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Roger Cutting Smith

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Lucille K. Barber Ph.D.
Major professor

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PLANNED SHORT-TERM TREATMENT IN A MENTAL HEALTH CLINIC

By

Reger C. Smith

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ABSTRACT

PLANNED SHORT-TERM TREATMENT
IN A MENTAL HEALTH CLINIC

By

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Planned Short-term Therapy has resulted from, and been supported by a number of trends and crises in the broader field of therapy in the past fifty years. The reaction to Freudian therapy placed emphasis on more objective and more environmentally-oriented treatment. The emergencies and shortages of World War II necessitated briefer and more goal-limited forms. The Community Mental Health Movement of the sixties reflected a long-term trend to make treatment services available to unserved and disadvantaged groups.

Unplanned termination makes most traditional therapy treatment cases short-term. A review of PSTT process in a number of studies revealed that time is a pivotal factor that affects the role of the therapist, the role of the client, and the content of the therapy.

The model of PSTT used in this study was developed by Frank Reid and Laura Epstein in the early 1970s. It contains seven categories of client problems which the authors found amenable to PSTT (Interpersonal Conflict, Dissatisfaction in Social Relations, Problems with Formal Organizations, Difficulties in Role Performance, Problems of Social Transition, Reactive

Emotional Distress, and Inadequate Resources). It also specifies four categories of client problems which were determined unsuitable for PSTT. The model includes a client-therapist contract of limited treatment objectives and no more than eight to twelve interviews.

The therapists in a small, urban-rural mental health clinic applied the Reid and Epstein model of PSTT to the clientele coming for treatment during a six-month period. During the preceding six months, the clinic's clientele was treated conventionally. The scaled outcomes of the two forms of treatment showed no significant difference. The second major finding of the study was that PSTT averaged 4.7 interviews per case and conventional therapy averaged 10.6 interviews.

Other significant findings of the study were:

When treating with PSTT:

1. there is no relationship between the time a client's problem took to develop and the length of time it took to treat it.

2. the therapists agreed with Reid and Epstein in determining that some problems could not be treated with PSTT.

3. clients, therapists, and the independent rater agreed in their assessments of therapy outcomes. They also agreed as groups in their outcome assessment of PSTT and conventional therapy.

The study focused on 66 cases classified under five of the model's seven problem categories and treated with an average of 4.7273 interviews. These 66 research cases were rated 2.9798 by clients, therapists, and the researcher on a five-position outcome

scale. (The positions were: (1) aggravated, (2) unchanged, (3) slightly alleviated, (4) considerably alleviated, (5) target problem no longer exists.) A rating of 3 actually represents 67 percent success since "aggravated" is a negative outcome and "unchanged" is neutral or zero.

The control group consisted of 86 cases treated conventionally with an average of 10.5843 interviews. The clients, therapists, and the researcher in combination rated the outcome of this therapy as 3.0899 on the same scale used for the experimental group. The difference in the average number of interviews for the experimental and the control group was highly significant. The difference in the treatment outcome ratings of the two groups was not significant. (The test of significance yielded a t of .5809 with 153 degrees of freedom and a probability of .568.)

The general hypothesis that PSTT is as effective as traditional treatment and requires fewer interviews was supported in this mental health clinic study. However, the sample was white and therefore the results were not generalizable to a number of minority and other special interest groups. Additional studies can increase the empirical support base for PSTT and demonstrate its client-centered characteristics.

PREFACE

Industrialization and technology are ongoing developments that support increasing production and services. The result of this burgeoning combination of science and economics has been an increasingly complicated and stressful life for individuals and families in Western society. During the last one hundred years, several professions have developed which specialized in alleviating trauma and stress. However, the rapid increase in personnel to treat emotional problems has not kept pace with the increasing demand for treatment services.

American society has gradually broadened (albeit reluctantly), the range of age, socio-economic, and ethnic groups that it attempts to provide for. These groups need mental health services in a variety of forms, locations and schedules. It has become increasingly apparent that traditional, leisurely modes of treatment were too inflexible and inadequate to provide the volume and variety of needed services.

This study developed because of the combination of the need to reduce a mental health clinic's waiting list and the limited time available to a temporary therapist to work on the waiting list. The writer is grateful to Mrs. Alice McKinnon, Director of the Blue Water Mental Health Clinic, for her gracious and enthusiastic support, to the late Dr. Margaret Blenkner who helped with research

design before she passed away, and to Dr. Lucille Barber who has been guide, critic, and mentor as chairman of the author's doctoral committee.

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CHAPTER I

INTRODUCTION

Purpose of the Study

The purpose of this study was to compare the effectiveness of planned, short-term treatment with traditional open-ended treatment in a mental health clinic. Some of the relevant issues were:

1. Is brief therapy as effective as long-term therapy?

2. Can the same techniques be used in both kinds of treatment?

3. Can the same problems and symptoms be treated in both lengths of service?

4. Can general mental health clinic staff effectively utilize long and short term treatment approaches?

5. Does PSTT increase the ability of treatment agencies to serve a greater number of clients?

6. Do contracted time limits influence the quality of treatment given in a mental health clinic?

7. Are there variations in goals for PSTT and long-term treatment?

General Hypothesis

Planned, short-term treatment is as effective as long-term, open-ended treatment.

The Reid and Epstein[1] model of planned short-term treatment was utilized in serving applicants who applied to the Blue Water Mental Health Clinic during a six month period. The clinic staff was trained briefly in this method just prior to the test period. The clients who applied for treatment during the test period and whose cases did not fit the Reid and Epstein model were rated also to support internal validity.

Prior to the test period, there was another six month period during which all of the incoming cases were fitted into the PSTT model or rejected for it. These two groups were treated according to the individual therapist's regular, traditional treatment approach.

The study, therefore, encompassed Experimental Group I and its corresponding Control Group I, and Experimental Group II and its corresponding Control Group II. These four groups were compared statistically using clients', therapists', and independent ratings of outcome.

Agency Setting

In 1959, the newly-formed Adult Mental Health Clinic of Saint Clair and Sanilac counties was united with the nine year old Child Guidance Clinic in those counties to form the Mental Health and Child Guidance Clinic of Port Huron. Since 1962, this clinic has occupied a building constructed for the purpose on the outskirts of Port Huron, Michigan.

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[1]William J. Reid and Laura Epstein, Task Centered Casework (New York: Columbia University Press, 1972.

The Clinic offers diagnostic and treatment services to the residents of Saint Clair and Sanilac counties. It offers consultation services to the schools, juvenile courts, agencies, welfare service organizations and clubs in its service area. Funding is from Act 54 Board funds, local United Funds, local governmental units, and client fees based on a sliding scale. Permanent clinic staff consists of a one-fourth time psychiatrist, three clinical psychologists, and five psychiatric social workers. The two-county population of approximately 150,000 has steadily increased its demands for clinic services. As the ratio of requests for service to clinic staff increased, it became more and more apparent that the population could not be served expeditiously by traditional types and terms of therapy. One of the treatment designs suggested to meet the need was planned, short-term therapy.

Rationale for the Study

A number of recent writers have described the plight of treatment agencies whose staffs and facilities cannot keep pace with demands for service. Wolberg cited the psychiatrist-population ratio of 1/16,000 as an index of the trained personnel needs in all of the clinic disciplines.[1] Mental health clinics tend to have fewer professionals than this population-at-large ratio indicates. The rapid expansion of community mental health services in the last two decades has popularized treatment and

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[1]Lewis R. Wolberg, M.D., (ed.), Short-term Psychotherapy (New York: Grune and Stratton Inc., 1965), p. 1.

made therapy more acceptable; the training and employment of personnel has not kept pace. Phillips and Johnson[1] and Harold Korner[2] reminded us that one of the negative results of the disparity between therapy needs and resources are long waiting lists in many clinics throughout the country. Although this report is several years old, and many waiting lists have been reduced through more efficient case administration, this problem has continued to plague a number of clinics from time to time.

Since planned, short-term therapy represents a departure from traditional methods, it was viewed initially with suspicion by many workers. Shaw, Blumenfeld, and Senf's[3] report of a staff's reaction to the introduction of a short-term treatment approach is typical of the attitudes reported by many researchers. When their study was presented to the therapists at a New York child guidance clinic, the skepticism was so pronounced that the authors feared that the results of the research would be skewed. (It apparently was not.) Clinicians more attuned to traditional psychotherapy tend to dismiss approaches such as PSTT on the basis of their bringing about only superficial attitude changes.

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[1]E. Lakin Phillips and Margaret Johnson, M.H., "Theoretical and Clinical Aspects of Parent-Child Psychotherapy," Psychiatry 37 (1954):267.

[2]Harold Korner, M.D., "Abolishing the Waiting List in a Mental Health Clinic," Social Casework 13 (1964):1097.

[3]Robert Shaw, Harry Blumenfeld, and Rita Senf, "A Short-term Treatment Program in a Child Guidance Clinic," Social Work 13 (1968):84.

Rosenbaum[1] lists some therapists' attitudes which may work against an early, mutual consideration between client and therapist--an integral part of PSTT. Since the therapist usually sees himself as an accepting person (and has few concrete validations of his effectiveness), he may see early termination as his own rejection of, or lack of interest in the client. In his uncertainty and insecurity, he continues to offer his two main commodities--time and attention.

A staff that successfully develops a PSTT approach must consider more than differences in treatment time. The more structured approach makes new technical and emotional demands on its practitioners. Each worker must feel emotionally secure and must be sufficiently flexible to examine his therapeutic process and then be prepared to deal with the problems he may discover in his examination.[2]

Elizabeth Kerns sums up the average therapist's readiness to accept PSTT in the following statement:

> The ease of assimilation seemed especially related to the following factors: the worker's casework philosophy, his willingness to assume a directive role, his view of the meaning of time, his ability to work well under pressure, and his general adaptability.[3]

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[1]Peter Rosenbaum, "The Events of Early Therapy and Brief Therapy," in Harvey Barten, M.D., Ed., Brief Therapies (New York: Behavioral Publications, 1971), pp. 73-74.

[2]Phillips and Johnson, p. 269.

[3]Elizabeth Kerns, "Planned, Short-Term Treatment: A New Service to Adolescents," Social Casework 51 (1970):345.

General Considerations

This study was undertaken to determine whether or not a certain model of time-limited therapy could be as effective in outcome as rated by client, therapist and researcher, as therapy that is not time limited, and could thereby save time and serve a larger population.

For the purposes of this study, psychotherapy is broadly defined. The definition cited by Meltzoff et al seems apropos:

> Psychotherapy is the intentional, causal, predictable modification of pathological behavior; the informed and planful application of techniques derived from established psychological principles by persons qualified through training and experience to understand these principles and to apply these techniques with the intention of assisting individuals to modify such personality characteristics as feelings, values, attitudes and behaviors which are judged by the therapist to be maladaptive or maladjustive.[1]

Psychotherapy is no longer the exclusive province of psychiatrists and clinical psychologists. It has been extended to include social workers, counseling psychologists, the clerical and legal professions, corrections workers, elementary and secondary guidance counselors, etc. At the same time, psychotherapy has developed laterally to include wider and wider heterogeneous categories and larger and more encompassing definitions of what needs changing. Therefore, today the "field" of psychotherapy is a multi-faceted, heterogeneous aggregate of conflicting, competing, segmented and unarticulated versions of theories, practices, practitioners, and researchers.

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[1] Julian Meltzoff and Melvin Kornreich, Research in Psychotherapy (New York: Atherton Press, 1970), p. 3.

The aim of psychotherapy as one of the healing arts is to help the patient feel better and function better. Psychotherapy attempts to improve social behavior and functioning in its braodest sense--that is, the patient's ability to establish mutually satisfying relationships with others. Some of the response variables which indicate this movement are: changes in the patient's behavior in the interview situation including certain autonomic responses, and content of his verbalizations, and verbal and non-verbal communication. Since the evaluation of his social functioning cannot be done naturally, estimates of his social effectiveness must be inferred from reports of patients or other informants, and supplemented, confirmed or called into question by observation of the patient in the interview situation. While these comments apparently refer to the evaluation of therapy in an in-patient situation, they do illustrate some of the general questions around self-reports and other subjective assessments of outcome.[1]

If psychotherapy is perceived as problem-solving, its process can be delineated by the following steps: (1) The initial recognition of a difficulty, (2) The identification (specification) of the problem, (3) Analysis of the problem, (4) A summary restatement of the problem, (5) The selection of objectives which are to be effected, (6) Depiction of the criteria (values) by which the solution will be judged, (7) The consideration of

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[1]Gary E. Stollak, Bernard G. Guerney, and Meyer Rothberg, eds., Psychotherapy Research (Chicago: Rand McNally, 1966), p. 87.

possible solutions, (8) The final solution, (9) The operations planning (how it is to be done and who is to do it), (10) The implementation (actuation of the solution), (11) The subsequent evaluation.[1] This paper is more concerned with the outcome of psychotherapy than with its process, but neither facet can be adequately studied independently. Therefore, some process considerations will be mentioned.

Psychotherapy research should not be exempt from the qualities of reproducibility, generalizability and experimental rigor. Dependent and independent variables should be made explicit and all relevant variables that might affect outcome should be controlled or at least recognized and accounted for. Criterion measures should be objective, reliable and valid. The design should demonstrate systematic and not chance effects and should permit generalization. Hypotheses are logical derivatives of the question that prompted the research; they can be specific or broad but they must be clear. They can be made about highly specific symptoms or behaviors.

Change implies a deviation from some baseline consistently outside the normal limits of fluctuation of an act, action sequence, or feeling state. The response, or set of responses to a given stimulus or complex of stimuli can be expected to vary on successive occasions and distribute themselves normally about a mean for each individual. Behavioral change for that individual

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[1]Allen E. Bergin and Sol L. Garfield, Handbook of Psychotherapy and Behavior Change (New York: John Wiley and Sons, 1971), p. 8.

would consist of responses that fall outside of this distribution and cluster about a new mean.[1]

Definition of Terms

Perhaps definition of some of the terms used in this discussion and as background for the study would be helpful at this juncture.

Analogue Studies are usually described in contradistinction to naturalistic research. In this type of study the variables are manipulated to stimulate certain relationships.

Naturalistic Studies identify variables in terms of measurements of already existing subject characteristics.

Change, defined above.

Placebo Effects of Therapy, the natural effect of the interpersonal contact between client and therapist that would take place without therapy.

Uniformity Assumption. This is the premise frequently used as a basis for research that therapists, or clients, or some other complex variable has a uniform effect.

Temporal Variables:

Total duration refers to the elapsed time between the onset and the termination of therapy.

Unit duration is the length of a single "session."

Amount concerns the total contact time between patient and therapist measured in units of time or sessions.

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[1]Bergin and Garfield, p. 354.

Frequency is the number of treatment contacts in a given unit of time.

CHAPTER II

SHORT-TERM THERAPY: REVIEW OF THE LITERATURE

This chapter is a survey of selected aspects of brief therapy as portrayed in the social sciences literature of the present and recent past. An effort will be made to explicate theoretical antecedants and assumptions supporting some of the significant and differential characteristics of short-term therapy.

Psychotherapy Research

Bergin and Strupp[1] have outlined the current status of psychotherapy research. They feel that, until about two years ago, it had failed to make a deep impact on practice and technique. The results of most investigations had not been of practical significance; follow-up studies had been difficult to carry out, and the crucial requirement of enlisting the full cooperation of therapists, patients and institutions had been a continual stumbling block. Vigorous design had been difficult to impose on the therapeutic phenomena themselves since the phenomena

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[1]Allen Bergin and Hans H. Strupp, Changing Frontiers in the Science of Psychotherapy (Chicago: Aldine-Atherton Co., 1968), pp. 2-99.

under study are extremely complex. There has been a lack of communication and cooperation among researchers and thus a lack of comparability of their research.

Psychotherapy is not a unitary process and is not applied to a unitary problem. Keisler[1] feels that psychotherapy can be defined ultimately as behavior modification; but it is traditionally related to personality modification. Cronbach[2] dichotomizes psychotherapy research into (1), personality research which seeks to determine high average or uniform performance and to manipulate variables toward that end, and (2), clinical research which seeks variations from the norms and wants natural rather than manipulated conditions. There is a need to synthesize these two sides by research designs that incorporate treatment manipulations and organismic factors so that the focus can shift the interaction effects.

Adequate research in psychotherapy should answer the following question: What specific therapeutic interventions produce specific changes in specific patients under what specific conditions? Such research should include the following considerations: (1) Therapists cannot be regarded as interchangeable units, therefore different therapists, depending on variables in

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[1]Donald J. Kiesler, "Experimental Designs in Psychotherapy Research," Handbook of Psychotherapy and Behavior Change, ed. Allen E. Bergin and Sol L. Garfield (New York: Wiley and Sons, Inc., 1971), pp. 37-38.

[2]L. J. Cronbach, cited by Donald J. Kiesler, "Experimental Designs in Psychotherapy Research," Handbook of Psychotherapy and Behavior Change, ed. Allen E. Bergin and Sol L. Garfield (New York: Wiley and Sons, Inc., 1971), p. 37.

their personality, training, experience, etc., exert different conditions, (2) Patients, depending on variables in their personality, education, intelligence, the nature of their emotional problems, motivation, and other factors, are diffentially receptive to different forms of therapeutic influence, (3) Technique variables cannot be dealt with in isolation but must be viewed in the context of the patient and therapist variables enumerated above. (4) Outcome measures are frequently restricted to dimensions derived from specific theoretical positions and thus evidence based upon such measures is difficult to generalize.[1] The inherent uniqueness of the particular dyadic relationship between patient and therapist limits exactitude and the weight of evidence suggests that change is multi-dimensional rather than unitary.

There are many other complexities to be considered in designing psychotherapy research. There are problems of conceptualization--the specification and uniformity of terms and parameters of precise behaviors is sorely needed. Another problem is brought about by the multitudinous and diverse theories extant that attempt to explain human behavior and causation. An additional serious problem relates to failures to formulate specific therapy objectives that are capable of implementation and empirical testing and the lack of a specification of desired outcome to which techniques are directed. The therapist permits changes to occur without foresight

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[1]Bergin and Strupp, p. 8.

and planning, and he reconciles himself to whatever changes emerge. There has been difficulty in rendering the goals of therapy and behavior change specific and sufficiently explicit to permit the utilization of effective criterion measures. Should the goal be symptom removal or a fully functioning person? Again, problems with respect to the specification of therapeutic objectives are inherently conceptual problems.

The psychotherapy "artisan" practices, using vague methods with little structure, definition or predictive ability. However, some practicing psychotherapists have attempted to order, formulate, and measure what they do--these therapists are scientists. Truax and Carkhuff go so far as to say that until society specifies criteria for "effectiveness" in an explicit manner, the effectiveness of the practice of psychotherapy cannot be empirically evaluated.[1] David Malan[2] has done two careful and complicated brief therapy research studies using precise methodology and rigorously controlled influencing variables. His orientation and case materials are decidedly clinical. He quotes from Barten to emphasize the tie between brief therapy and traditional, more extended methods: "The brief therapies are a distillation based upon the understanding of personality dynamics and patterns of illness which the traditional techniques delineated."

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[1] Truax and Carkhuff cited in Bergin and Garfield, p. 44.

[2] David H. Malan, The Frontier of Brief Psychotherapy (New York: Plenum Medical Book Co., 1976), p. 6.

