

Dropout Rates and Marital Status

Variable Marital Status	Total Drop Etc.	Total Finish Etc.	Experimental		Control		Total	
			Drop	Finish	Drop	Finish	Exp.	Control
Married	12	9	1	6	11	3	7	14
Single	4	1	4	1	0	0	5	--
Divorced	1	7	1	5	0	2	6	2
Separated	2	4	0	2	2	2	2	4

the TRF (degree to which counter-transference was a problem) was significantly greater with the experimental than with the control group (.05).

CHAPTER IV

DISCUSSION

Hypothesis 1

Members of the experimental group will drop out significantly less frequently than those of the control group. Finishers tended to be older, earn slightly more, and to have had an unsuccessful marriage, whereas persons who dropped out averaged three years younger, $1,000 less income (family of four) and were still married. None of these differences were, however, significant. While initial observation indicated that the experimental method facilitated the completion of the clinical contract (14 finishers in the experimental group as opposed to seven finishers in the control group), the analysis of covariance yields a nonsignificant result (.124). Much of the washing out of significant findings was accounted for by the fact that while a total of 40 cases was selected for the study, the dropping out of 19 (13 control and six experimental) left a total of only 21 finishers (seven controls and 14 experimentals). These small numbers facilitate the appearance of numerous

biasing variables. Marital status, for example, was a frequent covariate for most other variables. Four of the five single patients dropped. Seven of the eight divorced patients finished. It is presumed that a larger N would yield a greater number of finishers and that a greater N of finishers would offer a greater opportunity for either a randomization of these variables, or a demonstration that the method is more or less successful with particular marital status; single, divorced, separated, married.

The outcome of the biased distribution of all single persons (N=5) being in the experimental group was to disguise a significant finding.

Four of the five single patients dropped from the study. Four of the six experimental group dropouts were single. When all five single persons are not considered in the statistical analysis, one finds that the experimental method was significant beyond the .05 level. Several factors appear to account for the differences between persons who are, or have been, married and those who were never married. Single persons tended to be younger, and younger persons tended to drop out more frequently than older persons. Perhaps more important, however, was the notion that persons who are married have demonstrated a desire and an ability to form a close personal relationship with another human being. Further,

persons who were separated or divorced would be assumed to have had such a desire and, while not married in the traditional sense, were found to be (a) living with someone, (b) applying because of the breakup of a relationship, or (c) came in because of acute feelings of loneliness. It may be thus concluded that these married or once married persons were at similar positions concerning their ability or desire to form significant (love) object relationships. They also had a more fully developed network of social supports, i.e., husband, children, home, neighborhood, than did single persons who tended to live alone, in apartments, and have fewer stable social relationships, i.e., job, home, school, etc.

The interaction between the single persons more impoverished interrelatedness (relative to the married or once married) and the offering of a time limited (six session) contract might prove an interesting area for further research. These persons might be asking for more of a relationship than the six sessions can presume to offer. They, as opposed to the married group, would be less likely to enjoy the security of a supportive relationship outside of the therapy and might well be asking for that support from the therapist. In the crisis method the accent is on problem-solving, not on supportive work, and this factor may well discourage single persons from finishing the contract.

A replication study of the experimental method with two matched groups, 20 single and 20 married persons, might yield supportive data for the aforementioned speculations.

A second set of covariates resulted from the use of the MMPI wherein the low F and inversely related high Ma scales were significantly correlated with the drop vs. finish variable. It is accepted that these three MMPI scales are generally correlated with a patient's finishing or dropping. Finally, the positive A/C/L indicating that the person was reporting the experiencing of more and more intense positive feelings also correlated (.050) significantly with persons dropping out. Stated differently, persons who felt better to begin with had the tendency to not finish the treatment contract. It should be stated that all but one of the 19 drops occurred in either the first or second of the six- or 10-session contracts. The single exception was a drop from the control group after the fourth session.

While it is possible that marital status affects outcome sufficiently to account for the success or failure of crisis intervention techniques, two groups of at least 20 finishers in each group would be required to demonstrate that the weight of a demographic variable was in fact a finding, and not simply a random statistical anomoly. Ideally, crisis intervention research should be

conducted in an agency which serves a population larger than that of the setting in this study.

If a crisis intervention agency is used, much of screening for whether or not the case is a crisis can be eliminated. A larger agency with more crisis cases would require a shorter period of time for data collection on a greater number of cases. It was found that during the study, 42% of the calls to the study agency were crisis calls but that over half of those persons calling had either been taking tranquilizers or had been in a crisis state for longer than 30 days and had been continuing to deteriorate. Because of the limits for the study population, these persons had to be disqualified. The economic requirement for low/middle income also presented problems in this study in that seven of 10 applicants for service exceeded the income requirements of the study. Simply put, most persons who call in crisis at the study agency earned more family income than the study allowed, had seen their family physician who prescribed tranquilizers, and had also tried a number of other possible solutions and support systems prior to their contacting the Mental Health Center. The Center seemed to be a "last resort" for persons in crisis. See Table 7.

Hypothesis 2

Members of the experimental group will evidence significantly greater change than will those of the control group.

On none of the measures designed to deal with the question of change did the analysis demonstrate that the experimental method produced greater change than did the control method.

It was apparent on all measures that change occurred. On the MMPI scales, for all finishers the Hs, D, Hy, and Ma scales were considerably closer to the mean of the normal population after treatment than before. It is noteworthy that these four scales changed for both groups. In MMPI scoring, the Hs, D, Hy relationship is referred to as the neurotic triad, indicating the patient experiencing anxiety surrounding typical psychoneurotic concerns. The Ma scale is considered predictive of the relative likelihood of the patient "acting out" problems rather than "working out" the difficulty. The lowering of these four subscales, thus, would indicate for both groups that there is a lessening of the impulse to act out, and a lessening of the experiencing of psychoneurotic symptomatology.

The results of pre- and post-treatment testing on the adjective checklist, while not significantly different between groups, were interesting in themselves.

It is obvious that patients in both groups experienced something as changing over the course of therapy. Affects typically considered positive were experienced more frequently at termination than at the beginning of treatment, while a corresponding deminution of affects typically considered unpleasant was also reported.

The practical implications of an easily administered change measure are truly great given the pressure for accountability in the public mental health sector. More research in varied settings could yield a simple device, economically feasible, which would validate on an objective scale change in affect as a treatment outcome.

Therapists' ratings of defensiveness, anxiety, and degree of disturbance were all lower for finishers, both experimental and control. Capacity for insight, personal liking for the patient, ego strength, and overall adjustment were all rated higher upon the completion of treatment. It can be stated that there was essentially no difference in the ratings and for scores between the two groups. This point will be further discussed later in this section under the heading "Practical Considerations."

The consistency with which the MMPI subscales K, Hs, D, and Hy appeared as covariates with Therapist Rating Form items 1, 3, 5, 6, 7, and 8 might well

indicate that they are similarly sensitive to similar clusters of data. The two instruments both attempted to get at the assessment issue in the clinical interview. More study of the relationship between the TRF and the abbreviated MMPI would be required for a fuller explanation of this effect.

