UNIVERSITY OF CALGARY

Short-term Psychotherapy:

Nonspecific and Specific Therapist Variables that Influence Outcome

by

Brian Guthrie

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF DOCTOR OF PHILOSOPHY

FACULTY OF SOCIAL WORK

CALGARY, ALBERTA

JANUARY, 2000

ABSTRACT

This study examined the influence of the therapist on short-term psychotherapy outcome in relation to a possible interaction between specific and nonspecific variables that would predict a greater variance in level of functioning than the separate entry of each predictor variable. It investigated the emerging consensus in the literature that the specific versus nonspecific distinction seems irrelevant and that to promote the training of technically good therapists in the absence of deeply felt positive responses to the client (nonspecific variables) is a contradiction in terms. It was also based on the premise posited by Orlinsky and Howard (1986) that nonspecific variables likely have a "double barrelled" (p.351) effect compared to specific variables. They proposed that a good relationship not only had a direct impact on outcome through the enhancement of client morale but also was a major precondition for clients' openness to specific therapeutic interventions.

Unfortunately the results of this study, particularly the negative correlation of a number of the predictor variables with client outcome, do not support the emerging consensus in the literature. However, when the total sample was categorized into three level of functioning groups, there was a greater percentage of variance accounted for by an interaction between specific and nonspecific variables for the high level of functioning group.

It is hoped that this study will promote future interest in the influence that therapist's have on short-term psychotherapy outcome and in particular in the investigation of those therapist factors that improve and promote client well-being.

ACKNOWLEDGEMENTS

I am very grateful to my supervisor, Dr. J. R. (Jack) McDonald, for his assistance, guidance and patience while helping me to complete this research. He has a special gift of being able to support and motivate through difficult times.

The time given and suggestions provided by committee members, Dr. Don Collins, Dr. Wilfreda Thurston, Dr. Lary Mosley, and Dr. Nick Coady, are appreciated.

The author wishes to thank those therapists and their clients who were a part of this study.

Finally, special thanks to my wife, Laverne, my friend and partner, I could not have done this without you. To my daughters, Angie, thank-you for your belief in your Dad, and to Amy and Sarah, thank-you for your love which kept me going.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF TABLES

LIST OF TABLES

LIST OF FIGURES

Scientists would be wrong to ignore the fact that theoretical construction is not the only approach to the phenomena of life; another way, that of understanding from within (interpretation) is open to us.... of myself, of my own acts of perception, thought, volition, feeling and doing. I have direct knowledge entirely different from the theoretical knowledge that represents the parallel cerebral processes in symbols. This inner awareness of myself is the basis for the understanding of my fellowmen whom I meet and acknowledge as beings of my own kind, with whom I communicate sometimes so intimately as to share joy and sorrow with them.

H. Weyl, Philosophy of Mathematics and Natural Sciences.

CHAPTER ONE

INTRODUCTION

The current consensus in the field of psychotherapy outcome research is that psychotherapy is generally effective (Consumer Reports, 1995; Lambert & Bergin, 1994; Smith, Glass & Miller, 1980; Stiles, Shapiro & Elliot, 1986). This is supported by the psychotherapy outcome research evidence that indicates that clients who receive any form of psychotherapy improve more than controls observed over the same period of time who have received no psychotherapy (Sloane, Staples, Cristol, Yorkston, & Wipple, 1975). Specifically, this means that psychotherapy is considered superior to both placebo and no treatment control groups and that the average person who undergoes psychotherapy treatment is better off than 80% of those in a control group who receive no treatment (Lambert & Bergin, 1994; Smith, Glass & Miller, 1980). In addition, follow-up studies show consistently that, whatever the form of therapy, most clients who show initial improvement are able to maintain that improvement (Liberman, 1978).

Luborsky, Singer, and Luborsky (1975) conducted a comparative study of all major forms of psychotherapy. They concluded that all forms of psychotherapy studied have demonstrated effectiveness and that no approach to psychotherapy works any better than any other. Despite the

consensus that psychotherapy is generally effective this equal outcomes phenomenon does not adequately explain the factors that contribute to the effectiveness of psychotherapy. A decade later Luborsky, Crits-Christoph, McLellan, Woody, Piper, Liberman, Imber and Pilkonis (1986) updated their original study and further concluded that whatever differences do exist in the various types of treatment, they have little to do with the theory that is applied and everything to do with the therapist.

Statement of the Problem

The importance of the individual therapist in the treatment-outcome equation has not been adequately investigated in the research outcome literature. Therapists have not been considered as separate factors independent of the treatment and therefore have not been analyzed to determine their impact on psychotherapy outcome. Luborsky et al. (1986) reviewed more than 500 studies up to 1985 that compared different forms of psychotherapy with each other and control groups. None of these studies systematically investigated the therapists who carried out the different forms of treatment. As a matter of practice in psychotherapy outcome studies, therapist variables have been standardized, the presumption being that therapists are equal and interchangeable.

Of the research that has been conducted on the influence of the therapist on psychotherapy outcome, there is little consensus on which

therapist variables are predictive of outcome (Beutler, Crago, & Arizmendi, 1986; Orlinsky & Howard, 1986). There are as many assertions that particular therapist variables contribute significantly to outcome as there are counter assertions of a more significant influence on outcome of one variable over another. Beutler, Crago and Arizmendi (1986) and Beutler, Machado, and Neufelt (1994) reviewed studies that investigated therapist variables that influence psychotherapy outcome. Their extensive review evaluated therapist variables in the form of associated effect sizes extracted from the meta-analytic reviews studied. They concluded that the specific variables (the techniques employed in therapy) and the nonspecific variables (the aspects of the relationship between the client and therapist) developed within therapy influence outcome more than therapist cross-situational variables such as demographic characteristics, theoretical orientation, and experience.

Specific variables are generally defined as the therapeutic interventions and techniques that therapists identify as important components of effective therapeutic intervention. Nonspecific variables are generally defined to be factors that promote the therapeutic relationship. The latter are typically attributed to Carl Rogers's (1942/1951) model of facilitative conditions and referred to as the processes of the therapeutic alliance. Nonspecific variables are part of a broader group of variables referred to as common factors (Frank, 1973;

Garfield, 1981; Lambert & Bergin, 1994; Patterson, 1984). In addition to the nonspecific variables that promote the therapeutic relationship, Bergin and Garfield (1994) define general common factors as "the creation of hope, the opportunity for emotional release, explanations and interpretations of one's problems, support, advise, the trying out of new behaviors and the modification of cognition's" (p. 8).

Luborsky et al. (1986) suggested that future research on the treatments performed by experienced therapists might provide more insight about the process of change than the usual between-treatment comparisons. They recommended further research to refine knowledge of the therapist's ability to establish a helping alliance (nonspecific variables) and to adequately apply the appropriate techniques (specific variables).

Purpose of the Study

The purpose of this study is to investigate the influence of the therapist on short-term psychotherapy outcome and to assess the influence of nonspecific and specific therapist variables on the client's level of functioning. Specifically this study investigates:

1. The percentage of variance that nonspecific variables and specific variables independently account for in short-term psychotherapy outcome

(client's level of functioning) compared to the percentage of variance accounted for by an interaction between the variables.

2. If there is an interaction between the nonspecific and specific variables that account for a greater percentage of variance in short-term psychotherapy outcome, is this different between the total sample of cases and cases that are categorized into three level of functioning groups (low/medium/high).

As will be outlined in the literature review therapists are not uniform in their ability to perform psychotherapy. In response to the recommendations by Luborsky et al. (1995/1986) that the therapist factor should be evaluated in all psychotherapy outcome studies, Blatt, Sanislow, Zuroff, and Pilkonis (1996) also sought to identify therapist's variables that influence outcome by comparing therapists at three levels of therapeutic efficacy. They concluded that significant differences existed in therapeutic efficacy among therapists. Moreover, differences in therapeutic efficacy were independent of the type of treatment provided or the research site and not related to the therapist's level of general clinical experience. Their results suggested that therapists variables are important dimensions that appear to influence therapeutic outcome. In addition, they asserted that their findings supported the contention that it is important to differentiate levels of effectiveness among therapists and to

include therapist skills (specific variables) as dimensions in outcome studies.

Rationale for the Study

The focus of the majority of current research on specific and nonspecific therapist variables has attempted to identify which of these variables are the most significant variables contributing to outcome. Wexlar (1974) discouraged continued promotion of this dichotomy, stating that it is doubtful whether the promotion of the therapeutic relationship through the implementation of nonspecific variables alone "...is a particularly useful therapeutic tool to be relied upon." (pp. 95-96). He went on to say that therapists "do indeed do specific things [apply techniques] on a moment to moment basis that have observable effects" (p. 95). Recommendations by Luborsky, Diquer, McLellan & Woody (1995) supported this supposition. They assert that prediction of psychotherapy outcome would probably be enhanced by the addition of specific variables to nonspecific variables that are intended to promote the therapeutic alliance.

Orlinsky and Howard (1986) also believed that the prediction of outcome would probably be enhanced by the addition of specific to nonspecific variables; however, they took the view that relationship variables likely had a "double barreled" (p. 351) effect compared to

specific interventions. They proposed that a good relationship not only had a direct impact on outcome through the enhancement of client morale, but also was a major precondition for clients' openness to specific therapeutic interventions.

Frank (1984a), an early advocate of the investigation of the interactive nature of specific and nonspecific variables, described the techniques of psychotherapy and the client-therapist relationship as continuously interactive and interdependent in the process of effective treatment. He suggested that "it is the combination of the variables in a certain context that seems to be the crucial thing" (1984; p.149).

Strupp (1986) recommended that future research not support the discrimination between technique and the quality of the client-therapist relationship. He shared the same belief as Frank (1984a) and asserted that both are reciprocally interactive. Similarly, Henry et al. (1986) suggested that "to speak of the respective roles of technique versus relationship variables is to participate in a misleading dichotomy" (p. 31).

Almost twenty years following Wexlar's (1974) recommendation to abandon individual investigation and focus on the interaction between these two variables, Greenberg (1994) reiterated that "the alliance is not independent of technique" (p.117), rather a good alliance is characterized by the use of appropriate technical methods.

There is little disagreement between theorists and clinical practitioners on the importance of the therapist in the process of psychotherapy outcome (Frank, 1961; Freud, 1937; Strupp, 1986). However, the specific role that the therapist plays in influencing psychotherapy outcome continues to elude the investigation of researchers. Not only is the therapist a neglected and poorly understood variable (Beutler, Machado & Neufelt, 1994; Frank, 1959; Lambert, 1989; Luborsky, Auerbach, Chanldler, Cohen, & Bachrach, 1971; Luborsky et al.,1986; Luborsky, Diquer, McLellan & Woody, 1995; Najavits & Strupp, 1994), but the therapist variables that are significant in determining psychotherapy outcomes have yet to be identified by empirical research (Beutler, Crago & Arizmendi, 1986; Beutler, Machado & Neufelt, 1994; Gurman & Razin, 1977).

As summarized by Lambert et al. (1986):

> we simply do not know enough yet about the therapist factor to specify when and how it makes a difference, nor when it matters more than the treatment model. What we do know is that there are intriguing possibilities for new discoveries here and that this issue has been ignored to a surprising degree (p.180).

This chapter provided an introduction to the current state of knowledge of psychotherapy outcome and identified the problem to be investigated in this study. Chapter Two presents an overview of the

literature on psychotherapy outcome as well as a comparison to the literature on short-term psychotherapy outcome and a presentation of the model of treatment employed by the therapists in this study. This is followed by a review of the setting for this study, a national Employee Assistance Program, and a review of the therapist variables that are the focus of the investigation of this study. Chapter Three describes the research methodology used including a description of the design of the study. Chapter four presents the results of this investigation. The final chapter discusses the relevant findings and their implications in the area of psychotherapy outcome. The limitations of this study are also discussed as well as recommendations for future study.

CHAPTER TWO

LITERATURE REVIEW

This chapter is divided into four main sections. The first section provides an overview of the literature on psychotherapy outcome and the problems related to research in this area. The second section details the short-term psychotherapy model, the treatment employed by the therapists in the present study, and compares short-term psychotherapy to long-term psychotherapy outcome research. The third section provides an overview of Employee Assistance Programs, the setting of this study, and a description of clinical practice by therapists within this type of mental health service delivery model. The fourth section provides a review of the literature that examines therapist factors and their influence on psychotherapy outcome. Section four also describes the predictor variables (specific and nonspecific therapist variables) and the relevant studies that have investigated their influence on psychotherapy outcome. The chapter concludes with a brief summary of the major themes that emerged from the literature review as well as the potential contribution of the current study to the existing research on therapist variables and their influence on psychotherapy outcome.

Psychotherapy Outcome

Psychotherapy in this study is defined by the definition formulated by Nagy (1995):

> Psychotherapy is conducted by trained and qualified therapists and consists of diagnosing and treating mental disorders. This includes using psychological techniques to help a client or patient to develop and achieve goals, objectives and strategies which will ameliorate problems with behavior, mood, thought processes, or psychosomatic disorders (p.2).

Evolution of Psychotherapy Outcome Research

In 1952, Hans Eysenck threw down the gauntlet to the psychotherapy research community with his assertion that the spontaneous remission of patients' symptoms proves that no evidence exists to support the efficacy of psychotherapy. His study compared the outcome for 7,293 patients who had received eclectic psychotherapy to a control group of 500 patients, diagnosed with psychoneurotic disability, who had not received psychotherapy. The results of the study reported that 64% of the patients who had received psychotherapy showed improvement while 74% of the patients who had not received psychotherapy had improved over a period of two years. Of those 500 patients who had not received

psychotherapy, 90% had improved by the fifth year. Eysenck (1952) concluded that "roughly 2/3 of a group of neurotic patients will recover or improve to a marked extent within two years of the onset of their illness, whether they are treated by means of psychotherapy or not" (p. 321).

By 1978, it became clear that Eysenck's spontaneous remission arguments supporting his conclusion that there is no evidence to support the effectiveness of psychotherapy were false assumptions (Bergin, 1971; Bergin & Lambert, 1978; Kiesler, 1966; Subotnik, 1972). As Lambert et al., (1989) identified in his extensive review of outcome studies, spontaneous remission accounts for approximately 40% of the improvement in psychotherapy outcome, while nonspecific and specific variables account for 45% of the improvement (the remaining 15% is attributed to a placebo effect). Spontaneous remission can be attributed to the client's personality strengths and environmental supports and is often presented as an argument that positive change may occur over time in untreated cases. Howard et al. (1986) have demonstrated that the amount of change and the rate of change in untreated groups are substantially less than those occurring among treated cases. However, what was originally a challenge to the anecdotal claims of psychotherapeutic success and a research call for scientific studies to explore the effectiveness of psychotherapy, became a modern day crusade to find the Holy Grail of

psychotherapy; to prove the efficacy of one model of psychotherapy over another.

Smith and Glass (1980) evaluated a generation of psychotherapy outcome studies that evolved in response to Eysenck's challenge. They reviewed 475 published and unpublished studies. Among these studies were 1,766 comparisons between treatment and control groups. They concluded that there were nonexistent to small differences among psychotherapies. In those instances when two therapies being compared did yield differences in outcome at the termination of therapy the differences were reported to have disappeared over time. Interestingly, closing the gap between two therapies appeared to depend more on the clients who received the less successful therapy catching up than on both groups regressing equally toward the mean (Gelder, Marks & Wolf, 1967; Liberman, 1978). That is, regression toward the mean is the phenomenon where those that scored exceptionally high or low on the first measurement score closer to the mean on the second measure (Kachigan, 1986, p. 270).

Specifically, results of the Smith and Glass (1980) meta-analysis showed that:

> Psychotherapy is beneficial, consistently so and in many different ways. Its benefits are on par with other expensive and ambitious

> interventions, such as schooling and medicine. The benefits of psychotherapy are not permanent, but little is. (p. 183).
>
> Different types of psychotherapy (verbal or behavioral, psychodynamic, client centered, or systematic desensitization) do not produce different types or deeper benefits. (p. 184).
>
> Differences in how psychotherapy is conducted (whether in groups or individually, by experienced or novice therapists, for long or short periods of time, and the likes) make very little difference in how beneficial it is. (pp. 187 - 188).

Two decades after Smith and Glass (1980) first reported that there were nonexistent to small differences among psychotherapies, Wampold, Modin, Stitch, Benson, and Ahn (1997) concluded that their meta-analysis of the available evidence also supported the notion that all psychotherapies are nearly equal in terms of efficacy. It is generally accepted that all psychotherapies yield similar results and that there is little evidence to support claims of superiority of one form of psychotherapy over another (Efran, Lukens & Lukens, 1990; Lambert, 1992; Lambert & Bergin, 1994).

In spite of the general consensus that: (a) psychotherapy is, on average, effective (Consumer Report 1995; Garfield & Bergin, 1986); (b) there are no differences in relative efficacy among psychotherapies (Grisom, 1996; Lambert & Bergin, 1994; Lambert, Shapiro & Bergin,

1986; Orlinsky & Howard, 1986; Robinson, Berman & Neimyer, 1990; Shapiro & Shapiro, 1982), (c) short-term compared to long-term treatment demonstrates no discernible difference in efficacy (Frank, 1973), (d) the length or intensity of treatment has no significant effect on client improvement (Lorr & McNair, 1964) and (e) the expertise and training of therapists demonstrates no evidence of influencing effective psychotherapy outcome (Strupp & Hadley, 1977), many researchers and proponents of particular models of psychotherapy continue to challenge the equivalency of outcomes verdict (Eysenck, 1966/1978; Rachman & Wilson, 1980; Wilson & Rachman, 1983).

Kazdin (1986) speculated that "the absence of treatment differences reflect the true state of affairs" (p. 102), that the various manifestations of therapy are more alike than different and that psychotherapy is more of a single entity than separate and distinct models of therapy. Arguing that psychotherapy is best considered a single entity was suggested as early as 1936 by Saul Rosenzweig. He asserted that the clinical effectiveness of different therapies depended on their commonalties, not on their theoretical differences.

Phillips (1990) addressed the difficulties involved in measuring psychotherapy outcome by pointing out that, of all the variables studied, "...outcome predictions of psychotherapy are unable to account for more than 10 - 20% of the variance" (p.116). Given that there is 80 - 90% of

variance left unaccounted for in the typical psychotherapy outcome study, Phillips (1990) asserted that the evaluation of effective outcome should focus on the active ingredients, that is, the elements and processes of effective therapy within psychotherapy as opposed to between psychotherapies. He reiterated Rosenzweig's 1936 argument for a research focus on the examination of "commonalties" (p. 115) that reside in the conditions of the therapeutic process as opposed to a continued focus on variables internal to the therapist or specific to the theoretical premise of a specific model. He describes the commonalties as the techniques employed by the therapist and the relationship between the therapist and the client (ie, specific and nonspecific variables).

What are the commonalties within psychotherapy? Building on Rosenzweig's assertion, Frank (1973) concluded that features shared by all therapies account for an appreciable amount of the improvement observed in most clients who respond to psychotherapy and posited that a core group of factors was responsible for the uniform outcomes of different treatment models. The shared therapeutic components were identified as:

1. An emotionally charged, confiding relationship with a helping person.
2. A healing setting.

3. A rationale, conceptual scheme, or myth that provides a plausible explanation for the client's symptoms and a prescribed ritual or procedure for resolving them.

4. A ritual that requires active participation of both client and therapist and that is believed by both to be the means of restoring the client's health (Frank, 1973: pp.19-20).

The concept that common factors are responsible for equivalent outcomes between differing psychotherapies was further supported by Strupp and Hadley (1977) and Gomes-Swartz (1978). Their research, based on Frank's observations, defined the shared therapeutic components as specific (techniques) and nonspecific (relationship) variables. As indicated, specific variables are generally defined as the therapeutic interventions and techniques that therapists identify as important components of effective therapeutic outcome. These differ from study to study depending on whether a certain model of psychotherapy is being investigated. Nonspecific variables are generally defined to be factors that promote the therapeutic relationship. The latter are typically attributed to Carl Rogers's (1942/1951) model of facilitative conditions and referred to as the processes of the therapeutic alliance.

Bergin and Garfield (1994) also propose the concept of common factors as a possible explanation for the equivalent outcomes phenomenon of psychotherapy outcome studies. They suggest:

> If two supposedly very different forms of psychotherapy secure outcomes that are quite comparable, one possible explanation is that there may be therapeutic factors operating that are common to both forms of psychotherapy (p. 8).

Lambert and Bergin (1994) reviewed the literature on the influence of common factors on psychotherapy outcome. They discovered that researchers' views range from those who agree with Patterson (1984) that common factors are not only necessary but are sufficient to explain psychotherapy outcome to researchers' who agree with Garfield (1981) and view common factors as important to the process of change but also consider other unique variables as contributing to outcome.

Bergin and Garfield (1994) state that "regardless of the conceptual scheme that is used to organize common factors, it is obvious that emphasizing the study of common factors in addition to specific techniques will encourage greater cooperation and harmony among competing approaches, ultimately increasing the effectiveness of psychotherapy" (p.164). As indicated this study will investigate nonspecific and specific variables.