Again on the more positive side, Arnold et al[1] feel that many of the greatest advances in therapeutic theory came through clinical experimentation rather than through laboratory research or controlled field trials. They go on to suggest that different kinds of data and levels of information come from the laboratory and the clinic. Innovation is the outcome of experimentation and most clinical advances are preceeded by what might be termed a frustration-observation sequence. Clinicians should not be limited to trying only the methods suggested by their theories. Some techniques may prove effective for reasons that do not remotely relate to the theoretical ideas that gave birth to them. However, in utilizing this approach, the authors advocate caution, tentativeness, and empirical testing when adopting any theoretical position.[2]

Doubts Concerning Traditional Long-Term Therapy

The effectiveness of long-term therapy from the standpoint of patient benefits and therapist efficiency, and the cost in time and therapy resources of the traditional treatment approach, have both been questioned for a number of decades.

Harvey Barten[3] is typical in describing traditional therapy as tending to be more passive, reflective, open-ended, and

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[1]Arnold, cited in Bergin and Garfield, p. 196.

[2]Ibid., pp. 197-99.

[3]Harvey Barten, ed., Brief Therapies (New York: Behavioral Publications Inc., 1971), p. 9.

patient-steered; he saw it as oriented toward feelings, self-understanding as a prerequisite to action, and as reflecting the past in the present. He adds that traditional techniques are cautious, non-directive, comprehensive, and indirect.

Bellak, et al[1] see the traditional approach to therapy as long-term (which results in less emphasis on the immediate); and as placing more emphasis on transference and resistance, dreams, free association, and fantasies. It is also concerned with uncovering infantile wishes and conflicts. These emphases lead to a passive role for the therapist who spends much time in reflection and interpretation. What can also prolong therapy is the therapist's involvement in countertransference reactions.[2]

As early as 1938, Franz Alexander[3] led a Chicago group which questioned some assumptions concerning traditional treatment. One traditional belief that they questioned was that the depth of therapy is necessarily proportionate to the length of treatment and the frequency of the interviews. Another was that the therapeutic results achieved by a relatively small number of interviews are necessarily superficial and temporary, while

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[1]Leopold N. Bellak, et al, "Factors Related to Improvement in Brief Psychotherapy," An Evaluation of the Results of the Psychotherapies, ed. Stanley Lesse, M.D. (Springfield, Illinois: Charles Thomas, Publisher, 1968), p. 102.

[2]Franz Alexander, "Psychoanalytic Contributions to Short-term Therapy," Short-Term Psychotherapy, ed., Lewis Wolberg (New York: Grune and Stratton, Inc., 1954), p. 84.

[3]Franz Alexander cited in Libbie G. Parad, "Short-term Treatment: An Overview of Historical Trends, Issues and Potentials," Smith College Studies in Social Work (Vol. 41, No. 2, 1971), p. 130.

results achieved by prolonged treatment are necessarily more stable and more profound. The third assumption questioned was that the prolongation of an analysis is justified on the grounds that the patient's resistance will eventually be overcome and the desired therapeutic results achieved.

Parad[1] went on to compare long-term therapy by social workers with consultation: "This leisurely and long-time kind of assistance stands in contrast to most consultation practice, which may be described as short-time treatment and which certainly implies that the service given must itself be the basis of continued contacts." Her implication is that long-term therapy may not sell itself so well or justify itself in terms of patient satisfaction.

Alexander[2] notes a general trend toward over-treatment in traditional therapy. Functionally, this trend caters to a progressive dependency. This dependency, of course, tends to lengthen therapy.

Szasz,[3] Orlansky,[4] Stevenson,[5] King,[6] and Alexander,[7] all criticize traditional diagnosis as a part of traditional therapy which emphasizes past history. Others stress that, in an efficient approach to therapy, details of the patient's background

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[1]Ibid., p. 126.

[2]Alexander, p. 84.

[3]T. S. Szasz, cited in Short-term Psychotherapy and Structured Behavior Change, E. Lakin Phillips and Daniel N. Wiener (New York: McGraw-Hill Book Co., 1966), p. 48.

[4]Orlansky, cited in ibid.

[5]Stevenson, cited in ibid.

[6]King, cited in ibid.

[7]Alexander, p. 84.

cannot be explored and historical analysis must be minimized. Glasser tersely admonishes patients to "forget the past," and he focuses the therapy on the individual rather than the family.[1]

A significant part of the traditional therapy system is a lengthy delay between application for treatment and the treatment itself. This is exacerbated by the increasing demands for therapy and the shortage of personnel. One study indicated that clients who wait for treatment may make pathological adaptations to their symptoms. If the wait is prolonged, the pathology may deepen so that symptoms become superimposed on symptoms.[2]

Ratibor-Ray Jurevich[3] summarized findings from a number of writers who criticized traditional therapy. He found the following eight criticisms to be valid and strongly supported:

1. The gathering of insights about past traumas is not essential in treatment.[4]

2. The emphasis on the past and the unconscious is deleterious to treatment.[5]

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[1]William Glasser, Reality Therapy (New York: Harper and Row, 1965), pp. 37-38.

[2]Samuel Rosenberg, et al, "Factors Related to Improvement in Brief Psychotherapy," An Evaluation of the Results of the Psychotherapies, Stanley Lesse (Springfield, Illinois: Charles Thomas, Publishers, 1968), p. 83.

[3]Ratibor-Ray Jurevich, ed., Direct Psychotherapy: 28 American Originals (Coral Gables, Florida: University of Miami Press, 1973), pp. 20-21.

[4]Grinker, cited in ibid., p. 20.

[5]Glasser, cited in ibid., p. 21; Salter, cited in ibid., p. 21.

3. Healthy, rather than sick, aspects should be stressed in therapy.[1]

4. Symptom substitution is a canard.[2]

5. The medical model needs to be discarded.[3]

6. For many patients, their value structure is interwoven with their mental health.[4]

7. There is now a wide applicability of direct psychotherapy methods.[5]

8. Theoretical complexity is not equal to therapeutic effectiveness.[6]

Therapy Needs Versus Available Resources

As early as 1919, Sigmund Freud foresaw that psychoanalytic techniques would not be adequate for the demands placed upon the mental health community. From Freud's time until World War II, the recognized need for psychotherapy increased, while the length of psychoanalysis and other traditional forms of therapy became longer and longer.

Child Guidance clinics face an increasing discrepancy between demands for treatment services and available therapy hours.

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[1] Weiss, cited in ibid., p. 22.

[2] Eysenck, cited in ibid., p. 23.

[3] Mainord, cited in ibid., p. 23.

[4] Mowrer, cited in ibid., p. 22.

[5] Tweedie, cited in ibid., p. 23; Heine, cited in ibid., p. 24.

[6] Gottesman, cited in ibid., p. 25.

In 1970, Karl Lewin wrote that in one year in the United States 1,000 psychiatrists are added to the psychotherapy resources and 3,000,000 people are added to the general population.[1] A further indication of inadequate service delivery is Jacobsen's comment on the gap between the intention to serve the entire population and the relative lack of service to patients from the lower socio-economic classes.[2]

The rapid expansion of community mental health services in the 1950s and the 1960s was paralleled by increasing personnel shortages. This discrepancy led to the growth of long waiting lists. There is evidence that the decade of the seventies has seen the dimunition of the waiting lists as a result of crisis intervention and other more flexible services, and more efficient treatment in general. Shaw et al[3] posited that the concept of the waiting list is incompatible with the concept of the painfulness of emotional illness. They added that long waiting lists develop into a triad that includes delayed treatment services and little, if any preventive and consultation time.

Koegler and Koegler[4] believe that psychotherapy is unavailable to most people because of time-consuming procedures and that

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[1]Karl Lewin, Brief Psychotherapy: Brief Encounters (St. Lous, Missouri: Warren H. Green, Inc., 1970), p. 3.

[2]G. Jacobsen, cited in Leonard Small, The Briefer Psychotherapies (New York: Brunner/Mazel Publishers, 1971), p. 9.

[3]Robert Shaw, cited in Harold Korner, "Abolishing the Waiting List in a Mental Health Clinic," Social Work 13:3, p. 1097.

[4]Koegler and Koegler cited in Small, p. 8.

unless procedures are abbreviated, most people will go unaided. Bellak and Small[1] argue that adequate brief psychotherapy based on psychoanalytic principles is necessary to prevent extensive drug-based treatment.

From a functional as well as a pragmatic standpoint, traditional, long-term therapy has been questioned for some time. The increasing need for therapy, the limited supply of trained personnel, and, more recently, shrinking funding have supported the necessity for the more efficient treatment of selected emotional problems. Short-term therapy is viewed increasingly as fulfilling this need.

A Short History of Brief Therapy

Nearly everyone who has thought seriously about psychotherapy has entertained notions of how to shorten it. The Jewish Board of Guardians has a long history of exploring the suitability of varied psychotherapeutic techniques for large patient populations through the medium of a multidisciplinary team.[2] The development of crisis theory as well as an interest in prevention suggested that one promising avenue for possible solution to the problem of better utilizing the time of professionals is in the area of short-term therapy. The Community Mental Health Movement has encouraged change and a new perspective such as utilizing modest interventions before complex therapy.[3]

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[1]Bellak and Small, cited in Ibid., p. 10.

[2]Libbie Parad, pp. 137-38.

[3]Harvey Barten and Sybil Barten, Children and Their Parents in Brief Therapy (New York: Behavioral Publications, 1973), p. 3.

Private insurance plans are increasingly oriented toward short-term therapy and many proposals for federally-supported national health insurance visualize brief therapy. Thus treatment organizations are being pushed by considerations of expediency to be more innovative about ways and means of serving larger numbers of people more quickly and more effectively.

Libbie and Howard Parad, in three different articles, list some factors contributing to the relevance of short-term treatment. They mention:

1. The current interest among the mental health disciplines in models of crisis intervention which theorize that a state of psychosocial disequilibrium is by its very nature time-limited.

2. The emphasis in ego psychology on the mobilization of the individual's or family's strengths to improve social functioning with respect to specific and limited treatment goals.

3. The interest in time-limited behavior modification techniques.

4. The existential thrust which demands solutions in the here and now.

5. The limited financial and personnel resources that necessitate the efficient use of time.[1]

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[1]Howard J. Parad and Libbie Parad, "A Study of Crisis-oriented Planned Short-term Treatment," Social Casework 49:6 (1968): 344; Howard Parad, "The Use of Time-Limited Crisis Intervention in Community Mental Health Programming," Social Service Review 40:3 (1966):275; Libbie Parad, p. 119.

Barten lists some additional historical developments which were supportive of emerging brief therapy:

1. The growing professional commitment to provide immediate, relevant treatment to all segments of the community.

2. The increasing shift from psychoanalytic techniques to ego-oriented psychotherapy.

3. The new emphasis on preventive and emergency measures.

4. An acceptance of limited therapeutic goals.

5. The broadening and redefining of professional roles to include professionals in other disciplines and paraprofessionals.

6. The recognition of the non-standard therapy needs of different cultural and socio-cultural groups.

7. The growth of prepaid, limited, outpatient psychiatric insurance coverage.[1]

Brief therapy, as it is generally practiced today, has its roots in psychoanalytic theory. Malan,[2] who extensively reviewed Freud's works, wrote in 1963 that Freudian psychoanalysis began as brief treatment. Many of Freud's early patients were not extensively treated timewise. He started out by trying quick cures and active interpretation. He used brief treatment to cure the impotence of the composer, Gustav Mahler. He also treated Bruno Walter in six sessions.[3] His Studies in Hysteria describe his brief treatment of an hysterical woman and examine the problems of brief treatment in general.

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[1]Barten, p. 3.

[2]Malan, cited in Small, p. 3.

[3]Ibid.

However, Freud's theoretical formulations became more and more sophisticated and therapy as practiced by him and his successors grew longer and longer. As time progressed, therapy was forced to relate to some environmental factors and to some shifts in focus, especially within the realm of social work. Dr. Parad sums up the years between early Freud and World War II:

> The factors stimulating the study of the short-term case included the shift in emphasis from social diagnosis to social treatment, the interest in differential diagnosis and treatment, the newly-formulated concept of relationship, and the press of increasing numbers of cases (during the depression years) for which the limited resources of the agencies could offer only minimal help.[1]

The emergencies and crises of World War II increased the pressure to change. According to Grinker and Spiegel,[2] brief therapy was used during the War for relief of tensions, strengthening of the ego, and decreasing the severity of the super-ego. It did not attempt personality reconstruction. Under wartime conditions Guthiel[3] found eighteen kinds of emotional disorders which he felt would respond to brief therapy.

After the War, Baker[4] recommended short-term psychotherapy as "first aid when long-term therapy was impractical." He cited six steps in such a procedure: intellectual clarification of the problem, advice giving, catharsis, interpretation of the transference and resistance, the use of prolonged supportive therapy

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[1] Libbie Parad, p. 23.

[2] Grinker, cited in Small, p. 17.

[3] Guthiel, cited in Phillips and Weiner, p. 28.

[4] Baker, cited in ibid., p. 28.

devoid of personality change efforts, and the favorable attitude of the therapist.[1] Also immediately after the War, Alexander and French produced their Psychoanalytic Principles and Application.[2] The section on brief therapy was a landmark in the development of the mode. They emphasized that the patient's emotional experience must be focused on present life problems and the therapist must try to prevent regression and dependency. He must work at problem-solving and teach the patient to handle his new experiences.

In the late forties, Malumud, Koye, and Deutsch described brief therapy in medical and community settings, and examined the theoretical basis of brief therapy procedures.[3]

During the decade of the fifties, Wolpe was an effective and persistent voice in the formulation of the theoretical basis of brief therapy. Morton experimented with short-term therapy using learning theory and comparing his test groups to matched control groups. The number of psychoanalysts who showed an interest in brief therapy grew, but few fully accepted it on theoretical grounds. Pumpian-Mindlin became involved in brief therapy by necessity. He was fairly explicit concerning short-term treatment goals, the techniques to be used, and how to choose cases according to given criteria. During this period, Phillips and Johnston did a study comparing conventional methods with

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[1]Baker, cited in ibid.

[2]Franz Alexander and Thomas French, Psychoanalytic Principles and Application (New York: Ronald Press, 1946), p. 145.

[3]Malmud, cited in Phillips and Wiener, p. 29; Koye, cited in ibid.; Deutsh, cited in ibid.

short-term parent-child psychotherapy. The short-term group showed fewer dropouts before termination, fewer interviews, and greater parental satisfaction. In 1955, Ellis reviewed over 400 articles concerning newer approaches to psychoanalytic orthodoxy and a more active patient-therapist role. In addition to the above, Phillips and Weiner cited fifteen authors as examples of the many who did brief therapy between 1955 and 1960 and reported it as successful. The trends during this period included increasing use of controls and independent outcome measurements in therapy experiments. There was also increasing interest in the impact of spontaneous remission and the placebo effect. Variations in the short-term therapy experiments included the settings for treatment, client and therapist attitudes, structured versus permissive approaches, and, of course, the amount and scheduling of time spent in therapy. The rates of attrition also received increasing attention. In the fifties, the number of brief therapy practitioners who emphasized behavior change through learning theory continued to increase. They included Bandura, Paschal, Eysenck, Wolpe, Frankl, and Saul.[1]

As therapists accepted treatment of patients in all classes and with all kinds of problems, traditional, slow-paced techniques became increasingly insufficient. They were found unwieldly, impractical, and often excessive in treating emergencies

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[1]Wolpe, cited in ibid., p. 36; Morton, cited in ibid., p. 29; Pumpian-Mindlin, cited in ibid., p. 30; Phillips and Johnson, cited in ibid; Ellis, cited in ibid., p. 31; Phillips and Wiener, cited in ibid., pp. 31-39.

and crises, adjustment problems of recent origin, and uncomplicated anxiety and depressive reactions. They were equally unsuited for long-term disease processes such as alcoholism, chronic schizophrenia, or organic brain disorder.[1] Brief techniques have now expanded to include short-term group and family therapies, behavior therapies, drug therapies, etc.

Libbie Parad briefly traced the development of short-term treatment within social work. She pointed out that the bulk of casework practice has always been short term. In a variety of settings such as schools, courts, medical settings, Travelers Aid Societies, Red Cross Home Service, and public welfare, the function of the service or agency has determined that the case would usually be short-term. Even in the family service agencies and the child guidance clinics which tend to view themselves as therapeutic agencies devoted to insight-oriented treatment, examination of service statistics from three studies cited by Parad reveals that the majority of case contacts are of limited duration.[2]

The Development of Some Theories Supportive of Brief Therapy

Phillips and Weiner[3] see aims to shorten psychotherapy as following two broad trends: (1) The development of shortened

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[1]Barten, p. 3.

[2]Libbie Parad, p. 120; Leonard Kogan, "The Short-term Case in a Family Agency, Part I," Social Casework 38:5 (1957):232.

[3]Phillips and Wiener, p. 27.

approaches to therapy without regard to specific orientation, and (2) the application of learning theory to psychotherapy. However, the developing trend that they see as without a theoretical basis is probably broadly psychoanalytic. Menninger,[1] Alexander and French,[2] and Bellak and Small[3] all owe their brief therapy theories to psychoanalytic theory; but a number of therapists have developed their own brief therapy modifications of the psychoanalytic theory base. Fenichel,[4] in supporting his development of a brief therapy, stresses that psychoneurosis is the result of conflicts between impulses that are warded off, and anxieties and feelings of guilt which are warding off in nature; he posits that only a change in the dynamic balance and relationship between these two components can change the neurosis. Other brief therapists argue that repression (as above) can be avoided, and conflict resolved without increasing resistance.[5]

Lydia Rapaport,[6] in a journal article, discusses in detail some of the theories that tend to discount traditional therapy and support brief treatment. One of the fallacies concerning traditional treatment that she mentions is that "depth," as referring to the

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[1]Menninger, cited in Small, p. 27.

[2]Alexander and French, cited in ibid.

[3]Bellak and Small, cited in ibid.

[4]Fenichel, cited in ibid., pp. 28-30.

[5]Harris, Kalis, and Freeman, cited in ibid., p. 33.

[6]Lydia Rapaport, "Crisis Oriented Short-term Casework," Social Service Review 41:1 (1966):32-34.

strata of personality to be tapped, can only be reached by psychoanalytic treatment, which is therefore the preferred mode.

The opposite of "depth" is given as superficial; a more functional term conceptualizing that continuum might be "complexity." This refined understanding of ego-organization and emotional functioning requires a knowledge of the complex organization of the personality which is unrelated to the question of depth or superficiality. Another erroneous assumption is that, if change is to be lasting, it can be achieved only by a long process. One additional misunderstanding is the substitution of the concept of cure for the concept of restoration of function.

Another myth that Dr. Rapaport mentions is that in order to bring about a cure one must at least know and get at the causative factors. This concept of a specific etiology also tends to encourage a search for a single cause. Some structural realities can become confused with methodological considerations. An example is the process of intake which may include multiple workers, waiting periods, labelling, and other side effects which tend to be dysfunctional. The waiting for treatment may foster a re gressive transference which militates against the goals of therapy. More of the theoretical bases of brief therapy will be explicated in the section on the process and content of brief therapy.

The Goals and Focus of Brief Therapy

One early 1930s definition of short-term was "the single interview case." Its proponents advised "focusing on the problem

of most concern at the moment," dealing with the presenting situation rather than history-taking, and on leaving responsibility for the solution of his problems to the client. They claimed positive treatment value for this procedure.[1]

The nature of Travelers Aid Society's contact with transients was always dictated by very limited treatment contacts. The passage of the Social Security Act caused the Travelers Aid agency to take a broad look at its program which was published in a two-volume work.[2] This work showed some advanced thinking on the treatment possibilities of short-contact services and stressed the need for delineating tangible, reachable, limited goals and offering immediate treatment.