Hypothesis 3a

Members of the experimental group will self-rate a greater degree of positive change resulting from the therapy experience than will members of the control group.

While sufficient evidence did not exist in the results of data analysis for accepting the hypothesis, two trends were identified. First there was a tendency towards agreement between the patient and the therapist in the following manner: Patients who rated themselves as feeling more overwhelmed at the beginning of therapy, and as benefiting less from treatment, were generally rated by their therapist as being more anxious, more defensive, and more disturbed while being less motivated for treatment, having less ego strength, and a diminished capacity for insight. Therapists also liked these patients less. These observations held true for both groups when the patient rating was as mentioned above. The patient who presented as being overwhelmed and the victim of circumstances outside of his own control most

frequently wanted to have the treatment "done to" him and tended to resist a sense of personal involvement in the working process. Therapists interested in doing well and in alleviation of their patient's distress apparently were "angered" by the "refusal" of the patient to "get well." The lack of a "we-ness" in the initial interview produced indeed a poorer prognosis with the techniques in this study.

A second observation needing mention is that persons in the control group tended to rate their degree of change in the extreme. They tended to report either a great deal of change, or none at all. The experimental group, on the other hand, rated change more consistently as positive but not extremely so. The explanation for this difference likely rests in the explicit acceptance in crisis intervention of the notion of limited goals, along with the verbalization between patient and therapist that problems exist with which they will not deal in the therapy. With control group patients, termination can be accomplished without any exploration of other problem areas. Perhaps control group patients thought in terms of cured, or not cured, regarding their difficulties more as an illness than a problem. The experimental group was explicitly encouraged to adopt a problem-solving stance regarding their troubles. Future research in this area should be designed to look at the patient's

perception (illness to be cured vs. problem to be solved) of his difficulties as variable affecting outcome.

Hypothesis 3b

Members of the experimental group will self-rate a greater degree of satisfaction with the therapy experience than will members of the control group. The thinking behind this hypothesis centered around the belief that the patient would feel better about the active overt character of the therapist's involvement in the treatment than he would about a passive, non-directive approach.

This thinking would appear to be confirmed only with variable 94 (PRF 8) "How adequately do you feel you are dealing with any present problems?" While experimental group patients were able to accept the notion that they can still be having problems, they felt that they were still "normal" and that their problems could be solved. The solving process bred a sense of competence and confidence in their own abilities. There exists nothing in traditional short-term nondirective treatment which would accentuate and develop this patient perception.

Variables 88, 89, and 93 (PRF 2, 3, and 7) dealt less specifically with problems, and more globally with gain, benefit, and satisfaction with the treatment. No significant results were found with the analysis of these

items. It might be well to frame other questions in patient rating which are designed to narrowly speak to a specific issue (state why satisfied) in addition to obtaining global satisfaction ratings. In retrospect, it only makes sense that persons who finish a treatment contract would tend to be satisfied with it. It would be assumed that an extremely dissatisfied patient would number among treatment dropouts before too long. Thus, the question of patient satisfaction might have been better asked of the treatment dropouts, again with an instrument designed to elicit the specific reasons for satisfaction or dissatisfaction.

Hypothesis 4

Therapists will rate members of the experimental group as significantly more changed than members of the control group.

While therapists rated that change occurred, there was no evidence to support the hypothesis that the experimental group would be rated as changing more than the control group. Further, there was no tendency towards significance. Neither was there any evidence of the control patients changing more than the experimental patients. Rather, the therapists' ratings tended to be remarkably similar for all finishers, regardless of group. In essence, therapists stated that their

patients (who completed treatment) changed as an outgrowth of therapy regardless of method.

The therapist rating form items (20) were more frequently and more highly correlated with both demographic variables, and with pre-test data, than any of the other evaluation instruments. Within this form (TRF), rating 10 (degree to which countertransference was a problem), rating 7 (the extent to which the therapist liked the patient), TRF 14 (the degree to which the therapist felt warmly towards the patient), and TRF 15 (how much emotional investment the therapist had in the client) were all frequently correlated with numerous demographic variables (between 16 and 26). TRF scores were lower (poorer) for persons of lower income, less education, and for unemployed persons, and for those with more than four persons in the family. These highly class-oriented variables rated as they were indicate that therapists felt these persons were poorer treatment risks than were better educated, employed persons with higher incomes and four or fewer persons in the family. It must be noted that nine of the 10 therapists involved in the study were themselves of a middle class, relatively well-educated family of orientation, with four or fewer persons in their family, and all had more than six, and as many as 10, years of university education. While research into the relationship between patient and

therapist social class and other characteristics has been conducted, one can only wonder what the impact of these issues might be in the more active crisis approach. It is clear that the greater the gratification, liking, or warmth for the patient (TRF 14) or from the therapy (TRF 16), the higher was the overall rating on the TRF, and the higher was the patient rating of change in, and satisfaction with, the clinical contact. These phenomena occurred without respect for group assignment. The implications of this finding, not only for further research, but for clinical practice, are compelling and must be examined. In short-term methods where the relationship does not have the luxury of time to "build" the initial impressions of like or dislike of the patient may be crucial to the outcome. One might also ask for patient information about liking or disliking the therapist. Should cases be assigned not only on the basis of degree of skill required, experience and the like, but also on the relative intangibles of personal liking or therapists anticipated gratification from working with a particular patient? Should the client "shop" for a therapist of his or her liking? What would be the outcome results of such matching? The logistics of such research are mind-boggling but the effort may well be unavoidable in the age of accountability which demands increased cost effectiveness and cost efficiency.

In retrospect, it would have been very interesting to have included an item in the TRF which spoke to the question "Will the patient complete the treatment contract, and why?" The results of this question when correlated with the other TRF items might lend important information concerning the assignment of cases for maximum benefit of patient/therapist matching. Further, a structured training and/or review process preceding the study might have sharpened differences between the two groups, and should be considered in future research.

Practical Considerations

There remains one critical question as yet unexplored and not dealt with in the hypotheses. In the introduction, the reader will recall that the author's interest in this research was stimulated, not only out of a belief that the method worked, but also by notions of extreme pressure for dealing more rapidly and more appropriately and cost effectively with an ever-increasing demand for services in a time with ever-shrinking resources. The lack of significant differences between groups, while certainly not providing evidence for the greater effectiveness of the experimental method also does not demonstrate a greater effectiveness of the more traditional approach. Calling it a "draw" makes crisis intervention the "winner" by reason of necessity. Simply put, when one gets such similar results with the

experimental method in six sessions, why should one choose to achieve the same sort of result with traditional methods in 10 sessions? With clinical costs approaching and surpassing $40 per hour, the savings of four sessions yields a direct savings of $160 per patient or a 40% reduction in costs per patient, savings of hours and perhaps most important, where waiting lists exist, a 40% shorter wait for resolution of the painful state which precipitated the crisis situation. Further, there may well be a significantly greater number of persons who will not drop out of treatment with the experimental method. While not statistically significant (.124) it is clear that twice as many people finished treatment in the experimental group as compared to the control. A larger study (N) with fewer restrictions for admission to the study is nearly underway to determine what result the greater randomization of demographic variables will have on the patient dropout statistics. The state of the clinical art is such that when a significance of .124 is achieved it must be pursued. Anything that can impact upon the traditional 50% dropout rate will have a great effect upon the acceptance of psychotherapy by both clients and funding bodies.