The following sections will define and describe short-term psychotherapy, the model of treatment employed by the therapists in this study. This will include a description of the concepts, assumptions and similarities across short-term psychotherapy approaches as well as a

comparison of the differentiating characteristics between short-term and long-term psychotherapy. This section will conclude with an outline of the limitations of short-term psychotherapy.

Short-term Psychotherapy

A number of studies on short-term psychotherapy outcome have reinforced the notion that it is the similarities among approaches that contribute to the equal outcome phenomena. For instance, a meta-analysis study on psychotherapy outcome by Smith, Glass and Miller (1980) concluded that short-term psychotherapy, irrespective of the specific model, was highly effective. Results of a later review of the effectiveness of psychotherapy by Lambert & Bergin (1994) reiterated the consensus of equal outcomes among the variety of short-term psychotherapy approaches. Butcher and Koss (1978) suggest it does not make much difference what model of short-term psychotherapy a counsellor follows as all appear to be equally effective.

Empirical research has not only demonstrated the overall effectiveness of short-term psychotherapy (Koss & Butcher, 1986; Koss & Shiang, 1994; Strupp, 1980; Luborsky, Mintz, Auerbach, Christoph, Bachrach, Todd, Johnson, Cohen & O'Brien, 1980), it has also reported on the significant advancements in theory and technique of short-term treatment approaches (Mann, 1973; Malan, 1963; Sifneos, 1972; Strupp &

Binder, 1984). A recent review of research on short-term psychotherapy confirmed that "short-term psychotherapy is viewed as an entity and not merely as an analogue to understanding long-term psychotherapy" (Koss & Shiang, 1994, p. 664).

Budman and Gurman (1988) describe the theory and techniques of current approaches of short-term psychotherapy that include behavioral, crisis intervention, marital and family, group, cognitive and short-term dynamic therapy. A description of the specific models of short-term psychotherapy will not be detailed in this review. The reader is directed to Budman and Gurman (1988) for a thorough discussion of the respective forms of short-term psychotherapy.

Historical Overview

At the beginning of the psychoanalytic movement practitioners believed that psychoanalytic therapeutic interventions could be short-term, concise, and effective. Marmor (1971) described the psychotherapeutic process in the earliest days of the psychoanalytic movement as relatively short-term. He reported that many of Freud's treatments and training analyses were completed in a span of months rather than years. As psychoanalysis evolved, it became more complex and moved towards more extended treatment. Those analysts who disagreed with the move to a longer treatment focus were rejected by

Freud (Eisenstein, 1986). As a result the analytic movement became very orthodox in its adherence to Freud's dictates.

It was not until after Freud's death in 1939 that literature on short-term psychotherapy began to surface. Alexander and French (1946) were the first to publish the ideas and theory of a short-term approach to therapy. This book challenged many of the psychoanalytic dogmas of the time.

It was not, however, until the 1960's that the concept of short-term psychotherapy became generally accepted. With the passing of Kennedy's Community Mental Health Centers Act, mental health services became more accessible to the general population. Agencies and therapists began to experience an increased demand for short-term therapeutic services. To meet practitioners' demands for more efficient ways to meet the service needs of their clients a number of therapists published books on short-term psychotherapy. These early authors included Malan (1963), Sifneos (1972), and Mann (1973), who presented short-term psychotherapy from a psychoanalytic perspective, and Haley (1963) who published the short-term practice techniques and philosophies of Milton Erikson.

More and more therapists began to implement short-term psychotherapy strategies and concepts into their practices. Erich Lindemann (1976) experimented with short-term psychotherapy principles in the development of his crisis intervention model. As an outcome of his

experience with the families of the victims of the Coconut Grove night club fire, Lindemann described his short-term psychiatric intervention as consisting of 8-10 sessions.

The trend toward acceptance and promotion of a short-term psychotherapy approach has continued in direct relation to increasing health care costs and decreasing government funding. This is more obvious in the United States where Health Maintenance Organizations (HMOs) have strictly limited the number of mental health sessions provided to its members. These restrictions have placed increased pressure on therapists to become more effective in less time. In addition, consumers have become more informed and active in advocating for briefer, less costly and more efficient therapies.

Concepts and Methods

Although there is no clear definition of short-term psychotherapy across practitioners and approaches, there are commonalties in the process of short-term psychotherapy and essential characteristics of short-term psychotherapy. Short-term psychotherapy may generally be defined as a counselling process in which time is an intentional aspect of treatment planning given that specific time limits are established at the outset of treatment (Budman & Gurman, 1988). This process is typically characterized by the following:

1. Time is restricted or rationed.

2. The focus of therapeutic effort is identified and maintained.

3. Tasks are employed both within and outside the session to stimulate change (Wells & Giannetti, 1990).

Treatment Assumptions

The treatment assumptions across short-term psychotherapy approaches are considered essential characteristics to promote the process of therapeutic change. These assumptions, which are summarized in Table 1, provide an overview of the model of short-term psychotherapy utilized by the therapists in the current study and are elaborated on below:

1. The presenting problem is the focus of intervention.

In short-term psychotherapy, the therapist views the presenting problem as a source of motivation for client change. Short-term therapists typically engage clients in the present and inquire: "What do you hope to accomplish by seeking therapy at this time?". Improvement in the presenting problem is considered to be an index of the client's progress. Change in the presenting problem is assessed by inquiring from session to session "What is different (in the symptom) now compared to last session?". Focusing on the presenting problem and what is identified as requiring change reframes the client's experience as one of accomplishment rather than dysfunction.

Table 1

Short-term Psychotherapy Assumptions

THERAPY ASSUMPTION	THERAPY TASK	THERAPY PROCESS
The presenting problem is the focus of intervention	Therapist and client identify presenting problem	Therapist takes action stance and is directive providing a specific focus for therapeutic interventions
Problems and solutions exist within the client's point of view and patterns of interaction.	Therapist takes active role and focuses on present and future patterns and actions	Therapist is directive by challenging and confronting the client on patterns of interaction and beliefs that contribute or maintain the problem
The focus of short-term interventions is to facilitate a change in perspective or response.	Intervention is prescribed outside of the therapy session.	Client responds by taking active charge of change process.
The clients presentation determines the direction of the therapeutic intervention.	Therapist joins client to understand client's frame of reference.	Goals emphasize the change process.
The client is capable and there are forces within the individual that strive towards health.	Client expected to act on interventions prescribed.	Client and therapist are partners in the change process.

Table 1 continued

Table 1

Short-term Psychotherapy Assumptions

THERAPY ASSUMPTION	THERAPY TASK	THERAPY PROCESS
Termination is predicted from the beginning of therapy.	Mutually agreed to by client and therapist	Success is measured by the decrease in symptoms or emotional distress.

Compiled from (Wells and Giannetti, 1990)

2. Problems and solutions exist within the client's point of view and patterns of interaction.

The short-term therapist believes that the client's problems are created and maintained by his/her perceptions and behaviors, that is, problems are considered to be the result of the client's problem maintaining behavior. Clients are viewed as either doing the same behavior, but expecting different results or as failing to recognize that attempted solutions perpetuate the problem or generate new problems. The focus of short-term psychotherapy interventions is on interrupting the client's problem maintaining pattern of behavior.

3. The focus of short-term interventions is to facilitate a change in perspective or response.

Short-term therapists believe that, as an outcome of the appropriate intervention, the client will cease to perceive that the problem is the

problem or cease to engage in the behavior that perpetuates the problem. Small changes are considered empowering.

4. The client's presentation determines the direction of the therapeutic intervention.

Short-term therapists view the origin of client problems as an outcome of relationships. The therapist joins with the client to understand the client's frame of reference and what the client has attempted as possible solutions to the problem. The goal of interventions is to interrupt the behavior that is maintaining the problem and to enable the client to experience behavior that alleviates the emotional distress or typical reaction to the presenting problem.

5. The client is capable and there are forces within the individual that strive towards health.

Short-term therapists focus on the client's strengths. They consider the client to be an equal partner in the therapeutic relationship, in the formulation of treatment goals and in the development of the treatment plan. Therefore the client is expected to act on the interventions prescribed.

6. Termination is predicted from the beginning of therapy.

The therapist and client monitor progress on an ongoing basis, from session to session, and success is determined mutually by a decrease in the frequency and duration of the symptoms and the degree of emotional

distress. This allows the therapist and client to predict the length and frequency of treatment.

Focusing on the presenting problem and the client's identified goal of change ensures that the process of the therapy session is task oriented. As indicated above, any change in the presenting problem that alleviates distress is reframed as a client's success in achieving their goal. In order to support this process the therapist needs to:

1. Join with the client to communicate the expectations of change.
2. Clearly define the problem to be resolved.
3. Identify which behaviors and beliefs maintain the problem.
4. Implement appropriate strategies to precipitate the change process (Budman, 1981).

Similarities In Short-term Psychotherapy Approaches

Research studies on short-term psychotherapy indicate that the divergent schools of thought may be more similar than different in their actual clinical practice (Budman & Gurman, 1988; Garfield, 1989; Koss & Butcher, 1986; Steenbarger, 1992). The similarities underlying the various short-term psychotherapy approaches have been identified as a common dialectical change structure (Steenbarger, 1992; Tracey & Ray, 1984). That is, there is a common conceptualization and implementation of the therapeutic process. This process of reasoning across short-term

psychotherapy approaches is based on:

1. A rapid formation of rapport and alliance.

2. Challenges to the client's understanding of patterns of symptomatology.

3.Consolidation and generalization of the client's positive shifts in perspective and action (Koss & Shiang, 1994).

Koss and Butcher (1986) and Steenbarger (1992), in their reviews of short-term psychotherapy, comment on the similarities in the therapist's role across approaches. Short-term therapists are described as taking an active role that promotes the rapid formation of rapport and a therapeutic alliance. The therapist focuses on an immediate assessment of problems and strengths presented by the client. Once the problem has been identified the therapist initiates interpretations and confronts the client's understanding of the patterns of symptomatology to challenge the client's view of the problem and its solution. The short-term therapist typically assigns homework exercises in an attempt to mobilize the client's efforts at adaptation and positive problem-solving.

Client expectations of therapy is another commonality across short-term psychotherapy approaches. There is anecdotal evidence that clients, more so than therapists, expect effective therapy to be time-limited and planned (Pekarik & Wierzbicki, 1986). Some clients have indicated that even a single interview was enough to help them adopt a different

perspective on the problem and generate new ways of dealing with the problem (Talmon, 1990).

Differentiating Characteristics Between Short-term and Long-term Psychotherapy

Most authors who evaluate and investigate short-term psychotherapy highlight the therapeutic focus as the difference between short-term psychotherapy and traditional long-term therapy. Short-term psychotherapy is described as being a rapid collection of information and a rapid development of rapport. In contrast, traditional long-term therapy seeks to uncover a detailed account of the client's history through the slow development of the relationship and a gradual movement toward 'indepth' personal change.

This difference in the concept of time consciousness between short-term and long-term treatment is a major theme outlined by a number of researchers (Burlington & Fuhriman, 1987; Gelso & Johnson, 1983; Steenbarger, 1992). More specifically, it is the establishment of a treatment focus in relation to the number of sessions or length of time that is the primary differentiating factor between short-term psychotherapy and traditional long-term therapy (Fuhriman, Paul, & Burlingame, 1986; Steenbarger, 1992). In short-term psychotherapy, time is considered a treatment planning parameter for the therapist with the purpose of catalyzing the change process. Koss and Shiang (1994) reviewed the

clinical literature on brief (short-term) psychotherapy and reported that it consistently identifies a 25 session contract as the upper limit of brief treatment.

The duration of therapy has been one of the more contentious issues in the debate between long-term and short-term therapists. A number of studies claim that long-term therapy is more beneficial in resolving clients problems than the short-term psychotherapy approaches. Luborsky et al. (1971) reviewed 22 long-term psychotherapy studies and reported that in 20 of the studies "the length of treatment was found to be positively related to outcome [and that] the longer the duration of treatment or the more sessions, the better the outcome" (p.154). Similarly, Orlinsky and Howard (1986) reported that out of 114 long-term psychotherapy studies they reviewed 74 of these studies revealed a significantly positive correlation between length of therapy and outcome. They concluded that "the evidence rather consistently indicates that patients who have more therapy get more benefit from it" (p. 361). On the other hand the research of Reid and Epstein (1977) challenges these claims reporting that no specific number of sessions or interviews works best. There is, however, a significant amount of empirical evidence (Smith, Glass & Miller, 1980) which demonstrates that clients improve most significantly within the first eight sessions and that this improvement begins to taper off after ten sessions.

A review of the literature on the outcome of psychotherapy (Garfield & Bergin, 1978, 1986; Bergin, 1971; Bergin & Lambert, 1978; Lambert, Shapiro & Bergin, 1986; Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971; Orlinsky & Howard, 1986) not only revealed evidence of the efficacy of psychotherapy but also showed that, in fact, most therapy is short-term in nature. Furthermore, the data from the two most recognized meta-analyses of psychotherapy outcome (Shapiro & Shapiro, 1983; Smith, Glass & Miller, 1980) was compiled from the investigation of therapy lasting between 7 and 17 sessions. Historically, it is reported that the typical therapy patient received fewer than 10 sessions (Rubenstein & Lorr, 1956).

Even psychodynamic therapy, generally considered to be a long-term insight oriented approach to therapy, has adopted a short-term psychotherapy approach. The various models of short-term psychodynamic therapy described by Mann (1973), Malan (1963), Sifneos (1972), and Strupp and Binder (1984) generally depict therapy as lasting from 8 to 26 sessions (Flegenheimer, 1982; Pinkerton, 1986). In a review of data from psychotherapy outcome studies between 1948 and 1970, Garfield (1989) discovered that the majority of clients discontinued therapy before 20 sessions. He also found that the median number of sessions, in most clinical settings studied, was between 5 and 6 sessions.

Imber, Nash, Hoehn-Saric, Stone and Frank (1968) surveyed psychiatric practices in both the private and public sectors. They found that psychiatrists in private practice saw patients for 12.8 visits and that practitioner nurses in community mental health settings saw patients for 10.3 sessions. The median number of visits for all mental health disorders treated in outpatient psychiatric services in the United States "have been found to be 3.7 sessions" (Pardes & Pinkus, 1981, p.15). In a similar study of private psychology clinics, the median number of sessions was 8, with 80% of the clients discontinuing treatment before the 20th session (Levene, Berger & Patterson, 1972).

Budman and Gurman (1988) summarized the debate over what constitutes short-term as opposed to long-term psychotherapy by commenting that, with the exclusion of psychoanalytic therapy, the majority of outcome research has involved therapy of relatively short duration. They have suggested that the studies of psychotherapy traditionally identified as long-term are actually evaluations of unplanned time unlimited short-term psychotherapy (Budman & Gurman, 1988) and described the therapeutic process as unplanned short-term psychotherapy "by default" (p. 417). They found that although time limits were not established in the beginning of long-term therapy, the outcome still resulted in a relatively short time frame and number of sessions. Steenbarger (1992) addresses this apparent anomaly by arguing that the

major difference between long-term and short-term therapy is that short-term psychotherapy represents an intentional acceleration of the change producing ingredients found in all therapies.

Another theme differentiating long-term and short-term therapy is the issue of client inclusion. The majority of researchers take the position that short-term psychotherapy is not seen as appropriate for all clients or concerns (Budman & Gurman, 1988; Koss & Butcher, 1986; Steenbarger, 1992). The profile of a candidate for short-term psychotherapy is someone who has problems that are relatively circumscribed or of recent onset and expectable at the current developmental phase. Clients are deemed candidates for short-term psychotherapy if they have a history of successful interpersonal functioning and are considered capable of forming a relatively rapid therapeutic alliance.

Research out of the Penn Therapy Research Project (Luborsky, Mintz & Christoph, 1979) reinforced the belief that short-term psychotherapy is not effective for everyone, particularly individuals with more serious emotional problems. Luborsky et al. (1979) found that clients who were rated higher by clinical observers on an adequacy of functioning assessment did slightly better in short-term psychotherapy than those clients who were rated lower on the adequacy of functioning assessment. Similarly, Rounsaville, Weisman, and Prusoff (1981) indicated that clients who were judged to be more emotionally healthy

were likely to show greater improvement than clients experiencing greater emotional distress. However, Gelso et al. (1983), in an outcome study of time-limited therapy, did not find any supporting evidence that the therapist's initial assessment of client functioning had any influence on success in short-term psychotherapy. Nonetheless, he supported the common belief that certain clients were not amenable to success in short-term psychotherapy and suggested that "tested initial adjustment" (level of emotional functioning) may predict success or failure in time-limited therapy (p.111).

The caveat on certain clients participating in short-term psychotherapy continues to be supported in the research literature despite any evidence of research on clients that dropped out of short-term psychotherapy or, for that matter, clients that were excluded from short-term psychotherapy because of an assessed diagnosis deemed inappropriate for short-term psychotherapy. Anecdotal clinical practice evidence and the proliferation of literature on clinical case examples indicates that short-term psychotherapy has achieved wide spread acceptance as the treatment of choice for many of life's serious emotional problems, exclusive of the client's level of functioning.

It is easy to understand how conflicting reports on outcome, when taken in isolation, can contribute to the debate that long-term therapy is more effective than short-term psychotherapy and vice versa. The more

therapy the better may be 'optimal' but until research addresses the issue of how much time is not enough and how much time is too much, therapists may continue to gravitate towards the existing research that substantiates and validates their own values and beliefs.

Defining Short-term Psychotherapy

Results from the studies reviewed on the effectiveness of short-term psychotherapy as compared to long-term therapy have concluded that one approach is as effective as the other. However, the studies provide conflicting information on the definition of what constitutes 'short-term' in short-term psychotherapy. For example, short-term psychotherapy is defined and described as ranging from one session (Bloom, 1981) to upwards of 50 sessions (Malan, 1963; Sifneos, 1972). These authors argue that the uniqueness of client characteristics, therapist characteristics and treatment characteristics allows for the necessity of being flexible in the allocation of therapeutic time. However, Budman and Gurman (1983) assert that "merely tabulating hours spent in clinical contact does not offer an adequate index of whether therapy is short-term" (p. 277).

Each respective model of short-term psychotherapy promotes what it believes constitutes a short-term number of sessions and/or the length of time. However, none of the approaches address the issue of what constitutes a session or how the specified number of sessions can be

distributed and still be regarded as short-term psychotherapy. For example, if sessions are longer than the traditional period of 50 minutes to an hour, is the therapy still considered short-term psychotherapy; likewise, is 6 sessions over 18 months considered short-term psychotherapy? The lack of a clear definition makes it difficult to apply the findings to practice settings.

Budman and Gurman (1988) have attempted to clarify this conceptual dilemma. They assert, as practitioners, that "what in fact is being examined in any discussion of short-term treatment is therapy in which the time allotted to treatment is rationed" (p. 278). The goal of short-term psychotherapy is to assist the client to achieve maximum benefit with the lowest investment of therapist time and client cost, both financially and psychologically. Budman and Gurman (1983) propose that short-term psychotherapy might be more accurately described as "time sensitive, time effective or cost effective therapy" (p. 277).

One criticism that may continue to instill skepticism about the efficacy of short-term psychotherapy is that there is little evidence from the research studies reviewed of significant follow-up. Critics argue that there is little evidence to determine if psychological change was consolidated and maintained. Future research on short-term psychotherapy may need to address the issues of which techniques and strategies increase the durability of therapeutic change. In addition, there is no evidence that

the therapy did not resume following the completion of the study. If therapy did resume, it is perhaps not so short-term after all.

A major limitation of the studies reviewed was the lack of controlled outcome research with random assignment of subjects. The future directions of research need to include controlled studies with random assignment that address specifically the length of time and the number of sessions in which therapy can be deemed to be most efficient. In developing improved forms of research into the efficacy of short-term psychotherapy, future research should focus on the long-term benefits of short-term treatment.

The next section of the literature review will describe and define Employee Assistance Programs (EAPs) which constituted the setting for this study. The evolution of EAPs to a mental health service delivery system that focuses on short-term psychotherapy is also presented.

Employee Assistance Programs

There has been significant growth in Employee Assistance Programs (EAPs) during the past twenty-five years. Anecdotal references in the literature estimate that in 1970 were was approximately 400 Employee Assistance Programs in the United States (Busch, 1981; Dickman & Emener, 1982; Dickman, Emener & Hutchison,1985; Land, 1981; Roman, 1981; Sonneustuhl & O'Donnell, 1980). Roman (1982) reported that

surveys of U.S. companies from 1972 to 1979 found that the number of U.S. companies that have Employee Assistance Programs increased from 25% in 1972 to 56% in 1979. Some estimates put the number of U.S. companies with Employee Assistance Programs at as many as ten thousand (Blum & Roman, 1985). This rapid period of growth has promoted the involvement of professionals from a number of disciplines. To meet the demand for increased services, Employee Assistance Programs have begun to solicit the expertise and skills of professionals other than the traditional choice. In particular, alcohol and drug counsellors have become a large part of EAP programs (Jerrell & Rightmyer, 1985).