Fern Lowry,[3] who wrote on short-contact casework during that same early period, summed up her view of brief treatment in these words: "Just as time may be limited without being limiting, so in short-contact casework the limit of time need not limit our services."

A number of therapists have developed definitions which cover the goals and focus of brief therapy. Harvey Barten's follows:

Brief therapy is characteristically a technique which is active, focused, goal-oriented, circumscribed, warmly-supportive,

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[1]Libbie Parad, p. 123.

[2]Robert S. Wilson, The Short Contact in Social Casework, Volumes I & II (New York: National Association for Travelers Aid and Transient Service, 1937), pp. 193-201.

[3]Lowry, cited in Libbie Parad, p. 124.

action-oriented and concerned with present adaptation. Initially, the treatment approach need not be comprehensive and definitive if periodic reevaluations are available. It deals with a specific problem constellation; it may aim for the resolution of a present conflict or discomfort and it may be of an emergency or stopgap nature. Basic brief therapy principles include early formulation of the problem, focussing, bypassing areas of resistance, and accepting and sometimes strengthening defenses rather than challenging them.[1]

Wolberg's[2] paradigm includes: (1) The relief of symptoms; (2) The restoration to the level of functioning existing prior to the illness; (3) Some understanding of the forces that precipitated the current upset; (4) The recognition of some interfering personality problems; (5) A partial understanding of the origin of problems in past experiences; (6) Some awareness of relationships between personality problems and the current illness; and (7) A comprehension of measures to remedy environmental difficulties. Others cite the resolution of current crises as a viable goal of short-term therapy.

Barten's and Wolberg's paradigms condensed above cover the goals and focus of brief therapy as formulated by a number of writers. Maquire's and Gillman's briefer definitions are congruent.

Maguire writes of tightly-structured brief therapy that selects the emotional conflict to be treated and emphasizes active

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[1]Barten, pp. 8-9.

[2]Wolberg, cited in Small, p. 18.

therapy, instruction on techniques, a sequential ordering of perceptions, and the use of partial interpretations. Gillman focuses on current reality, face-to-face interviews of less frequency, a "healthy" employment of free association, an avoidance of regressive dependency and ambivalent transference, and an active therapist.[1]

Most authors who describe the focus of contemporary short-term therapy find some way of saying that this mode of treatment should be concerned with current problems of living. Many further narrow the immediate focus to the relief of symptoms. Rosenbaum warns that the symptoms may persist but change in importance. They also may disappear but return later in a different perspective. Norman and his colleagues cite similar goals for short-term clinic service to lower socio-economic populations--immediate intervention to ameliorate symptoms. Lester adds equivalent brief psychotherapy goals for children. They are to eliminate or relieve symptoms which he sees as exaggerations of otherwise adequate behavior patterns.[2]

Several therapists see the primary goals of brief therapy as prevention and/or restoration. Normand et al posit that its goals are not to cure, but to reestablish a prior, more effective

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[1]McGuire, cited in ibid., p. 20; Gillman, cited in ibid., p. 25.

[2]Rosenbaum, cited in Small, p. 17; Normand et al, cited in ibid; Lester, cited in ibid.

state of equilibrium. Coleman and Zwerling add to this the restoration of previously effective defensive structures. Bellak tersely emphasizes a preventive goal: "To still pain, make functioning possible, and save life." Rado sess brief therapy as palliative; instead of reforming from within, its supports from without. Lewin posits a two-part goal for children: the reverse of the process of infantile expectations and gratifications, and the turning of complex anger from its inward direction against the self. His goals sound more complex but are still quite limited in focus.[1]

Some therapists stress the limited "depth" of brief therapy Malan stresses a limited aim, a limited number of sessions, and a "focal" technique. Malumud sets as a goal some degree of operational relationship with the environment. Sifneos somewhat disagrees. He states that the aims of such therapy involve the choice of and concentration on one of the predicted areas of emotional conflict and the avoidance of conflict involving character problems.[2]

Other therapists discuss the potential that brief therapy has for working on more submerged factors or extensions of problems. Lydia Rapaport explains how this can happen in social work treatment.

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[1]Coleman and Zwerling, cited in ibid., p. 17; Bellak, cited in ibid., p. 19; Rado, cited in ibid.; Lewin, cited in ibid., p. 18.

[2]Malan, cited in ibid., p. 19; Malmud, cited in ibid., p. 18; Sifneos, cited in Barten, p. 12.

> Treatment should be highly focused and segmental. The focus is on the present and the segment to be dealt with is the precipitating stress and its consequences for the individual or family . . . when possible and necessary, there should be a clarification of the linkage of the current stress and upset with a previous, old, preconscious or unconscious conflict that was not entirely successfully resolved.[1]

Peter Sifneos sees confrontation as the key tool in short-term therapy. He feels that anxiety should be generated rather than suppressed and that the therapist should work as quickly as possible to prevent limiting complications.

Although many brief therapists confine their discussions with clients to the present problem, some will probe the past, examine characterological problems, or interpret transference distortions. Sowis, Dewees, and Johnson posit that the therapist should deal with whatever will facilitate adaptation but should begin with the presenting difficulty and use it as a point of reference.[2]

This paper describes short-term therapy in terms usually associated with better-known traditional therapy. However, it would be helpful to look at a few writings that compare the two modes more directly. Barten and Barten[3] describe short-term treatment as rapidly delineating problem areas and as being active, focused, and incisive. They emphasize that it is an

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[1] Rapaport, p. 39.

[2] Sifneos, cited in Small, p. 157; Sowis, et al, cited in Barten, p. 9.

[3] Harvey Barten and Sybil Barten, Children and Their Parents in Brief Therapy (New York: Behavioral Publications, 1973), p. 5.

expansion of a therapist's repertoire rather than a substitute for it. Bellak and Small[1] differentiate brief therapy from psychoanalysis by discussing goals, time factors, and methods. The goal is to focus on the symptoms or maladjustments that demand the quickest possible relief; it is limited to the removal or amelioration of specific symptoms and is not concerned with personality reconstitution. It seeks to improve the individual's psychodynamic situation sufficiently to allow nature to continue the healing process.

Brief psychotherapy is freed from the investigative goals of psychoanalysis. Its limited and well-defined aims make it distinct and not just abbreviated therapy. It differs from traditional psychoanalysis in that it uses limited free association, modified interpretation, constraints on transference neurosis, an emphasis on positive transference, and the coupling of modified interpretation with environmental change.[2] Hoch[3] finds the most important methodological difference between the two therapies to be the degree of activity of the therapist. Krick[4] asks and answers the same question: "How active should the counselor be? As active as the sophistication of his techniques permits, to get the clients to take charge of their own lives right then and there."

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[1]Bellak and Small, cited in Small, p. 16.

[2]Ibid., p. 22.

[3]Paul Hock, "Short-term Versus Long-term Therapy," Lewis Wolberg, ed., Short-term Psychotherapy (New York: Grune and Stratton, Inc., 1955), p. 55.

[4]Aaron Krick, "Active Strategies in Marriage Counseling," Active Psychotherapy, Harold Greenwald, ed. (New York: Atherton Press, 1967), p. 166.

An active, rather than a passive stance, is certainly a part of brief therapy according to the literature reviewed here.

In summary, it can be seen that most writers adopt limited goals, stress symptom removal or amelioration, reversal of current distress, or prevention of more serious problems. Barten[1] sees a consensus on the focus, on health rather than a sickness orientation, and on time limits as summarizing characteristics. Dr. Edwin Stainbrook once stated: "The geneticist figures you're done for when you're born, the psychoanalyst figures you're done for when you're six, but the crisis interviewer says you're not done for 'till you're dead."[2]

Time Limits for Brief Therapy

There are a number of factors which affect the availability of treatment services and provide a setting which permits the optimum utilization of therapy time.

Structure in the organization of short-term therapy refers to the purposeful selection by therapist and client of variables related to behavior change. The structuring process can be promoted by selecting specific variables for manipulation such as specific tasks or time schedules, or arranging behaviors to achieve a specific goal. The limits must not be the goal but must only be set in relation to goals.

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[1]Barten, pp. 25-27.

[2]Stainbrook, cited in Small, p. 180.

Several studies have shown that patient and therapist work more quickly when time is limited (Frank,[1] Shlien,[2] and Gottschalk[3]). In fact, if we closely examine the matter of time, we note that almost everything that happens or is thought about in brief therapy may be related to it.

Phillips and Weiner,[4] broaden the application of the concept of structure to brief therapy. They feel that it can include the therapist's use of external controls and manipulations that will lead to self-control and direction. It can also include observing the relationship between given antecedent and resultant elements--interfering in pathology to realign variables so as to produce a different outcome or effect, using environmental manipulations, introducing and assuring as much certainty and dependability and control as possible in heretofore uncontrolled and uncertain situations. What structure does not mean here is permissiveness with nebulous purpose; reliance on creative, sporadic, or unpredictable bursts to solve problems that have been chronically unsolved; it does not include the belief that nonenvironmental or internal conditions and motivations will solve problems through unfocused or indirect methods.

> In order to help people who are in a state of crisis, we need to have rapid access to them and they need to have easy access to us--a little help, rationally directed and

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[1]Frank, cited in Barten, p. 10.

[2]Shlien, cited in ibid.

[3]Gottschalk, cited in ibid.

[4]Phillips and Weiner, p. 25.

> purposefully focused at a strategic time, is more effective than more extensive help given at a period of less emotional accessibility--there needs to be a continuity of contact, and within such limits, flexibility arranged.[1]

Louis Gottschalk[2] emphasizes that the schedule of interviews should be individualized. He feels that highly disturbed patients may need interviews as frequent as five to seven days a week. When the acute state has receded somewhat, two or three interviews a week may suffice. When the patient has reached a fairly stable emotional state, weekly, bimonthly or monthly interview periods may be satisfactory. As long as changes in the frequency of interviews are made in a consistent way, according to some definite plan that the patient can appreciate and has some part in determining, there is less danger of confusing the patient or jeopardizing the patient-therapist relationship.

Gottschalk explained how therapy can be related to the variable of time, Lakin and Wiener[3] contend that time is not a true variable but a concept that carries other variables. Therefore, when time limited therapy is practiced, all other variables and considerations are brought into bold relief; "when the pivotal consideration is time, changes in goals result."

The consideration of the time factor must include the interval between sessions as illustrated by Gottschalk above. Once weekly is an average schedule but therapy can be daily. Another

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[1]Rapaport, p. 38.

[2]Louis Gottschalk, "An Introductory Outline of a Short Method of Psychotherapy," Journal of Nervous and Mental Disease 110:3 (1933):321.

[3]Phillips and Weiner, p. 4.

aspect of the time factor is the range of time required by the entire course of brief therapy (usually from one month on up). Another factor is the length of the individual session. These can be as brief as fifteen to twenty minutes but they average forty-five to sixty minutes. Then there are the intensive, marathon sessions of several hours per day for a brief number of days.

Jessie Taft's[1] delineation of the function of time in brief therapy still has relevance after four decades. She felt that if one interview provided no therapeutic understanding, many interviews would not help. She viewed time as a tool in casework within a broad philosophical conception of time. "Time represents more vividly than any other category the necessity of accepting limitation as well as the inability to do so, and symbolizes therefore the whole problem of living." She did not see the therapeutic relationship as the reworking of the earlier oedipal and other conflicts through the transference, but rather as a reworking of the client's problems through his reactions to the reality limitation of the therapeutic relationship shared by worker and client--that is, the reality of time. Unfortunately, Miss Taft's influence on brief therapy was lost to social work in the general rejection of functionalism.

A number of authors explicitly mention some time limits for brief therapy and provide some rationale for their limits.

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[1]Taft, cited in Libbie Parad, p. 125.

McGuire[1] specifies ten to twenty interviews as a format that evolved from his clinical experience and as roughly adequate to achieve certain therapeutic goals. He states that the acknowledgement of limits determines the therapist's objectives and techniques; thus the emphasis is on active therapist participation and therapy is tightly structured.

How short is short-term therapy? Because the broad field of short-term therapy practice includes such a variety of models, an exact number of hours cannot be set. Various figures are used in different studies so that any set number is arbitrary. Phillip and Wiener's[2] survey found the number of session contacts defined as brief therapy ranging from one to 217. However, they do summarize five general time categories from the literature: (1) from one to six sessions, (2) around ten sessions, (3) between twelve and twenty-five sessions, (4) includes several formats, i.e. one to twenty, three to thirty, eight to fifty sessions, (5) Wolpe's wide range of four to 217 sessions for behavior therapy.

Barten[3] advises that brief therapy time limits should fall somewhere between six and twenty session; but he feels that this mode can also be defined in terms of its limited objectives. However the limits are established, it is essential that both therapist and patient know that they exist. The duration of treatment often

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[1]Michael McGuire, "The Process of Short-term Insight Psychotherapy," Journal of Nervous and Mental Disease 141:1 (1965):219.

[2]Phillips and Wiener, cited in Small, p. 21.

[3]Barten, p. 10.

expands to fill the available time; dependent patients are inclined to drag out the process.

Normand, et al[1] are more restrictive. They see brief therapy limited to six interviews followed by a possible referral.

Sol Garfield[2] surveyed traditional therapy research and concluded that the median number of treatment interviews is five or six and the majority of patients are seen for five interviews or less. He quoted other studies that show a majority of patients leaving treatment before the eighth interview. This pattern of treatment service utilziation is viewed as a problem and is not the result of deliberately planned brief therapy. In most instances, the patient failed to return for a scheduled appointment; therefore unplanned and premature termination is common for a large number of clients. According to Garfield, brief treatment is distinguished from regular therapy by planning and focus rather than by time limits. Leonard Kogan's[3] comprehensive study of short-term Family Service Agency contacts revealed that over 80 percent of the clients were treated in less than five interviews and two-thirds of the brief contacts ended by planned terminations.

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[1]William Normand, et al, "A Systematic Approach to Brief Therapy for Patients from Low Socio-Economic Community," Community Mental Health Journal 3:4 (1967):349.

[2]Sol Garfield, "Research on Client Variables in Psychotherapy," Handbook of Psychotherapy and Behavior Change, Allen Bergin and Sol Garfield (New York: John Wiley and Sons, Inc., 1971), p. 275.

[3]Leonard Kogan, "Short-term Case in a Family Agency, Part II," Social Casework 38:6 (1957):296-99.

Other research that relates time limits to therapy outcome indicates that the frequency of one interview a week is optimum. Barten[1] reports from his review of brief therapy studies some evidence that time limits may facilitate and accelerate the therapeutic process. The research evidence also indicates that thirty and fifty minute interviews are equally productive.

The time element alone does not characterize and distinguish brief treatment from other treatment modalities. However, even the operationalization of time factors within brief therapy is not simple. The temporal variables can be defined as (1) total duration and (2) unit duration, (3) amount, (4) frequency and (5) regularity. Decisions concerning these five variables are based to some extent on custom, dogma, personal predilection, availability of the patient and therapist, and economic considerations. Stieper and Wiener[2] remind us of the natural tendency to overtreat; the amount of help most people need to get moving satisfactorily is surprisingly modest.

The time limit in brief therapy is the independent variable that operates a number of other variables. The limited amount of time, set in advance by patient and therapist, activates the therapist and makes the fewer therapy sessions more productive.

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[1]Barten, p. 358.

[2]Steper and Weiner, cited in Phillips and Weiner, p. 22.

The Types of Problems that Can be Treated with Brief Therapy

Bellak[1] suggests that we utilize trial brief therapy as an intake procedure for the gamut of problems that are presented. After intake, more therapy could be offered if necessary. Short-term therapy can play a preventive role. It can be helpful in the treatment of grief reactions and it can prevent the chronicity of many other difficulties by treatment during the onset of the condition or early childhood. It can also prevent hospitalization or rehospitalization.[2] Paul Hoch,[3] writing in Wolberg's anthology, sees planned, short-term treatment useful for acute conflictual problems and for neurotic responses that are immediately reactive to the environment.

Phillips and Weiner[4] posit that any problem that troubles the individual or any behavior that creates a problem for others is worth treating. However, Wolberg[5] considers short-term therapy second-best and he believes that there are long-term problems that do not yield to short-term therapy.

When it comes to selection criteria, there are a number of opinions and classifications, some focusing on the type of client and others on the type of problem. Some therapists feel that the response of the patient to test interpretations is

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[1]Bellak, cited in Barten, p. 10.

[2]Kris, cited in Small, p. 10; Lindemann and Dawes, cited in ibid.; Jacobsen, et al, cited in ibid.

[3]Hoch, cited in Wolberg, p. 51.

[4]Phillips and Weiner, p. 19.

[5]Wolberg, cited in ibid., p. 17.

prognostically significant. However, the more commonly-mentioned factors are acuteness of onset, adequacy of previous adjustment, circumscribed complaint, environmental stability, favorable diagnosis, and degree of precipitating stress. Some of the patient variables deemed significant in the selection of clients for short-term therapy will be discussed in the next section.

Perhaps Rosenbaum's[1] discussion of situations that bring people into brief therapy can be used as a summary for this section. Certain recent events must have upset the patient's inner and outer equilibrium sufficiently for him to seek help. Some examples would be a recent disruption of object relationships, a bind with a previous source of help, identification with another person followed by disequilibrium, a surge of unmanageable and possibly unfamiliar impulses, or a threat to current adjustment because of changes in the environment.

Characteristics of Clients Considered Suitable For Short-term Therapy

A number of authors suggest personal and environmental factors which make some clients better prospects for brief therapy than others. However, these criteria, and proper time limits are less certain and agreed-upon than amenable problems and relevant techniques. Rosenberg[2] et al, lists some client criteria for good therapy prognosis for both long and short therapy. They

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[1]C. Rosenbaum, "The Events of Early Therapy and Brief Therapy," in Brief Therapies, ed. Harvey Barten (New York: Behavioral publications, 1971), p. 6.

[2]Rosenburg, et al, in Lesse, p. 99.

feel that the best risks have youth, lack of chronicity, are neurotic but not psychotic, have a positive relationship with the therapist, have a nonpathological work history and can utilize medication as an adjunct to therapy. Sifneos[1] gives a longer list which is predictive of successful short-term therapy and somewhat overlaps the one above. His criteria include:

1. Above average intelligence.

2. At least one meaningful relationship with another person during the lifetime.

3. Patient must be able to interact with the therapist by expressing feelings and showing flexibility.

4. Patient must be able to voice a specific chief complaint.

5. Patient must be motivated to change more than his symptoms; he must be able to recognize symptoms as psychological, be able to be introspective and to give an honest and truthful account of his emotional difficulties.

6. He must be curious, and be willing to understand himself and participate actively in treatment.

7. He must be willing to explore, experiment, and make reasonable sacrifices.

8. He must have realistic expectations of outcome.

Phillips and Johnson[2] describe the children suitable for short-term therapy who come to their clinic as out-patients with no problems of a deep nature. Typically, they suffer from a

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[1]Peter Sifneos, Short-term Psychotherapy and Emotional Crisis (Cambridge, Mass.: Harvard University Press, 1972), pp. 78-85.

[2]E. Lakin Phillips and Margaret Johnson, "Theoretical and Clinical Aspects of Short-term Parent-Child Psychotherapy," Psychiatry 17:8 (1954):269.

too-loose structure of interpersonal relationships; the parent-child problems tend to be management difficulties.