Short-term psychotherapy outcome research is difficult to conduct but must be undertaken if we are to change what is now an art into an artistic science.

The numerous problems of length of time required, expensive statistical analyses, and sanction by governing bodies must be solved. Results in new areas of research may yield more questions than answers and may simply demand more research but in spite of these potential obstacles, efforts must be begun and continued.

APPENDICES

APPENDIX A

TABLE OF RANDOM NUMBERS

APPENDIX A

TABLE OF RANDOM NUMBERS

03991	10461	93716	16894	98953	73231	39528	72484	82474	25593
38555	95554	32886	59780	09958	18065	81616	18711	53312	44276
17546	73704	92052	46215	15917	06253	07586	16120	82611	22820
32643	52861	95819	06841	19640	99113	90767	01245	13574	17200
69572	68777	39510	35905	85241	35159	40188	28193	29593	88627
24122	66591	27699	06494	03152	19121	34414	82157	86887	55087
61196	30231	92962	61773	22109	78508	63439	75363	41889	16822
30532	21704	10274	12202	91205	20480	67019	09070	93389	45517
04788	97599	75867	20717	82037	10268	79495	01116	52162	90256
48228	63379	85784	47619	87181	37220	91704	30552	01727	21031
88618	19161	41290	67312	71857	15957	48545	35247	18619	13674
71299	23853	05870	01119	92784	26340	75122	11724	74627	73707
27954	58909	82444	99005	04921	73701	92904	14141	32392	19763
80863	00514	20247	81759	45197	25332	69902	63742	78464	22501
33564	60780	48160	85558	15191	18782	94972	11598	62095	36787
90899	75754	60833	25983	01291	41349	19152	00023	12302	80783
78038	70267	43529	06318	38384	74761	36024	00867	76378	41605
55986	66485	88722	56736	66164	49131	94158	74284	05041	49807
87589	08823	94813	31900	54155	83436	54158	31243	46978	35182
16815	60311	74157	90561	72848	11834	75051	93029	47665	64482
34677	58300	74910	64345	19325	81549	60365	94653	35075	33949
45305	07521	61485	41855	14413	70951	84799	42402	56623	34442
59747	67277	76503	31513	39663	77514	32960	07405	36409	83232
16520	69676	11654	99893	02181	65161	19322	53845	57620	52606
68652	27376	92852	55866	88448	03584	11220	91747	07399	37408
79375	95220	01159	63267	10622	48391	31751	57260	68980	05339
33521	26665	55823	47641	86225	31704	88492	99882	14454	01504
59589	49067	66821	41575	49767	04037	30944	47741	07481	83828
20554	91409	96277	48257	50846	97616	22888	48893	27499	98748
59404	72059	43947	51680	43852	59693	78212	16993	35902	91386
42614	29297	01918	28346	25163	01889	70044	15021	68971	11403
34994	41374	70071	14736	65251	07629	37239	33295	18477	65622
99385	41600	11133	07586	36815	43625	18637	37509	14707	94997
66197	68646	78138	66559	64397	11692	05327	82162	83745	22567
48509	23929	27482	45476	01515	25624	95096	67940	16930	33361
15470	48355	88651	22596	83761	60873	43253	84145	20368	07126
20094	98977	74813	93113	14487	06415	80854	09279	41196	37480
73788	06533	28597	20105	51321	92246	80088	77074	66919	31678
60530	45128	74022	84617	72472	00008	80890	18002	35352	54131
44372	15486	65741	11014	05166	55306	93128	18164	79982	68416
18611	19241	66083	24653	84609	58232	41849	81517	46850	52326
58419	15997	08355	60860	29735	47762	46852	33019	69218	93160
61199	67940	55121	29281	59076	07936	11087	96294	14013	31792
18627	90872	00911	98936	76355	93779	52701	08337	56303	87315
00141	58997	14060	40619	29549	69616	57275	36898	81304	48585
32624	68691	14845	46672	61958	77100	20857	73156	70284	24326
65961	73189	41839	55382	17267	70943	15633	81924	90415	93614
20288	34060	39685	23309	10061	68829	92694	48297	39904	02115
59462	95978	71116	53166	35208	33374	77613	19019	88152	00080
99782	93478	53152	07163	35663	52972	38088	32486	45134	63545

Source: Paul G. Hoel, Elementary Statistics (New York: John Wiley & Sons, 1960), p. 241.

APPENDIX B

ADULT INTAKE FORM

LIVINGSTON COUNTY COMMUNITY MENTAL HEALTH CENTER

APPENDIX B

ADULT INTAKE FORM

Date Today _____

Last Name: _____ First Name: _____

Middle Name: _____ Maiden Name: _____

Address: _____ City: _____ Township: _____

Home Phone: _____ Business Phone: _____

Living Situation: (Check as many as appropriate)

( ) Urban
( ) Rural
( ) Own (or buying) home
( ) Rent Home
( ) Apartment
( ) Trailer

How long have you lived in Livingston County? _____

Who referred you to the Center (check one)?

( ) Self
( ) Friend
( ) Spouse
( ) Court
( ) Minister
( ) Doctor
( ) Employer
( ) School
( ) State Hospital
( ) Other (list)

Date of Hearing: _____ _____

INDIVIDUAL DATA:

Age: _____ Birth Date: _____

Sex: _____ Education: _____

Birth Place: _____ Nationality: _____

Religion in Childhood: _____ Religion Now: _____

Occupation: _____ Firm: _____

How long have you worked for present firm? _____

Military Service? _____ If yes, list branch: _____

Date of military service: _____ Type of Discharge: _____

MEDICAL INSURANCE INFORMATION: Please submit insurance card to receptionist.