Discussion in the literature agrees on the prediction of continued growth within the employee assistance industry, but there is no consensus on what constitutes an Employee Assistance Program. The trend is to label any industrial or organizational program that addresses the mental health of an employee an Employee Assistance Program or Employee and Family Assistance Program (EFAP). Existing programs possess a wide variety of organizational structures ranging from assessment and referral to programs that offer short-term psychotherapy. Employee Assistance Programs can be either internal (in house) programs or external programs with or without enhanced wellness programs. Despite this lack of consistency in the definition of the organizational structure of these programs each one shares a common purpose: preventing, identifying and

treating personal problems that adversely affect the employee and his/her job performance.

In order to understand the evolution of Employee Assistance Programs into a mental health delivery system providing short-term psychotherapy a brief history of Employee Assistance Programs follows.

History and Philosophy

Employee Assistance Programs have their roots in Occupational Mental Health and Industrial Alcoholism. At the beginning of the 20th century a number of companies began to offer assistance to employees out of management's desire to balance humanitarianism with the demands for productivity (Ames,1989; Roman 1988; Sonnenstuhl,1986; Steele,1988; Staudenmeier,1985; Trice & Beyer, 1984).

These early experiments were conducted by industrialists who promoted the Social Betterment Movement (Brandes, 1970), which provided a number of social welfare services to workers. These ranged from inexpensive housing to medical care and in some cases, education. By the mid 1930s the Social Betterment Movement had died out due to the Depression, forcing companies to cutback on many operations and subsequently dispensing with the existing social welfare services.

As the Depression Era came to an end, companies began to experiment with providing personal counselling to employees modeled on

the work of Ethan Mayo (1923) and his experiments at Western Electric's Hawthorne plant (Roethlisberger & Dickson, 1939). The belief of the time, that was promoted by Mayo, was that the irrational sentiments of employees prevented them from cooperating with management and caused union sanctioned strikes and slowdowns in production. Based on Mayo's principles management reasoned that demonstrating concern for employees increased their moral and thereby improved productivity.

The next major model of employee counselling to evolve was the Occupational Mental Health movement. This is considered the precursor to EAPs and surfaced as an outcome of WW II conscripting the available labor pool which was largely untrained and inexperienced (Carter, 1977). To compensate for this Government hired on-site Occupational Mental Health workers in an attempt to improve the work environment to improve moral and thereby improve productivity. They emphasized treatment for emotionally impaired employees either through self-referral or management's encouragement.

Shortly after the end of WW II the majority of companies abandoned this commitment to the employee's emotional well-being (Mumm & Spiegal,1962) and provided no or minimal resources to Occupational Health programs. Occupation Health programs that did survive were typically government sponsored. Ferguson and Fersing (1965) chronicle this period during the 1950's and 1960's as a legacy of

neglect.

As health care costs escalated and productivity declined during the 1970's and 1980's companies sought solutions from the Occupational Health field. This resulted in the re-emergence of prevention programs in the form of Wellness and Health Promotion programs. These programs, like their predecessors, were characterized by attempts to improve the work environment by teaching healthy behaviours and promoting healthy environments, thereby promoting productivity.

The term Employee Assistance Program is credited to the NIAAA (National Institute of Alcohol Abuse and Alcoholism) which was established in 1971. This organization believed that alcoholism was the most prevalent personal problem of employees and that the work place was the most effective place to identify, motivate and provide for the treatment of alcoholics. The NIAAA employed Occupational Program Consultants (OPC's) many of whom were Social Workers and Psychologists trained in traditional mental health counselling. Their role was to promote Employee Assistance Programs to the American work force.

A review of the literature on Employee Assistance Programs shows that the services they offer have expanded from a focus on alcohol and drug problems to a focus on intrapersonal and interpersonal issues that may impact not only a worker's performance but his/her family

functioning (Kurtz, Googins & Howard, 1984). The primary service that Employee Assistance Programs currently provide is short-term psychotherapy to assist employees and their family members in emotional distress.

The following section examines the research on the influence of the therapist on psychotherapy outcome. This will include an examination of the typical therapist variables that have been examined in the outcome literature.

Therapist Influence on Psychotherapy Outcome

In the classic psychotherapy training film 'Gloria' (Shatrom, 1965), future therapists watch a young woman interviewed on the same day by Albert Ellis, Fritz Perls, and Carl Rogers. The purpose of this training exercise was to demonstrate the differences in the theoretical orientations of the three master therapists, each of whom developed the model of psychotherapy they were demonstrating. Gloria, however, found each therapist to be effective, albeit in their own unique way.

As indicated, the decision of researchers to compare the effects of treatments and not the effects of therapists has been influenced by a number of assumptions. One assumption is that experienced therapists are roughly equivalent in their performance and therefore interchangeable. Kiesler (1966) referred to this as the "uniformity myth" (p.112). In fact,

in the majority of psychotherapy outcome studies, clients are randomly assigned as a device to try to equalize the characteristics of each therapist's caseload.

Najavits and Strupp (1994) identified two additional assumptions that they credit as responsible for the lack of empirical research to identify therapist factors that might contribute substantially to outcome. The first common assumption, referred to as the "assumption of averages" (p. 115), is the tendency of the majority of psychotherapy research to focus on the mean scores across therapists. This strategy has attempted to identify therapeutic activities believed beneficial to the therapy process, but has resulted in hiding any identifiable behavior that could be associated with how the therapist influences therapy.

The second common assumption is referred to as "the influence of therapist demographics on psychotherapy outcome" (p. 115). These include such variables as age, sex, years of experience and theoretical orientation. Contrary to the belief that these variables are predictive of outcome, the meta-analyses of psychotherapy outcome studies have concluded that therapist demographic data do not relate to outcome (Berman & Norton, 1985; Hattie, Sharpley & Rogers, 1984; Lambert, Shapiro & Bergin, 1986).

The influence of the therapist on psychotherapy outcome was examined in 1974 by Ricks who labeled the more effective of two

therapists studied as "supershrink" and the less effective therapist as "subshrink" (p. 285). Although limited as a study because of the retrospective use of case notes, Ricks found that the more successful therapist was distinctly different in a number of characteristics. These were identified as greater support of the patient's autonomy, use of resources outside therapy and a better relationship with the patient's parents. Ricks attributed the effectiveness of "supershrink" to his use of both the technical skill of therapy and the ability to establish an interpersonal relationship with the client. In contrast, "subshrink" was described as distant and uninterested in a relationship with his client and/or his client's family. A number of other researchers (Frank, 1973; Strupp, Hadley, 1977; Gomes-Swartz, 1978) supported Ricks observation that use of both the technical skill of therapy and the ability to establish an interpersonal relationship seemed associated with an effective outcome.

Historically, the influence of professional therapists on psychotherapy outcome has been challenged by the assumption that anyone who possesses empathy and concern for another individual can be as effective as a trained therapist. The Vanderbilt Project that began in the early 1970's, investigated this assumption by attempting to determine differences in outcome between clients treated by professional therapists and untrained college professors.

This study comprised a sample of 30 male college students selected based on a diagnosis of depression or symptoms of anxiety disorder. The professional therapist group consisted of five experienced therapists. These therapists treated 15 (three each) patients in individualized treatment for up to 25 hours. The five members of the college professors group were assigned a comparable group of patients.

The sample of college professors had a reputation of being warm, understanding and empathetic and had no formal training in psychotherapy. They formed the group who employed only the nonspecific variables. As indicated this group's performance was compared to a group of professional therapists who employed both the specific and nonspecific variables. The results of the study indicated that the patients undergoing psychotherapy with the college professors showed, "on average, quantitatively as much improvement as patients treated by a professional psychotherapists" (pp. 1134-1135). The group results failed to prove the hypothesis that the professional therapist group would achieve superior treatment outcomes.

Despite a number of stated cautions about the results of the study by the authors (Strupp & Hadley, 1977), the Vanderbilt I Study (as it has became known) has been frequently cited to support the argument that professional training and expertise in psychotherapy are unrelated to treatment outcomes and that the technical skills of the therapists are,

therefore, expendable (Dawes, 1994). As Strupp (1998) asserts, nearly 20 years later, the Vanderbilt I Study was undertaken to explore the nature of the psychotherapeutic experience "not impugn psychotherapy or denigrate its practitioners" (p.18), in that it has sometimes been used to bolster the argument that therapists are not effective.

In retrospect he acknowledged that the Vanderbilt I Study had several design flaws. The major error was assuming that the selected college professors would not employ specific skills. This group was composed of mature professionals who had a high level of interpersonal skills over and above their reputation of being warm and empathetic. The likelihood of them not utilizing those skills in the study was nonexistent. A second error was the assumption that the professional therapists would provide both sets of factors, the nonspecific and the specific variables. The study measured the specific variables therapists employed but assumed that the therapists would also incorporate the nonspecific variables. In addition, the professional therapists had no training in the time limited-short-term psychotherapy model they were expected to execute. Although the hypothesis of the Vanderbilt I that specific and nonspecific variables are independent of the psychotherapy treatment process (ie, not necessary for change to occur) , Strupp and Hadley (1977) did demonstrate that specific and nonspecific variables have an influence on psychotherapy outcome albeit not dramatically different from college

professors. Strupp's (1998) clarification of the Vanderbilt I Study results has dispelled the belief that lay counsellors are as effective as professional therapists.

An additional myth perpetuated by the equal outcome conclusion of psychotherapy research is the belief that psychotherapy is generally effective and that all clients benefit from their experience in psychotherapy. Similar to Ricks (1974) discovery that not all therapists are universally effective Lambert, Shapiro and Bergin (1986), in a meta-analysis on the topic of negative effects, concluded that approximately 9% -11% of clients actually worsen in treatment.

Orlinsky and Howard (1980) also studied the influence of the therapist on psychotherapy outcome by reviewing case notes. In a retrospective study of 150 women they discovered that, out of 23 therapists, six therapists demonstrated beneficial results with at least 70% of their clients with no negative effects. Five therapists studied demonstrated beneficial results with less than 50% of the clients with a 10% rate of negative effects. However, the retrospective examination of case notes limits the applicability of the data and the ability to generalize this outcome to therapists in the general population.

Additional evidence that not every client benefits from psychotherapy was brought forward by Garfield and Bergin (1986). In examining length of stay in treatment, they discovered that many clients

leave treatment before the therapist would expect or predict. Approximately 50% of therapists' clients depart before the eighth session. Sledge et al. (1990) found a 32% - 67% rate of attrition in their study of time-limited psychodynamic therapy. Miller, Taylor and West (1980) in an investigation comparing focused versus broad-spectrum behavior therapy for problem drinkers discovered that there was a 75% to 100% range of success rates between the nine therapists in the study.

In an attempt to discover the variables that promote more effective therapy, Lafferty, Beutler and Crago (1989) studied 30 trainee therapists who treated a total of 60 clients. In this study the identified low effective therapists showed less empathy and valued comfort, stimulation, and intellectual goals less than did the high effective therapists.

More recently, Najavits and Strupp (1994) investigated the influence of the therapist in relation to psychotherapy outcome. The main goal of this process-outcome study was to assess the therapist's effectiveness in short-term psychodynamic therapy by measuring therapist in-session behavior. Najavits found that therapists were not uniform in their ability to perform psychotherapy and that effective therapists displayed more positive behaviors, fewer negative behaviors and more self-criticism than less effective therapists. This study was limited in methodology given the post-hoc design.

In response to the recommendations by Luborsky et al. (1995/1986) that the therapist factor should be evaluated in all psychotherapy outcome studies, Blatt, Sanislow, Zuroff, and Pilkonis (1996) reanalyzed the data from the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (TDCRP) originally published by Elkin et al. (1989). The TDCRP is considered to be a comprehensive, well designed and carefully conducted multi-site randomized trial. The TDCRP evaluated several forms of short-term (16-27 sessions) outpatient treatments for depression. It compared the relative efficacy of four treatment conditions and the effects of patient characteristics on outcome. The study discovered only modest differences in therapeutic outcome among the three short-term treatments for depression (the fourth treatment condition was pharmacology).

The goal of Blatt and his colleagues, in reanalyzing the data of the TDCRP, was to identify the characteristics of more effective therapists. Although the outcome of this reanalysis was consistent with prior research (Crits-Christoph, 1992; Crits-Christoph & Mintz, 1991; Luborsky et al., 1986; Miller & Berman, 1983; Smith et al., 1980; Stiles, Shapiro & Elliott, 1986), that is, that all psychotherapies yield similar results, they found that the outcome of the original TDCRP appeared to be more related to differences among patients and therapists than types of treatment.

Blatt et al. (1996) also sought to identify characteristics of more effective therapists by comparing therapists at three levels of therapeutic efficacy. They concluded that significant differences existed in therapeutic efficacy among therapists. Moreover, differences in therapeutic efficacy were independent of the type of treatment provided or the research site and not related to the therapist's level of general clinical experience. More specifically, they found that the more effective therapists in this study had more of a psychological rather than a biological orientation, while the less effective therapists reported that they used psychotherapy in combination with medication. The results suggested that the skills of therapists are important dimensions that appear to influence therapeutic outcome. In addition, they asserted that their findings supported the contention that it is important to differentiate levels of effectiveness among therapists and to include therapist skills as dimensions in outcome studies.

The conclusion of Blatt et al. (1996) supported Strupp's (1986) earlier arguments that there are specific therapeutic skills, founded in verifiable theories and principles, which serve to promote resolution of the clients' symptoms and promote an improvement in mental health. Strupp (1986) clearly believed that "the ability to forge a positive working alliance, make accurate interpretations and act in a plan-compatible fashion, involves skills that reside in individuals, not in a

body of therapy" (p. 514). They expressed hope that as research begins to focus more on the characteristics of successful therapeutic interventions, that investigations will promote the characteristics of those who deliver them.

To date, efforts to identify the therapist's variables that account for observed systematic variations in case outcome have often been unproductive. Despite the clinical and theoretical emphasis on the importance of the therapist to psychotherapy outcome, there is no clear empirical evidence that therapist variables contribute substantially to outcome (Beutler, Crago & Arizmini, 1986).

Therapist Variables

The majority of research investigating the influence of therapist variables on psychotherapy outcome has focused on global variables, such as the therapist's demographic characteristics. The typical variables that have been studied include age, sex, experience, theoretical orientation, and personal and psychological characteristics of the therapist. However research in this area has been inconclusive and contradictory.

Alexander, Barton, Schiavo and Parsons (1976) concluded that some demographic characteristics of the therapist, particularly sex and age, have been shown to make differences in the therapeutic process. However, Parloff, Waskow, and Wolfe (1978), in their review of the research on

therapist variables, found no evidence to suggest that sex, race or age influences outcome. They concluded that only a few therapist characteristics appear related to the outcome of therapy. They cited the therapist's psychological well-being and the matching of client and therapist on cognitive dimensions as promising variables to investigate further. Research has yet to confirm that these variables contribute significantly to psychotherapy outcome.

Smith, Glass and Miller (1980) found no evidence to indicate that specific theoretical orientations result in better outcome. However, as Beutler et al. (1994) concluded, the relationship between theoretical orientation and actual therapy procedures is still sufficiently uncertain as to make it difficult to extract the effects of therapist orientation. In their opinion, it is premature to draw firm conclusions regarding the effects of theoretical orientations.

A number of literature reviews have suggested that there is little effect on psychotherapy outcome from either experience or level of training (Auerbach & Johnson, 1977; Beutler et al., 1986; Stein & Lambert, 1984). In contrast, other studies (Baekeland & Lundwell, 1975; Luborsky, Auerbach, Chandler, Cohen & Bachrach, 1971) have concluded that effective outcome is most often associated with experienced therapists. There appears to be little disagreement that therapist experience with a particular treatment model is an important component to

the therapy process; however, the degree of experience and how it influences the outcome of treatment remains controversial.

Beutler et al. (1994) in their review of research on therapist variables, concluded that a limited number of therapists qualities can be identified as influencing outcome. They reviewed the following studies which investigated the following variables and reported that at best they have a moderate effect on outcome: (a) cognitive level (Holloway & Wampold, 1986), (b) capacity to establish a therapeutic alliance (Horvath & Symonds, 1991), (c) a background in short-term therapy (Lyons & Woods, 1991; Miller & Berman, 1983), (d) professional background (ie, designated degree and qualifications, for example, registration in professional association) (Smith, Glass & Miller, 1980; Stein & Lambert, 1984), (e) a lack of directiveness in treatment (Scartberg & Stiles, 1991), (f) the therapists psychological health and skill and interest in helping patients (Luborsky, McLellan, Woody, O'Brien & Auerbach, 1985), (g) the degree to which the therapist adhered to the treatment manual, and (h) the degree to which the patient (in the third session) reported the therapist as being helpful (Blatt, Zuroff, Quinlin & Pilkonis, 1996). Beutler et al., (1994) reported that these variables were correlated positively with the client's outcome but did not achieve statistical significance. The common design error contributing to lack of statistical significance was the small sample size of the studies reviewed.

A recurrent research dilemma and methodological problems have led researchers to abandon continued focus on demographic variables as the significant contributors to therapeutic change. These include: (a) the inability to resolve the inherent methodological problems of these studies, (b) the lack of standardized outcome measures across studies that would promote replication, (c) the consistent use of small sample size, and (d) the use of trainees as therapists and volunteers as clients. In response to this stalemate, Luborsky et al. (1995) reiterated their earlier conclusion that despite the limited number of therapist's qualities that can be identified as influencing treatment outcome the "frequency and the size of the therapists effects generally overshadowed any differences between different forms of treatment" (1986, pp. 509-510).

Nonspecific Variables

Carl Rogers (1951) hypothesized that there are common factors within the psychotherapy relationship such as empathy, unconditional positive regard and genuineness that promote therapeutic change. He believed that the therapist created these "facilitative" conditions and that they were "necessary and sufficient" components of psychotherapy change. Early research investigations of Rogers' hypothesis that common relationship factors may be responsible for therapeutic change across treatment modalities generated a great deal of research interest. However,

more recent research on Rogers's facilitative conditions has cast doubt on their generalizability to other modes of psychotherapy (Parloff, Waskow, & Wolfe, 1978). Despite continued challenges to the hypothesis that nonspecific variables contribute to outcome, it continues to be generally accepted that the factors associated with the therapeutic relationship (respect, empathy, warmth and commitment) are important to the process of change (Lambert, Shapiro & Bergin, 1986). Due to the strong clinical consensus, researchers continue to recommend further investigation of the components of nonspecific variables that may contribute to therapy outcome.

Recent studies (Svartberg & Stiles, 1994; Gaston, Marmar, Gallagher & Thompson, 1991) that have investigated the therapeutic relationship and client outcome have shown a significant association. A meta-analysis of therapeutic relationship studies by Horvath and Symonds (1991) confirmed that the therapeutic relationship is consistently a powerful predictor of psychotherapy outcome.

The early studies on therapeutic relationship (Gomes-Schwartz, 1978; Marziali, 1984; O'Malley, Suh, & Strupp 1983) focused on the clients contribution to the therapeutic relationship. In these studies, the characteristics of the client that surfaced as significant were identified as the client being open, trusting and nondefensive. More recent studies have focused on the therapist's contribution to the therapeutic relationship

(Luborsky et al., 1986; Rounsaville, Chevron, Prusoff, Elkin, Imber, Sotsky, & Watkins, 1987; Windholz & Silberschatz, 1988). In these studies the therapist's contribution was identified as warmth, positive emotional involvement, and the lack of negative attitudes.

The majority of the studies examining therapeutic relationship reached their conclusions from the perspective of either the client, the therapist or an external evaluator. Only a few studies that examined the therapeutic relationship have incorporated multiple perspectives. Marziali (1984) found significant agreement across client, therapist and judge ratings in three of the four subscales used as measures in that particular study. A subsequent study by Tichenor and Hill (1989) challenged Marziali's (1984) outcome and suggested that there may not be a significant relationship between client, therapist and clinical judge perspectives on relationship. The difference in reported outcome between these studies may be due to the different methods used to measure relationship variables. In addition, given that the studies incorporated a small sample of cases, the results should be interpreted cautiously.

What the studies on therapeutic relationship have highlighted is the importance of the therapist-client relationship to the outcome of psychotherapy. Along with this they recommend that future research focus on the task of identifying nonspecific therapist variables that consistently either positively or negatively impact psychotherapy outcome.

Specific Variables

Specific variables are generally defined as therapeutic interventions or techniques that therapists from the respective schools of psychotherapy consider as important components of effective psychotherapy outcome. Not only do the respective schools espouse a specific theory of therapy that conceptualizes therapeutic change, each school of psychotherapy promotes their own battery of techniques that they consider paramount in influencing the human change process. Orlinsky and Howard (1986) define therapeutic interventions as "acts that include what is generally thought of as the techniques of psychotherapy, that is, the specific tasks and procedures presented by the therapist in response to the manifest problems presented by the patient" (p.33).