Greenwald[1] warns us that the patient's psychological strengths also must be carefully evaluated. The brief therapy patient should be one who can form a therapeutic alliance and who can sustain some degree of independent functioning. Gottschalk[2] adds the absence of paranoid trends and the inclusion of varifiable emotional stress and conflict that can accompany physiological and anatomical alterations. He sees this mode as applicable to patients classified clinically as having a psychoneurosis, a psychosomatic disorder, or even a character disorder. He even suggests it for some psychotic patients who have undergone a partial or complete remission of symptoms. This is certainly in contradistinction to the majority who see brief treatment as limited to the relief of symptoms and short-term emotional problems. Pumpian-Mindlin[3] would also try brief therapy on some depth problems. He says that it can have more than supportive objectives. In fact, it can be useful for those who manifest severe pathology provided that there is sufficient ego strength, some adequate coping techniques, some capacity to obtain gratification, some degree of frustration tolerance, and some flexibility in

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[1]Harold Greenwald, ed., Active Psychotherapy (New York: Atherton Press, 1971), p. 273.

[2]Louis Gottschalk, "An Introductory Outline of a Short Method of Psychotherapy," Journal of Nervous and Mental Disease 110:3 (1933):316.

[3]Pumpian-Mindlin, cited in Barten, p. 96.

interpersonal relationships. McGuire[1] also discusses some poor risks who nevertheless benefit from short-term therapy. He argues that those whose egos are less organized, whose impulses are less well controlled, who have a larger variety of symptoms and whose symptoms are more debilitating, can benefit noticeably from therapy of the same length as that planned for the better risks.

In summary, the literature indicates that there can be successful short-term therapy with poor prognostic risks if people seek help at a time when they want to change and are sufficiently motivated. There is less hope for stubbornly resistive patients or those who deny the existence of any problem. The literature also indicates that clients and therapists can form limited transference relationships to reach the limited goals of PSTT.

Some therapists emphasize the adaptibility and potential resources of the patient rather than the nature and severity of the illness. Peter Sifneos[2] divides brief therapy techniques into anxiety suppressive and anxiety expressive modes. The type of patient who can use anxiety suppressive (or supportive) therapy is someone who is genetically, biologically, developmentally or environmentally inadequately developed with a precarious level of emotional functioning which leads to poor interpersonal relationships, limited ability to cope, and lifelong emotional difficulties.

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[1]Michael McGuire, "The Process of Short-term Psychotherapy," Journal of Nervous and Mental Disease 141:1 (1965):83-94.

[2]Sifneos, p. 34.

But another class of patients who can use anxiety-suppressive brief treatment are those who have adequate character, who deal with reality and function well but who undergo stress which temporarily incapacitates. Their developed emotional problems are limited, their complaints are clearcut and do not interfere with their overall emotional functioning.

It can readily be seen that in spite of some concensus, there is no clear-cut agreement among therapists as to whom should be treated with brief therapy. The majority of writers would select the better adjusted and more environmentally sound as candidates.

The Process and Content of Brief Therapy

This division is somewhat arbitrary since some process and content has been included in each of the above sections. However, this section may help by explicating some of the typical methodology and subject matter of short-term treatment.

Peter Sifneos[1] helps us begin this discussion by defining some of the terms that may occur. Many of the relevant concepts also belong to crisis intervention and show a relationship between that mode and brief therapy.

An emotional crisis is a focal point in the lifelong, ever-changing continuum of psychological processes; it is an intensification or aggravation of a painful state of being. The understanding of an emotional crisis throws light on the steps

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[1] Ibid., pp. 29-33.

involved in the production of psychiatric symptoms before such symptoms become crystallized into a neurosis.

A stressful situation is one which elicits painful emotions in an individual.

A hazardous situation is a difficult or dangerous situation that becomes stressful to some individuals but not to others. Hazardous situations may arise from the environment (the threat of nuclear war), or from within the individual (the adolescent stage of development).

A painful state is an unpleasant emotional state in which anxiety, sorrow, anger, and fear predominate and which usually arises as a result of stressful or hazardous situations.

Dr. Franz Alexander[1] sees no methodological differences between long and short-term therapy. In his view, whether therapy will be long or short depends in the ultimate analysis of the ego's integrative capacity. However, defining for patients that treatment must be as short as possible discourages their procrastination in the face of important issues (and thus also affects the length of therapy).

The role of the therapist in brief treatment can generally be described as active. His initial assessment of the treatment situation should include dynamic and action

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[1]Alexander in Wolberg, pp. 84-126.

formulations and an action-oriented working hypothesis, according to Normand, et al.[1] His treatment must be more active and aggressive, not traditionally passive. He should be more directive, and focus on the target symptoms and the patient's difficulties. Hardened resistance is rare in this mode but it should be handled immediately if it arises. Counseling, supportive, and reconstructive techniques can be used in PSTT treatment.

McGuire[2] further defines the therapist's active role in treatment. He organizes the patient's already conscious perceptions and emotions in response to both internal and external stimuli. Out of the vast number of seemingly unrelated experiences, organizing concepts and ideas--"reference points"--are introduced to tie together similar experiences and to establish that certain repetitious kinds of feeling and behavior stand out. The therapist's ordering and activity are required initial steps in getting therapy under way and defining its limits.

There are a number of ways that definitions of time and other structures affect the process and content of brief therapy. Patients respond to the knowledge of "briefness" both by assigning a number of meanings to it and anticipating a number of happenings. Certain patients imagine their "cure" will require only a few visits--the patient expects to be "cured" magically rather than by his own participation. Some may assume that the clinic does not really care and others will conclude that "very little must be troubling me."

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[1]Normand, p. 349.

[2]McGuire, p. 87.

The patient's expectancy response to short-term therapy is that the therapist will "direct" tasks. If the patient's ego is receptive and flexible, the guiding may be helpful. But if he feels subjected to his environment, he may imagine that the therapist may manipulate him and he thus becomes ambivalent to treatment. Ego support is provided through the therapist's active participation in conflict ordering and solution. Expectations are supported in that the therapist's ordering suggests that there is a problem and that it may be solved by therapy.

Another effect of briefness is the timing of therapy to coincide with the patient's beginning of his mental ordering and analysis of conflicts. (This usually occurs in the period between the evaluation and the beginning of therapy.) Although the ordering may not be accurate, it is time saved in the first phase.

Part of the therapist's "task" of therapy is to keep it a "task" for the patient but to change the aim of the task when it is to avoid discussion of conflicts and symptoms. The response of the patient to the "task" can have the effect of "filtering out" some useful information that might surface if the patient talked in a more random fashion.

Turning to a different aspect of time, patient fantasies concerning the relationship of their life to time are affected by their comprehension of "briefness." McGuire[1] mentions six types of time-related fantasies that may surface in brief therapy:

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[1]Ibid.

the return of the past (patients ordering their experiences in this way believe that previous unpleasant occurrences are "imminent" in the immediate future), the present is alone (these patients believe that the present is isolated from both past and future), expected moment of realization (these patients feel that the immediate future holds the potential of becoming the time for fulfillment), the present is door to the future (these patients believe that both the immediate and the distant future will be determined by moves made now), the present is the inevitable result of the past (these patients think that the present is the result but not the cyclical reoccurrence of previous trends).

The present-directedness of therapy focuses on the immediate or pending future and only allows discussion of a few important past experiences that are related to the immediate conflict. Patients tend to expect more specific answers to their questions and these direct exchanges do facilitate ordering of the patient's experiences and concentrating on the present. This present-directedness also delays the development of the transference neurosis.

The type of transference interpretations called for in short-term therapy, again according to McGuire, are more than "support" but less than interpretations in traditional analysis. The interpretations should stress the patient's positive feelings and his fears about them, and perhaps hint at his ambivalence. They should be aimed at consolidating what has already been perceptually ordered, learned, and uncovered in therapy and should not attempt to "uncover." These consolidating or "partial"

interpretations are focused on the dissection of a single emotional conflict; this focus means that some information must be withheld from therapy in order to limit it. The content, the construction, and the timing of the interpretation are crucial.

An experience bias may be defined as the repetitious way patients order their experiences in life. Experience biases may be useful in short-term therapy since patients are uniformly aware of both the extent and depth of this determined ordering, and these biases are generally outside the range of therapeutic intervention. The biases usually influence the patient's presentation of his conflict, and therefore determine in large part both the content of statements and the way the early phases of therapy will be conducted. The more subtle manifestations are found when clarifications, and/or interpretations, at first apparently understood and accepted by patients, are reformulated to fit the bias view in between therapy sessions. Then, at a following session, this reformulation can be analyzed and reinterpretations made to utilize the bias in achieving the aims of therapy.

McGuire goes on to discuss some of the problems in using short-term therapy with sick patients. A major difficulty is the determination of the optimal time for interventions. Several variables which appear to be related to the optimal time are the positive transference, the transference neurosis, the experience bias, and the symptom generated in therapy. It is interesting to note that McGuire considers a transference neurosis not a "dirty

word" or an experience to be avoided in brief therapy, but a useful stage in the therapeutic process.

Normand et al believe that transference can occur in brief therapy and evolve rapidly and traumatically. Sifneos speculates that there is an optimal time in which the aims may be achieved; they are achieveable as long as the positive transference exists but must be achieved prior to the full development of the transference neurosis. This avoidance of a transference neurosis is an important point emphasized by many proponents of short-term therapy. Alexander differs from many of his colleagues in understanding that a transference neurosis always develops in both therapy modes. Rosenbaum warns that the therapist may become over-concerned with the client's use of him as a transference object. He may worry about hurting the client by having become a part of his magical thinking. He would therefore spend a disportionate amount of time in attempting to resolve the transference.[1]

Lydia Rapaport reflects the broader field of therapy as she suggests process and content appropriate to short-term casework:

> 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 to 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.[2]

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[1] Normand et al; Sifneos, cited in Small; Alexander in Wolberg; and Rosenbaum in Barten.

[2] Rapaport, p. 38.

In general, the approach needs to be more active and directive than in traditional work. This includes advice-giving and a greater use of authority. Time management is an important consideration. It can be used to provide structure and limits and as pressure to get on with the problem-solving task. Time limits also serve to relieve the client of anxiety concerning development of dependency or a regressive transference. Time can also be an important variable in relation to the goal of enlarging the client's sense of autonomy and mastery as far and as fast as possible. Dr. Rapaport would permit the client to set his own treatment schedule within limits but on a self-demand basis.

She echoes Dr. McGuire in stressing the importance of the client describing, defining, and reordering recent experiences. She sees this process as helping to lower anxiety, reduce confusion, and enhance cognitive mastery as first steps in problem solving. In addition to the restoration of previously useful and adequate defenses, attention is given to finding new adaptive patterns as ways of handling conflict or finding solutions. Other techniques include anticipatory guidance, rehearsal for future reality, learning new social and interpersonal skills, and enlarging the capacity for anticipatory thinking and predicting.

In short-term therapy with children, Phillips and Johnson emphasize the need to perceive a child's testing of an unstable parent-child relationship as clumsy, inarticulate ways of seeking a dependable relationship with an adult rather than indicating deep, underlying problems.

The treatment experience must be structured so that the load is carried by the total milieu rather than by the time limits alone. Since the child can be regarded as a shifting point in an interaction matrix, changing his interpersonal system of family, neighborhood, school, etc., should change the child. Emphasis is placed on his own forward direction in treatment. Since in therapy he is placed in a situation of "concurrent stimulation" from all sides, he can change as he will and when he will, without any prescribed order of "getting at this before tackling that," "seeing their hostility before they can relax" etc. Changes can occur concurrently and in nondiscernable ways.[1]

This section on the process and content of brief therapy will be concluded with a summary of Gottschalk's[2] paradigm of a brief therapy procedure.

I. Ascertaining the Personality Problem

A. First or early interviews should cover the determining of the patient's problem; strong rapport should be established.

B. Goals of First Interview

1. Allow patient to reconstruct present illness.

2. Relate symptoms to life experience. Look for common factors in life events that symptom complexes are related to.

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[1]Phillips and Johnson, pp. 269-272.

[2]Gottschalk, pp. 315-334.

3. Construct an initial mental status survey.

4. Formulate initial diagnostic and prognostic impressions.

C. Use significant others and key persons as sources of information.

D. Evaluate the patient's appropriateness for therapy and prepare him for it.

E. Individualize the schedule of interviews.

F. In beginning therapy, deal with the many forms of resistance.

G. Make interpretations of what has been verbalized or acted out.

H. Try to understand unsatisfactory psychological mechanisms.

II. Modifying Behavior Patterns and Psychological Mechanisms

A. Explain and foster therapeutic behavioristic techniques.

1. Avoid situations which have induced motivational conflict by changing environment, rest, physiotherapy, medication, reassurance, practicing desired responses, etc.

B. Select out those who do not respond and refer them to other modes of therapy.

III. Termination

This outline in its original form was quite detailed and written for students. It illustrates some of the sophistication that now makes brief therapy an accepted mode for the treatment of a broad spectrum of emotional problems.

CHAPTER III

METHODOLOGY

The purpose of this chapter is to present the research hypotheses, the sampling procedure, the methods of gathering the data, and the statistical techniques used in analyzing the findings of the study.

Hypotheses

On the basis of the assumptions and issues from the review of the literature that were deemed relevant to this study, the following research hypotheses were developed:

Major Hypothesis

Planned, Short-term Treatment in a mental health clinic is as effective as traditional, open-ended treatment, and is more economical of patient-therapist time.

Research Hypotheses

H-1. Planned, Short-term Treatment is as effective as traditional, open-ended treatment.

H-2. Planned, Short-term Treatment achieves its objectives in fewer interviews than does traditional, open-ended treatment.

H-3. Clients assessing their own treatment, therapists assessing their treatment of clients, and independent raters

assessing the same treatment as the clients and therapists will derive consistency in scores on outcome evaluations.

H-4. The seven client problem categories in Reid and Epstein's[1] model of PSTT will require varying numbers of interviews to reach their treatment objectives.

H-5a. In PSTT therapy, the number of interviews required for treatment will vary according to the length of time the problem being treated has been developing.

H-5b. In conventional therapy, the number of interviews required for treatment will vary according to the length of time the problem being treated has been developing.

Statistical Hypotheses

HO-1. There is no difference between the treatment outcome of PSTT and the treatment outcome of conventional therapy.

HO-2. PSTT requires an equal or greater number of interviews than does conventional therapy to reach its treatment goals.

HO-3a. There is no consistency among the assessments of outcome of clients, therapists, and independent raters.

HO-3b. There is no difference between the outcome ratings of clients in Treatment Group I and Control Group I.

HO-3c. There is no difference between the outcome ratings of therapists in treatment Group I and Control Group I.

HO-4. There is no difference in the number of treatment interviews for each of the seven categories of client problems.

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[1]William J. Reid and Laura Epstein, Task-Centered Casework (New York: Columbia University Press, 1972).

HO-5a. In PSTT, there is no difference in the number of interviews for the three time periods that client problems took to develop.

HO-5b. In conventional therapy, there is no difference in the number of therapy interviews for the three time periods that client problems took to develop.

Rationale for the Hypotheses

H-1. If PSTT was found as effective as traditional therapy in meeting manifest treatment goals and (H-2) it met these goals in fewer interviews, it would have been proven more economical in time and money.

H-3. If the clients, the therapists, and the independent rater agreed in their assessment of an individual case and if the clients, therapists, and raters as groups derived equivalent mean scores in their ratings of all the cases, their agreement would have supported the validity of the outcome ratings, and the reliability of the individual and group scores.

H-4. There was a question as to whether or not cases which were assigned to some category of the Reid and Epstein PSTT paradigm took so long to treat that they were not handled as PSTT problems. There was also a need to know which category of problems in the paradigm or deliberately excluded from it took longer than others to treat.

H-5a. Crisis theory seemed to support the assumption that problems which were a long time developing would take a long time

to treat. Conversely, problems with a short developmental history should have been treatable in a short period of time.

H-5b. This relationship of the length of developmental history of a problem and the length of treatment required to correct it was also tested on the control group to provide further support for the assumption mentioned in 5a.

Sampling of the Population

The subjects of this study were divided into Experimental and Control groups which were further divided into Experimental Groups I and II and Control Groups I and II. All of the groups were selected from the population which applied for treatment to the Blue Water Mental Health Clinic during a twelve-month period. The manner of selection was as follows:

1. Experimental Group I consisted of all the cases that fit the Reid and Epstein model (according to the treating therapist) in which the first treatment interview occurred between June 15, and December 15, 1973. N>100.

2. Experimental Group II consisted of all of the cases in which the first treatment interview occurred between June 15, and December 15, 1973, but which were rejected by the individual therapists for the PSTT model and treated traditionally by the individual therapist. N>70.

3. Control Group I consisted of all of the cases that were closed between January 15, and June 15, 1973, that fit the Reid and Epstein model of PSTT according to the Researcher. N>100.

4. Control Group II consisted of all of the cases that were closed between January 15 and June 15, 1973, and that did not fit the Reid and Epstein model according to the researcher. N>50.

One of the characteristics of a classic research design is the random assignment of subjects to experimental and control groups. Two of these groups are usually selected simultaneously from a single population. However, this study does not follow that "pure" research design for the following reason.

One of the purposes of well-designed research is to "keep all conditions the same for both groups, except for exposing only the experimental group to the experimental treatment for a specified period of time.[1] The study was done in a small clinic where the staff of seven had to be trained in the PSTT method which differs in several important characteristics from traditional therapy process. If the staff had attempted to treat every other case with PSTT and the other cases with traditional therapy, the PSTT training would have contaminated the traditional treatment. If the staff had been divided, with one half (three or four therapists) being trained in, and using PSTT, and the other half using conventional therapy, it would have been difficult to prove that therapists' characteristics did not account for the major variance in the dependent variable.

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[1] Ibid.

Experimental Group I and Control Group I were assumed to have similar characteristics. The two groups were compared according to four client characteristics. The results of these four comparisons supported the assumption of comparability.

As a test of internal validity, the two major groups (Experimental and Control), were compared according to the income category, age, race, and presenting problem of the primary client.

Possible sample bias could have been caused by seasonal differences in clinic clientele. However, the two major groupings included in the study did encompass the universe of intake for a limited period of time. Some variables which may have accounted for some seasonal differences in intake were: referrals from schools were heavier during school months; summer vacations decreased middle-class referrals; hot weather and decreased parental supervision may have increased court referrals. However, the major effect of seasonal differences was to decrease the number rather than to significantly vary the types of cases that came to the clinic during those comparative halves of a calendar year. The fact that school based problems are not clinically different than other family problems minimizes the variations between the samples.

Bias could also have resulted from staff changes during the study year. However, it was assumed that most, if not all of the therapists were treating during both experimental and control phases of the study year.

The two samples in the study were all of the cases taken in during the two time periods. They therefore are representative

of the Blue Water Clinic's population and the resultant statistics should be generalizable to similar clinic populations. However, to test the comparability of the two sets of samples and the internal validity of the study, tables were prepared comparing percentages of the various factors found in comparable groups. Experimental Group I, Control Group I, Experimental Group II, and Control Group II were all compared on two levels of family income. The four groups were also compared on four age categories of the primary client. They were compared next on race categories, "White," "Black," or "other," and they were finally compared by comparing the seven problem categories of Experimental Group I and Control Group I and separately comparing Experimental Group II and Control Group II in their four problem categories. Chi-square was used to test for significant differences between the tabulated results of paired groupings. The data of age and income were collected as categories. Therefore, age, income, race, and problem category were all analyzed as nominal data.