Do you have Blue Cross? _____ Other medical insurance? _____

Blue Cross Number: _____ Company: _____

Blue Shield Number: _____ Policy Number: _____

Group Number: _____

Service Code: _____ Policyholder: _____

( ) Single
( ) Remarried
Date Remarried: _____
( ) Married
Date Married: _____
( ) Separated
Date Separated: _____

( ) Divorce Pending:
Date Applied For: _____
( ) Divorced
Date Final: _____
( ) Widowed
Date Widowed: _____

PLEASE SUPPLY THE FOLLOWING INFORMATION ABOUT YOUR SPOUSE:

Name: _____ Age: _____

Birth Date: _____ Birth Place: _____

Nationality: _____ Education: _____

Occupation: _____ Firm: _____

How long with present firm? _____

Military service; branch, date and type of discharge: _____

_____

How long did you date? _____

PLEASE SUPPLY THE FOLLOWING FINANCIAL INFORMATION:

Your weekly gross pay: _____

Spouse's weekly gross pay: _____

Total income from other sources (child support, social security, etc.): _____

_____

Total Weekly income: _____

List any unusual expenses that you have at this time: _____

_____

CHILDREN:

Children by present marriage (list names and ages): _____

_____

Children from any previous marriages (list names, ages and comment on residence, custody, support, etc.): _____

_____

_____

FATHER:

Age now (if living): _____ **Age at death & date:** _____

Education Completed: _____ **Occupation:** _____

Religion: _____ **Age at marriage:** _____

MOTHER:

Age now (if living): _____ **Age at death & date:** _____

Education Completed: _____ **Occupation:** _____

Religion: _____ **Age at marriage:** _____

Rate your parent's marriage:

( ) Very Happy
( ) Happy
( ) Average
( ) Unhappy
( ) Very Unhappy

List names, ages and sex of brothers & sisters: _____

_____

As a child, did you live with your parents (if no, explain): _____

_____

When you lived with your parents, name & describe other persons living in the house: _____

PHYSICAL HEALTH DATA:

Describe your present health:

( ) Very Good
( ) Good
( ) Average
( ) Poor

List present illnesses, symptoms, (include allergies): _____

_____

List childhood and other illnesses, surgery, handicaps, etc. (Underline any whic caused serious difficulty) _____

_____

When was your last medical check-up? _____ **Doctor?** _____

Reason for this and findings: _____

_____

List and describe the purpose of any medication you are now taking: _____

_____

Have you ever had a serious mental disturbance of a "nervous breakdown"?

( ) No

( ) Yes When? _____ Treated By: _____

Hospitalized At: _____ How Long? _____

Date of Discharge: _____

List all previous psychotherapy, counseling, or other treatment for personal and family problems: _____

Has any other member of your family been seen at this agency? _____

Name and date of service: _____

PRESENT PROBLEM:

(Describe your present problem and explain why you are coming to the Center at this time)

_____

_____

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(use back of page if necessary)

APPENDIX C

ADJECTIVE - SYMPTOM CHECKLIST (ASCL)

PRE-TREATMENT - POST-TREATMENT

APPENDIX C

ADJECTIVE - SYMPTOM CHECKLIST (ASCL)

PRE-TREATMENT - POST-TREATMENT

Recently I have been feeling:

	Always	Frequently	Sometimes	Seldom	Never
Calm	()	()	()	()	()
Aggressive	()	()	()	()	()
Bored	()	()	()	()	()
Kind	()	()	()	()	()
Nervous	()	()	()	()	()
Energetic	()	()	()	()	()
Cheerful	()	()	()	()	()
Moody	()	()	()	()	()
Friendly	()	()	()	()	()
Selfish	()	()	()	()	()
Contented	()	()	()	()	()
High Strung	()	()	()	()	()
Good Tempered	()	()	()	()	()
Mature	()	()	()	()	()
Suspicious	()	()	()	()	()
Tense	()	()	()	()	()
Independent	()	()	()	()	()
Worrying	()	()	()	()	()
Flexible	()	()	()	()	()
Trustful	()	()	()	()	()
Dependent	()	()	()	()	()
Irritable	()	()	()	()	()
Jealous	()	()	()	()	()
Relaxed	()	()	()	()	()
Reliable	()	()	()	()	()
Lonely	()	()	()	()	()
Frightened	()	()	()	()	()
Sleeping well	()	()	()	()	()
Impatient	()	()	()	()	()
Active	()	()	()	()	()

APPENDIX D

SEVEN SCALES FROM THE MMPI

APPENDIX D

SEVEN SCALES FROM THE MMPI

		TRUE	FALSE
1.	I am liked by most people who know me.	()	()
2.	I am easily awakened by noise.	()	()
3.	Much of the time my head seems to hurt all over.	()	()
4.	I feel anxiety about someone or something almost all the time.	()	()
5.	A person should try to understand his dreams and be guided by or take warning from them.	()	()
6.	I have diarrhea once a month or more.	()	()
7.	My judgment is better then it ever was.	()	()
8.	I can be friendly with people who do things which I consider wrong.	()	()
9.	Sometimes I become so excited that I find it hard to get to sleep.	()	()
10.	I have often had to take orders from someone who did not know as much as I did.	()	()
11.	I do not always tell the truth.	()	()
12.	I have nightmares every few nights.	()	()
13.	At periods my mind seems to work more slowly than usual.	()	()
14.	I am bothered by acid stomach several times a week.	()	()
15.	I usually feel that life is worth while.	()	()
16.	I frequently notice my hand shakes when I try to do something.	()	()
17.	I usually have to stop and think before I act even in trifling matters.	()	()
18.	I am an important person.	()	()
19.	I have met problems so full of possibilities that I have been unable to make up my mind about them.	()	()
20.	Often I cross the street in order not to meet someone I see.	()	()
21.	I enjoy detective or mystery stories.	()	()
22.	The sight of blood neither frightens me nor makes me sick.	()	()
23.	I go to church almost every week.	()	()
24.	I believe in the second coming of Christ.	()	()
25.	Parts of my body often have feelings like burning, tingling, crawling or like "going to sleep".	()	()
26.	I have sometimes felt that difficulties were piling up so high that I could not overcome them.	()	()
27.	I have a cough most of the time.	()	()
28.	Everything tastes the same.	()	()
29.	I have often met people who were supposed to experts who were no better than I.	()	()
30.	I am troubled by discomfort in the pit of my stomach every few days or oftener.	()	()
31.	My memory seems to be all right.	()	()
32.	I like to flirt.	()	()
33.	I have never had a fainting spell.	()	()
34.	I drink an unusually large amount of water every day.	()	()
35.	I am worried about sex matters.	()	()

		TRUE	FALSE
36.	At times I have fits of laughing and crying that I cannot control.	()	()
37.	When I was a child, I belonged to a crowd or gang that tried to stick together through thick or thin.	()	()
38.	I have never done anything dangerous for the thrill of it.	()	()
39.	I am afraid when I look down from a high place.	()	()
40.	I have a habit of counting things that are not important such as bulbs on electric signs and so forth.	()	()
41.	I almost never dream.	()	()
42.	There seems to be a lump in my throat much of the time.	()	()
43.	I believe I am no more nervous than most people.	()	()
44.	I dream frequently about things that are best kept to myself.	()	()
45.	My sleep is fitful and disturbed.	()	()
46.	I find it hard to set aside a task that I have undertaken, even for a short time.	()	()
47.	My soul sometimes leaves my body.	()	()
48.	When I am with people I am bothered by hearing very queer things.	()	()
49.	It would be better if almost all laws were thrown away.	()	()
50.	I do not read every editorial in the newspaper every day.	()	()
51.	At times I am full of energy.	()	()
52.	A minister can cure a disease by praying and putting his hand on your head.	()	()
53.	As a youngster I was suspended from school one or more times for cutting up.	()	()
54.	I like to let people know where I stand on things.	()	()
55.	There seems to be a fullness in my head or nose most of the time.	()	()
56.	I am afraid of losing my mind.	()	()
57.	I do not worry about catching diseases.	()	()
58.	I am a good mixer.	()	()
59.	I wish I were not so shy.	()	()
60.	I like to read newspaper articles on crime.	()	()
61.	I get anxious and upset when I have to make a short trip away from home.	()	()
62.	I am easily embarrassed.	()	()
63.	When I get bored I like to stir up some excitement.	()	()
64.	It would make me nervous if any member of my family got into trouble with the law.	()	()
65.	It is not hard for me to ask for help from my friends even though I cannot return the favor.	()	()
66.	Bad words, often terrible words, come into my mind and I cannot get rid of them.	()	()
67.	Most of the time I feel blue.	()	()
68.	I see things or animals or people around me that others do not see.	()	()
69.	Everything is turning out just like the Prophets in the Bible said it would.	()	()
70.	At times I feel like smashing things.	()	()