Currently, research evidence supporting specific variables as contributors to outcome report that specific variables account for approximately 15% of the variance in explained outcome (Orlinsky & Howard, 1986). In addition specific variables are reported as contributing less significantly than nonspecific variables which account for approximately 30% (Lambert, 1989). One explanation for the significant difference in the percentage of variance explained by these variables is that the methodology employed in the research studies examining therapist techniques was much too global in nature (Jones, Cummings &

Horowitz, 1988). That is, the instruments used lacked the sensitivity to measure the effect techniques actually have on outcome.

The most common therapeutic interventions investigated to determine their relationship to psychotherapy outcome have been: (a) interpretation, (b) confrontation, (c) exploration and questioning, (d) support and encouragement, (e) advice, (f) reflection, and (g) self-disclosure (Olinsky & Howard, 1986).

Therapist interventions involve strategies to develop the emotional state and psychological strategies that can promote change or assist the client bring about change in themselves and their life situations. Orlinsky, Grawe and Park (1994) identify these change principles as defined by Ambuhl and Grawe (1988) as , strengthening the alliance, furthering reflective abstraction, deepening emotional processing and enhancing adaptive skills (p.296). They recommend that the design of outcome research control for the effects of these process variables and to focus on the interaction effects with other outcome variables.

Coady (1991) investigated the association between complex types of therapist interventions and psychotherapy outcome by comparing five individual therapy cases with good outcomes to four with poor outcomes. This study examined four sets of variables as potential predictors of psychotherapy outcome: (a) therapist-response modes, (b) the affiliation or disaffiliation of therapist communications, (c) therapist focus on the

therapist-client relationship, and (d) therapist focus on client affect. Results demonstrated that therapists with poor outcome exhibited significantly more dissaffiliative communications and significantly more disaffiliative interpretive communications that did not focus on the therapist-client relationship or client affect. As in the majority of studies examining the influence of specific variables on psychotherapy outcome (Hill, Carter, & O'Farrell, 1983; Foreman & Murmar, 1985; Henry, Schact, & Strupp1986; Orlinsky & Howard, 1986) this study's small sample size and the lack of design to test the rival hypothesis limited the establishment of significant group differences.

Apart from the recommendations in the psychotherapy outcome literature to focus on specific and nonspecific variables, the literature has also offered some direction with respect to the manner in which these variables are examined. For instance, Strupp (1986) has argued that in continuing to pursue the dichotomy of specific versus nonspecific variables researchers are pursuing a blind alley. He has cautioned against assuming that nonspecific variables alone are the prerequisite and impetus for change believing this fuels the mistaken belief that any caring empathic individual can function in a therapeutic role without receiving training in psychotherapy. As Strupp (1986) asserts, to accept the conclusion that nonspecific factors are the common ingredient across psychotherapy models responsible for therapeutic change because they

appear more significant than specific factors is an error. He further states that defining which variables are more important in explaining psychotherapy outcome should not be a process of choosing the logical alternative. Given that the therapist's attributes that promote the therapeutic relationship and their technical skills that promote change are clearly the warp and woof of the tapestry of psychotherapy, it would seem that little can be gained by further attempts to separate out the relative effects of specific versus nonspecific factors.

Summary

As indicated, Lambert (1989) identified the percentage of variance accounted for in psychotherapy outcome studies by the typical variables being investigated by researchers of the time. He calculated that 'spontaneous remission' accounted for 40% while an additional 15% of reported change resulted from placebo effects. Of the remaining 45%, 30% of the client's improvement was attributed to the nonspecific therapeutic factors such as trust, empathy, insight, and warmth while only 15% of the client's overall improvement could be attributed to any specific variables.

This review of the research literature concerning the contribution of the therapist to outcome in psychotherapy reveals the dearth of empirical research. The limited number of studies investigating the role of the

therapist in psychotherapy outcome have serious methodological problems. Existing research has relied on retrospective examination of case notes or on self-report data from therapists about their practice. None of the studies have incorporated adequate control groups. The majority of the studies also employed outcome measures that were too global and lacked the sensitivity to assess the change process in therapy. Moreover, the studies evaluated outcome from only one perspective though it has been recommended that several perspectives are preferable (Kazdin, 1986).

All of the studies' samples were chosen by strict selection and rejection criteria and were comprised of groups that were too small to establish sufficient power to declare any significance to the findings. Small sample sizes and the selection of candidates gives rise to potential bias. For example, clients chosen may be either more amenable to the therapy employed in the study or less disturbed than the general population that access psychotherapy. As Wright, Gabriel and Hamowitz (1961) have asserted, if studies include more disturbed clients, the results are more powerful because the study involves a less restricted range of clients.

To date previous studies of the therapists' role in psychotherapy outcome have been limited in methodology in that they either utilized case notes, self report data, trainees as therapists or single measure

outcomes. All previous studies were of a retrospective design with small sample sizes comprised of therapists highly restricted in their range of theoretical orientations and clients who were typically screened for participation in the study. The current study is an attempt to extend beyond previous research in a number of important aspects. It employed outcome data that used the perspectives of both the client and the therapist and multiple outcome measures. This study was also multi-site. Participants included experienced therapists from a variety of orientations and training and clients presenting with a variety of problems. It is a study based on unscreened, unselected Employee Assistance clients in a variety of 'natural' EAP locations.

This second chapter outlined the research on psychotherapy outcome, typically referred to as long term psychotherapy, and short-term psychotherapy outcome, the model of treatment employed in this study. A description of Employee Assistance Programs was provided, and the relevance of this service delivery model to the provision of short-term mental health services was discussed. Finally, an overview of the research related to the variables chosen for this study was presented. Chapter Three focuses on the methodology developed to study the influence of nonspecific and specific therapist variables on short-term psychotherapy as found in a multi-centered Employee Assistance Program.

CHAPTER THREE

METHODOLOGY

This chapter presents the research questions and hypotheses that formed the focus of this study and the steps that were followed to address them. Subsequent sections will outline the research design, the setting, the sample and a description of the instruments used to gather the data. In addition the methods of data collection are described together with the procedures used in analysis. Ethical considerations specific to the study are summarized at the end of the chapter.

Research Question and Hypotheses

This research study investigated the influence of the therapist on short-term psychotherapy outcome by analyzing the relationship between the two sets of independent variables, nonspecific and specific, and the dependent variable, client's level of functioning, that is, case outcome (Figure 1). The goal of this study was to determine the percentage of variance accounted for by nonspecific and specific variables as predictor variables (X) on the criterion variable (Y), level of client functioning (case outcome). The purpose of this research was to determine the relative

Figure 1: The Operationalization and Conceptualization of the Criterion and Predictor Variables

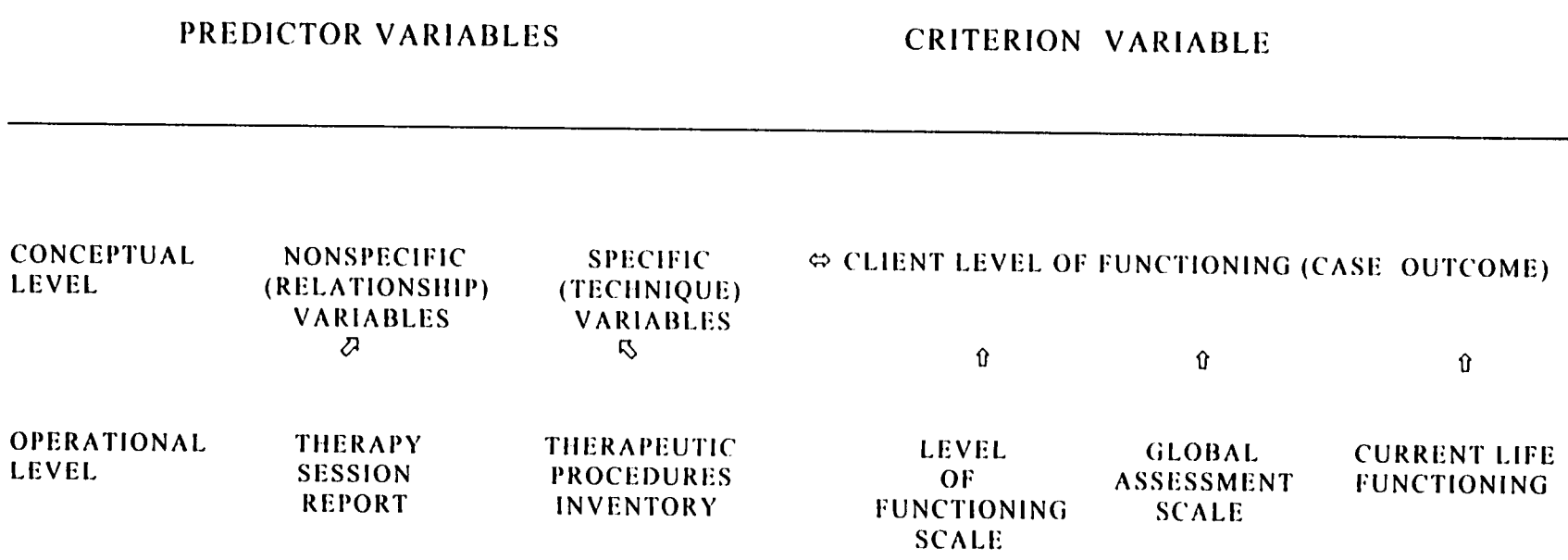


FIGURE 1. Conceptual and operational levels of the predictor and criterion variables. Adapted from Karloy, (1985). Measurement strategies in health psychology, John Wiley and sons, Inc.

relationship of the predictor variables to the criterion variable and to develop a prediction equation that would enable one to determine the effect that the therapist variables, specific and nonspecific, would have on case outcome.

The terms predictor variables, to designate the independent variables, and criterion variables, to designate the dependent variables, are used in this study. As in this study, when the independent variables are not manipulated by the researcher and there is no control over the assignment of subjects to levels of the dependent variable, the distinction between independent variables and dependent variables is usually arbitrary. Tabachnick and Fidell (1996) suggest that, in this case, it is preferable to call independent variables predictors and dependent variables criterion variables.

This study addressed the following research questions:

1. Is there a difference in the percentage of variance that nonspecific variables and specific variables independently account for in case outcome compared to the percentage of variance accounted for when the predictor variables are combined?

2. Is there a difference in the percentage of variance accounted for by specific and nonspecific variables in level of functioning when cases are categorized into three level of functioning groups (low/medium/high) compared to the total sample?

In view of the literature outlined in the previous chapter the following research hypotheses were formulated:

Research Hypotheses

1. There is a difference in the percentage of variance accounted for in level of functioning when nonspecific variables and specific variables are measured independently compared to when they are measured together.

2. There is a difference in the percentage of variance accounted for by specific and nonspecific variables in level of functioning when cases are categorized into three level of functioning groups (low/medium/high) compared to the total sample.

These hypotheses were tested using a .05 level (two-tailed) of statistical significance. The .05 level of statistical significance was selected for this study as researchers have traditionally regarded this as an acceptable level at which to reject the null hypothesis (Gravetter & Wallnau, 1992; Kazdin, 1992; Reid & Smith 1989; Rubin & Babbie, 1989; Wechsler, Reinherz & Dobbin, 1981; Weinbach & Grinnell, 1991,1996). In addition, although there is some expectation, based on the literature, that the results will be in a specific direction, a two-tailed test was chosen since the direction of the relationship could not confidently be predicted; nor was the researcher interested only in those outcomes that fell in one direction (Weinbach & Grinnell, 1996). Moreover, a two-tailed test is recommended even in research situations where there is a definite

directional hypothesis (Gravetter & Wallnau, 1992; Rubin & Babbie, 1989).

Research Design

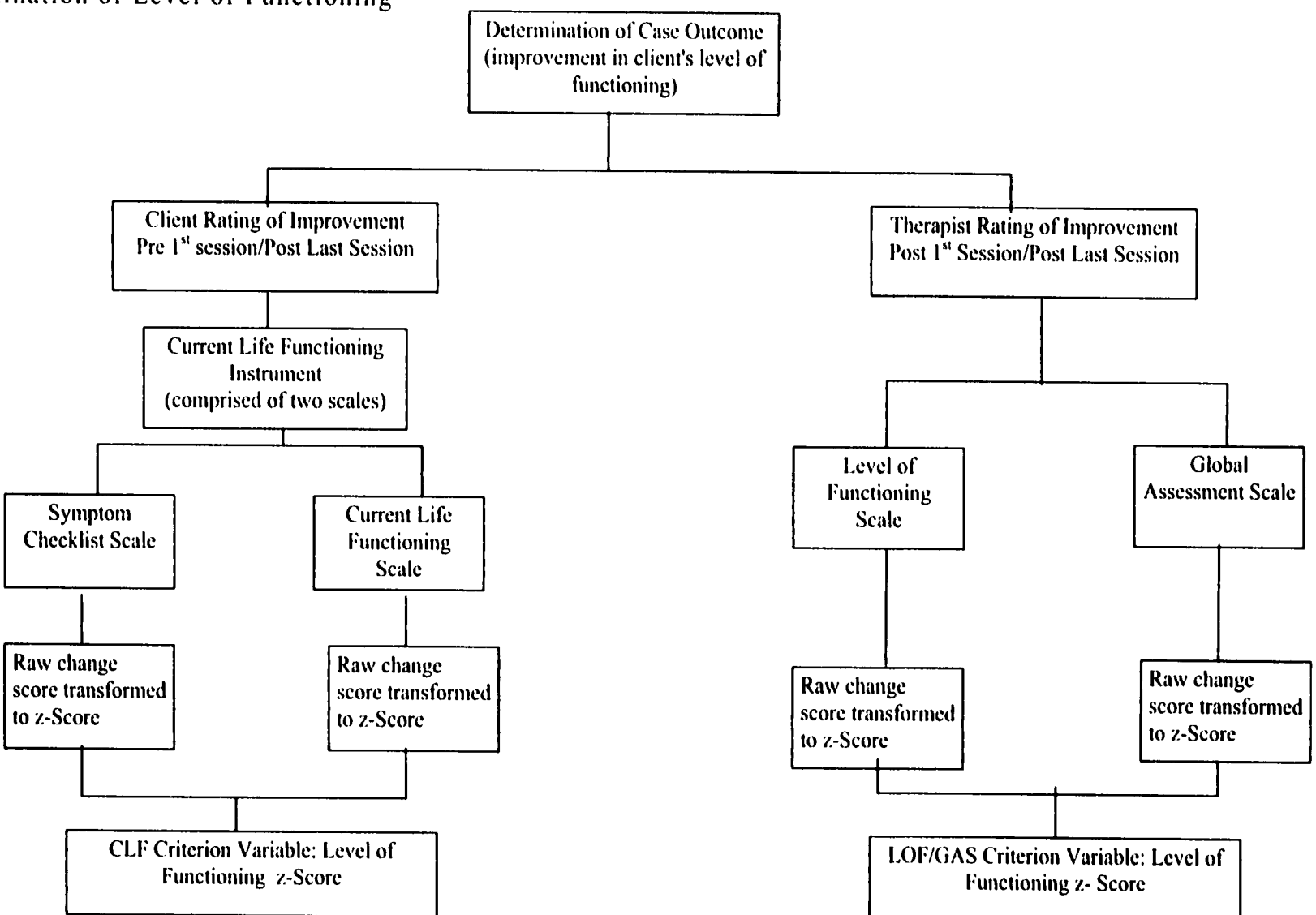
This study employed a correlational (passive-observational) research design. It should be noted that Cook and Campbell (1979) have criticized the general use of the term correlational research as it mixes a type of data analysis (correlational) with a type of design (nonmanipulation of predictor variables). They recommend that a better name for this type of design would be a Passive-Observational Study. Kazdin (1992) concurs that this term is more appropriate than calling a study a correlation design, since a study employing correlational design actually "emphasizes the fact that the [researcher] does not intervene, manipulate, and control the intervention of interest" (p. 76).

This design allows for the study of a single group of subjects where several different variables are measured for each subject and where the researcher can explore the relationship between the variables (Lehman, 1991). Passive-Observational research is chosen when a study is not intended to establish a causal connection between the criterion and predictor variables, but rather when it is trying to determine if there is a relationship, as in the current study (Figure 1).

Although the overall research design used to address the stated research questions was a correlational research design, the study

Figure 2: Criterion Variable:

Determination of Level of Functioning



also incorporated other designs within this framework. The study involved two stages. The first stage involved the identification and definition of the criterion variable (client's level of functioning). This was calculated from pre (prior to the assessment session) and post treatment tests completed by the client and from pre (following the assessment) and post treatment tests completed by the therapist (Figure 2). These measures of the criterion variable involved incorporating a one-group pretest-posttest design into the overall passive-observational design of the study. The transformed case outcome z-Scores were then used to divide the sample of cases into the three groups of level of functioning (low/medium/high) which were then analyzed in addition to the total sample as stage two of this study.

The second stage, the multiple regression analyses of the data, involved a with-in subjects procedure where the single group of subjects received each of the predictor variables. In addition, this stage involved a comparison of the influence of the predictor variables on level of functioning for the total sample as well as for the three level of functioning groups.

Setting

The study was conducted with the co-operation of a national Employee Assistance Program (EAP) provider whose service delivery

model is defined as a comprehensive EAP. Masi (1994) provides the following definition of comprehensive EAPs:

> An employee assistance program (EAP) is a professional assessment, referral, and/or short-term counselling service offered to employees with alcohol, drug, or mental health problems that may be affecting their jobs. Employees are either self-referred or referred by supervisors. EAP services also include childcare, eldercare, critical incident stress debriefing, and wellness education. Eligible clients often include the employee's family members (p. 13).

Since this is a national program, the research study was multi-site involving therapists and their clients from locations across Canada (Vancouver, Edmonton, Calgary, Toronto, Scarborough, Missisauga, Cambridge, Sarnia, Hamilton, Whitby, London, Ottawa, and Montreal).

An Employee Assistance Program setting was chosen for three reasons. First, as outlined in the literature review, EAPs have evolved into a major mental health service delivery model on the same level as public nonprofit and government services. In spite of this there are few studies that have investigated the provision of psychotherapy in this environment (Dasher, 1989). This study's setting afforded an opportunity to pursue the investigation of the provision of psychotherapy in a relatively unexplored area.

Second, the model of therapy employed in this particular EAP program is short-term psychotherapy; a focus of this present study. As described in the literature review and as is practiced in this EAP, therapists and clients mutually identify short-term treatment goals and develop a time limited treatment plan. The average number of sessions per case in this particular EAP is 4.5.

Third, the majority of investigations into psychotherapy outcome and previous attempts to study therapist variables that influence outcome have been conducted in University clinics with student therapists and student clients. In addition, the client groups in these studies were typically screened for participation in the program based on single diagnosis criteria and minimal severity of the presenting problem. An EAP setting provided access to experienced therapists who provide treatment to clients from the general population of individuals who voluntarily access private mental health services. That is, access to the EAP by the client is voluntary and determined by an identified self-need. In this particular program clients access a centralized 1-800 number and identify the presenting problem after which they are referred to an EAP counsellor in their locale. There is no screening criteria based on presenting problems that prohibits access to the program and all clients are seen by the EAP counsellor they were assigned to. As indicated above, the investigation of psychotherapy and the variables that influence outcome with this population is clearly limited in the literature, therefore

this study's setting affords an opportunity to pursue the investigation of the provision of psychotherapy in this relatively unexplored area.

Sample

Therapists of the identified national EAP were invited by the researcher to participate in this study. All therapists of the EAP have a minimum of a Masters degree in the field of clinical counselling, five years post graduate clinical counselling experience, registration and/or certification with their respective professional associations and are either in the process of or are eligible to write the CEAP certification (Certified Employee Assistance Professional).

Anonymity and confidentiality were guaranteed by the researcher as outlined in the Therapist Consent Form (Appendix A) and in a memo from the CEO of the EAP (Appendix B). Therapists who agreed to participate in the study were fully briefed on the research procedures in order to answer questions about the purpose of the research and the process involved either by themselves or their clients. The therapists were then requested to invite their clients to participate in the study.

Clients of the EAP were approached by their therapists with an invitation to participate in the study. Anonymity and confidentiality were guaranteed as outlined in the Client Consent Form (Appendix C). Clients were comprised of employees and their families of the companies serviced by this particular EAP.

Data Collection

Data collection took place over the period of one year, from March 1997 to March 1998. The data collected for this study was analyzed in two stages. The first stage was the determination of the degree of criterion variable client's level of functioning. This involved collecting data from both the client's and the therapist's perspective pretreatment and post treatment. The resultant case outcome scores were then utilized to divide the total sample of cases into the three level of functioning groups.