Mechanical Procedures

Experimental Period (June 15 to December 15, 1973)

The Research Clerk assigned all of the incoming cases to the seven therapists according to the following guidelines:

1. A uniform pattern of rotation
2. The current workload of the individual therapist

During the first, or first and second treatment interviews, the client and therapist determined what the target problem(s)

were and the therapist determined whether or not the case was included in Experimental Group I. (If it fit into one of the seven problem categories in Reid and Epstein's typology and into the other guidelines listed below, it was included in Experimental Group I.) Client and therapist made a contract during the first or second interview which included:

1. the agreed-upon target task or tasks
2. the planned number of interviews for working on the specific task or tasks.

The contract was recorded on form number 2a (see appendix A) by the therapist on the day the contract was agreed upon.

The therapist used the guidelines delineated below to determine which cases fell into Experimental Group I and which became Experimental Group II.

For Experimental Group II cases, the therapist did not make a contract with the client, but treated according to his customary manner.

In both Experimental Group I and Experimental Group II, the number of treatment interviews that had actually taken place were recorded on the rating sheet by the therapist.

Control Period

During this phase, the therapist treated according to his customary manner, made no contract, and recorded the number of interviews after the termination of treatment for each case. The

researcher later reviewed these cases and assigned them to one of the seven problem categories and determined whether they fit the PSTT criteria (the same guidelines and problem categories used for Experimental Group I). The cases that fit these guidelines became Control Group I. The cases which did not fit the above guidelines but did correspond to the categories of Experimental Group II, became Control Group II.

Guidelines for Excluding Cases From Experimental Group I and Control Group I

The therapist in the experimental phase, and the researcher in the control phase, assigned to Experimental Group II and Control Group II, respectively, all of the cases which fell into at least one of the following categories: (see Figure 1)

h. Neuroses

i. Well-established behavior and personality disorders (over twenty-four months in development and/or at least twelve months in development and firmly entrenched).

j. Alcoholism or drug addiction

k. Character disorders

l. Client problems which the therapists excluded from Experimental Group I and which could not be subsumed under categories h to k. (Experimental phase, June 15 - December 15.)

Control phase: All of the cases which were not placed in Control Group I and which could not be subsumed under h to k.

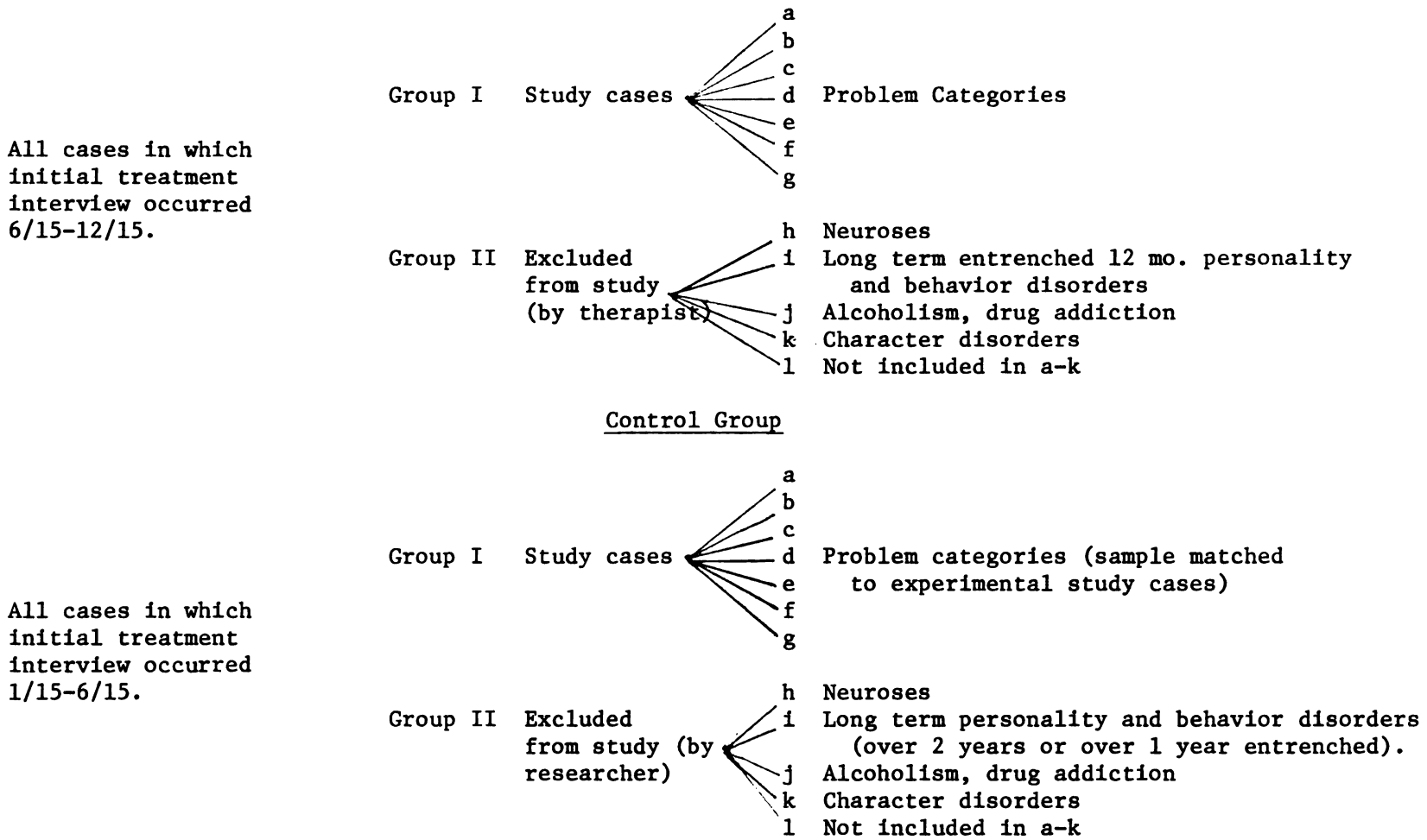

Figure 1. Experimental and Control Groups

Guidelines for Selecting PSTT Cases

1. The client must be able to see the problem clearly and must express a willingness to work on it.

2. The problem must fall within the scope of the resources of the client and the therapist--the client must be in a position to act to relieve the problem with the worker's help.

3. The problem must be relatively limited and specific.

4. The targeted problem must fall within one of the seven following categories:[1]

a. Interpersonal Conflict: Problems of conflict between two specific individuals which involves their interaction. The behavior of one or both is objectionable to the other; but the two antagonists are bound together in a relationship from which neither can readily withdraw.

b. Dissatisfaction in Social Relations: This problem is centered in the individual client rather than between two clients. The client usually perceives deficiencies or excesses in his interaction with others. He may lack assertiveness, be isolated, lonely, or too shy, dependent or aggressive. He may be dissatisfied with his relations with a particular group such as the opposite sex or those in authority.

c. Problems with Formal Organizations: This occurs between the client and a specified other--an organization. His interaction with individuals may be troublesome but their troublesome behavior is based on their role in the organization.

d. Difficulties in Role Performance: Difficulty in carrying out a particular social role such as family role or student, employee or patient. (Limited to achieved roles rather than ascribed roles such as age or sex.)

3. Problems of Social Transition: This category includes problems regarding potential changes and problems concerning changes already decided upon. Problems can include discharge, migration, divorce or becoming a parent.

f. Reactive Emotional Distress: Includes the anxiety, depression or other affective disturbances which might accompany problems in categories a to e. Client must be more concerned with these feelings than with the situation that gave rise to them.

g. Inadequate Resources: The client lacks tangible and specific resources and the therapist can help him secure them through systematic effort.

Rating of Outcome

In both Experimental and Control groups, the therapist filled out a rating sheet (form no. 1, Appendix A) as soon as possible after treatment. The client was mailed a rating sheet with a covering letter (form 1-a, Appendix A), and the independent rater filled out a rating sheet from case record information. None of the raters saw another's results. The sheets were kept folded in an envelope in the case folder. Each simply placed a check mark in a bracket after one of the five ranked assessment-of-outcome positions that had been defined in a few words on the assessor's rating sheet.

The Research Clerk maintained a checklist (form 4, Appendix A) and checked off each step in the research as it was completed. These steps included: (1) assignment of the case to a therapist, (2) assignment of the case to the research or the control group phase, (3) the closing of each case, (4) the completion of the data sheet and rating sheet by the therapist, (5) the mailing of the rating sheet and covering letter to the client, (6) the mailing of the follow-up letter to the client (if necessary), (7) the receipt of the rating sheet from the client, (8) the completion of the rating sheet by the Independent Rater, and (9) the recording of the three ratings on the data sheet (form 3, Appendix A). During the entire process, the cases involved in both phases of the study were maintained in a separate file. It was assumed that almost 100 percent of the cases would be rated by the therapists and the independent rater. Since the clients' responses were dependent on mail contact and followed termination by two weeks to three months, their response rate was not expected to be over 50 percent. If it was significantly less than this, some of the cases rated by therapist and independent rater but not by clients would have been excluded from the study.

Statistical Procedures

HO-1. There is no difference between the treatment outcome of PSTT and the treatment outcome of conventional therapy.

The five positions on the outcome rating scale (form 1, Appendix A), were assigned numerical ranks as follows:

Aggravated ..... #1

Unchanged ..... #2

Slightly alleviated ..... #3

Considerably alleviated ..... #4

Target problem no longer exists ..... #5

It is assumed that these are scaled scores and of at least ordinal level data. However, a number of authorities consider the numerical equivalents assigned to ranked outcome values to be interval level data. Presumably, this scale has an arbitrary zero point and fixed intervals between designations.[1]

The treatment outcomes for Experimental Group I and Control Group I were compared using the t test for independent sample means. Because it was felt that the assumption of homogeneity of variance might not be tenable, this assumption was first tested. If the assumption had not been upheld, the Welch[2] method would have been used to correct for degrees of freedom.

HO-2. PSTT requires an equal or greater number of interviews than does conventional therapy to reach its treatment objectives.

This variable number of interviews (the term, "interview" was defined earlier in the paper) is assumed to be interval level

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[1]Sheldon G. Levy, Inferential Statistics in the Behavioral Sciences (New York: Holt Rinehart, and Winston, 1968), p. 49; William L. Hays, Statistics for the Social Sciences (New York: Holt, Rinehart, and Winston, 1973), p. 89.

[2]George A. Ferguson, Statistical Analysis in Psychology and Education (New York: McGraw-Hill, 1976), pp. 68-170.

data but could be considered ordinal. It ranged from two to one hundred for an individual case or treatment sequence. The means of the four groups in the study were compared for significant differences using two methods.

1. The t test for independent means was applied along with the same procedures with respect to homogeneity of variance that were outlined under hypothesis 1.

2. Kendall's tau was used on the assumption that the data were only on an ordinal scale.

The groups were arranged in the following order:

1. Experimental Group I
2. Control Group I
3. Experimental Group II
4. Control Group II

The sample sizes were large enough to assume normality. One or the other of the two statistical procedures tried should have fit according to the equalness or unequalness of the standard deviations in the samples.

The inclusion of Experimental Group II and Control Group II in the comparisons was to give internal validity to the study by determining whether or not the same kinds and proportions of cases were assigned to comparable groups.

HO-3a. There is no consistence among the assessments of outcome by clients, therapists, and independent raters.

This operation helped determine the reliability of the outcome scoring, and, hopefully, showed a high correlation among the mean evaluation scores of the three types of evaluators.

Analysis of variance[1] was used to show reliability between the ratings of the three evaluators. The three observations for each case were assumed to remain constant as repeated measures, while the error in measurement for each of the three was assumed to vary. With the assumption that repeated measures of the same person remain constant, then the variance between the measures for that person (within the person) was due to error of measurement. The pooled within-person variance therefore estimated the total variance due to error of measurement. On the other hand, the variance between the persons in the group was in part due to the true magnitude of the characteristics possessed by the different people in the group, and, in part due to differences in the average error of measurement for each person.

The estimated reliability for the mean of K persons is:

$$r_k = \frac{(1/k)\ (\text{MS between people} - \text{MS within people})}{(1/k)\ (\text{MS between people} - \text{MS within people}) + (1/k)\ \text{MS w. people}}$$[2]

The reliability of a single measure was estimated thus:

$$r_1 = \frac{\text{MS between people} - \text{MS within people}}{\text{MS between people} + (K-1)\ \text{MS within people}}$$[3]

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[1] B. J. Winer, Statistical Principles in Experimental Design (New York: McGraw-Hill Book Co., 1971), p. 278.

[2] Ibid.

[3] Ibid.

r_3 = the estimate of the reliability of the average of the three ratings.

$$r_3 = 1 - \frac{\text{MS within people}}{\text{MS between people}} =$$

This analysis of variance process was run using the data from Experimental Group I. A coefficient of unity would indicate perfect consistence between raters. A coefficient of zero would indicate no consistence and would support the HO.

HO-3b. There is no difference between the outcome ratings of clients in Treatment Group I and Control Group I.

The means of the two samples were compared using the pooled variance t-test since the assumption of homogeneity of variance was upheld by an F-test.

HO-3c. There is no difference between the outcome ratings of therapists in Treatment Group I and Control Group I.

The means of the two samples were compared using the pooled variance t-test and the same procedures with respect to homogeneity of variance outlined under HO-1.

HO-4. There is no difference in the number of treatment interviews for each of the seven categories of client problems.

The mean number of interviews for each problem category of Experimental Group I was determined and the seven means compared with each other. The same process was carried out for Control Group I. Since these are considered interval level data, and the numbers in each category are presumed unequal, analysis of

variance was used for each group. The independent variable was the seven problem categories and the dependent variable was the number of interviews.

HO-5a. In PSTT, there is no difference in the number of interviews for the three time periods that the various client problems took to develop.

Questions to the client such as, "When did this difficulty begin?," or, "When did you first notice a change?," identified a date for the therapist that began the time period in which the problem surfaced. The period ended with the date of the first treatment interview. Zero to three months fell into category 1, three months to nine months into category 2, and more than nine months into category 3. The assumption was, the longer the problem was in developing, the more interviews it took to alleviate it. Therefore there should be a direct relationship between the number of interviews and the problem categories. Since the length of time divided into three categories is an ordinal variable, Kendall's tau was used to compute the degree of association. This statistic includes a method of correcting for tied ranks that was needed since there are three time period ranks to relate to approximately 100 treatment interview ranks.

The above process for HO-5a was repeated for HO-5b using the data for Control Group I.

Since the number of interviews might be considered interval level data, HO-5a and HO-5b were tested also by a one-way analysis of variance program.

CHAPTER IV

RESULTS OF THE RESEARCH

Comparability of Groups

As a test of internal validity and comparability of corresponding groups, Experimental Group I was compared to Control Group I, and Experimental Group II with Control Group II according to the income category, age, race (Experimental Group I and Control Group I), and contracted problem of the primary client. Chi-square was used to determine whether or not the selected statistics of the corresponding samples were significantly different.

TABLE 1

INCOME OF PRIMARY CLIENTS OF EXPERIMENTAL GROUP I AND CONTROL GROUP I

	Under $8,000.00	Over $8,000.00	Totals
Experimental Group I	42	24	66
Control Group I	47	39	86
Totals	89	63	152

The number with incomes above and below $8,000.00 in each group were comparable. Chi-square was 1.24 with one degree of freedom; the difference in income between Experimental Group I and Control Group I was not significant.

TABLE 2

INCOME OF PRIMARY CLIENTS OF EXPERIMENTAL GROUP II AND CONTROL GROUP II

	Income		
	Under $8,000.00	Over $8,000.00	Totals
Experimental Group II	34	31	65
Control Group II	33	15	48
Totals	67	46	113

The number with incomes above and below $8,000.00 in each group were comparable. Chi-square was 3.09 with one degree of freedom; the differences in income between Experimental Group II and Control Group II were not significant.

TABLE 3

AGES OF PRIMARY CLIENTS IN EXPERIMENTAL GROUP I AND CONTROL GROUP I

	Ages				
	0-5	6-12	13-19	20+	Totals
Experimental Group I	5	24	14	20	63
Control Group I	5	24	18	36	83
Totals	10	48	32	56	146

The number of primary clients in the four age categories were comparable in the two groups. Chi-square was 1.66 with three degrees of freedom; the differences in age distribution between Experimental Group I and Control Group I were not significant.

TABLE 4

AGES OF PRIMARY CLIENTS IN EXPERIMENTAL GROUP II AND CONTROL GROUP II

	Ages				
	0-5	6-12	13-19	20+	Totals
Experimental Group II	4	28	24	7	63
Control Group II	7	10	29	47	93
Totals	11	38	53	54	156

The number of primary clients in the four age categories were not comparable in the two groups. Chi square was 32.24 with three degrees of freedom; the differences in age distribution between Experimental Group II and Control Group II were highly significant at the .001 level of probability. Although statistically significant, the actual differences in the numbers of clients served in each age group were not as great as they appear. (See discussion, Chapter V, p. 92.)

TABLE 5

RACE OF PRIMARY CLIENTS OF EXPERIMENTAL GROUP I AND CONTROL GROUP I

	Race			
	White	Black	Other	Totals
Experimental Group I	64	0	1	65
Control Group I	86	1	1	88
Totals	150	1	2	153

The numbers of clients in the three categories of races were almost equal in the two groups. By inspection it became obvious that the differences in the racial composition of Experimental Group I and Control Group I were slight and not significant.

TABLE 6

CONTRACTED TREATMENT PROBLEMS IN EXPERIMENTAL GROUP I AND CONTROL GROUP I

	Problem Categories											
	a	b	c	d	e	f	g	h	i	j	k	Totals
Experimental Group I	21	13	2	16	0	13						65
Control Group I	27	13	1	22	0	24						87
Total	48	26	3	38	0	37						152

The number of clients assigned to each of the seven problem categories used in these two groups was comparable. Chi square was .97 with four degrees of freedom; the differences in problem category distribution between Experimental Group I and Control Group I were not significant.

TABLE 7

CONTRACTED TREATMENT PROBLEMS IN EXPERIMENTAL GROUP II AND CONTROL GROUP II

	Problem Categories											
	a	b	c	d	e	f	g	h	i	j	k	Totals
Experimental Group II	6	4	0	14	5	22	0	1	9	3	2	66
Control Group II	0	0	0	0	0	0	0	9	22	5	8	44
Totals	6	4	0	14	5	22	9	10	31	8	10	110

The number of clients assigned to each of the eleven problem categories used in these two groups were not comparable. Chi-square was 51.98 with eight degrees of freedom; the difference in the numbers of problems in the categories of Experimental Group II and Control Group II are highly significant at the .001 level of probability.

Testing the Hypotheses

HO-1

There is no difference between the treatment outcome of PSTT and the treatment outcome of conventional therapy.

An N of 66 represents the cases which the therapists chose to treat with Reid and Epstein's PSTT model during the Experimental phase of the study. The client's, therapist's, and researcher's outcome ratings for this group were compared with the ratings of the eighty-nine cases during the Control, or conventional treatment phase, that were fitted into the seven categories of the PSTT model by the researcher. The resultant means are compared in the following table.

TABLE 8

MEANS OF EXPERIMENTAL AND CONTROL GROUPS COMPARED ACCORDING TO THE THREE TYPES OF RATERS

	Means					
	Exp. Group I	Control Group I	Diff.	t	Deg. of Freedom	Prob.
Clients	2.6061	2.7191	.1130	.3776	153	.706
Workers	3.1970	3.3146	.1176	.7868	153	.433
Researcher	3.1364	3.2360	.0996	.5785	153	.564

The assumption of homogeneity of variance was upheld in all three cases. The results of the t tests are shown in the last three columns of Table 8.