		TRUE	FALSE
71.	I am liked by most people who know me.	()	()
72.	If people had not had it in for me, I would have been much more successful.	()	()
73.	I work under a great deal of tension.	()	()
74.	I am not apt to speak to people until they speak to me.	()	()
75.	I have been inspired to a program of life based on duty which I have since carefully followed.	()	()
76.	I know who is responsible for most of my troubles.	()	()
77.	I never worry about my looks.	()	()
78.	I have a great deal of stomach trouble.	()	()
79.	I have never felt better in my life than I do now.	()	()
80.	Sometimes I am strongly attracted by the personal articles of others such as shoes, gloves, etc., so that I want to handle or steal them though I have no use for them.	()	()
81.	I brood a great deal.	()	()
82.	Once in a while I laugh at a dirty joke.	()	()
83.	In school I found it very hard to talk before the class.	()	()
84.	I have had no difficulty in starting or holding my bowel movement.	()	()
85.	I worry over money and business.	()	()
86.	Once a week or oftener I feel suddenly hot all over without apparent cause.	()	()
87.	My table manners are not quite as good at home as when I am out in company.	()	()
88.	Something exciting will always pull me out of it when I am feeling low.	()	()
89.	Sometimes I feel as if I must injure either myself or someone else.	()	()
90.	I hardly ever feel a pain in the back of my neck.	()	()
91.	I commonly wonder what hidden reasons another person may have for doing something nice for me.	()	()
92.	I have very few headaches.	()	()
93.	Life is a strain for me much of the time.	()	()
94.	I am happy most of the time.	()	()
95.	Once in awhile I put off until tomorrow what I ought to do today.	()	()
96.	I don't blame anyone for trying to grab everything he can get in this world.	()	()
97.	I do many things which I regret afterwards.	()	()
98.	I believe that my home life is as pleasant as that of most people I know.	()	()
99.	I am very seldom troubled by constipation.	()	()
100.	I have never vomited blood or coughed up blood.	()	()
101.	I have a good appetite.	()	()
102.	I think nearly anyone would lie to keep out of trouble.	()	()
103.	I enjoy children.	()	()
104.	If I could get into a movie without paying and be sure I was not seen, I would probably do it.	()	()
105.	I resent having anyone take me in so cleverly that I have had to admit that it was one on me.	()	()

		TRUE	FALSE
106.	I have the wanderlust and am never happy unless I am roaming or traveling about.	()	()
107.	It takes a lot of argument to convince most people of the truth.	()	()
108.	My hardest battles are with myself.	()	()
109.	My daily life is full of things that keep me interested.	()	()
110.	I am about as able to work as I ever was.	()	()
111.	At times I have been so entertained by the cleverness of a crook that I have hoped he would get away with it.	()	()
112.	In walking, I am very careful to step over sidewalk cracks.	()	()
113.	I am inclined to take things hard.	()	()
114.	I have periods when I feel unusually cheerful without any reason.	()	()
115.	Someone has been trying to rob me.	()	()
116.	I commonly hear voices without knowing where they come from.	()	()
117.	I think most people would lie to get ahead.	()	()
118.	I would rather win than lose in a game.	()	()
119.	I like to know some important people because it makes me feel important.	()	()
120.	If several people find themselves in trouble, the best thing for them to do is agree with a story and stick to it.	()	()
121.	I cry easily.	()	()
122.	I sometimes tease animals.	()	()
123.	Sometimes without any reason or even when things are going wrong, I feel excitedly happy, "on top of the world".	()	()
124.	I am more sensitive than most other people.	()	()
125.	I do not like everyone I know.	()	()
126.	During the past few years I have been well most of the time.	()	()
127.	I have never had a fit or convulsion.	()	()
128.	I enjoy many different kinds of play or recreation.	()	()
129.	When I leave home I do not worry about whether the door is locked and the windows closed.	()	()
130.	Even when I am with people I feel lonely much of the time.	()	()
131.	It makes me feel uncomfortable to put on a stunt at a party even when others are doing the same sort of thing.	()	()
132.	I am very religious (more than most people).	()	()
133.	I have had periods in which I carried on activities without knowing later what I had been doing.	()	()
134.	It is safer to trust nobody.	()	()
135.	I gossip a little at times.	()	()
136.	At times I feel I can make up my mind with unusually great ease.	()	()
137.	I believe women should have as much sexual freedom as men.	()	()
138.	I am in just as good physical health as most of my friends.	()	()
139.	I certainly feel useless at times.	()	()
140.	I get mad easily and then get over it soon.	()	()

		TRUE	FALSE
141.	I am troubled by attacks of nausea and vomiting.	()	()
142.	There are people who are trying to steal my thoughts and ideas.	()	()
143.	I feel weak all over much of the time.	()	()
144.	I am neither gaining nor losing weight.	()	()
145.	I believe my sins are unpardonable.	()	()
146.	At times it has been impossible for me to keep from stealing of shoplifting something.	()	()
147.	Often I can't understand why I have been so cross and grouchy.	()	()
148.	My neck spots with red often.	()	()
149.	I feel that it is certainly best to keep my mouth shut when I am in trouble.	()	()
150.	At times I have very much wanted to leave home.	()	()
151.	Much of the time I feel as if I have done something wrong or evil.	()	()
152.	I can sleep during the day but not at night.	()	()
153.	My father was a good man.	()	()
154.	I think a great many people exaggerate their misfortunes in order to gain the sympathy and help of others.	()	()
155.	Often I feel as if there were a tight band around my head.	()	()
156.	My conduct is largely controlled by the customs of those about me.	()	()
157.	I wish I could be as happy as others seem to be.	()	()
158.	I find it hard to keep my mind on a task or job.	()	()
159.	I am certainly lacking in self-confidence.	()	()
160.	I have very few quarrels with members of my family.	()	()
161.	It does not bother me particularly to see animals suffer.	()	()
162.	I have been told that I walk during sleep.	()	()
163.	I get angry sometimes.	()	()
164.	I am always disgusted with the law when a criminal is freed through the arguments of a smart lawyer.	()	()
165.	My hands and feet are usually warm enough.	()	()
166.	Sometimes at elections I vote for men about whom I know very little.	()	()
167.	My speech is the same as always (not faster nor slower, or slurring; no hoarseness)	()	()
168.	I do not have spells of hay fever or asthma.	()	()
169.	I have numbness in one or more regions of my skin.	()	()
170.	At times I feel like swearing.	()	()
171.	I feel that I have often been punished without cause.	()	()
172.	I am almost never bothered by pains over my heart or in my chest.	()	()
173.	I do not blame a person for taking advantage of someone who lays himself open to it.	()	()
174.	I have reason for feeling jealous of one or more members of my family.	()	()
175.	Criticism or scolding hurts me terribly.	()	()