Stage two focused on the multiple regression analyses of the specific and nonspecific variables to determine the relative significance each variable had on the criterion variable. Therapists and clients completed their respective measures separately following the completion of the last therapy session. Both client and therapist instruments were sealed in a self-addressed envelope forwarded to the researcher. Table 2 provides a summary of the data collection instruments.

Data Collection Instruments

This section describes the two sets of data collection instruments. The level of functioning measures are described first followed by a discussion of the data collection instruments employed to measure the predictor variables.

Table 2

CRITERION VARIABLE (LEVEL OF FUNCTIONING) MEASURES

Measure	Variables	Rater	Administered	Group
Current Life Functioning	Level of Functioning (case Outcome)	Client	Pre (assessment), Post (last) Session	Total Sample
Level of Functioning Scale	Level of Functioning (case Outcome)	Therapist	Pre (treatment), Post (last) Session	Total Sample
Global Assessment Scale	Level of Functioning (case Outcome)	Therapist	Pre (treatment), Post (last) Session	Total Sample

Table 2 continued

Table 2

PREDICTOR VARIABLES (NONSPECIFIC/SPECIFIC) MEASURES

Measure	Variables	Rater	Administered	Group
Nonspecific Variables				
Therapy Session Report	Working Alliance	Client	Post (last) Session	Total Sample, Group 1,2,3
	Empathic Resonance	Client		
	Mutual Affirmation	Client		
	Openness	Client		
	Encouragement	Client		
	Therapeutic Relationship	Therapist		
Specific Variables				
Therapeutic Procedures Inventory	Directive-Behavioral	Therapist	Post (last) Session	Total Sample, Group 1,2,3
	Psychodynamic/Past-Focused	Therapist		
	Affective	Therapist		

Criterion Variable Measures

The level of functioning measures utilized were designed to provide data from the vantage points delineated by Strupp and Hadley (1977). These include outcomes from the perspective of the:

1. *Individual client*, as measured by pre-treatment and post-treatment differences in their level of functioning from the *Current Life Functioning* instrument.
2. *Therapist*, as measured by the pre-treatment (following the assessment) and post-treatment differences in client level of functioning on the *Level of Functioning Scale* and the *Global Assessment Scale.*

Level of functioning was measured by this comparative approach as the CLF client measure and the LOF/GAS therapist measure were not significantly correlated. The CLF scales, current symptoms and current life functioning, were significantly correlated. The LOF/GAS scales were also significantly correlated.

Current Life Functioning.

The instrument used to determine the level of functioning from the client's perspective was Current Life Functioning (Appendix D). The Current Life Functioning instrument is comprised of two outcome measure scales (Current Symptoms and Current Life Functioning) and a presenting problem list. The presenting problem list was used as a descriptive

measure and not as an outcome measure. Clients' were asked to rate on a five point scale the extent to which each of 23 problems is a reason for seeking treatment and at post treatment how much each of the 23 problems improved.

The two outcome scales measured the criterion variable (level of functioning):

1) ***Current Symptoms Scale*** (Symptom checklist scale which measures symptomatic distress adapted from Symptom Checklist-90R, Derogatis, 1977) where subjects are asked to rate how often they have had of each experiences in the last month. This scale employs a 5-point fixed response format. Based on a sample of 160 patients at the intake stage the Current Symptoms scale had an internal consistency of .94. Test-retest correlation's were computed over a three-four week period from registration to the second session of psychotherapy. The test-retest reliability for the total score was .85 (N=53).

2. ***Current Life Functioning Scale*** which measures the degree of interference that the client's presenting problem has on his/her current life functioning. In the Current Life Functioning Scale (CLF) the subject is asked to report the degree to which his/her emotional and psychological problems are interfering with functioning in six life areas. The intent of the scale is to assess the extent of disability caused by the patient's emotional and psychological condition. Based on a sample of 70 patients

prior to treatment, the internal consistency (alpha) of the total score of the CFL was .93. The three to four week (from registration to the second therapy session) test-retest correlation was .76 (N=48).

Level of Functioning Scale.

The first instrument employed to determine the level of functioning from the therapist's perception was the Level of Functioning Scale (Appendix E). The Level of Functioning Scale (Carter & Newan, 1980) is an anchored rating scale of current functioning. The therapist is asked to rate (on a 0-9 point scale) the subjects ability to function autonomously in the community using the areas of physical functioning, interpersonal relationships, social role performance, and psychological signs and symptoms. Intercorrelations (N=1521) of ratings of the four domains ranged from .36 to .67. The sum of the rating for the four life areas had an internal consistency of .86 (N=1287) and a test-retest (two to three week interval, rated by different clinicians at each point) correlation of .77 (N=81).

Global Assessment Scale.

The second instrument employed to determine the level of functioning from the therapist's perception was the Global Assessment Scale (Appendix F). The Global Assessment Scale (Endicott, Spitzer,

Fleiss, & Cohen, 1976) is an anchored rating scale of overall severity of psychiatric disturbance. This scale is a rating of the subject's lowest level of current functioning using a hypothetical continuum of mental health-illness. The scale consists of ten 10-point intervals, which correspond to a description of the subject's general functioning, on an overall 1-100 rating continuum with 100 representing superior status. The therapist is asked to categorize the patient into one of these intervals by providing a specific numerical rating within the range. For example, if the therapist believes the subject belongs in the lowest interval (1-10) he/she must indicate where in that range the subject falls (1, 4, 7, etc.). Endicott et al. (1976) conducted five studies resulting in test-retest reliabilities ranging from .69 to .91. Clark and Friedman (1983) found the GAS test-retest reliability ranged from .74 to .78, decreasing as the length of time between tests increased.

Predictor Variable Measures

Nonspecific Variables /Therapy Session Report.

The Therapy Session Report [Client self-report (Appendix G)] is a 147 item-structured response instrument assessing the clients' experience of the therapeutic bond (therapeutic alliance, empathic resonance and mutual affirmation) as well as openness and encouragement. Clients' in

this study completed the questionnaire following the last psychotherapy session. It is intended to take approximately 10-15 minutes to complete.

The identified nonspecific variables measured by this instrument's scales include and are defined as:

*1. **Working Alliance**.* The investment of the self into the appropriate role by each participant.

*2. **Empathic Resonance**.* The quality of communication between the therapist and the client that depends on their compatibility in range and style of expressiveness and understanding.

*3. **Mutual Affirmation**.* The care, respect and commitment to the other person's welfare that the therapist and client may evoke or feel for the other.

*4. **Openness**.* The degree the client is willing to enter into a collaborative relationship with the therapist.

*5. **Encouragement.*** The degree the client feels he or she is supported.

The Therapy Session Report was developed and revised by Orlinsky and Howard (1966/1975/1987). It was originally completed by 113 psychotherapy outpatients who underwent treatment at Northwestern Memorial Hospital Institute of Psychiatry. The ratings completed by all 113 patients were highly correlated across raters (average r=.90).

Interrater reliability of the outcome index was high, reported as r=.91 (Saunders, Howard, & Orlinsky, 1989).

An additional nonspecific variable measured in this study was rated by the therapist as part of the Therapeutic Procedures Inventory (see below). This variable, called the ***Therapeutic Relationship***, is defined as the degree of investment of the therapist in their role of helper.

Specific Variables/Therapeutic Procedure Inventory.

The Therapeutic Procedure Inventory [Therapist Measure (Appendix H)] is a 73 item questionnaire developed to elicit therapists' reports of the treatment procedures that they are using in treatment with their clients (Orlinsky, Lundy, Howard, Davidson & Mahoney, 1987). Therapists' in this study completed this questionnaire following the last session of therapy. Respondents were asked to rate (on a 1-4 point scale) to what extent they actually utilized each type of psychotherapeutic intervention. A factor analysis on the original data collected from the Therapeutic Procedure Inventory was conducted and three scales were constructed. The internal reliability for the respective scales was reported as: Directive/Experiential, alpha=0.82; Psychodynamic/Past-focused, alpha=0.74; and Affective, alpha=0.63 (McNeilly & Howard, 1991). Inter correlations ranged from 0.05 to 0.28.

The particular specific variables measured by this instrument include and are defined as:

1. ***Directive-Behavioral***. Active present focused direct interventions.
2. ***Psychodynamic/Past-focused***. More explicit psychodynamic interventions focused on past developmental history and experiences.
3. ***Affective***. Reflects experiential feeling based interventions.

Permission to use these instruments was obtained from Dr. K. Howard (Appendix I), the principle investigator in a research project entitled, Long-term psychotherapy: Patients, processes and outcomes (Howard, Orlinsky, & Bankoff, 1993). The above instruments comprised part of the evaluation package of instruments employed in that study.

Data Analysis Procedure

All completed instruments were coded and a SPSS (Statistical Package for Social Sciences) (SPSS Inc., 1997) data file was created. For the purpose of this study, data analysis processes involved the following two stages.

For the purposes of this study, data analyses processes involved the following:

1. Frequency distributions of all criterion variables were completed.
2. Descriptive statistics were calculated on all criterion variables.

3. Pearson correlation coefficients were computed to examine relationships between level of functioning measures and the predictor variables.
4. Multiple regression analysis was performed to examine the relative effects of the predictor variables on the criterion variable.

The first stage of data analysis involved definition and identification of the criterion variable. When data for the criterion variable was checked three data values were considered to be outliers, that is, far enough away from the bulk of the data to have the effect of skewing the distribution. Data was checked to determine if the data values were the result of an error in data entry. There was no error in coding and no clear indication that the data values were erroneous could be determined. Therefore the outliers needed to be considered valid data points that may be simply unusual in this data set. The risk of course of including the outliers is that if it is an erroneous value its inclusion can distort the frequency distributions, as well as, the descriptive statistics. Given that there is no screening for eligibility based on severity of presenting problems for the short-term therapy program investigated in this study, individuals with very serious mental health problems could access the program and may not achieve much or any improvement as a result of therapy.

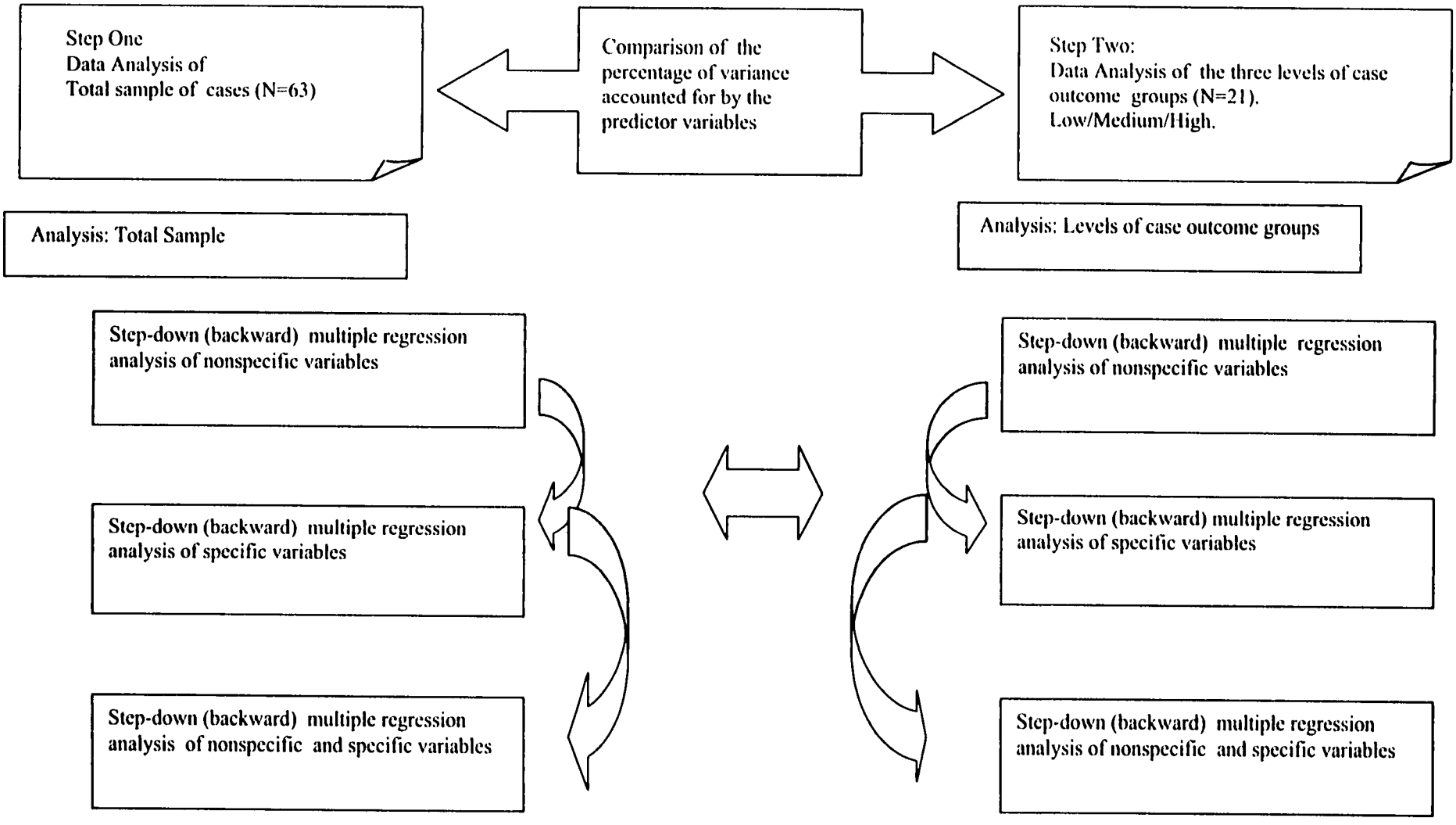
The second phase of data analysis involved a multiple regression analysis of the predictor variables (nonspecific and specific) in order to

determine the percentage of variance they accounted for in the criterion variable (level of functioning). A step-down (backward elimination procedure) multiple regression was employed.

Multiple regression is a multivariate technique for determining the correlation between a criterion variable and a combination of two or more predictor variables. A step-down backward multiple regression procedure begins with the total set of predictor variables and eliminates variables one by one, beginning with the one accounting for the least variation in the criterion variable, or the one that is the least predictive of the criterion variable (Craft, 1990). Munro and Page (1993) define regression as a useful technique that allows the researcher to predict outcomes and explain the interrelationships among variables. Analysis was performed using 'SPSS REGRESSION' and 'SPSS FREQUENCIES' for evaluation of assumptions.

In order to determine whether an interaction between nonspecific and specific variables maximized the amount of variance accounted for in the criterion variable, the data was analyzed in two steps. Step one involved multiple regression analyses of the total sample. Step two involved multiple regression analyses of the respective levels of functioning groups. The regression equations for each respective level of functioning groups (low/medium/high) were then compared to the regression equations for the total sample. Figure 3 details the steps of the

Figure 3: STEP-DOWN (backward) MULTIPLE REGRESSION ANALYSIS STEPS



step- down backward elimination procedure) multiple regression analyses.

Multiple Regression: Step One

The total sample (N=63) of cases underwent three step-down (backward elimination procedure) multiple regression analyses. The first analysis involved entering only the nonspecific variables to determine which of these variables accounted for what percentage of variance in level of functioning. Next, the results of this analysis were compared to the results of the step-down (backward) multiple regression analysis of only the specific variables. This was done in order to determine if the percentage of variance in level of functioning accounted for by the identified specific variables differed from the percentage of variance in level of functioning accounted for by the identified nonspecific variables.

The last analysis of Step One involved a step-down (backward) multiple regression of both the nonspecific variables and the specific variables combined. The results of this regression equation were compared to the first two analyses to determine if the identified combination of specific and nonspecific variables increased the percentage of variance in level of functioning compared to the separate entry of the nonspecific variables and the separate entry specific variables.

Multiple Regression: Step Two

Step Two involved the same step-down (backward) multiple regression analyses process as Step One. However, in these analyses the stepdown (backward) multiple regression was applied to each of the three level of functioning groups. The results of the respective multiple regression analyses were compared on the separate entry of the nonspecific variables and the separate entry of the specific variables. These results were then compared to the regression equation of both variables entered together.

The three levels of level of functioning groups were compared in order to determine if there was any significant difference between the respective groups and the total sample of cases. That is, of the variance accounted for by the predictor variables in level of functioning is there a significant difference in relation to the percentage of variance accounted for in each level of level of functioning group when compared to each other and then to the total sample of cases. If so, which combination of predictor variables account for what percentage of the variance in the levels of level of functioning groups compared to each other and to the total sample.

Similar to the examination of the total sample, the comparisons of the respective multiple regression equations were intended to determine whether there is an interaction between nonspecific variables and specific variables that maximize the percentage of variance in relation level of

functioning groups. Moreover, if an interaction between the predictor variables is identified for the respective levels of level of functioning groups, is the percentage of variance accounted for by the identified variables of the multiple regression equation markedly different between the respective level of functioning groups. Finally, is the percentage of variance accounted for by the identified variables in the levels level of functioning groups different from the percentage of variance accounted for by the identified variables of the regression equations for the total sample.

Ethical Considerations

The proposal for this study was submitted to the Research Ethics Committee Faculty of Social Work the University of Calgary. The Certificate of Approval (Appendix K) was issued indicating that in the judgment of the Committee this study had met the University of Calgary's ethical requirements for research with human subjects. The proposal to undertake this research study received the sanction of the CEO of the EAP participating in this research (Appendix B).

All participants were asked if they were willing to participate in the study for the purpose of increasing the knowledge base of psychotherapy outcome in order to provide optimal services. Each individual (both therapist and client) who agreed to participate in the study was required to complete a consent form (Appendix A and C), which included a full

description of the study and specified provisions for confidentiality of all information collected in the study. All participants were informed that they had the right to decline participation and that they had the right to withdraw from the study at any point without any effect on their position or treatment at the EAP. In addition, every instrument included a statement of these conditions of participation. Participants were also informed that access to the completed research would be in the form of a Ph D dissertation available from the University of Calgary.

This chapter outlined the methodology employed in this study. The questions and hypotheses to be addressed in the study were identified followed by a description of the design used, the sample to be investigated, the method of data collection and the specific data analyses procedures that were utilized.

Chapter Four provides the results of the data analyses. The first section reports on the sample characteristics and provides the descriptive analyses of the criterion variable. The second section reports on the results of the multiple regression analyses of the influence of the predictor variables on the criterion variable.

CHAPTER FOUR

RESULTS

This chapter presents the statistical analyses of the data and outlines the results of the study. One of the primary objectives of this study is to identify the relationship between nonspecific and specific variables and the criterion variable level of functioning. In order to achieve this goal, pearson correlation, one way analysis of variance and multiple regression were the statistical tools used in the analysis of the data.

As indicated, the data analysis involved two stages. Stage one involved comparison of the client's level of functioning from the perspective of the client as measured on the CLF and from the perspective of the therapist as measured on the LOF/GAS, as well as analysis (by t tests) of the pretest/posttest differences for each outcome measure.

The second stage involved the multiple regression analyses of the influence of the predictor variables on the client's level of functioning. A multivariate model explaining the influence of the predictor variables on the client's level of functioning is presented.

Descriptive Analysis

Sample Characteristics

Therapists

Forty therapists indicated an intent to participate in the study. Over the period of the year (March 1997 to March 1998) that data was collected 20 therapists dropped out of the study for a variety of reasons. Of these twenty, ten dropped out of the study due to a change in their status with the company. These changes included five therapists who decreased their clinical time and felt that they could no longer manage organizing and administering the instruments, two therapists who were promoted out of clinical positions and two therapists that went on early maternity leave.

One therapist resigned from the company during this period. The other 10 failed to notify the researcher of the difficulties they were encountering in organizing and tracking their research cases and therefore had no cases enlisted in the study. Of the remaining 20 therapists in the study, 8 submitted incomplete data sets or instruments with many missing one or more of the post therapy measures. Therefore, they were excluded from the data analysis.

Table 3 summarizes the therapist characteristics. Of the 12 therapists with complete data sets, there were five male therapists and seven female therapists. Two had a Master of Science degree and one had a Master of Arts degree. All of these three were chartered as psychologists. Of the remaining therapists, nine had Masters of Social

Table 3

THERAPIST CHARACTERISTICS

Therapist	Gender	Professional Designation	Professional Association
A	M	MSW	Registered Social Worker
B	F	MSc	Chartered Psychologist
C	F	MSW	Registered Social Worker
D	M	MSW	Registered Social Worker
E	F	MSW	Registered Social Worker
F	F	MSW	Registered Social Worker
G	M	MSW	Registered Social Worker
H	M	MSW	Registered Social Worker
I	F	MSc	Chartered Psychologist
J	F	MSW	Registered Social Worker
K	M	MSW	Registered Social Worker
L	F	MA	Chartered Psychologist

Work degrees and were registered with their provincial Association of Social Workers.

An univariate analysis of variance was performed to test between subject effects. No significant ($p < .05$) effects were determined for therapist sex or professional group against the criterion variable.

Sample Attrition.

Therapists were contacted by phone every two weeks to review their progress and to answer any questions that they may have had. In addition, each therapist was sent a letter of appreciation every month with the invitation to contact this researcher if they were encountering any problems.