The comparison of the means of the client ratings in the PSTT sample and the corresponding control group yielded a t of .3776 with 153 degrees of freedom. At a probability of .706 on a 2-tailed test the difference is not significant.

The means of the therapists' ratings in Experimental and Control Group I were not significantly different. Mean of Experimental Group I - Mean of Control Group I = 3.1970 - 3.3146 = .1176. This data was also found to be homogeneous. A t of .7868 with 153 degrees of freedom has a probability of .433; and therefore the means are not significantly different.

The researcher's mean ratings of Experimental Group I and Control Group I were only .0996 apart. A t of .5785 with 153 degrees of freedom showed a probability of .564 (two-tailed test). Again the means were not significantly different.

The mean of the three ratings of Experimental Group I compare favorably with the mean of the three ratings of Control Group I--2.9798:3.0899.

HO-2

PSTT requires an equal or greater number of interviews than does conventional therapy to reach its treatment objectives.

The mean number of interviews was 4.7273 for the 66 cases in Experimental Group I and 10.5843 for the 89 cases in Control

Group I. These means were compared in two ways: Method 1: t-test for independent means. The test of homogeneity of variance yielded F=33.00 with $p<.001$. Hence the assumption could not be upheld, and the method of Welch was used for adjusting degrees of freedom. The test yielded $t = -3.3235$ with 93 df and $p< .001$. This difference was highly significant. Method 2: Considering the measures to be an ordinal rather than an interval scale, Kendall's tau was used for two groups (Experimental Group I and Control Group I). This test gave $\tau = .273$ which was highly significant ($Z = 5.043$, $p<.001$).

The two procedures gave closely similar results. The difference between the mean number of interviews for the two groups is highly significant.

Method 1 above was repeated with two extreme scores (over 100 interviews) deleted. The mean of Experimental Group I remained the same but the mean of Control Group I was decreased to 8.4138. The assumption of homogeneity of variance was not upheld and the Welch procedure was used to adjust for degrees of freedom. t was -4.1190 with 108 degrees of freedom and $p<.0001$. Again the difference in the number of interviews for the two groups is highly significant.

The mean number of interviews for Experimental Group II (65 cases) and Control Group II (47 cases) were compared also. The means were 6.7692 and 20.4893 respectively. The F test yielded 12.9492 with a probability $<.0001$. Since the homogeneity of variance was not upheld, the Welch procedure was used to adjust the

degrees of freedom. t was -2.9592 with 53 degrees of freedom and a probability $<.005$. The difference in the number of interviews for the two groups was significant.

The number of interviews and frequencies of cases during the experimental phase (Experimental Groups I and II), and during the control phase (Control Groups I and II), were compared in a line graph. It demonstrates that the PSTT phase took fewer interviews consistently. (See Figure 2.)

HO-3a

There is no difference among the assessments of outcome of clients, workers, and the researcher.

Seventy percent of the clients contacted after the Experimental phase returned their rating sheets. The rating sheets sent to them offered a choice of five positions to be marked: Number 1 was labelled "aggravated," number 2 was labelled "unchanged," number 3 was "slightly alleviated," number 4 was "considerably alleviated," and number 5 was "target problem no longer exists." The clients' ratings on this scale averaged 2.6061 for the Experimental Group I PSTT cases (N=66). An F-test upheld the assumption that the variances within the group were homogeneous. The same cases were rated on the same scale by the workers who treated the clients. The workers who treated with PSTT during the experimental phase had a mean rating of 3.1970. The F-test upheld homogeneity of variance for this set of data. The researcher rated therapy outcome by reading all of the cases in both groups. His ratings averaged 3.1364 for the PSTT group (Experimental Group I). Again

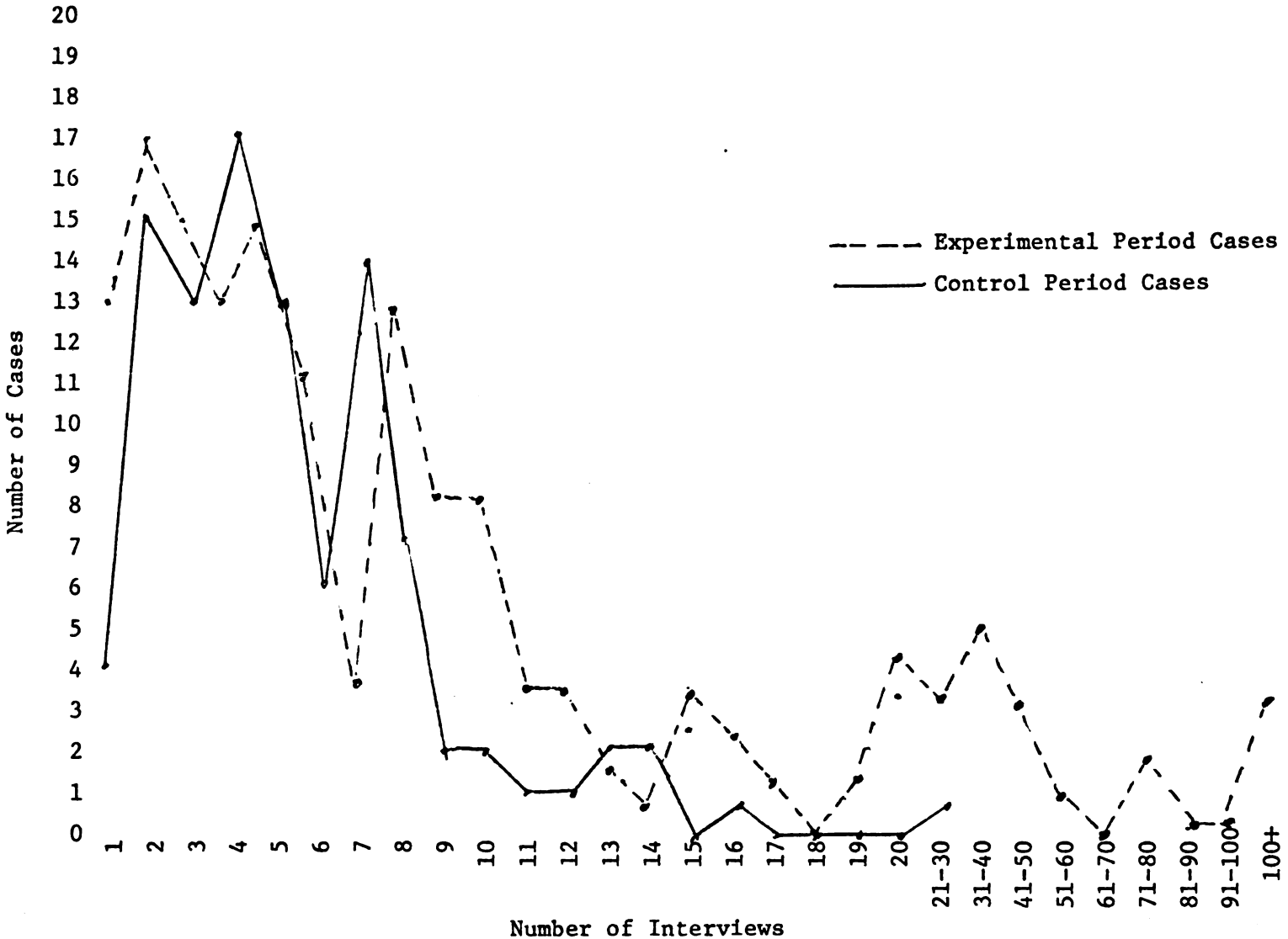

Figure 2. The distribution of Experimental and Control cases according to number of interviews.

the F-test upheld homogeneity of variance, therefore analysis of variance was used. The reliability of the mean was:

$$1 - \frac{1.333}{3.333} = 1 - .40 = .60$$

The reliability of a single measure was:

$$\frac{1.989}{5.988} = .33 \quad 1 - .33 = .67$$

Both coefficients were relatively high. The HO is rejected. There is a reasonable degree of consistency between the ratings of clients, therapists, and independent researcher when the ratings are taken as groups, and also a high correlation between the three ratings on a given case.

HO-3b

There is no difference between the outcome ratings of clients in Treatment Group I and Control Group I. The difference between the ratings of outcome for PSTT and traditional treatment was measured by comparing the client ratings in Experimental Group I with client ratings in Control Group I (see Table 9). The F test yielded F - 1.1240 with p = .6049 which upheld the assumption of homogeneity of variance. The difference was not significant so the null hypothesis was upheld; there is no significant difference between the client ratings of the two types of treatment.

HO-3c

There is no difference between the outcome ratings of therapists in Treatment Group I and Control Group I. The difference between the ratings of outcome for PSTT and traditional

treatment were measured by comparing the therapists' ratings in Control Group I (see Table 9). The F-test yielded F = 1.4234 with P = .1226 which upheld the assumption of homogeneity of variance. The difference was not significant so the null hypothesis was upheld; there is no difference between the therapists' ratings of Experimental Group I and Control Group I.

If the t values from these three comparisons are taken together, it can readily be seen that, from the ratings of clients, workers, and the researcher, the outcome of both kinds of therapy is essentially the same (see Table 9).

TABLE 9

TREATMENT OUTCOME MEANS OF EXPERIMENTAL AND CONTROL GROUPS COMPARED ACCORDING TO THE THREE TYPES OF RATERS

Raters	Exp. Group I	Control Group I	Diff.	t	d.f.	Prob.
Clients	2.6061	2.7191	.1130	.3776	153	.706
Workers	3.1970	3.3146	.1176	.7868	153	.433
Researcher	3.1364	3.2360	.0996	.5785	153	.564
Totals	8.9395	9.2697	.3305	1.8429	459	1.703
Average	2.9798	3.0899	.1101	.6143	153	.5677

HO-4

There is no difference in the number of treatment interviews for each of the seven categories of client problems (in the Reid and Epstein model).

Number seven of Reid and Epstein's seven problem categories, "Inadequate Resources," was not chosen by the workers as fitting any of the cases in any part of the study. Therefore, only six problems were included in the PSTT phase analysis of the number of interviews it took to treat each problem. Category 5, "problems of social transition" was not chosen either but it was included in the study and is shown as blank cells in the Anova tables (see Table 10). The clinical orientation of the therapists led them to perceive client problems as intrapersonal or interpersonal between two individuals.

With the exception of "Problems With Formal Organizations," the cell frequencies were large and uniform enough to use analysis of variance. "Problems With Formal Organizations" had a frequency of 2 in Experimental Group I and 1 in Control Group I. This data was analyzed by inspection.

The variation in the number of interviews for each of the six problem categories included in Experimental Group I (only five of these were utilized), was not significant. The same problem categories treated as Control Group I did not vary significantly in the number of interviews they required. The F ratios for both Experimental Group I and Control Group I were non-significant.

HO-5a

In PSTT therapy, there is no difference in the number of interviews for the three time periods that client problems took to develop.

TABLE 10

SIX PSTT PROBLEM CATEGORIES AND MEAN NUMBER OF INTERVIEWS
EXPERIMENTAL GROUP I AND CONTROL GROUP I

	Interpersonal Conflict		Dissatis-faction in Soc Relations		Problems With Formal Organization		Difficulties in Role Performance		Problems in Social Transition		Reactive Emotional Distress		Inadequate Resources	
	Cases	Mean # Int.	Cases	# Int.	Cases	# Int.	Cases	# Int.	Cases	# Int.	Cases	# Int.	Cases	# Int.
Exp G I	21	4.476	13	4.231	2	2.50	16	4.750	0	0	13	6.071	0	0
Con G I	27	7.889	14	9.643	1	3.0	22	9.081	0	0	24	15.583	0	0

TABLE 11

ANALYSIS OF VARIANCE SUMMARY TABLE
FOUR PSTT PROBLEM CATEGORIES AND MEAN NUMBER OF
INTERVIEWS FOR EXPERIMENTAL GROUP I

Source	D.F.	Sum of Sq.	Mean S.	F Ratio	Proba-bility	Signifi-cance
Between Groups	3	27.6105	9.2035	1.1278	65	N.S.
Within Groups	59	481.468	8.1605			
Total	62	509.0786				

TABLE 12

ANALYSIS OF VARIANCE SUMMARY TABLE
FOUR PSTT PROBLEM CATEGORIES AND MEAN NUMBER OF
INTERVIEWS FOR CONTROL GROUP I

Source	D.F.	Sum of Sq.	Mean S.	F Ratio	Proba-bility	Signifi-cance
Between Groups	3	857.3867	285.7954	1.0561	.6	N.S.
Within Groups	83	22,461.4687	270.6199			
Total	86	23,318.8555				

The three time periods that problems took to develop in Experimental Group I were correlated with the number of interviews for each case. The Kendall's Tau of .135 produced a Z of 1.602 which was not significant. There was no meaningful relationship between the number of interviews it took to treat a case and the length of time the problem treated was in development. N = 66 cases.

HO-5b

In conventional therapy, there is no difference in the number of therapy interviews for the three time periods that client problems took to develop.

The three time periods that problems took to develop in Control Group I were correlated with the number of interviews for each case. The Kendall's Tau of .208 produced a Z score of 2.888 which meant that there was a significant relationship between the number of interviews it took to treat a case and the length of time that the problem treated had been developing. N = 89 cases.

CHAPTER V

INTERPRETATION OF THE RESULTS

Comparability of Groups

As a test of internal validity of the study and comparability of corresponding groups, Experimental Group I was compared to Control Group I on the income, age, race and problem category of the primary client. Experimental Group II was compared to Control Group II on the income, age, and problem category of the primary client.

Experimental Group I and Control Group I were not significantly different when family income was compared. Control Group I contained a few more clients with middle class incomes; this could reflect slight seasonal or cyclic variations in economic conditions. However, the fact that the differences were slight indicated that the two samples were drawn from the same populations.

Clients' incomes in Experimental Group II and Control Group II were also comparable. Control Group II had a slightly greater preponderance of lower class clients. This would not indicate that a seasonal or economic variation was operating since this skew is the opposite of the skew of the income distribution for corresponding groups Experimental I and Control I. Perhaps clients whose problems could be categorized into the Reid and Epstein categories were more expressive verbally and tended to be

middle class. However, the differences were not significant so that income did not seem to be a variable affecting therapy outcome.

The ages of primary clients were grouped and compared to see whether or not clients were picked for the two kinds of treatment according to their ages. Experimental Group I and Control Group I were comparable according to client ages and the differences were not significant. However, when comparing Experimental Group II and Control Group II--those cases excluded from the PSTT categories during the PSTT treatment and the conventional treatment phases--it was found that the two groups were not comparable and the differences were highly significant. Experimental Group II cases were taken in and treated during a six-month period <u>after</u> the Control Group II cases were treated. Experimental Group II had many more elementary age children and far fewer adults than did its corresponding Control Group II. This reflects a change in Clinic intake policy; the parent planning organization began at that time to limit the Blue Water Clinic to children's cases. The age statistics were tabulations of primary clients, or the family members for whom help was sought. Child primary clients were seen with their parents. The younger the primary client, the more likely it was that the child was treated through the parent. Therefore, the shift to a greater proportion of child primary clients did not mean a pro-rata reduction in the number of adults served.

Presumably, teen-age clients in their middle to late teens were seen sometimes without the involvement of a parent. Therefore, there may have been less involvement of adults in Experimental

Group II when compared to Control Group II. However, the major focus and concern of the study is Experimental Group I and its counterpart, Control Group I. In these groups the percentages of child primary clients presumably treated with their parents or through their parents are 52 percent and 42 percent respectively. The Chi-square comparison of the two groups found the differences not significant. The change in clinic policy during the study did not vary the population served enough to threaten the validity of the research.

Table 5 shows that the number of minority group clients seen by the Clinic is very limited. Since non-whites were only about 2 percent in both Experimental Group I and Control Group I, they were readily seen as comprising about the same proportion of either group. The lack of significant numbers of minority clients in the study means that the results cannot be generalized to minority or racially mixed populations.

In Table 6 the Experimental and corresponding Control groups were compared on the basis of the assignment of client problems to the problem categories designated by Reid and Epstein. Experimental Group I and Control Group I were not significantly different in the proportions of cases assigned to each category.

The therapists who made these decisions during the experimental phase saw some of the cases assigned to them as not treatable through the Reid and Epstein seven-category model. The rejected cases became Experimental Group II. However, the problem category distribution of cases selected for the model during the control

phase of the study when conventional treatment was used, was not significantly different from the distribution into problem categories during the treatment phase where PSTT was used.

The client problems rejected for the PSTT paradigm of the Reid and Epstein model during the treatment and control phases of the study became Experimental Group II and Control Group II. The cases in these groups were fitted into the four categories that Reid and Epstein said were not suitable for PSTT treatment. (Neurosis, well-established behavior and personality disorders, alcoholism or drug addiction and character disorders.) The problem category distribution of cases in Experimental Group II and Control Group II was significantly different. Information on which to base a decision for problem categories in these two groups differed somewhat. In Experimental Group II, the therapists gathered information for a decision from the first, or first and second, interview with the client. In Control Group II, the researcher used the case records as the basis for his decisions concerning problem categories. During the experimental phase, the emphasis was on treating as many cases as possible with PSTT; many therapists treated almost all of their cases with PSTT during this period. Experimental Group II, therefore, represents rejects from the normative program for that six months.

A basic assumption of Reid and Epstein's PSTT model is that PSTT is <u>not</u> appropriate for all client problems. Conventional therapy is not limited specifically to certain types of problems. This research supported the limited characteristic of the PSTT

model when the problem paradigm was applied by the individual therapist during the experimental phase and when it was applied by the researcher during the control phase. PSTT was found not suitable for all client problems.

Discussion of Results

Hypothesis 1

Planned, short-term treatment is as effective as traditional, open-ended treatment.

One of the two major concerns of this study is whether or not PSTT is as effective as more traditional therapy. The two types of treatment were found to be equally effective. However, the goals of the two types and potential lengths of therapy differ. In fact, the goal of any individual series of treatment interviews in either treatment category should be idiosyncratic.

A number of studies have established the premise that a variety of types and lengths of treatment under a number of conditions are 60 to 75 percent successful when evaluated by a variety of raters and devices.[1] It was felt that, if the results of PSTT in this study (Experimental Group I) were comparable to the results of traditional treatment in the test group (Control Group I), and if both sets of results fell within the broad range established for the outcome of "successful" therapy, then the therapy outcome could be considered held constant while the average length of treatment for the two groups was compared for significant variation.

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[1]Denker cited in Bergin and Garfield, p. 239; Eysenck, cited in Ibid.

A number of researchers and clinicians believe that the effect of therapy cannot be measured adequately without some follow-up feed-back at periodic intervals after the initial therapy is completed. They state that it is important to know whether or not progress claimed at the close of therapy has held up over time. Other research-oriented therapists believe that time distorts a client's or worker's perception of what happened during treatment and that various post-treatment influences also may bias a follow-up evaluation. The clients in both phases of this research rated their treatment from two weeks to three months after treatment termination. This time lapse provided some perspective without the danger of distortion posed by a longer delay.

The sixty-six clients who responded to the request for a rating of their treatment represent a 79 percent return, which is a high percentage of response to a mailed questionnaire. Some clients had moved or could not be reached for other reasons. This left a small percent who refused to cooperate. The clients who did respond to the request for rating provided an opinion or viewpoint of their therapy which may have been more subjective than a before-and-after symptom's checklist or psychological profile. However, it could be argued that the client's opinion of his or her treatment is more real than someone else's categorization of what the client needed and an outside assessment of whether or not he or she received what was needed in treatment.