		TRUE	FALSE
176.	Once in a while I think of things too bad to talk about.	()	()
177.	Sometimes when I am not feeling well I am cross.	()	()
178.	I do not tire quickly.	()	()
179.	I do not often notice my ears ringing or buzzing.	()	()
180.	I have no dread of going into a room by myself when other people have already gathered and are talking.	()	()
181.	I seldom or never have dizzy spells.	()	()
182.	What others think of me does not bother me.	()	()
183.	At times I have a strong urge to do something harmful or shocking.	()	()
184.	I frequently have to fight against showing that I am bashful.	()	()
185.	I seldom worry about my health.	()	()
186.	I have strange and peculiar thoughts.	()	()
187.	No one cares much what happens to you.	()	()
188.	My sex life is satisfactory.	()	()
189.	I frequently find it necessary to stand up for what I thing is right.	()	()
190.	My family does not like the work I have chosen (or the work I intend to choose for my life work).	()	()
191.	I can read a long while without tiring my eyes.	()	()
192.	I am against giving money to beggars.	()	()
193.	I have had blank spells in which my activities were interrupted and I did not know what was going on around me.	()	()
194.	I have periods of such great restlessness that I cannot sit long in a chair.	()	()
195.	I seem to be about as capable and smart as others around me.	()	()
196.	I have been afraid of things or people that I knew could not hurt me.	()	()
197.	I believe in a life hereafter.	()	()
198.	Evil spirits possess me at times.	()	()
199.	I hardly ever notice my heart pounding and I am seldom short of breath.	()	()
200.	At times my thoughts have raced ahead faster than I could speak them.	()	()
201.	Most nights I go to sleep without thoughts or ideas bothering me.	()	()
202.	The only interesting part of newspapers is the "funnies".	()	()
203.	I have used alcohol excessively.	()	()
204.	I believe I am being followed.	()	()
205.	I have few or no pains.	()	()
206.	I can easily make other people afraid of me, and sometimes do it for the fun of it.	()	()
207.	Someone has been trying to poison me.	()	()
208.	I have had periods of days, weeks, or months when I couldn't take care of things because I couldn't "get going".	()	()
209.	I cannot understand what I have read as well as I used to.	()	()
210.	I an never happier then when I am alone.	()	()

		TRUE	FALSE
211.	My eyesight is as good as it has been in years.	()	()
212.	It makes me impatient to have people ask my advice or otherwise interrupt me when I am working on something important.	()	()
213.	I believe I am being plotted against.	()	()
214.	I like to visit places where I have never been before.	()	()
215.	I have had no difficulty in keeping my balance in walking.	()	()
216.	People often disappoint me.	()	()
217.	Some people are so bossy that I feel like doing the opposite of what they request even though I know that they are right.	()	()
218.	I sometimes keep on a thing until others lose their patience with me.	()	()
219.	I often think, "I wish I were a child again."	()	()
220.	I have more trouble concentrating then other seem to have.	()	()
221.	Sometimes some unimportant thought will run through my mind and bother me for days.	()	()
222.	I believe I am a condemned person.	()	()
223.	Most of the time I would rather sit and daydream than do anything else.	()	()
224.	I loved my mother.	()	()
225.	I sweat very easily, even on a cold day.	()	()
226.	At times I feel like picking a fist fight with someone.	()	()
227.	I find it hard to make talk when I meet new people.	()	()
228.	Once a week or oftener I become very excited.	()	()
229.	Someone has control over my mind.	()	()
230.	Children should be taught all the main facts about sex.	()	()
231.	I prefer to pass by school friends, or people I know but have not seen for a long time, unless they speak to me first.	()	()
232.	I have difficulty starting to do things.	()	()
233.	I easily become impatient with people.	()	()
234.	Someone has been trying to influence my mind.	()	()
235.	I don't seem to care what happens to me.	()	()
236.	Some of my family have habits that bother and annoy me very much.	()	()
237.	When in a group of people, I have trouble thinking of the right things to talk about.	()	()
238.	I have often lost out on things because I couldn't make up my mind soon enough.	()	()
239.	I wake up fresh and rested most mornings.	()	()
240.	Almost every day, something happens to frighten me.	()	()
241.	At one or more times in my life I felt that someone was making me do things by hypnotizing me.	()	()
242.	I have at times stood in the way of people who were trying to do something, not because it amounted to much but because of the principle of the thing.	()	()
243.	I loved my father.	()	()
244.	There is something wrong with my mind.	()	()
245.	I like to study and read about things that I am working at.	()	()

		TRUE	FALSE
246.	I forget right away what people say to me.	()	()
247.	I have little or no trouble with my muscles twitching or jumping.	()	()
248.	I frequently find myself worrying about something.	()	()
249.	I have had attacks in which I could not control my movements or speech, but in which I knew what was going on around me.	()	()
250.	I usually expect to succeed in things I do.	()	()
251.	I believe there is a God.	()	()
252.	Sometimes, when embarrassed, I break out in a sweat which annoys me greatly.	()	()
253.	I believe in law enforcement.	()	()
254.	I have several times given up doing a thing because I thought too little of my ability.	()	()
255.	Most people will use somewhat unfair means to gain profit or an advantage rather than to lose it.	()	()
256.	My people treat me more like a child than a grown-up.	()	()

APPENDIX E

PATIENT RATING FORM

(PRF)

APPENDIX E

PATIENT RATING FORM (PRF)

1. How adequately do you feel you were dealing with any problems at the time you entered therapy?
   - [ ] very adequately
   - [ ] fairly adequately
   - [ ] neither adequately nor inadequately
   - [ ] fairly inadequately
   - [ ] very inadequately

2. How much have hou benefited from your therapy?
   - [ ] a great deal
   - [ ] a fair amount
   - [ ] to some extent
   - [ ] very little
   - [ ] not at all

3. Everything considered, how satisfied are you with the results of your psychotherapy experience?
   - [ ] extremely satisfied
   - [ ] fairly satisfied
   - [ ] somewhat satisfied
   - [ ] fairly dissatisfied
   - [ ] very much dissatisfied

4. How upset were you when you entered therapy?
   - [ ] tremendously
   - [ ] very
   - [ ] fairly
   - [ ] slightly
   - [ ] not at all