The attrition may be explained by a number of circumstances. Both clients and therapists complained that the measures, although easily interpreted, were too complex and involved more time than they expected. This may have decreased individuals' motivation to participate. Therapists expressed concern that the amount of information requested prior to therapy may have been overwhelming for some clients given their emotional distress and therefore may have influenced their willingness to participate in the study.

Two events significantly impacted those therapists who eventually chose not to complete the study. Firstly, early in the study a company decision led to an increase in the caseload targets for therapists. This had

a direct impact on therapists who did not complete the study. Most indicated that the increase made it impossible for them to both meet their targets and participate in the study. Secondly, the company that employed the therapists was sold and this appeared to instill a degree of anxiety about the future for the therapists. It was the researcher's impression that those therapists who failed to complete the study did so because of this anxiety and their uncertainty about any new management and assessment of their performance. They were, of course, assured that the study would remain confidential and that there would be no access to the data by the company. However, this did not seem to decrease their anxiety and they chose to drop out of the study.

Clients

Sixty-three clients from the participating therapists' caseload completed treatment with complete data sets. Tables 4 to 6 report the frequency distributions of the demographic characteristics of the clients who participated in the study.

Sex of Clients.

Of the 63 clients, nineteen were male and forty-four were female. Table 4 reports on the distribution of the client group by sex.

Table 4: Distribution of Clients by Sex

Sex	f	%
Male	19	30.2
Female	44	69.8
Total	63	100

Age of Clients.

The age of the clients ranged from 18 to 59 years. The largest percentage of clients, 42.9%, ranged in age from 31 to 40. The mean age of the client group was 36.7 years with a standard deviation of 9.14 years. Table 5 reports the distribution of the clients by age.

Table 5: Distribution of Clients by Age

Age	f	%
18-30	16	25.4
31-40	27	42.9
41-50	15	23.8
51-60	5	7.9
Total	63	100

$\bar{\chi}$=36.7 , SD=19.4

Marital Status.

Fifty of the clients were married while four were divorced and nine were in the process of separation. Table 6 presents the distribution of the marital status of the client group.

Table 6: Distribution of Clients by Marital Status

Marital Status	f	%
Married	50	79.3
Separated	9	14.3
Divorced	4	6.4
Total	63	100

Length of Therapy

The average number of hours per case for the short-term therapy program setting of this study is 4.5 hours per case. The average number of hours per case of the study sample is 4.4 hours per case. The hours per case ranged from 1.5 hours to 13 hours with a mean of 4.4 hours. The duration of therapy ranged from one month to twelve months with a mean of 5.7 months. Table 7 reports the average hours per case for the sample of cases in this study.

Table 7: Length of Therapy : Average Length of Therapy in Hours and Duration in Months.

Total Number of Cases	Mean number of Hours per Case	Mean Duration of Therapy in Months
63	4.4	5.7

Presenting Problems

Prior to beginning therapy, clients were requested to rank the extent that each of a possible twenty three presenting problems were the reason for seeking therapy. Problems were rated on a five point scale from 1 to 5. Clients' ratings on the presenting problem list ranged from; 1 (not at all) the problems were rated as not the reason for seeking therapy; 2 (a little), problems were rated as having a little influence on the reason for seeking therapy; 3 (some), problems were rated as having some influence on the reason for seeking therapy; 4 (a lot) problems were rated as having a lot of influence on the reason for seeking therapy; 5 (very much), problems were rated as influencing the reason for seeking therapy very much. Table 8 provides a summary of the numbers and percentages of clients who identified the various presenting problems as a reason for seeking therapy.

Table 8: Distribution of Clients by Extent that Presenting Problems are a Reason for Seeking Therapy by 'Is a Problem/Is not a Problem'.

Presenting Problem	f			%		
	Is a problem	Is not a problem	Total	Is a problem	Is not a problem	Total
1. Problems with spouse or romantic partner.	37	26	63	68.7	41.3	100
2. Difficulty forming or maintaining an intimate relationship.	24	29	63	46.0	34.0	100
3. A sexual problem.	25	38	63	39.7	60.3	100
4. Problems getting along with a friend or friends.	20	43	63	31.7	68.3	100
5. An unsatisfactory social life.	31	32	63	49.2	50.8	100
6. Difficulties getting along with family members (not spouse).	31	32	63	49.2	50.8	100
7. Problems getting along with people at work or school.	28	35	63	44.4	55.6	100
8. Feeling uncomfortable with people in general.	29	34	63	46	54.0	100
9. Not getting things done at work or school.	32	37	63	51.8	49.2	100

Table 8 continued

Table 8: Distribution of Clients by Extent that Presenting Problems are a Reason for Seeking Therapy by 'Is a Problem/Is not a Problem'.

Presenting Problem	f			%		
	Is a problem	Is not a problem	Total	Is a problem	Is not a problem	Total
10. Problems handling family responsibilities.	31	32	63	49.2	50.8	100
11. Not having a sense of direction or goals in life.	41	22	63	65.1	34.9	100
12. Not managing life well in general.	44	19	63	69.8	30.2	100
13. Low self-esteem.	40	23	63	63.5	36.5	100
14. Not understanding myself.	42	21	63	66.7	33.3	100
15. Reacting too emotionally to events.	48	15	63	76.2	23.8	100
16. Feeling distress, anxiety, depression or anger.	56	7	63	88.9	11.1	100
17. A physical problem, such as illness, pain or medical symptoms.	16	47	63	25.4	74.6	100
18. Alcohol or drug problems.	8	55	63	12.7	87.3	100
19. An eating problem or weight problem.	19	44	63	30.2	69.8	100

Table 8 continued

Table 8: Distribution of Clients by Extent that Presenting Problems are a Reason for Seeking Therapy by 'Is a Problem/Is not a Problem'.

Problem	f			%		
	Is a problem	Is not a problem	Total	Is a problem	Is not a problem	Total
20. Problems developing or managing my career.	30	33	63	47.6	52.4	100
21. Missing work or school or not getting there on time.	9	54	63	14.3	85.7	100
22. Difficulties caused by the substance abuse or emotional problems of a family member.	17	46	63	27.0	73.0	100
23. Another problem (specify):	11	52	63	17.5	82.5	100

Table 9 reports clients' ratings (on a 5 point scale) of the extent to which each problem was a reason for seeking therapy. Of the five most frequently identified presenting problems from the twenty three presenting problems listed, fifty-six clients or eighty-nine percent of clients reported that feeling distress, anxiety, depression or anger (question 16) was a reason for seeking therapy. Forty-six percent of that group indicated that the presenting problem was "very much" the reason for seeking therapy.

The second highest ranked question, reacting too emotionally to events (question 15) was reported by 76.2% of the clients. Of this group 27% rated the extent of the problem as "very much" a reason for seeking therapy.

Not managing life well (question 12) was ranked third, as a reason for seeking therapy. Sixty-nine percent of the clients identified this problem as a reason for seeking therapy with 11.1% assessing the extent of the problem as "very much" a reason for seeking therapy.

Problems with spouse or romantic partner ranked fourth as the reason for seeking therapy, with 68.7% of the clients indicating that this problem was the reason for seeking therapy. Of this group, 36.5% assessed the extent of the problem as "very much" a reason for seeking therapy.

Not understanding myself (question 14) ranked fifth as a reason for seeking therapy. Sixty-six percent of the clients identified this problem as a reason for seeking therapy with 20.6% of the group assessing the extent as "very much" a reason.

Table 9: Distribution of Clients by 'Is a Problem' by Extent that Presenting Problems are a Reason for Seeking Therapy.

Presenting Problem	f	%					
		Extent problem is a reason for seeking therapy.					
	Is a problem	Not at all	A little	Some	A lot	Very much	Total
1. Problems with spouse or romantic partner.	37	41.3	3.2	1.6	17.5	36.5	100
2. Difficulty forming or maintaining an intimate relationship.	24	46	11.1	11.1	12.7	19.0	100
3. A sexual problem.	25	60.3	17.5	9.5	6.3	6.3	100
4. Problems getting along with a friend or friends.	20	68.3	9.5	12.7	7.9	1.6	100
5. An unsatisfactory social life.	31	50.8	17.5	12.7	11.1	7.9	100
6. Difficulties getting along with family members (not spouse).	31	50.8	17.5	12.7	9.5	9.5	100
7. Problems getting along with people at work or school.	28	55	7.9	22.2	7.9	6.3	100
8. Feeling uncomfortable with people in general.	29	54	19.0	22.2	1.6	3.2	100
9. Not getting things done at work or school.	32	49.2	17.5	12.7	6.3	14.3	100

Table 9 continued

Table 9: Distribution of Clients by 'Is a Problem' by Extent that Presenting Problems are a Reason for Seeking Therapy.

Presenting Problem	f	%					
		Extent problem is a reason for seeking therapy.					
	Is a problem	Not at all	A little	Some	A lot	Very much	Total
10. Problems handling family responsibilities.	31	50.8	17.5	11.1	9.5	11.1	100
11. Not having a sense of direction or goals in life.	41	34.9	20.6	14.3	19.0	11.1	100
12. Not managing life well in general.	44	30.2	25.4	17.5	15.9	11.1	100
13. Low self-esteem.	40	36.5	14.3	15.9	20.6	12.7	100
14. Not understanding myself.	42	33.3	11.1	17.5	17.5	20.6	100
15. Reacting too emotionally to events.	48	23.8	15.9	17.5	15.9	27.0	100
16. Feeling distress, anxiety, depression or anger.	56	11.1	7.9	14.3	20.6	46.0	100
17. A physical problem, such as illness, pain or medical symptoms.	16	74.6	7.9	7.9	3.2	6.3	100
18. Alcohol or drug problems.	8	87.3	4.8	4.8	1.6	1.6	100
19. An eating problem or weight problem.	19	69.8	12.7	6.3	9.5	1.6	100

Table 9 continued

Table 9: Distribution of Clients by 'Is a Problem' by Extent that Presenting Problems are a Reason for Seeking Therapy.

Problem	f	%					
		Extent problem is a reason for seeking therapy					
	Is a problem	Not at all	A little	Some	A lot	Very much	Total
20. Problems developing or managing my career.	30	52.4	22.2	9.5	7.9	7.9	100
21. Missing work or school or not getting there on time.	9	85.7	7.9	1.6	3.2	1.6	100
22. Difficulties caused by the substance abuse or emotional problems of a family member.	17	73	4.8	7.9	4.8	9.5	100
23. Another problem (specify):	11	82.5			6.3	11.1	100

Table 10 presents a rank ordering of the twenty-three presenting problems according to the percentage of clients who identified them as a reason for seeking therapy.

Determination of Level of Functioning: Stage One

This first stage of the data analyses served the purpose of identifying and determining the criterion variable, that is, each client's level of functioning at the completion of therapy. As noted in Chapter Three, the criterion variable was measured by a comparative approach. Clients rated their level of functioning on the Current Life Functioning (CLF) scales (Howard, 1988) prior to their assessment (pre 1st session) and on completion of treatment (post last session). The two scales of this measure, current symptoms and current life functioning were correlated at r= .711 (p=.000).

In addition, all participants were rated by their therapists at the completion of the assessment (post 1st session) and at the completion of therapy (post last session) using the LOF/GAS, which is comprised of the Level of Functioning Scale (Carter & Newan, 1980) and the Global Assessment Scale (Endicott, Spitzer, Fliess, & Cohen, 1976). These scales were correlated at r= .353 (p= .005).

Table 10: Presenting Problems as Reason for Seeking Therapy by Percentage of Clients

Problem	%
16. Feeling distress, anxiety, depression or anger.	88.9
15. Reacting too emotionally to events.	76.2
12. Not managing life well in general.	69.8
1. Problems with spouse or romantic partner.	68.7
14. Not understanding myself.	66.7
11. Not having a sense of direction or goals in life.	65.1
13. Low self-esteem.	63.5
9. Not getting things done at work or school.	51.8
5. An unsatisfactory social life.	49.2
6. Difficulties getting along with family members (not spouse).	49.2
10. Problems handling family responsibilities.	49.2
20. Problems developing or managing my career.	47.6
2. Difficulty forming or maintaining an intimate relationship.	46.0
8. Feeling uncomfortable with people in general.	46.0
7. Problems getting along with people at work or school.	44.4
3. A sexual problem.	39.7
4. Problems getting along with a friend or friends.	31.7
19. An eating problem or weight problem.	30.2
22. Difficulties caused by the substance abuse or emotional problems of a family member.	27.0
17. A physical problem, such as illness, pain or medical symptoms.	25.4
23. Another problem (specify):	17.5
21. Missing work or school or not getting there on time.	14.3
18. Alcohol or drug problems.	12.7

The criterion variable was determined by measuring the difference between pretherapy and post therapy scores on the respective measures. Following the comparison of the client's assessment of change in level of functioning to the therapist's assessment of change in the client's level of functioning, the respective outcome scores for each instrument are transformed into z-Scores which are then used to categorize the sample of cases into the three identified levels of functioning for analysis in stage two.

Tables 11, 12, 13 and 14 report the results of the t tests for the significance of pretest and posttest differences for current symptoms, pretest and posttest differences in current life functioning and pretest and posttest differences for LOF/GAS. The data indicate significant pretest and posttest differences supporting the conclusion that short-term therapy had a significant positive effect on level of functioning.

CLF

As indicated in Chapter Three, the CLF instrument was used to determine the level of functioning at completion of therapy from the client's perspective. The two scales of the instrument measured the degree of change in the number of occurrences of symptoms and the degree of interference that the identified problems had on clients' functioning.

Current Symptoms

The current symptoms scale requested clients to report the number of occurrences of the symptom within the month prior to accessing therapy and again within a month prior to the termination of therapy. Table 11 presents the results of the paired sample t test for individual current symptoms. Table 13 reports the results of the t test for the significance of pretest and posttest differences for the current symptoms scale. The t value of 6.101 for the pretest and posttest differences was significant at .001 level. These results indicate a significant improvement in current symptoms.

Current Life Functioning

Clients were requested to indicate prior to the beginning of therapy and again at the completion of therapy the extent that the identified emotional problems interfere with their current functioning. Table 12 presents the results of the paired t test for current life functioning tasks. Table 13 reports the results of the t test for the significance pretest and posttest differences for current life functioning scale. The t value of 4.688 for the pretest and posttest differences was significant at .001 level. These results indicate a significant improvement in current life functioning.

Table 11: t Test on Pretest and Posttest Differences for Current Symptoms

Current Symptoms		Mean	SD	t Value
Having repetitive thoughts	Pretest	2.1270	1.5811	5.035*
	Posttest	1.2063	1.2070	
Problems at work or school because of my alcohol or drug use.	Pretest	7.937	.6299	-.444
	Posttest	9.52	.5598	
Thoughts that seemed to race through my mind.	Pretest	2.1746	1.4869	3.914*
	Posttest	1.4286	1.4779	
Avoiding places that seemed too closed in.	Pretest	.5238	1.2294	-.327
	Posttest	.5714	1.2144	
Headaches.	Pretest	1.3016	1.4988	1.586
	Posttest	1.0000	1.3198	
Feeling sad most of the day	Pretest	2.0000	1.5134	3.619*
	Posttest	1.3492	1.3814	
Trying to push thoughts out of my mind	Pretest	2.1111	1.4714	3.335*
	Posttest	1.4286	1.4996	
Guilt or remorse over my alcohol or drug use	Pretest	.1587	.6012	.497
	Posttest	.1270	.6089	
Being sluggish or lethargic	Pretest	1.6508	1.5467	4.337*
	Posttest	.9524	1.0840	
Thoughts about ending my life	Pretest	.4603	.9127	2.227
	Posttest	.2381	.5879	
Muscular tension or aches	Pretest	1.7460	1.6458	3.074
	Posttest	1.1905	1.3058	
Feeling hopeless about the future	Pretest	1.9206	1.6877	4.472*
	Posttest	1.0952	1.4779	
Difficulty concentrating	Pretest	2.0794	1.5059	4.490
	Posttest	1.3651	1.2989	
Feeling blocked at work or school	Pretest	1.0952	1.5210	1.605
	Posttest	.8254	1.1987	
Being irritable and easily angered	Pretest	2.3968	1.6900	4.755*
	Posttest	1.4921	1.3425	
Afraid of leaving my home	Pretest	.3968	.9925	-.574
	Posttest	.4603	.9809	
Dizziness	Pretest	.7302	1.3936	1.157
	Posttest	.4921	1.0140	
Feeling ill or rundown	Pretest	1.6984	1.5620	3.133
	Posttest	1.1111	1.2840	
Trouble sleeping	Pretest	1.9524	1.6503	2.608
	Posttest	1.4921	1.5541	

Table 11 continued

Table 11: t Test on Pretest and Posttest Differences for Current Symptoms

Current Symptoms		Mean	SD	t Value
Feeling worthless	Pretest	1.4444	1.4117	3.801*
	Posttest	.8571	1.1196	
Shortness of breath or rapid heartbeat	Pretest	1.0952	1.3406	3.972*
	Posttest	.4762	.8203	
Not enjoying things as much as I used to	Pretest	2.6349	1.5377	6.043*
	Posttest	1.5556	1.4343	
Very strong mood swings	Pretest	2.1905	1.8215	4.406*
	Posttest	1.3492	1.2846	
Difficulty making decisions	Pretest	1.7778	1.6009	3.656*
	Posttest	1.2063	1.3095	
Troubling events in my life	Pretest	1.6667	1.5027	3.184**
	Posttest	1.1429	1.3661	
Bothered by a fear of something specific	Pretest	1.2540	1.5859	2.464
	Posttest	.7619	1.2406	
Problems with my health because of my alcohol or drug use	Pretest	4.762	.3780	1.000
	Posttest	6.349	.3965	
Needing very little sleep	Pretest	.6190	1.1972	1.093
	Posttest	.4603	1.0132	
Problems resulting from the loss of an important person or relationship	Pretest	1.2063	1.7885	.864
	Posttest	1.0159	1.5708	
Feeling tense or anxious	Pretest	2.8095	1.6250	6.341*
	Posttest	1.6508	1.3579	
Sleeping too much	Pretest	.7460	1.2696	1.079
	Posttest	.5556	1.0125	
Fear of rejection	Pretest	1.5397	1.6736	2.005
	Posttest	1.2063	1.3339	
Feeling that I or a situation I was in was not real	Pretest	1.0000	1.4919	2.319
	Posttest	.5714	1.0582	
Having to avoid certain places or situations because of fearfulness	Pretest	.6825	1.1754	.406
	Posttest	.6190	1.0840	
Doing things that could have caused trouble for my family	Pretest	.6984	1.3397	2.005
	Posttest	.3651	.8854	
Experiencing a great deal of stress	Pretest	3.1111	1.5252	6.626*
	Posttest	1.8889	1.5975	

Table 11 continued

Table 11: t Test on Pretest and Posttest Differences for Current Symptoms

Current Symptoms		Mean	SD	t Value
Periods of intense fear that seem out of place or out of proportion.	Pretest	.7619	1.2664	1.187
	Posttest	.5397	1.0290	
Problems with my family or friends because of my alcohol or drug use	Pretest	.1429	.7374	
	Posttest	.524	.5302	1.350

*p<.001

Table 12: t Test on Pretest and Posttest Differences for Current Life Functioning

Current Life Functioning		Mean	SD	t Value
1.Ability to perform routine tasks.	Pretest	2.1429	1.4464	
	Posttest	1.3333	1.3198	4.921*
2.Interactions with friends.	Pretest	2.1587	1.3223	
	Posttest	1.4921	1.1622	4.252*
3.Interactions with people at work.	Pretest	2.0159	1.4198	
	Posttest	1.4444	1.2284	3.958*
4.Interactions with my spouse/romantic partner.	Pretest	2.7619	1.6917	
	Posttest	2.3175	1.7490	2.562
5.Ability to maintain my personal appearance.	Pretest	1.5079	1.0906	
	Posttest	1.1905	.9648	2.281
6.Interaction with my parents.	Pretest	1.5873	1.5516	
	Posttest	1.2540	1.3675	1.627
7.Interaction with my sibling.	Pretest	1.4286	1.4336	
	Posttest	1.1905	1.2682	1.019
8.Ability to concentrate and complete tasks.	Pretest	2.2857	1.3372	
	Posttest	1.6032	1.2384	4.111*
9.Performance at work or school.	Pretest	2.3651	1.5586	
	Posttest	1.4762	1.2162	4.725*
10.Carrying out family responsibilities.	Pretest	1.7937	1.3218	
	Posttest	1.3333	1.2443	2.489
11.Participation in physical activities.	Pretest	2.0635	1.4241	
	Posttest	1.4127	1.1864	3.386*
12.Participation in social activities.	Pretest	2.3016	1.3154	
	Posttest	1.6984	1.2133	3.713*
13.Ability to function as an independent person.	Pretest	2.0635	1.4354	
	Posttest	1.3175	1.1890	4.916*
14.Developing or managing my career.	Pretest	1.8730	1.5292	
	Posttest	1.3810	1.2238	2.547*
15.Ability to manage my finances.	Pretest	1.7937	1.4386	
	Posttest	1.3016	1.1999	2.991
16.Planning and enjoying leisure time activities.	Pretest	2.5079	1.3663	
	Posttest	1.8413	1.3223	3.573
17.Being the kind of person I would like to be.	Pretest	3.3810	1.4304	
	Posttest	2.5079	1.4687	4.148*
18.Ability to form or sustain intimate relationships.	Pretest	2.1111	1.6570	
	Posttest	1.9206	1.5272	.925*
19.Enjoyment of sexual activities.	Pretest	2.2540	1.6941	
	Posttest	2.0317	1.7224	1.027

Table 12 continued

Table 12: t Test on Pretest and Posttest Differences for Current Life Functioning

Current Life Functioning		Mean	SD	t Value
20.Maintaining good health habits.	Pretest	2.0952	1.2536	
	Posttest	1.7619	1.2790	1.934
21.Creative activities.	Pretest	2.0476	1.4528	
	Posttest	1.6984	1.3753	1.957
22.Ability to control myself and stay out of trouble.	Pretest	1.4127	1.3753	
	Posttest	1.2222	1.7547	.830
23.Attending work or school or getting there on time.	Pretest	1.0952	1.1030	
	Posttest	1.0794	1.1543	.110
24.Ability to be comfortable with people.	Pretest	2.0794	1.4176	
	Posttest	1.7778	1.2882	1.820

*p<.001

Table 13: t Tests on Pretest and Posttest Differences for Current Symptoms and Current Life Functioning

Variable	Mean	SD	t Value
Current Symptoms			
Pretest	52.825	30.461	
Posttest	34.841	27.674	6.101*
Current Life Functioning			
Pretest	49.127	20.506	
Posttest	37.587	21.679	4.688*

*P<.001

LOF/GAS

Therapists were requested to rate their clients' level of functioning following the assessment session and again at the completion of therapy. Table 14 reports the results of the t tests for the significance of pretest and posttest differences for the LOF/GAS. The t value of 7.889 for pretest and posttest differences on the LOF was significant at a .001 level. The t value of 7.202 for the pretest and posttest differences on the GAS was significant at a .001 level. These results indicate that therapists believe that the majority of clients' level of functioning improved after treatment.