The researcher who rated all of the cases for outcome had had no direct contact with the client. He was dependent on

whatever information was written in the case record, especially the contract between client and worker. However, his ratings were consistent with the ratings of the clients and therapists.

A number of mechanical procedures were used to prevent contamination between raters, especially between clients and therapists. A research clerk provided an envelope in the case folder in which the therapist could deposit his folded rating sheet. The clerk mailed rating sheets to the clients and folded and deposited them when they were returned. The researcher then added his folded sheet to the envelope. The research clerk recorded the ratings on the data sheet.

Hypothesis 2

Planned, short-term treatment achieves its objectives in fewer interviews than does traditional, open-ended treatment.

The major advantage of PSTT over traditional therapy is its economy of time and more expeditious use of expensive therapy resources. The focused use of time in this type of therapy does reach the limited goals contracted for in fewer interviews than does the less focused traditional therapy which is directed toward less explicit goals.

A number of research studies show that most movement in any type of therapy takes place in the first few interviews, and because of early, unplanned termination by clients, most conventional treatment sequences do not go beyond the six to eight interview limit set for most PSTT. Therefore, the mean number of interviews for

Control Group I is skewed by a small number of high scores. (Seventeen cases of between twenty and one hundred interviews.) When the data was run a second time omitting the two most extreme scores (over one hundred), the mean score for Control Group I was reduced from 10.5843 to 8.4138. However, the difference between the means of Experimental Group I and Control Group I with the two extreme scores omitted from the latter group, is still significant.

PSTT takes less time to reach more limited goals, but its goals should be closer to the expressed needs of the client because of the explicit statements recorded as part of the contracting process.

The non-PSTT cases treated during the two major phases of the study (Experimental Group II and Control Group II) were compared according to the average number of treatment interviews. The fact that the ratio of Experimental Group II to Control Group II mean number of interviews was comparable to the ratio of mean interviews for Experimental Group I to Control Group I represents a validation of Reid and Epstein's client category model. The therapists (during the experimental phase), and the researcher (during the control phase), independently decided that proportionate numbers of cases did not fit the Reid and Epstein model. The therapists selected cases for Experimental Group II by deciding that certain cases were not treatable by PSTT and fit the non-PSTT categories of the model. The therapists handled those cases in far fewer interviews than they did comparable cases during the Control phase before they were trained in PSTT. However, the comparison of the mean number

of interviews for Experimental Group I and Control Group I is the most relevant to this study.

Hypothesis 3

Clients assessing their own treatment, therapists assessing their treatment of clients, and independent raters assessing the same treatment as the clients and therapists will all derive equivalent scores on outcome evaluations.

The five-position rating instrument used in assessing the three group's evaluations of outcome was suggested by Dr. Laura Epstein, one of the developers of the PSTT model. It was used in the Reid and Epstein studies of the early 1970s. Its primary use in this research was the comparison of treatment effectiveness by different groups in the study rather than comparing results to a baseline or standardized result from other studies. There were a limited number of positions on the rating scale, but the numbers in the groups being rated were large enough to smooth out the modal effect of the data.

There are many possible sources of bias that may have affected the clients, the therapists and the independent researcher's assessment of outcome. The client could be influenced by his like or dislike for the clinic itself, or any person connected to the clinic or for any part of the clinic process. The independent rater could have been influenced by his desire for a certain outcome for his research. The therapists could be influenced by a preference for a method of treatment, a desire for "successful"

research, a like or dislike for a client, and a host of other factors. But the similarity of evaluations among the three groups suggests a balancing of the potentially positive and negative biasing factors.

There were no significant differences in outcome ratings. The clients, therapists, and independent researcher all indicated that the outcome of PSTT and conventional therapy was about the same. However, all three groups rated conventional therapy as slightly more successful than PSTT. (The clients' mean for Experimental Group I was 2.6 and for Control Group I was 2.7. The therapists' ratings were 3.2 and 3.3 and the researcher's ratings were 3.1 and 3.2, respectively.)

Of the three types of raters, the therapists were most positive in rating the outcome of their own therapy. The independent researcher was slightly less positive and the clients the least positive. However, these differences were not significant. Perhaps the most comprehensive knowledge of the problem and its setting provided the most critical look at its resolution.

The clients treated conventionally (Control Group I), and the clients treated with PSTT (Experimental Group I), evaluated their treatment results almost equally. The therapists in both groups also assessed their treatment as equally successful. The therapy outcome variable remained constant during both types of treatment while the time variable fluctuated.

Hypothesis 4

The seven client problem categories in Reid and Epstein's model of PSTT will require varying numbers of interviews to reach their treatment objectives.

The seven-category model used in this study was developed and used by Reid and Epstein at an earlier stage in their research. Its range of coverage was sufficient for most problems encountered by a mental health clinic, but it specifically eliminated some broad and some narrow categories of other client problems (see Figure 1, h-1).

The decisions to define problems in certain ways and place them in certain categories varied somewhat among the different therapists. They were trained briefly in making such decisions, but their idiosyncratic backgrounds were a bias. None of the group used the category "inadequate resources," perhaps because the provision of resources was not a clinic function according to their traditional perspective of clinic services. They therefore tended to classify a problem handled primarily by referral not as a part of clinic services nor within the bounds of the PSTT phase of this study.

The category "problems in social transition" relates to a developmental model of problem definition that apparently was not congruent with the problem paradigms the therapists were familiar with. There were problems in social transition that were treated during the study but otherwise defined. Because of this and perhaps other factors, this category was not used by any therapist. Better

problem differentiation would have resulted in some client problems being categorized as problems in social transition. Problems with formal organization was used only twice in Experimental Group I and once in Control Group I.

"Interpersonal conflict" was the category most frequently chosen for client problems. This large number probably included many client situations that would have been labeled "problems in social transition" if the therapists had used a theoretical framework congruent with that concept. Again, this relates to the therapists' way of perceiving problems as well as to the number of clients who presented that problem for treatment. Most of the therapists were closer to a psychological view of human behavior than they were to a sociological or anthropological viewpoint. In spite of differential labeling, the study covered the gamut of common clinic problems. There were zero frequencies in some cells, but problems were shifted rather than lost.

The uniformity in the number of interviews that each type of problem took to treat in Experimental Group II may have been influenced by the structural limits of the prescribed number of interviews in PSTT. The Experimental Group I problems compared to Control Group I problems did take a significantly different number of interviews in this traditional mental health clinic setting. This result agrees with the major findings of Hypothesis II--that PSTT and conventional therapy does require a significantly different number of interviews. The traditional mode of therapy usually accomplishes most of its movement and terminates in a few interviews.

It is the few cases that require many interviews that make the average treatment longer for conventional therapy. The statistics do support the premise that PSTT type problems can be treated with either type of therapy in most cases, with a small variation in the number of interviews.

The fact that the therapists and researcher decided to classify proportionate numbers of cases into each category during both Treatment and Control phases indicates that they did not generally exclude cases from PSTT that they thought were too difficult or complicated. They used both treatment methods on the same types of problems and excluded similar types of problems from the Reid and Epstein paradigm during both phases of the study.

Experimental Group II and Control Group II included somewhat different types of cases that were selected differently. The therapists decided that some cases fell into one of the seven categories of Experimental Group I, but could not be treated by PSTT. Since the cases were rejected for PSTT, they became part of Experimental Group II. Control Group II cases were selected by problem category alone, therefore none of those types of cases were assigned to a-g (Experimental Group I) categories.

Hypothesis 5a

In PSTT the number of interviews required for treatment will vary according to the length of time the problem being treated has been developing.

This assumption seemed logical and seemed to be supported by crisis theory, but it did not hold true for PSTT cases in this study. The term "problem" as used in the experimental phase of therapy, was defined by what was contracted, in contradistiction to the broader definition of problem that is more generally used in therapy. Many of the client problems that arose within a few weeks of treatment took as long as problems that had been developing for over a year.

There was a possibility that the difficulty the client contracted to treat was the current manifestation of a deeper, more long-term problem. In PSTT, it is acceptable to work on the alleviation of symptoms; the problems that these symptoms illustrated may never be fully explicated.

There are a number of factors which operate together to help a client decide to seek help with a certain problem at a certain time. The painfulness of a certain problem or the discomfort of an acute phase of a long-term problem are only two of them.

Related to the assumption that short-termed problems would take less time is the assumption that clients would tend to contract more short-term problems for PSTT treatment. It was assumed that clients faced with a time limit would focus on and contract something immediate and limited rather than to attempt to treat a chronic condition with PSTT. This unwritten assumption was not supported by the study.

Hypothesis 5b

In conventional therapy, the number of interviews required for treatment will vary according to the length of time the problem being treated has been developing.

In the regular treatment cases in Control Group I, the relationship between the length of treatment and the length of time the problem being treated was developing was significant at a low level. This low level of significance called into question the unwritten assumption that clients and therapists would decide that long-term problems could not be treated in PSTT.

Although the term "problem" was not as specifically defined in conventional therapy, it was more concisely defined in the PSTT phase of this study. Therefore, the assumption that something different was defined and contracted for in each of the two groups, and that the term "problem" as used in the conventional therapy phase was more generally defined, may be valid.

The average problem in Control Group I took longer; there was more freedom for the range of the number of interviews to assume a wider spread than would interviews for the PSTT group which were constrained by the arbitrary limit of eight interviews.

CHAPTER VI

SUMMARY AND CONCLUSIONS

"Reid and Epstein have formulated a theory for short-term casework based on the assumption that effectiveness and efficiency of treatment can be greatly increased."[1]

"While we think that the problem typology comprises most of the problems caseworkers can be expected to deal with successfully, it is not meant to be exhaustive. It certainly does not span the range of human problems that caseworkers generally deal with."[2] The authors addressed these remarks to caseworkers. However, this study applying PSTT in a clinic setting included three clinical psychologists and four caseworkers.

These two statements from the authors of the book in which the research model is defined, epitomize the two foci of the study. Does this experiment using the Reid and Epstein model of PSTT demonstrate that treatment can be effective and efficient? Does the research support the model in showing that some client problems are suitable for PSTT and some are not?

The study did demonstrate that therapy outcome can remain constant when using PSTT or conventional, open-ended therapy as a treatment method. Since the PSTT treatment was accomplished in

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[1] Reid and Epstein, jacket. [2] Ibid., p. 54.

less time, that method represents efficiency and effectiveness for certain settings and types of client problems.

The individual therapists during one treatment phase, and the researcher during one other phase, distributed client problems into various categories within and outside of Reid and Epstein's PSTT typology. This operationalized the structural characteristic of the model's suitability for some client problems and unsuitability for others.

Therapy outcome research is complicated, expensive and usually ambiguous because of the difficulty of keeping variables constant. However, the increasing emphasis on accountability, the need to extend treatment services to more and more unserved or poorly served groups, and the escalating cost of treatment make PSTT programs desirable and necessary; but their value must be demonstrated by objective studies and hard data.

There is a need to test forms of PSTT with minority groups, the aged, and other distinctive groups. If control groups are used in such studies (and many researchers believe that studies have limited validity without them), care should be taken to keep the PSTT and the contrasting method as "pure" and free from cross-contamination as possible. Some form of specific contrast is needed in both phases to provide baselines for measuring the accomplishment of goals. The debate over the efficacy of treating symptoms versus treating the whole person goes on and may never be settled. However, the utility of treating symptoms must be more thoroughly tested by well-designed studies. Staffs which

attempt a differential approach to treatment such as PSTT need careful training which includes open discussion to help them overcome prejudice against a different methodology. Related to this is the question of whether the client or the therapist is the best definer of what the problem is and what successful treatment is. There is also continuing disagreement on the role of the therapist--how active he or she should be, whether or not any advice should be given, etc. These and other questions make the worth of studies such as this one depend to a large extent on value judgments related to the theoretical orientation of the judge.

This author's initial interest in PSTT developed out of necessity--a limited work assignment in a treatment center which forced the setting of time limits and limited goals for individual cases. That experience and this study, which was prompted by that experience and the ratio of the Clinic's therapy needs to its resources, have been truly rewarding and have permanently shaped the basic counseling style of the writer.

PSTT offers the busy therapist an efficient mode of treatment that perhaps can be applied even beyond the limits of the Reid and Epstein model. To the counselor who does not want a new mode, PSTT offers many objective and client-centered components and characteristics that can enrich an eclectic approach. Examples of these are the use of the treatment contract and more active and focused goal-setting and direction for treatment dictated by time limits.

A P P E N D I C E S

APPENDIX A

RESEARCH FORMS

FORM 1

RATING SHEET

Pre-Study [ ]

Study [ ]

Coordinator [ ]

Worker [ ]

Client [ ]

Number of Case_____ Date _____

I now see the problem we agreed to work on as:

(1) Aggravated (worse) [ ]

(2) Unchanged [ ]

(3) Slightly Alleviated (a little better) [ ]

(4) Considerably alleviated (much better) [ ]

(5) Target problem no longer exists [ ]

Please mark the box in front of the words that come closest to expressing your opinion.

FORM 1a

COVER LETTER FOR RATING SHEET

BLUE WATER MENTAL HEALTH AND CHILD GUIDANCE CLINIC
1501 Krafft Road
Port Huron, Michigan 48060
Telephone: 985-5125

Mrs. Alice McKinnon
Director

Charles N. Hoyt, M.D.
Psychiatric Consultant

Dear

Within the last few months, you came to this clinic for counseling. We are now trying to find out from those who have been to the clinic whether or not they found the service helpful.

Would you please mark an X in one of the boxes on the enclosed rating sheet and return it in the stamped, addressed envelope? Your prompt cooperation will be greatly appreciated and will help us evaluate our service in order to improve it.

Your response will be kept confidential. The information will be reviewed by Reger C. Smith, Study Coordinator.

Sincerely yours,

Worker

FORM 2

CASE SUMMARY SHEET

SUMMARY SHEET FOR DIRECT SERVICES

DEFINITION OF PROBLEM:

TREATMENT DESIGN: (Planned Short Term or Open-ended treatment: patient and family members involved; individual, group, family, conjoint or Workshop, Specify: Consultation with other Community Agencies.)

FORM 2a

GOALS: (Specify)

CLOSING ASSESSMENT (include length of treatment, no. of interviews improved, etc.)

FORM 3

DATA SHEET

Name_____ Case Number_____ Name of Worker_____

Age Category	Dates	History of Problem
0-5 ( )	First Interview _____	Less than 3 months ( )
5-12 ( )	Recontract _____	3 months to 1 year ( )
13-18 ( )	Final Interview _____	more than 1 year ( )
19- ( )		

Referral Source _____

Problem Category

a. Interpersonal conflict	( )	g. Inadequate resources	( )
b. Dissatisfaction in social relations	( )	h. Neuroses	( )
c. Relations with formal organizations	( )	i. Personality disorders	( )
d. Role Performance	( )	j. Drug addiction	( )
e. Social transition	( )	k. Character disorders	( )
f. Reactive emotional distress	( )	l. All not in a-k	( )

Family Income

Under $8,000 ( ) $8,000 and over ( )

Race

White ( ) Black ( ) Other ( )

Number of treatment interviews

Core____,____,____,____,____,____,____,____,____,____,

Collateral___,____,____,____,____,____,____,____,____,

Ratings

Client_____ Worker_____ Independent Rater_____

FORM 4

MASTER CONTROL SHEET

	WORKER								CHECK		CHECK						
Case Number	McKinnon	Anderson	Jones	Beggs	White	Fisher	Trocchio	York	STUDY	EVALUATION (Pre-Study)	Initial Data Sheet	Summary Sheet Completed	Preparatory Phone Call	Rating Sheet Returned from Client	Intake	Data Sheet Completed	Worker Rating Sheet

APPENDIX B

RAW DATA

RAW DATA

	Case Number	Exp/Cont	PSTT/Non PSTT	Age	History of Problem	Problem Category		Number of Interviews			Ratings Client	Worker	Independent	Race	Referral	Income
Column	123456	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Desig.		1,2	1,2	1-4	1-3	1-11		1-120			1-5	1-5	1-5	1-3	1-4	1,2
1	053280	1	1	4	3	0	2	0	0	2	3	3	3	1	1	2
2	015401	1	1	4	3	0	2	0	0	4		3	3	1	1	2
3	015317	1	1	2	3	0	6	0	0	4	4	3	5	1	4	2
4	105291	1	1	2	3	0	6	0	1	0	3	3	4	1	4	2
5	015290	1	1	2	3	0	3	0	0	2	4	3	3	1	2	1
6	015289	1	1	3	3	0	4	0	0	2	2	3	2	1	2	1
7	015288	1	1	3	3	0	1	0	0	2	2	3	2	1	2	1
8	015256	1	1	2	2	0	6	0	1	2	4	5	4	1	2	2
9	015224	1	1		2	0	1	0	0	8	4	4	4	1		1
10	014843	1	1	2	3	0	1	0	0	7	3	3	4	1	2	2
11	014725	1	1	3	2	0	6	0	0	2	3	3	4	1	2	1
12	012918	1	1	3	3	0	4	0	0	1		2		1	2	2
13	014893	1	1	2	3	0	4	0	0	6	4	4	5	1	2	1
14	015333	1	1	2	3			0	0	3	2	2	3	1	2	2
15	015338	1	1	3	3	0	1	0	0	3		3	4	1	2	2
16	015247	1	1	1	2	0	6	0	1	1		2	2	1	2	1
17	015301	1	1	2	3	0	4	0	0	1	2	2	2	1	3	1
18	053282	1	1	4	3	0	6	0	0	5	3	3	4	1	1	2
19	014811	1	1	2	3	0	4	0	0	9	3	2	3	1	2	2
20	015252	1	1	3	3	0	4	0	0	7	3	3	3	1	2	1
21	015261	1	1	2	2	0	1	0	0	4		3	3	1	2	2
22	014789	1	1	1	2	0	1	0	0	4	5	5	4	1	2	2
23	052085	1	1	4	3	0	2	0	0	4	5	4	4	1	1	1
24	053255	1	1	4	3	0	2	0	0	4	5	4	4	1	2	1
25	053277	1	1	4	2	0	2	0	0	7		2	2	1	1	1
26	015283	1	1	3	2	0	2	0	0	4		2	3	1	2	1
27	015254	1	1	2	3	0	6	0	0	3		2	2	1	2	1
28	015211	1	1	2	3	0	1	0	0	5	4	4	3	1	2	2
29	015210	1	1	2	3	0	2	0	0	6	3	1	2	1	3	1
30	015218	1	1	4	3	0	4	0	0	6	4	4	4		1	
31	015265	1	1	3	3	0	2	0	0	2		2	3	1		1
32	013449	1	1	3	3	0	4	0	0	2		4	3	1	2	1
33	053259	1	1	4	2	0	2	0	0	4		3	3	1	1	1
34	053276	1	1	3	3	0	2	0	0	2	5	2	2	1	1	1