5. How upset have you generally felt since your therapy?
   - [ ] tremendously
   - [ ] very
   - [ ] fairly
   - [ ] slightly
   - [ ] not at all

6. How much do you feel you have changed as a result of your therapy?
   - [ ] a great deal
   - [ ] a fair amount
   - [ ] somewhat
   - [ ] very little
   - [ ] not at all

7. On the whole, how well do you feel you are getting along now?
   [ ] extremely well
   [ ] fairly well
   [ ] neither well nor poorly
   [ ] fairly poorly
   [ ] extremely poorly

8. How adequately do you feel you are dealing with any present problems?
   [ ] very adequately
   [ ] fairly adequately
   [ ] neither adequately nor inadequately
   [ ] fairly inadequately
   [ ] very inadequately

9. To what extent have your complaints or symptoms that brought you to therapy changed as a result of treatment?
   [ ] completely disappeared
   [ ] considerably improved
   [ ] somewhat improved
   [ ] no change at all
   [ ] got worse

10. Do you feel a need for further therapy?
   [ ] no need at all
   [ ] slight need
   [ ] could use more
   [ ] considerable need
   [ ] very great need

APPENDIX F

THERAPIST RATING FORM

(TRF)

APPENDIX F

THERAPIST RATING FORM

Please rate each of the following items, comparing the patient with other patients whom you see in psychotherapy.

			Very little	Some	Moderate	Fairly great	Very great
1.	Defensiveness	before					
		after					
2.	Anxiety	before					
		after					
3.	Ego Strength	before					
		after					
4.	Degree of disturbance	before					
		after					
5.	Capacity for insight	before					
		after					
6.	Over-all adjustment	before					
		after					
7.	Personal liking for patient	before					
		after					
8.	Motivation for therapy	before					
9.	Improvement expected (prognosis)	before					
10.	Degree to which countertransference was a problem in therapy						
11.	Degree to which you usually enjoy working with this kind of patient in psychotherapy						
12.	Degree of symptomatic improvement						
13.	Degree of change in basic personality structure						
14.	Degree to which you felt warmly toward the patient						

		Very little	Some	Moderate	Fairly great	Very great
15.	How much of an "emotional investment" did you have with this patient?	_____	_____	_____	_____	_____
16.	Degree to which you think the patient felt warmly to you	_____	_____	_____	_____	_____
17.	Over-all success of therapy	_____	_____	_____	_____	_____

18. How would you characterize your working relationship with this patient?

Extremely poor	Fairly poor	Neither good nor poor	Fairly good	Extremely good

19. How satisfied do you think the patient was with the results of his therapy?

Extremely dissatisfied	Fairly dissatisfied	Neither satisfied nor dissatisfied	Fairly satisfied	Extremely satisfied

20. How would you characterize the form of psychotherapy you conducted with this patient?

Largely supportive				Intensive analytical

APPENDIX G

TABLE OF COVARIATES

APPENDIX G

TABLE OF COVARIATES

Table 8

Variable	Covariates
MMPI	
Post L Scale	Marital status; number of children; number of persons supported; income, Pre L, K, Hs, D, Hy Scales; pre therapist ratings 1, 3, 5, 6 and 8
Post F Scale	Pre L, F, K, scales; therapist rating 8
Post K Scale	Marital status; number of children; relation; Pre K, Hs, D Scales; pre positive A/C/L; therapist ratings 3 and 5
Post Hs Scale	Age; age squared; number of persons supported; employment; religion; pre K, therapist ratings 1, 2 and 8
Post D Scale	Age; marital status; number of children; employment; religion, pre F, Hs, Pt; pre-postive A/C/L; pre therapist ratings 2, 3, 5 and 8
Post Hy Scale	Sex; marital status; number of persons supported; employment; years in the county; own home; pre K, Hs, D, Hy, Pt; Negative A/C/L; pre therapist rating 3, 5, and 6
Post Ma Scale	Marital status; number of persons supported; pre L, Ma scales; pre therapist ratings 1, 2 and 7
Post Pt Scale	Sex; marital status; employment; years in county; Pre K, Ma, Pt; Pre therapist ratings 1, 4 and 8
Adjective Check List	
Negative	Marital status; number of persons supported; number of children; employment; years in county; Pre K, D, Hy; pre therapist ratings 1, 3, 6, 7 and 8
Positive	Age; age squared; number of persons supported; employment; religion; Pre F, D, Hy, Ma; positive pre A/C/L; therapist ratings 3, 5, 7 and 8

Variable	Covariates
Patient Rating Scale	
P1	Pre therapist rating 2
P2	Age; marital status; employment; income; own home; religion; Pre D, Pt; therapist rating 1, 3, 4, 6 and 8
P3	Age; marital status, number of persons supported; employment; income; own home; religion; Pre F, K; pre therapist 1, 3, 4, 5, 6 and 8
P4	Age; income; own home; Pre F, K, D, Hy, Pt; pre therapist 1, 3, 4, 5, 6 and 8
P5	Age; number of persons supported; employment; income; religion; Pre F, K, Hy, Pt scales; pre therapist ratings 1, 4 and 5
P6	Age; income; religion; Pre Hy, Pt scales; pre therapist 1 and 4
P7	Age; marital status; children; number of persons supported; income; own home; religion; Pre F, K, D scale; pre therapist ratings 2, 3, 4, 5 and 8
P8	Age; marital status; number supported; employment; own home; pre F, K, D, Hy, Ma; pre therapist rating 3, 4, 6 and 8
P9	Age; marital status; income; Pre F, K; pre therapist 1
P10	Income; pre L scale; pre therapist rating 3 and 5
Pating Rating Total	Age; marital status; number supported; income; years in county; own home; religion, Pre K, Hy, Pt scale; therapist rating 1, 3, 4, 5 and 6

Variable	Covariates
Post Treatment Therapist Ratings	
T1	Sex; marital status; employment; own home; religion; pre K, D, Hy, Pt; pre negative A/C/L; pre therapist rating 1, 3, 5, 6, and 8
T2	Age; marital status; children; children supported; employment; years in county; own home; pre K, Pt scale; pre therapist rating 1, 2, 3, 5, 6 and 8
T3	Children; number of persons supported; religion; pre Hs Scale; pre therapist rating 3
T4	Pre Pt scale; pre therapist rating 4 and 5
T5	Marital status; children; number supported income; years in county; own home; pre F, D, Hy scale; pre therapist 1, 2, 3, 5 and 6
T6	Marital status; pre therapist rating 6 and 9
T7	Age; marital status; children; number supported; years in county; own home; religion; pre F, K, Hs, D scales; pre therapist ratings 3, 6, 7 and 8
T10	Age; marital status; number of persons supported; employment; years in county; religion; pre F, K, Pt scales; pre A/C/L; pre therapist rating 1, 3 and 8
T11	Marital status; number supported; employment; income; religion; pre L, F, K, D, Pt; pre therapist rating 1, 3, 4, 5 and 6
T12	Marital status; number supported; employment; own home; religion; pre F, K, D, Hy scale; pre therapist rating 1, 3, 4, 5, 6 and 8
T13	Marital status; number supported; employment; income; own home; religion; pre F, D, Hy scales; pre therapist ratings 1, 3, 4, 5, 6 and 8
T14	Age; marital status; number supported; employment; income; own home; religion; pre K, Hy, Pt scales; pre therapist rating 4, 5, 6 and 8
T15	Age; employment; income; own home; religion; pre F, K, D, Hy, Pt scale; pre therapist ratings 3, 4, 5 and 8