Table 14: t Tests on Pretest and Posttest Differences for LOF/GAS

Variable	Mean	SD	t Value
LOF			
Pretest	5.936	.931	
Posttest	7.619	1.763	7.889*
GAS			
Pretest	64.50	10.14	
Posttest	77.39	13.54	7.202*

*p<.001

The mean pretest LOF score was 5.9. The mean posttest LOF was 7.6. The mean pretest GAS score was 64.5. The mean posttest GAS score was 77.39.

Comparison of Client and Therapist Determination of Level of Functioning

Given that the two outcome measures (CLF, LOF/GAS) utilized have different scales which result in different distributions, the raw scores were transformed into a standardized variable through the calculation of z-Scores. Table 15 and Table 16 display the raw scores per instrument and their final transformed z-Scores.

This new (criterion) variable, z (for each level of functioning measure), is defined as the original data minus the mean divided by the

standard deviation. Lehman (1991) describes standardizing as a linear transformation of the original data. He further defines the purpose of standardizing a variable to preserve the distance information in the original data, "... and is thus a mean-preserving operation." (p. 156).

Standardized variables are considered to have three properties:

1. The mean is always zero.

2. The standard deviation of a standardized variable is always 1.0.

3. A linear transformation does not change the form of the distribution so the form of the z distribution is unchanged from the form of the original (Lehman, 1991; p.156).

Taking the average of the z-Scores for each of the scales on the respective instruments and comparing their level of functioning score is consistent with the recommendation that multiple points of view offer different information and that such an average is the most valid indicator of change (Suh, Strupp, & O'Malley, 1986). These scores were then used to compare the client's assessment of level of functioning (CLF) to the therapist's assessment of level functioning (LOF/GAS) following the completion of therapy.

Table 15 presents the transformation of the raw scores from the subscales of the CLF into z-Scores. Table 16 presents the transformation of the raw scores from the LOF/GAS into z-Scores. Table 17 presents a comparison of the level of functioning as measured by the CLF compared to the level of functioning as measured by the LOF/GAS.

Table 17 indicates that therapists and clients differ in their assessment of level of functioning. The client mean of .867 and the therapist mean of .662 indicates that overall therapists rate the level of functioning lower than clients.

Determinants of Level of Functioning

Determination of Variance Accounted for in Level of Functioning by the Predictor Variables: Stage Two

As indicated, one of the primary objectives of this study is to identify the relationship between nonspecific and specific variables and the criterion variable client's level of functioning. A second objective of this study is to investigate if there was a difference in the percentage of variance accounted for by nonspecific and specific variables when cases are categorized into three level of functioning groups (low scores/medium scores/high scores) as compared to the total sample of cases. To accomplish this the level of functioning scores were used to divide the sample of cases into the three categories of level of functioning as measured by the CLF and the LOF/GAS.

Table: 15
Stage 1: Transformation of Criterion Variable Client Level of Functioning from Raw Scores to z-Scores.

Client Rating of Level of Functioning			
	Current Level of Functioning Scale		
Case	Current Symptoms (difference between pre and post scores)	Current Life Functioning (difference between pre and post scores)	CLF Criterion Variable z-Score (mean score of subscales)
H1	29.00	18.00	.25
H2	28.00	26.00	.37
H3	52.00	8.00	.96
E1	-62.00	-34.00	-1.94
E2	45.00	31.00	.04
E3	-5.00	-3.00	-1.15
E4	26.00	22.00	.38
E5	30.00	27.00	.97
F1	-27.00	-6.00	-1.07
F2	-40.00	4.00	-1.08
F3	54.00	8.00	.98
G1	-1.00	-6.00	-1.14
G2	13.00	32.00	.15
G3	25.00	13.00	.22
G4	50.00	43.00	1.52
G5	20.00	18.00	.23
J1	-14.00	-20.00	-1.89
J2	-6.00	12.00	-.13
J3	15.00	11.00	-.18
J4	31.00	23.00	.69
L1	36.00	-13.00	-.07
L2	17.00	11.00	-.15
L3	20.00	00	-.52
L4	33.00	42.00	1.05
L5	45.00	13.00	.94
L6	12.00	15.00	.17
C1	14.00	-20.00	-.72
C2	7.00	-18.00	-.79
C3	47.00	46.00	.76
C4	56.00	41.00	1.44
A1	7.00	11.00	-.52
A2	5.00	10.00	-.23
A3	12.00	-10.00	-.47
A3	-1.00	-7.00	-.50
A5	25.00	9.00	-.07

Table 15 continued

Table: 15
Stage 1: Transformation of Criterion Variable Client Level of Functioning from Raw Scores to z-Scores.

Client Rating of Level of Functioning			
Current Level of Functioning Scale			
Case	**Current Symptoms** (difference between pre and post scores)	**Current Life Functioning** (difference between pre and post scores)	**CLF Criterion Variable z-Score** (mean score of subscales)
A6	14.00	3.00	.00
A7	22.00	19.00	-.17
A8	20.00	12.00	.57
A9	44.00	19.00	.81
A10	39.00	44.00	1.05
B1	13.00	38.00	.03
B2	12.00	13.00	-.08
B3	7.00	1.00	-.80
B4	59.00	44.00	1.67
B5	57.00	37.00	.97
I1	.00	-4.00	-.98
I2	15.00	10.00	.00
I3	18.00	-4.00	-.17
I4	5.00	-5.00	-.82
I5	31.00	28.00	.56
I6	48.00	67.00	1.69
I7	28.00	7.00	.38
D1	8.00	5.00	-.27
D2	-16.00	-11.00	-1.22
D3	33.00	18.00	-.03
D4	18.00	10.00	.62
K1	1.00	-14.00	-.59
K2	17.00	17.00	.-.05
K3	-15.00	-10.00	-1.19
K4	-11.00	-14.00	-1.09
K5	34.00	17.00	.52
K6	9.00	3.00	-.18
K7	25.00	10.00	.27

Table: 16
Stage 1: Transformation of Criterion Variable Functioning-Level of Functioning from Raw Scores to z-Scores.

Therapist Rating of Client Level of Functioning			
Case	**Global Assessment Scale** (difference between pre and post scores)	**Level of Functioning Scale** (difference between pre and post scores)	**LOF/GAS Criterion Variable z-Score** (mean of GAS and LOF)
H1	24.00	2.00	.49
H2	17.00	3.00	.54
H3	24.00	3.00	.79
E1	6.00	3.00	.14
E2	26.00	1.00	.27
E3	00	-1.00	-1.25
E4	24.00	2.00	.49
E5	00	00.	-.96
F1	00	1.00	-.40
F2	13.00	1.00	-.20
F3	28.00	3.00	.93
G1	9.00	1.00	-.34
G2	15.00	2.00	.17
G3	15.00	7.00	.17
G4	17.00	2.00	.24
G5	18.00	3.00	.57
J1	9.00	2.00	-.05
J2	20.00	2.00	.35
J3	19.00	3.00	.61
J4	16.00	3.00	.50
L1	19.00	-5.00	-1.76
L2	20.00	3.00	.64
L3	19.00	1.00	.02
L4	21.00	3.00	.68
L5	39.00	3.00	1.32
L6	21.00	2.00	.38
C1	5.00	1.00	-.48
C2	22.00	3.00	.72
C3	29.00	3.00	.97
C4	10.00	2.00	-.01
A1	8.00	3.00	.21
A2	17.00	2.00	.24
A3	23.00	3.00	.75
A4	4.00	2.00	-.22
A5	-52.00	2.00	-2.23
A6	4.00	2.00	-.22
A7	5.00	2.00	-.19
A8	33.00	3.00	1.11
A9	11.00	3.00	.32
A10	18.00	3.00	.57
B1	-16.00	00	-1.17
B2	2.00	1.00	-.59

Table 16 continued

Table: 16
Stage 1: Transformation of Criterion Variable Functioning-Level of Functioning from Raw Scores to z-Scores.

Therapist Rating of Client Level of Functioning			
Case	**Global Assessment Scale** (difference between pre and post scores)	**Level of Functioning Scale** (difference between pre and post scores)	**LOF/GAS Criterion Variable z-Score** (mean of GAS and LOF)
B3	29.00	1.00	.38
B4	23.00	1.00	.16
B5	-14.00	1.00	-1.16
I1	20.00	2.00	.35
I2	00	1.00	-.66
I3	10.00	2.00	-.01
I4	20.00	3.00	.64
I5	20.00	2.00	.35
I6	20.00	-1.00	.94
I7	10.00	2.00	-.01
D1	3.00	1.00	-.56
D2	10.00	1.00	-.30
D3	6.00	00	-.74
D4	73.00	00	-1.42
K1	30.00	3.00	1.00
K2	-10.00	00	-1.32
K3	1.00	00	-.92
K4	00	-6.00	-1.54
K5	6.00	2.00	-.15
K6	15.00	3.00	.46
K7	28.00	3.00	.93

Table 17: Comparison of Client (CLF) and Therapist (LOF/GAS) Assessment of Level of Functioning Post Therapy.

			Variance Between Client and Therapist Score	
CASE	Client CLF	Therapist LOF/GAS	Client Assessment of Level of Functioning Higher	Therapist Assessment of Level of Functioning Higher
H1	.25	.49		.24
H2	.37	.54	.16	
H3	.96	.79		.17
E1	-1.94	.14		1.80
E2	.04	.27		.23
E3	-1.15	-1.25		.01
E4	.38	.49		.11
E5	.97	-.96	1.93	
F1	-1.07	-.40		.67
F2	-1.08	-.20		.88
F3	.98	.93		.51
G1	-1.14	-.34		.80
G2	.15	.17		.02
G3	.22	.17	.05	
G4	1.52	.24	1.28	
G5	.23	.57		.34
J1	-1.89	-.05		1.84
J2	-.13	.35		.48
J3	-.18	.61		.74
J4	.69	.50	.19	
L1	-.07	-1.76	1.69	
L2	-.15	.64		.79
L3	-.52	.02		.50
L4	1.05	.68	.37	
L5	.94	1.32		.38
L6	.17	.38		.13
C1	-.72	-.48		.24
C2	-.79	.72		1.51
C3	.76	.97		.21
C4	1.44	-.01	1.45	
A1	-.52	.21		.73
A2	-.23	.24		.47
A3	-.47	.75		1.22
A4	-.50	-.22		.38
A5	-.07	-2.23	2.16	
A6	.00	-.22	.22	
A7	-.17	-.19	.02	
A8	.57	1.11		.54
A9	.81	.32	.49	
A10	1.05	.57	.48	

Table 17 continued

Table 17: Comparison of Client and Therapist Assessment of Level of Functioning Post Therapy.

			Variance Between Client and Therapist Score	
CASE	Client CLF	Therapist LOF/GAS	Client Assessment of Level of Functioning Higher	Therapist Assessment of Level of Functioning Higher
B1	.03	-1.17	1.20	
B2	-.08	-.59	.51	
B3	-.80	.38		1.18
B4	1.67	.16	1.51	
B5	.97	-1.16	2.13	
I1	-.98	.35		1.33
I2	.00	-.66	.66	
I3	-.17	-.01		.16
I4	-.82	.64		1.48
I5	.56	.35	.21	
I6	1.69	.94	.75	
I7	.38	-.01	.39	
D1	-.27	-.56	.29	
D2	-1.22	-.30		.92
D3	-.03	-.74	.71	
D4	.62	-1.42	2.04	
K1	-.59	1.00		1.59
K2	.-.05	-1.32	1.27	
K3	-1.19	-.92		.27
K4	-1.09	-1.54	.45	
K5	.52	-.15	.67	
K6	-.18	.46		.44
K7	.27	.93		.66
			$\bar{\chi}$= .867	$\bar{\chi}$= .662

Level of Functioning and Nonspecific Variables

Pearson correlation was calculated by examining the association between the predictor variables scores and the criterion variable. Pearson correlation was performed for each level of functioning measure. Pearson correlation results indicated that a significant negative correlation ($p < .05$) was observed between the scores of the respondents on the CLF level of functioning measure and the nonspecific variables working alliance, mutual affirmation and openness, and a significant negative correlation ($p < .01$) for the nonspecific variable empathic resonance (Table 18).

No significant correlation was observed between the scores of the respondents on the LOF/GAS level of functioning measure and the nonspecific variables. Table 18 reports the pearson correlation coefficients between level of functioning measures and nonspecific variables.

Level of Functioning and Specific Variables

Pearson correlation results indicated that no significant correlation was observed between the scores of the respondents on the CFL level of functioning measure and the specific variables (Table 19).

No significant correlation ($p < .001$) was observed between the scores of the respondents on the LOF/GAS level of functioning and the specific variables. Table 19 reports the pearson correlation coefficients between level of functioning measures and specific variables

Table 18: Pearson Correlation Coefficients between Client Level of Functioning Measures and Nonspecific Variables

Nonspecific Variables	Client Measure CFL r	Therapist Measure LOF/GAS r
Working Alliance	-.270*	-.169
Empathic Resonance	-.324**	-.244
Mutual Affirmation	-.176*	-.230
Openness	-.280*	-.190
Encouragement	-.174	-.186
Therapeutic Relationship	.083	-.238

P< .05*, p<.01**

Table 19: Pearson Correlation Coefficients between Client Level of Functioning Measures and Specific Variables

Specific Variables	Client Measure CFL r	Therapist Measure LOF/GAS r
Directive/Behavioral	.095	-.059
Affective	.183	-.030
Psychodynamic/Past-focused	.056	-.156

Multivariate Model of Level of Functioning

A step-down multiple regression model was employed to determine if the predictor variables (specific and nonspecific) interacted to account for a greater percentage of the variance in short-term psychotherapy outcome than either set of variables on their own. Through the use of multiple regression, a multivariate model explaining the effects of the various predictor variables was generated.

Data Screening

Data was checked before being submitted to the regression procedures. Frequency distributions were run on variables to assess for outliers and for violation of normality of distribution. The distribution was determined to be normal, that is, the result of the frequency check was a distribution that was unimodal and symmetrical at the midpoint (Craft, 1990). The distribution of scores were also tested for heteroscedacity to determine if the data depicted unequal variance in the criterion variable across values of the predictor variables. This was done in order to determine if the data met the assumption of homoscedasticity. Data is considered homoscedastic (Craft, 1990) when there is equal variances in Y across X. Testing for heteroscedacity examines the residual scores in each distribution and produces scattergrams. Examination of the scattergrams indicated that the data was linear and homoscedastic in all conditions.

The tolerance of a variable was used as a measure of multicollinearity. Each predictor variable was treated as a criterion variable and regressed on the other predictor variables. A high multiple correlation indicates that the variable is closely related to the other predictor variables and therefore contain redundant information. Tolerance is defined as $1-R^2$, therefore a tolerance of 0 would indicate perfect multicollinearity. Tolerance was requested by SPSS. An examination of the tolerance scores indicated no evidence of multicollinearity between the predictor variables.

Measurement Strategy

The multiple regression analyses began with the total set of predictor variables and eliminated variables one by one, beginning with the variable accounting for the least variation in the criterion variable, "or the one that is least predictive of the criterion variable" (Craft, 1990, p.161). This yielded a multicorrelation coefficient (R). The multiple correlation coefficient (R) is a measure of the magnitude of the relationship between a criterion variable and a predictor variable or some combination of predictor variables. The larger the R the stronger the relationship.

The *b* weights in this study, the individual's scores on the predictor variables that are multiplied by their respective regression weights and then summed to give the best possible prediction of the individual's score

on the criterion variable, were converted to beta (β) weights. Beta weights are the regression weights in a multiple regression equation in which all of the variables in the equation are in standard score form.

A correlation analysis formed the basis for the multiple regression. The correlation between two variables was used to develop a prediction equation. In order to accomplish this, the relationship between the two variables, the predictor (X) and the criterion (Y), was measured. The purpose of this statistical technique is to determine which of the predictor variables can be combined to form the best prediction of the criterion variable. The objective of multiple regression is to use the subjects' scores on some or all of the predictor variables to predict their scores on the criterion variable.

Multiple regression analysis has the potential to be misused by confusing prediction with explanation. Prediction is the definition of the relationship, that is, the degree of influence the predictor variables have on the criterion variable and not an explanation of cause and effect.

The multivariate model developed will be presented in the following sequence:

A) Step One: Multiple regression analyses of the total sample.

The multiple regression analyses of the total sample involved the following procedures for each level of functioning measure:

1. Separate entry of nonspecific variables.
2. Separate entry of specific variables.

3. Joint entry of nonspecific and specific variables.

Each regression equation was compared to examine the effects of the predictor variables on level of functioning and to ascertain if the hypotheses could be validated.

B) Step Two: Multiple regression analyses of the three level of functioning groups for each level of functioning measure:

The multiple regression analyses of the level of functioning groups involved the following procedures:

1. Separate entry of nonspecific variables.
2. Separate entry of specific variables.
3. Joint entry of nonspecific and specific variables.

Each regression equation was compared to examine the effects of the predictor variables on level of functioning and to ascertain if the hypothesis could be validated. Next the multivariate model developed in Step One was compared to the multivariate model developed as a result of the analyses of the three level of functioning groups (Step Two).

Step One: Multiple Regression Analyses of the Total Sample of Cases

This section will provide the interpretation of the results of the multiple regression analyses applied to the total sample of cases. The predictor variables will be entered into the multiple regression equation separately and then together in order to determine their influence on level of functioning.

The Influence of Nonspecific Variables on Level of Functioning

CLF.

The first multiple regression was performed by using the CLF measure of level of functioning as the criterion measure (Table 20). When only the nonspecific variables are entered into the regression equation the variable empathic resonance remained in the regression equation. The R^2 of .106 indicates that 10% of the variance in level of functioning was accounted for by this variable. Using a p=.05 level of significance (p=.010) empathic resonance contributes significantly to the regression equation. The Beta score associated with empathic resonance is negatively correlated with the criterion variable level of functioning. This indicates that as empathic resonance increases level of functioning decreases.

LOF/GAS.

The second multiple regression was performed by using the LOF/GAS measure of level of functioning as the criterion variable. When only the nonspecific variables were entered into the regression equation, the variables, therapeutic relationship and empathic resonance remained in the regression equation. The R^2 of .118 indicates that 12% of the variance in level of functioning was accounted for by these two variables. Using a p=.05 level of significance, only empathic resonance (p=.048)

TABLE 20 **STEP-DOWN MULTIPLE REGRESSION ANALYSIS OF NONSPECIFIC VARIABLES ON LEVEL OF FUNCTIONING BY CLF.**

TOTAL SAMPLE (N=63)

Nonspecific Variables	Beta	t	Sig
Empathic Resonance	-.326	-2.018	.010

R^2 = .106, F=7.146
p = .010

contributes significantly to the regression equation.