	Case Number	Exp/Cont	PSTT/Non PSTT	Age	History of Problem	Problem Category		Number of Interviews			Ratings Client	Worker	Independent	Race	Referral	Income
Column	123456	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Desig.		1,2	1,2	1-4	1-3	1-11		1-120			1-5	1-5	1-5	1-3	1-4	1,2
36	052060	1	1	4	2	0	6	0	0	7	4	4	4	1	1	1
37	015297	1	1	1	2	0	1	0	0	2	4	4	4	1	3	1
38	014059	1	1	2	2	0	1	0	0	2	4	4	4	1	]	1
39	053267	1	1	4	1	0	6	0	0	1	5	5	4	1	3	1
40	015226	1	1	2	3	0	1	0	0	6		4	3	1	2	2
41	014015	1	1	3	3	0	1	0	0	2	1	4	3	1	2	2
42	015228	1	1	3	3	0	2	0	0	6	3	3	3	3	2	1
43	050805	1	1	4	3	0	4	0	1	0		3	4	1	4	1
44	015199	1	1	1	3	0	4	0	0	1	4		2	1	2	2
45	015208	1	1	1	2	0	1	0	0	4	4	2	2	1	2	1
46	053275	1	1	4	3	0	1	0	0	7	4	4	4	1	1	2
47	013162	1	1	3	3	0	4	0	0	3	5	3	3	1	3	1
48	053269	1	1	4	3	0	1	0	0	4		2	2	1	4	1
49	015227	1	1	3		0	6	0	0	3	5	4	2	1		1
50	015264	1	1	1	1	0	6	0	0	2	5	5	4	1	2	2
51	015213	1	1	2	2	0	1	0	0	2		2		1		1
52	014264	1	1	2	3	0	1	0	0	7	4	4	4	1	2	1
53	015273	1	1	3		0	4	0	0	7	4	2	3	1	2	1
54	015204	1	1		3	0	1	0	0	5	4	4	3	1	2	1
55	015219	1	1	2	2	0	4	0	0	5		4	4	1	2	2
56	015248	1	1	2	2	0	1	0	0	4		3	3	1	2	1
57	015242	1	1	3	2	0	2	0	0	6	4	4	4	1	2	2
58	043264	1	1	4	3	0	1	0	0	5	4	3	3	1	1	1
59	053260	1	1	4	3	0	4	0	0	4		3		1	4	1
60	015220	1	1		2	0	6	0	0	5		4	4	1	2	1
61	015196	1	1	2	2	0	4	0	0	2		4	5	1	2	2
62	015222	1	1	2	2	0	1	0	0	5	4	4	4	1	4	2
63	053263	1	1	4	3	0	4	0	1	0	4	4	4	1	1	2
64	015207	1	1	3	2	0	2	0	0	4	4	3	3	1	3	2
65	050952	1	1	4	3	0	6	0	1	4	4	3	2	1	1	1
66	014491	1	1	2	3	0	1	0	0	6	3	3	3	1	2	2
67	015292	1	1	2	1	0	3	0	0	3	5	5	4	1	2	2
68	052063	2	1	4	3	0	6	0	0	2		4	3	1	1	1
69	014741	2	1			0	1					3	2	1		1
70	014915	2	1	2	3	0	1	0	0	5	5	4	5	1	2	1
71	053123	2	1	4	2	0	1	0	0	5		4	4	1	1	2
72	050296	2	1		3	0	1	0	0	8	2	4	4	1	1	2
73	051585	2	1	4	3	0	6	1	1	0	4	4	4	1	1	2
74	014785	2	1	2	2	0	6	0	3	2	5	4	5	1	4	1

	Case Number	Exp/Cont	PSTT/Non PSTT	Age	History of Problem	Problem Category		Number of Interviews			Ratings: Client	Worker	Independent	Race	Referral	Income
Column	123456	7	8	9	10	11	12	13	14	15	16	17	18	10	20	21
Desig.		1,2	1,2	1-4	1-3	1-11		1-120			1-5	1-5	1-5	1-3	1-4	1,2
75	051705	2	1	4	3	0	4	0	4	0		5	4	1	2	2
76	052084	2	1	4	3	0	2	0	2	0	4	5	4	1		2
77	050692	2	1		2	0	2	0	0	9	5	4	5	1	1	2
78	050775	2	1	4	3	0	2	0	1	0	4	4	4	1	1	1
79	014890	2	1	2	3	0	1	0	0	9	3	4	3	1	2	1
80	050767	2	1	4	3	0	1	0	0	2	3	3	2	1	1	1
81	014827	2	1	3	3	0	2	0	0	5		3	2	1	3	2
82	014844	2	1	2	3	0	1	0	0	3		2	2	1	2	1
83	014907	2	1	3	3	0	2	0	0	9		2	3	1	3	1
84	053156	2	1	4	3	0	6	0	0	2	2	2	2	1	1	1
85	014782	2	1	3	2	0	2	0	0	5	4	4	4	1	2	2
86	051915	2	3	4	3	0	6	0	0	8		3	2	1	1	2
87	014838	2	1	2	3	0	1	0	0	9	4	4	4	1	2	1
88	053043	2	1	4	3	0	4	0	0	3	3	2	2	1	2	1
89	053075	2	1	4	3	0	4	0	0	4		3	2	1	3	1
90	014885	2	1	3	2	0	2	0	0	8	2	3	2	1	2	2
91	014929	2	1	2	2	0	6	0	0	4		2	4	1	2	2
92	014928	2	1	2	1	0	6	0	0	5		4	3	1	2	2
93	053134	2	1	4	3	0	1	0	0	8	4	4	4	1	1	2
94	051166	2	1	4	3	0	4	0	1	5	4	5	3	1	2	1
95	053125	2	1	4	3	0	6	0	0	5	3	3		1	1	1
96	015169	2	1	2	2	0	4	0	0	2	4	5	3	1	2	2
97	015158	2	1	3	2	0	6	0	0	4	5	5	4	1	2	2
98	015143	2	1	2	3	0	4	0	0	6	3	2	3	1	2	2
99	014992	2	1	2	2	0	6	0	1	0	4	3	3	1	2	1
100	014985	2	1	3	2	0	6	0	0	2		2	2	1	2	2
101	014808	2	1	2	3	0	6	0	2	1	4	3		1	2	2
102	014894	2	1	2	3	0	4	0	0	3	2	3	3	1	3	2
103	014930	2	1	2	3	0	6	0	0	5	3	3	2	1	2	2
104	014350	2	1	2	3	0	6	0	0	2	3	2	3	1	3	1
105	014731	2	1	3	3	0	4	0	0	2	4	3	3	1	2	1
106	014853	2	1	3	3	0	1	0	1	5	4	4	4	1	2	1
107	014860	2	1		3	0	3	0	1	5	4	3	5	1	2	1
108	050834	2	1	4	3	0	4	0	0	2	4	2	3	1	1	1
109	053059	2	1	4	3	0	6	0	2	0	5	3	4	1	1	1
110	053017	2	1	4		0	4	0	1	2	4	3	5	1	1	2
111	053164	2	1	4	2	0	2	0	0	1		2	4	1	1	1
112	053110	2	1	4	3	0	1	0	0	7	4	3	3	3	1	1
113	053109	2	1	4	3	0	2	0	2	0	4	4	3	1	1	2

	Case Number	Exp/Cont	PSTT/Non PSTT	Age	History of Problem	Problem Category		Number of Interviews			Ratings: Client	Ratings: Worker	Ratings: Independent	Race	Referral	Income
Column	123456	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Desig.		1,2	1,2	1-4	1-3	1-11		1-120			1-5	1-5	1-5	1-3	1-4	1,2
114	053135	2	1	4	3	0	2	0	0	4	4	3	3	1	1	1
115	053122	2	1	4	3	0	4	0	1	7	3	4	4	1	1	2
116	014478	2	1	3	3	0	6	0	0	1	4	4	4	1		2
117	013082	2	1	2		0	6	0	0	1	4	3	3	1	2	1
118	015119	2	1	3	2	0	6	0	0	2	2	3	3	1		1
119	015116	2	1	2	3	0	4	0	0	8	3	3	3	1	2	1
120	053041	2	1	4	3	0	4	0	0	3		3	2	1	3	1
121	053096	2	1	4	3	0	1	0	0	3		3	4	1	1	2
122	050788	2	1	4	3	0	1	0	0	5	4	4	4	1	1	1
123	052065	2	1	4	3	0	1	0	1	0		2	2	1	3	1
124	014763	2	1	2	3	0	6	0	1	0	3	4	4	1	4	2
125	015200	2	1	3	3	0	1	0	0	5	4	3	4	1	2	1
126	015185	2	1	2	2	0	6	0	0	5		3	3	1	2	1
127	014817	2	1	2	3	0	4	0	1	7	3	3	3	1	2	2
128	015155	2	1	2	2	0	4	0	0	8		3	3	1	2	2
129	014382	2	1	2	3	0	4	0	0	6	5	3	4	1	2	2
130	05315	2	1	4	3	0	1	0	0	3	3	4	4	1	1	2
131	053174	2	1	4	3	0	1	0	0	3		4	4	1	1	2
132	053121	2	1	4	2	0	1	0	0	7	4	4	4	1	1	1
133	053082	2	1	4	2	0	6	0	1	0	4	4	4	1	3	1
134	053137	2	1	4	3	0	1	0	0	3	4	4	4	1	1	1
135	012354	2	1	3	3	0	6	1	0	0	4	4	4	1	2	2
136	014975	2	1	3	2	0	4	0	1	1	4	4	3	1	3	2
137	014931	2	1	3	3	0	4	0	0	6	4	2	2	1	3	1
138	014120	2	1	3	1	0	6	0	0	1	4	4	4	1	2	2
139	014897	2	1	2	2	0	2	0	0	7	2	3	3	1	4	1
140	014934	2	1	1	2	0	4	0	1	2	4	3	4	1	2	1
141	014917	2	1	2		0	4	0	1	2	0	4	4	1	2	1
142	014953	2	1	1	4	0	2	0	0	9	3	3	4	1	2	1
143	014952	2	1	1	3	0	2	0	0	9	3	3	4	1	2	1
144	014532	2	1	2	3	0	1	0	4	0	4	3	3	1	2	1
145	015157	2	1	3	3	0	4	0	0	5		3	3	1	2	2
146	053026	2	1	4	3	0	1	0	2	1	1	3	3	1	1	1
147	014480	2	1	3	3	0	2	0	1	9	4	4	4	1	2	1
148	014948	2	1	3	3	0	1	0	0	2	5	2	2	1	1	2
149	053112	2	1		3	0	1	0	0	5	4	4		1	1	2
150	053204	2	1			0	1				3	2	2	1	1	1
151	053079	2	1	4	3	0	4	0	0	6	5	4	4	1	1	1
152	053011	2	1	4	3	0	1	0	0	8	3	4	4	1	1	2

	Case Number	Exp/Cont	PSTT/Non PSTT	Age	History of Problem	Problem Category		Number of Interviews			Ratings Client	Worker	Independent	Race	Referral	Income
Column	123456	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Desig.		1,2	1,2	1-4	1-3	1-11		1-120			1-5	1-5	1-5	1-3	1-4	1,2
153	051930	2	1	4	3	0	1	0	1	3		2	2	1	1	1
154	014857	2	1	3	3	0	1	0	1	2	2	3	3	1	2	1
155	014906	2	1	2	1	0	6	0	0	4	5	5	4	1	2	2
156	051971	2	1	4	3	0	6	0	1	6	5	4	4	1	1	2
157	053038	2	1	4		0	1	0	0	5		2	2	1	1	2
158	014863	1	2	2	3	0	1	0	0	4				1		1
159		1	2	1	3	0	5	0	0	1				1	2	1
160	015251	1	2	1		0	4	0	0	7				1		1
161	015267	1	2	1	3	0	6	0	0	5				1		2
162		1	2	3	3	0	9	0	2	1				1		2
163	013463	1	2	3	3	0	1							1		2
164	015308	1	2	2		0	9	0	1	3				1		2
165	015229	1	2	2		0	4	0	0	1				1		2
166	015271	1	2	2	2	0	6	0	0	1				1		1
167	015316	1	2	3	3	0	4	0	0	6				1		2
168	015173	1	2	2	3	0	6							1		1
169	015286	1	2	3	2	1	0	0	1	0				1		1
170	015137	1	2	3	2	0	6	0	0	1				1		1
171	016005	1	2	2	3	0	4	0	0	3				1		2
172		1	2	2	2	0	6	0	0	1				3		1
173	015397	1	2	2	3	0	1	0	0	1				1		1
174	015368	1	2	2	1	0	5	0	0	3				1		1
175	014764	1	2	2	3	0	6							1		1
176	015394	1	2	2		0	6	0	0	7				1		2
177	015374	1	2		3	0	9	0	2	0				1		2
178	015275	1	2	3	2	1	0	0	3	7				1		1
179	015309	1	2	2	3	0	4	0	0	2				1		2
180	015355	1	2	2	3	0	4	0	0	3				1		1
181	015352	1	2	3	2	0	6	0	0	1				1		
182	015377	1	2	2		0	9	0	0	4				1		2
183	013494	1	2	3	3	0	9	0	0	1				1		1
184	015262	1	2	3	3	1	0	0	0	9				1		2
185	015233	1	2	3	3	0	6	0	0	6				1		1
186	015250	1	2	3	3	0	4	0	0	2				1		2
187	015269	1	2	2		0	6	0	0	6				1		2
188	015191	1	2	3	2	0	5	0	1	2				1		1
189		1	2	2	3	0	2	0	0	2				1		1
190	015280	1	2	3		0	4	0	0	1				1		2
191	015313	1	2	1	3	0	6	0	1	3				1		2

	Case Number	Exp/Cont	PSTT/Non PSTT	Age	History of Problem	Problem Category		Number of Interviews			Ratings Client	Ratings Worker	Ratings Independent	Race	Referral	Income
Column	123456	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Desig.		1,2	1,2	1-4	1-3	1-11		1-120			1-5	1-5	1-5	1-3	1-4	1,2
192	015369	1	2	3		1	0	0	0	4				1		2
193	015339	1	2		3	1	1	0	0	9				2		1
194	015315	1	2	2		0	6	0	0	5				1		1
195	015358	1	2	2		0	6	0	0	6				1		2
196	005340	1	2	3		0	8	0	0	3				1		2
197	014780	1	2	2		0	1	0	0	6				1		1
198	015362	1	2	4	2	0	4							1		2
199	015287	1	2	2	2	0	4	0	0	1				1		2
200	013258	1	2	3	2	0	6	0	0	5				1		2
201	014903	1	2	3	1	0	6	0	0	6				1		1
202	014327	1	2	3	1	0	4	0	0	3				1		1
203	015324	1	2	3	3	0	4	0	0	6				1		2
204	015388	1	2	2	2	0	5	0	0	9				1		2
205	015319	1	2	3	3	0	6	0	0	5				1		2
206	015183	1	2	2	2	0	6	0	0	1				1		1
207	015303	1	2	2	3	0	5							1		1
208	015364	1	2	2	3	0	2	0	1	3				1		2
209	013815	1	2	3	3	0	4	0	1	4				1		2
210	015253	1	2	3	3	0	1	0	0	5				2		1
211	015305	1	2	2	3	0	6	0	3	3				1		1
212	015311	1	2	2	3	0	9	0	0	8				1		1
213	015240	1	2	3	3	0	2	0	4	6						2
214	015382	1	2	2	3	0	6	0	1	1				1		1
215	015236	1	2	3	3	0	5	0	0	4				1		2
216	015284	1	2	4	3	0	1	0	0	1				1		1
217	015299	1	2	2	2	0	2	0	1	2				1		1
218	053274	1	2	4	3	0	5	0	0	2				1		2
219	053274	1	2	4	3	0	6	0	0	2				1		1
220	053287	1	2	4	3	0	9	0	0	1				1		1
221	053278	1	2	4	1	0	6	0	1	3				1		1
222	053236	1	2	4	3	0	9	0	0	2				1		1
223	014982	2	2	3	3	1	1	0	0	4		3	3	1	2	1
224	014773	2	2	3	3	0	9	0	2	4	3	4	5	1	2	2
225	053087	2	2	4	2	0	8	0	1	0	5	4	4	1	3	1
226	053144	2	2	4		0	8	0	0	8		3	3	1	1	2
227	053189	2	2	4	2	0	8	0	0	5		4	4	1	4	2
228	053076	2	2	4	3	0	9	0	0	8	5	3	3	1	3	1
229	053008	2	2	4	4	0	9	0	0	7		3	4	3	4	1
230	053131	2	2	4	2	0	8	0	0	9		3	5	1	1	1
231	053199	2	2	4	3	1	1	0	0	3		3	3	1	1	1

	Case Number	Exp/Cont	PSTT/Non PSTT	Age	History of Problem	Problem Category		Number of Interviews			Ratings: Client	Worker	Independent	Race	Referral	Income
Column	123456	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Desig.		1,2	1,2	1-4	1-3	1-11		1-120			1-5	1-5	1-5	1-3	1-4	1,2
232	053197	2	2	4	3	0	9	0	0	4	4	3	4	1	1	1
233	053168	2	1	4	3	1	0	0	0	5		3	4	1	1	2
234	015186	2	2	3	1	0	9	0	0	1	5	4	4	1	3	1
235	014963	2	2	3	2	1	0	0	0	2	3	3	3	1	3	2
236	051580	2	2	4	3	0	9	0	0	1	5	3	2	1	1	1
237	053155	2	2	4		0	9	0	0	3		2	2	1	1	2
238	014936	2	2	3	3	1	0	0	0	9	4	4	4	1	2	2
239	014862	2	2	2	2	0	9	0	0	5		4	3	1	3	1
240	053030	2	2	4		1	1	0	1	0	4	2	2	1	1	1
241	053192	2	2	4	3	1	0	0	0	4		3	3	1	1	1
242	051999	2	2	4	3	1	0	0	5	7	3	4	5	1	1	1
243	053165	2	2	4	3	0	9	0	0	4	4	4	4	1	1	1
244	053153	2	2	4	2	0	9	0	0	1		2	3	1	1	2
245	051770	2	2	4	3	0	9	0	5	0	5	3	4	1	1	1
246	051178	2	2	4	3	0	8	0	0	2	3	2	2	1	1	2
247	014386	2	2	2		0	9	1	0	0	4	4	3	1	3	2
248	014957	2	2	2	2	0	9	0	0	5	4	3	4	1	2	2
249	014803	2	2	2	3	0	9	0	3	7	4	3	4	1	2	1
250	051033	2	2		3	0	9	0	4	0	4	4	4	1	1	1
251	014228	2	2	2	3	0	9	0	4	5	4	4		1	4	1
252	051473	2	2	4	3	0	9	0	7	5	3	3	3	1	3	1
253	053091	2	2	4	3	0	9	0	0	4	3	3	3	1	1	1
254	053057	2	2	3		0	8	0	0	8	5	4	4	1	1	2
255	053021	2	2	4	3	1	1	0	0	6		2	2	1		1
256	014878	2	2	2	2	0	8	0	0	2	4	3	3	1	2	1
257	014848	2	2	3	3	0	8	0	1	2		3	4	1	3	1
258	014876	2	2	2	2	1	1	0	0	4		3	2	1	3	2
259	014956	2	2	3	3	1	1	0	0	2	5	2	2	1	3	1
260	012475	2	2	3	3	1	1	0	0	2		2	2	1	3	1
261	051597	2	2	4	3	1	1	0	7	9	3	4	4	1	2	1
262	050846	2	2	4	3	0	8	1	0	2	4	3	3	1	2	1
263	051046	2	2	4	4	0	9	1	3	5	4	3	4	1	1	1
264	050752	2	2	4	3	0	9	0	1	3	4	4	3	1		1
265	053129	2	2	4	3	0	9	0	1	0	4	4	5	1	1	1
266	051135	2	2	4	3	0	9	0	0	7	3	3	4	1	1	1
267	051912	2	2		3	0	8	0	2	3		4	4	1	1	1
268	014793	2	2	3	3	1	0	0	1	5	4	3	4	1	3	2
269	053194	2	2	4	3	0	8	0	0	3		2	3	1	1	2
270	014944	2	2	3	2	0	9	0	0	3		4	3	1	3	1

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