Variable	Covariates
Post Treatment Therapist Ratings (Continued)	
T16	Number of supported; employment; income; own home; religion; pre F, K, D, Ma, Pt scales; pre therapist ratings 3, 4, 5, 6 and 8
T17	Age; marital status; own home; religion; pre K, D, Hy scales; pre therapist ratings 1, 4, 5, 6 and 8
T18	Marital status; employment; income; religion; pre K scale; pre therapist rating 1, 5, 6 and 8
T19	Age; marital status; employment; income; religion; pre F, K, D, Hy, Pt scales; pre therapist ratings 1, 3, 5, 6 and 8
T20	Marital status; number supported; employment; own home; religion; pre F, K, Pt scales; pre therapist rating 1, 4, 5, 6 and 8

APPENDIX H

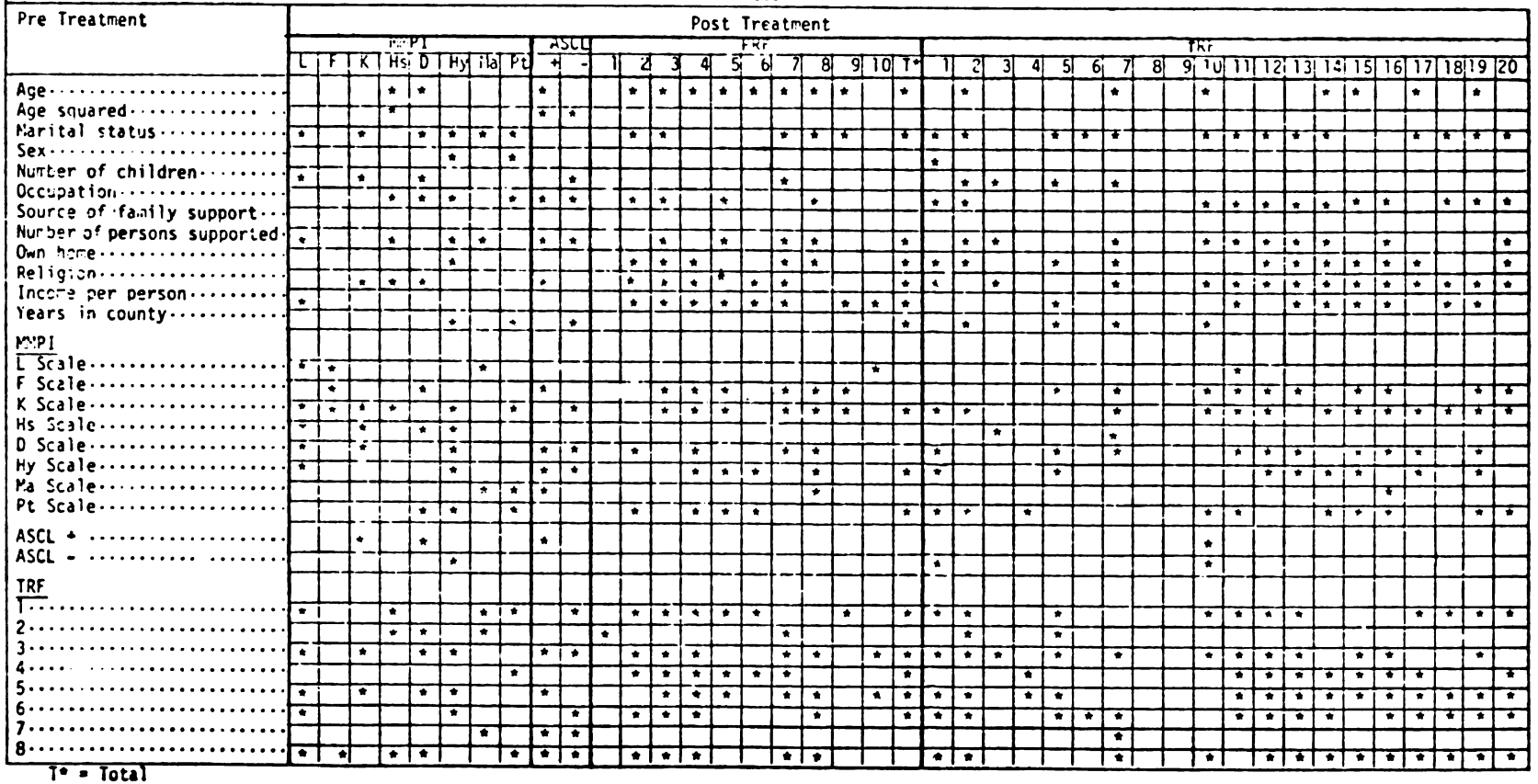
MATRIX OF COVARIATES

APPENDIX H

MATRIX OF COVARIATES

Table 9

Matrix of Covariates



T* = Total

APPENDIX I

FEE SCHEDULE

LIVINGSTON COUNTY COMMUNITY MENTAL HEALTH CENTER

APPENDIX I

FEE SCHEDULE

Table 10

Gross Weekly Income	1	2	3	4 or more
0 - 36.50	100			
36.51 - 49.00	200			
49.01 - 61.50	300	100		
61.51 - 74.00	400	200		
74.01 - 86.50	500	300	100	
86.51 - 99.00	600	400	200	
99.01 - 111.50	700	500	300	100
111.51- 124.00	800	600	400	200
124.01- 136.50	900	700	500	300
136.51- 149.00	1000	800	600	400
149.01- 161.50	1100	900	700	500
161.51- 174.00	1200	1000	800	600
174.01- 186.50	1300	1100	900	700
186.51- 199.00	1400	1200	1000	800
199.01- 211.50	1500	1300	1100	900
211.51- 224.00	1600	1400	1200	1000
224.01- 236.50	1700	1500	1300	1100
236.51- 249.00	1800	1600	1400	1200
249.01- 261.50	1900	1700	1500	1300
261.50- 274.00	2000	1800	1600	1400
274.01- 286.50	2100	1900	1700	1500
286.51- 299.00	2200	2000	1800	1600
299.01- 311.50	2300	2100	1900	1700
311.51- 324.00	2400	2200	2000	1800
324.01- 336.50	2500	2300	2100	1900
336.51- 349.00	2600	2400	2200	2000
349.01- 361.50	2700	2500	2300	2100
361.51- 374.00	2800	2600	2400	2200
374.01- 386.50	2900	2700	2500	2300
386.51- 399.00	3000	2800	2600	2400
399.01- 411.50	3100	2900	2700	2500

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