The Beta score associated with empathic resonance is negatively correlated with the criterion variable level of functioning. This indicates that as empathic resonance increases level of functioning decreases. Table 21 reports the multiple regression results of the separate entry of nonspecific variables as measured by the LOF/GAS.

The Influence of Specific Variables on Level of Functioning

CLF.

The first multiple regression was performed by using the CLF measure of level of functioning as the criterion measure. When only the specific variables were entered into the regression equation, the R^2 was .000. This indicates that 0% of the variance in level of functioning was accounted for by the specific variables. That is, no specific variables remained in the regression equation as contributors to level of functioning measured by the CLF.

LOF/GAS.

The second multiple regression was performed by using the LOF/GAS measure of level of functioning. When only the specific variables were entered into the regression equation, the R^2 was .000. This indicates that 0% of the variance in level of functioning was accounted for by the specific variables. That is, no specific variables

TABLE 21 **STEP-DOWN MULTIPLE REGRESSION ANALYSIS OF NONSPECIFIC VARIABLES ON LEVEL OF FUNCTIONING BY LOF/GAS.**

TOTAL SAMPLE (N=63)

Nonspecific Variables	Beta	t	Sig
Therapeutic Relationship	.208	-1.689	.097
Empathic Resonance	-.249	-2.018	.048

R^2 = .118, F=3.935
p = .025

remained in the regression equation as contributors to level of functioning measured by the LOF/GAS.

The Influence of Nonspecific Variables and Specific Variables on Level of Functioning

To address the research question of whether there is an interaction between specific and nonspecific variables and level of functioning, the analyses next looked at the results of the regression equation when both specific and nonspecific variables were combined and entered into the regression equation.

CLF.

The first multiple regression was performed using the CLF as the measure of level of functioning. As shown in Table 22 when the nonspecific variables and the specific variables were entered into the regression equation together only the nonspecific variable empathic resonance remained in the regression with a R^2 of .106. This indicates that 10% of the variance in level of functioning was accounted for by this nonspecific variable.

The Beta score associated with the nonspecific variable empathic resonance was negatively correlated with the criterion variable level of functioning; that is, as the scores for empathic resonance increased, level of functioning scores decreased. The nonspecific variable empathic resonance (p=.010) did not contribute significantly to the regression

equation.

As measured by the CLF, the comparison to the separate entry of the nonspecific variables (R^2=.106) and the separate entry of the specific variables (R^2=.000) into the regression equation, the joint entry of the predictor variables (R^2=.106) did not improve the regression equation.

LOF/GAS.

The second regression analysis was performed using the LOF/GAS as the measure of level of functioning. As shown in Table 23, when the nonspecific variables and the specific variables were entered into the regression equation together, the specific variable psychodynamic/past-focused in combination with the nonspecific variables therapeutic relationship and empathic resonance remained in the regression with a R^2 of .166. This indicates that 16% of the variance in level of functioning was accounted for by this combination of specific and nonspecific variables.

The Beta scores associated the specific variable psychodynamic/past-focused and the nonspecific variable empathic resonance were negatively correlated with the criterion variable level of functioning, that is, as the scores for psychodynamic/past-focused and empathic resonance increased, level of functioning scores decreased. The specific variable psychodynamic/past-focused (p=.071) did not contribute significantly to the regression equation.

TABLE 22 **STEPDOWN MULTIPLE REGRESSION ANALYSIS OF NONSPECIFIC VARIABLES AND SPECIFIC VARIABLES ON LEVEL OF FUNCTIONING BY CLF**

	TOTAL SAMPLE (N=63)		
INDEPENDENT VARIABLES	Beta	t	Sig
Empathic Resonance*	-.326	-1.735	.010

R^2 = .106, F = 7.146
p = .010
*nonspecific variable

As measured by the LOF/GAS, the comparison to the separate entry of the nonspecific variables (R^2=.118) and specific variables (R^2=.000) into the regression equation, the joint entry of the predictor variables (R^2=.166) minimally improved the regression equation. The multiple R of .408 indicates a moderate correlation but significant between the predictor variables and the criterion variable when measured by the LOF/GAS. The joint entry of the predictor variables increased the percentage of variance accounted for in level of functioning compared to the separate entry of the predictor variables. In addition, the joint entry of the predictor variables increased the influence of the specific variables none of which remained in the regression equation when entered on their own. Table 24 presents the multiple regression model of the predictor variables and level of functioning for the total sample.

In summary of the Step One analyses, when level of functioning was measured by the CLF, the nonspecific variable empathic resonance remained in the regression equation while no specific variables remained in the regression equation when each set of predictor variables were entered separately. When the predictor variables were entered together into the regression equation only one nonspecific variable, empathic resonance, remained in the regression equation. No combination of specific and nonspecific variables remained in the regression equation. The percentage of variance in level of functioning accounted for by the

TABLE 23 **STEPDOWN MULTIPLE REGRESSION ANALYSIS OF NONSPECIFIC VARIABLES AND SPECIFIC VARIABLES ON LEVEL OF FUNCTIONING BY LOF/GAS**

	TOTAL SAMPLE (N=63)		
INDEPENDENT VARIABLES	Beta	t	Sig
Psychodynamic/Past-focused**	-.230	-1.842	.071
Therapeutic Relationship*	.282	2.214	.031
Empathic Resonance*	-.230	-1.901	.002

R^2 = .166, F = 3.860
p = .014
*nonspecific variable **specific variable

joint entry of the predictor variables is R^2 was .106.

When level of functioning was measured by the LOF/GAS, the separate entry of the predictor variables resulted in two nonspecific variables, therapeutic relationship and empathic resonance, at a R^2 of .118, and no specific variables remaining in the regression equation. When the predictor variables were entered together into the regression equation a combination of specific and nonspecific variables remained in the regression equation. Of the nonspecific and specific variables examined three variables remained in the regression equation, one specific variable, psychodymanic/past-focused and two nonspecific variables, empathic resonance and therapeutic relationship. The percentage of variance in level of functioning accounted for by the joint entry of the predictor variables is R^2 was .166.

Step Two: Multiple Regression Analysis of the Predictor Variables by Levels of Functioning Groups

As noted in Chapter Three, a second objective of this study is to investigate if there was a difference in the percentage of variance accounted for by nonspecific and specific variables when cases are categorized into three level of functioning groups (low scores/medium scores/high scores) as compared to the total sample of cases. To accomplish this the level of functioning z-Scores were used to divide the sample of cases the three categories of level of functioning for each level

TABLE 24 MULTIPLE REGRESSION MODEL OF PREDICTOR VARIABLES (Total Sample)

PREDICTOR VARIABLE DEFINITIONS	CLF		LOF/GAS	
	SEPARATE ENTRY OF VARIABLES	JOINT ENTRY OF VARIABLES	SEPARATE ENTRY OF VARIABLES	JOINT ENTRY OF VARIABLES
	Beta	Beta	Beta	Beta
NONSPECIFIC VARIABLES				
WORKING ALLIANCE: The investment of self into the appropriate role by each participant	*	*	*	*
EMPATHIC RESONANCE: The quality of communication between the therapist and the client that depends on their compatibility in range and style of expressiveness and understanding.	-.326	-.326	-.249	-.230
MUTUAL AFFIRMATION: The care, respect and commitment to the other person's welfare that the therapist and client may evoke or feel for the other.	*	*	*	*
OPENNESS: The degree the client is willing to enter into a collaborative relationship with the therapist.	*	*	*	*

Table 24 continued

TABLE 24 MULTIPLE REGRESSION MODEL OF PREDICTOR VARIABLES (Total Sample)

PREDICTOR VARIABLE DEFINITIONS	CLF		LOF/GAS	
	SEPARATE ENTRY OF VARIABLES	JOINT ENTRY OF VARIABLES	SEPARATE ENTRY OF VARIABLES	JOINT ENTRY OF VARIABLES
	Beta	Beta	Beta	Beta
ENCOURAGEMENT: The degree the client feels they are supported	*	*	*	*
THERAPEUTIC RELATIONSHIP: The degree of investment of the therapist in their role of helper	*	*	.208	.282
	R^2 .106		R^2 =.118	
SPECIFIC VARIABLES				
DIRECTIVE-BEHAVIORAL: Active present focused direct interventions.	*	*	*	*
PSYCHODYNAMIC/PAST FOCUSED: More explicit psychodynamic interventions focused on past developmental history and experience.	*	*	*	-.230
AFFECTIVE: Reflects experiential feeling based interventions.	*	*	*	*
	R^2 .000	R^2 .106	R^2 .000	R^2 .166

of functioning measure.

Table 25 reports the z-Scores and the division of cases chronologically for the CLF and LOF/GAS and the respective levels of functioning groups: low scores=group 1; medium scores=2; high scores=3. The investigation of this second objective is intended to be exploratory given two caveats. First, the attrition of cases over the data collection period resulted in fewer cases than the recommended 10 cases to 1 variable ratio (Craft, 1991, p 157). Without this minimum ratio the regression results can get unusually large R^2 by chance alone. When the sample was categorized into the three level of functioning groups the ratio of cases to variables was 21 to 9, therefore, by chance alone the R^2 would be .3. Caution is expressed in interpreting the results given that the ratio of the number of cases to variables is low.

The second caveat is that there was no established formula for the measurements used to establish a cut off point for the respective groups that would accurately classify a case in the appropriate group. The consequence of this is that cases at the transition points between groups could in reality be in either group.

Influence of Nonspecific Variables and Specific Variables on Levels of Functioning

CLF.

Table 26 displays the results of the multiple regression analyses of

Table 25: Level of Functioning by Category

CASE	CLF	GROUP	CASE	LOF/GAS	GROUP
E2	-1.94	1	K4	-4.54	1
J1	-1.89	1	A5	-2.23	1
D3	-1.22	1	L1	-1.76	1
K4	-1.19	1	D4	-1.42	1
E3	-1.15	1	K2	-1.32	1
G5	-1.14	1	E3	-1.25	1
K3	-1.09	1	B1	-1.17	1
F2	-1.08	1	B5	-1.16	1
F1	-1.07	1	E5	-.96	1
I3	-.98	1	K3	-.92	1
I5	-.82	1	D3	-.74	1
B2	-.80	1	I2	-.66	1
C4	-.79	1	B2	-.59	1
C1	-.72	1	D1	-.56	1
K5	-.59	1	C1	-.48	1
L1	-.52	1	F1	-.40	1
A5	-.52	1	G1	-.34	1
A8	-.50	1	D2	-.30	1
A1	-.47	1	A4	-.22	1
D1	-.27	1	A6	-.22	1
A10	-.23	1	F2	-.20	1
K2	-.18	2	A7	-.19	2
J3	-.17	2	K5	-.15	2
I7	-.17	2	J1	-.05	2
A6	-.15	2	C4	-.01	2
L2	-.13	2	I3	-.01	2
J2	-.08	2	I7	-.01	2
B5	-.07	2	L3	.02	2
A9	-.07	2	E1	.14	2
L3	-.07	2	B4	.16	2
K8	-.05	2	G2	.17	2
D4	-.03	2	G3	.17	2
I5	.00	2	A1	.21	2
A3	.00	2	G4	.24	2
B3	.03	2	A2	.24	2
E5	.04	2	E2	.27	2
G1	.15	2	A9	.32	2
L5	.17	2	J2	.35	2
G2	.22	2	I1	.35	2
G4	.23	2	I5	.35	2
H2	.25	2	L6	.38	2
K1	.27	2	B3	.38	2
H1	.37	3	K6	.46	3
I1	.38	3	H1	.49	3
E1	.52	3	E4	.49	3
K6	.56	3	J4	.50	3

Table 25 continued

Table 25: Level of Functioning by Category

CASE	CLF	GROUP	CASE	LOF/GAS	GROUP
I4	.56	3	H2	.54	3
A2	.57	3	G5	.57	3
D2	.62	3	A10	.57	3
J4	.69	3	J3	.61	3
C2	.76	3	L2	.64	3
A7	.81	3	I4	.64	3
L6	.94	3	L4	.68	3
H3	.96	3	C2	.72	3
E4	.97	3	A3	.75	3
B4	.97	3	H3	.79	3
F3	.98	3	F3	.93	3
L4	1.05	3	K7	.93	3
A4	1.05	3	I6	.94	3
C3	1.44	3	C3	.97	3
G3	1.52	3	K1	1.00	3
B1	1.67	3	A8	1.11	3
I2	1.69	3	L5	1.32	3

the predictor variables on the CLF for the three designated level of functioning groups.

For the low score group the specific variables affective and psychodynamic/past-focused remained in the regression equation with a R^2 of .367 (p=.020) when the variables were entered jointly into the regression equation. This indicates that 37% of the variance in level of functioning for the low score case group was accounted for by these variables. When the predictor variables were entered separately into the regression equation for the low score group, the nonspecific variable openness remained in the regression equation with R^2 of .159 (Table 27). That is, 16% of the variance in level of functioning was accounted for by the nonspecific variable openness. When entered separately the specific variables psychodynamic/past-focused and affective remained in the remained in the regression equation with a R^2 .367 (Table 28).

For the medium score group, the nonspecific variable openness had a R^2 of .169 (p=.064) when the predictor variables were entered jointly (Table 26). This indicates that 17% of the variance in level of functioning for the medium score case group was accounted for by these variables.

When the nonspecific variables were entered separately into the regression equation openness accounted for 17% (R^2 = .169) of the variance in level of functioning (Table 27). When the specific variables

were entered into the regression equation separately no variables remained in the regression equation (Table 28).

For the high score group when the predictor variables were entered together the specific variables directive/behavioral and psychodynamic/past-focused and the nonspecific variable openness remained in the regression equation at a R^2 of .282. It was not significant at p= .123 (Table 26). This indicates that only 28% of the variance in functioning was accounted for by this specific variable. The specific variable psychodynamic/past-focused and the nonspecific variable openness were negatively correlated with level of functioning. That is, as the Beta scores of these variables increased level of functioning decreased. In contrast, when the predictor variables were entered into the regression equation separately no nonspecific variables and no specific variables remained in the regression equation.

LOF/GAS.

Table 29 displays the results of the multiple regression analyses of the predictor variable on the LOF/GAS for the three designated level of functioning groups. For the low score group the nonspecific variables empathic resonance and mutual affirmation in combination with the specific variable psychodynamic/past-focused accounted for 41% of the variance in the level of functioning (R^2 = .408) and which was significant

TABLE 26 STEPDOWN MULTIPLE REGRESSION ANALYSES OF PREDICTOR VARIABLES BY LEVEL OF FUNCTIONING GROUPS ON THE CLF MEASURE.

LOW				MEDIUM				HIGH			
PREDICTOR VARIABLES	Beta	t	Sig	PREDICTOR VARIABLES	Beta	t	Sig	PREDICTOR VARIABLES	Beta	t	Sig
Affective	.772	3.141	.006	Openness	.412	1.968	.04	Psychodynamic/ past-focused	-.581	-1.825	.086
Psychodymanic /Past-focused	-.498	-2.019	.059					Openness	-.484	-1.982	.064
								Directive/Behav ioral	.540	1.927	.071
R^2 = .367, F=4.937 P=.020				R^2 = .169, F=3.875 P=.064				R^2 = .282, F=2.2624 p=.123			

TABLE 27 STEPDOWN MULTIPLE REGRESSION ANALYSES OF NONSPECIFIC VARIABLES BY LEVEL OF FUNCTIONING GROUPS ON THE CLF MEASURE.

LOW				MEDIUM				HIGH			
PREDICTOR VARIABLES	Beta	t	Sig	PREDICTOR VARIABLES	Beta	t	Sig	PREDICTOR VARIABLES	Beta	t	Sig
Openness	-.399	-1.844	.082	Openness	.412	1.968	.064				
R^2 = .159, F=3.399 P=.082				R^2 = .169 F=3.875 P=.064				R^2 = .000			

TABLE 28 STEPDOWN MULTIPLE REGRESSION ANALYSES OF SPECIFIC VARIABLES BY LEVEL OF FUNCTIONING GROUPS ON THE CLF MEASURE.

LOW				MEDIUM				HIGH			
PREDICTOR VARIABLES	Beta	t	Sig	PREDICTOR VARIABLES	Beta	t	Sig	PREDICTOR VARIABLES	Beta	t	Sig
Psychodynamic/ past-focused	-.496	-2.019	.059								
Affective	.772	3.141	.006								
R^2 = .367, F=4.937 P=.020				R^2 = .000				R^2 = .000			

at p=.035.

In contrast when the nonspecific variables were entered separately into the regression equation mutual affirmation and empathic resonance accounted for 27% (R^2 = .270) of the variance in level of functioning (Table 30). When the specific variables were entered into the regression equation separately, affective, psychodynamic/past-focused and directive/behavioral all remained in the regression equation at a R^2 = .439 (Table 31).

For the medium score group when the predictor variables were entered together the nonspecific variables of mutual affirmation and therapeutic relationship had a R^2 of .318 (p=.032) (Table 29). This indicates that 32% of the variance in level of functioning for the medium score group was accounted for by these variables. No specific variables remained in the regression equation. The nonspecific variables mutual affirmation and therapeutic relationship were negatively correlated with functioning. For this group of medium score cases, as the Beta scores of these variables increased functioning decreased.

When the nonspecific variables were entered separately into the regression equation mutual affirmation and therapeutic relationship accounted for 32% (R^2 = .318) of the variance in functioning (Table 30). When the specific variables were entered into the regression equation separately no variables remained in the regression equation.

TABLE 29 **STEPDOWN MULTIPLE REGRESSION ANALYSES OF PREDICTOR VARIABLES BY LEVEL OF FUNCTIONING GROUPS ON THE LOF/GAS MEASURE.**

LOW				MEDIUM				HIGH			
PREDICTOR VARIABLES	Beta	t	Sig	PREDICTOR VARIABLES	Beta	t	Sig	PREDICTOR VARIABLES	Beta	t	Sig
Empathic Resonance	-.541	-2.332	.033	Mutual Affirmation	-.548	-2.816	.011				
Mutual Affirmation	.606	2.692	.018	Therapeutic Relationship	-.370	-1.741	.099				
Psychodynamic/ Past-focused	-.375	-1.932	.071								
R^2 = .408, F=3.675 P=.035				R^2 = .318, F=4.189 P=.032				R^2 = .000			

TABLE 30 **STEPDOWN MULTIPLE REGRESSION ANALYSES OF NONSPECIFIC VARIABLES BY LEVEL OF FUNCTIONING GROUPS ON THE LOF/GAS MEASURE.**

LOW				MEDIUM				HIGH			
PREDICTOR VARIABLES	Beta	t	Sig	PREDICTOR VARIABLES	Beta	t	Sig	PREDICTOR VARIABLES	Beta	t	Sig
Empathic Resonance	-.489	-1.968	.066	Mutual Affirmation	-.598	-2.816	.011				
Mutual Affirmation	.591	2.379	.029	Therapeutic Relationship	-.370	-1.741	.099				
R^2 = .270, F=3.141 P=.069				R^2 = .318, F=4.189 P=.032				R^2 = .000			

TABLE 31 **STEPDOWN MULTIPLE REGRESSION ANALYSES OF SPECIFIC VARIABLES BY LEVEL OF FUNCTIONING GROUPS ON THE LOF/GAS MEASURE.**

LOW				MEDIUM				HIGH			
PREDICTOR VARIABLES	Beta	t	Sig	PREDICTOR VARIABLES	Beta	t	Sig	PREDICTOR VARIABLES	Beta	t	Sig
Affective	1.261	3.016	.008								
Psychodynamic/ past-focused	-.477	-1.787	.093								
Directive/Behav ioral	-1.084	-2.659	.017								
R^2 = .439, F=4.165 P=.023				R^2 =.000				R^2 = .000			

For the high score group no predictor variables remained in the regression equation for either the joint entry or the separate entry of nonspecific and specific variables. That is, $R^2 = .000$.

This chapter presented the results of the descriptive analysis of the criterion variable, level of functioning, and the multiple regression analysis of the predictor variables and their effect on the criterion variable. Chapter Five presents the summary and conclusion of these results, in addition to the limitations, methodological problems and the recommendations for future research.

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

This chapter summarizes the outcome of this study and identifies the conclusions that can be drawn from the results of the research. The limitations of this study are discussed and the recommendations for future research are identified.

Summary of Findings

The purpose of this study was to investigate the influence of the therapist on clients' level of functioning in relation to nonspecific and specific variables. Specifically this study investigated whether there is an interaction between specific variables and nonspecific variables that account for a greater percentage of variance in level of functioning than by either specific or nonspecific variables on their own.

The premise of this study was based on the recommendation of Luborsky et al. (1986) that research on psychotherapy provided by experienced psychotherapists might provide more insight about the process of therapeutic change than the usual between treatment comparisons. It was also based on the belief supported by Kolden, Howard, and Maling (1994) that the therapist "is both the provider and the instrument" (p. 82) of therapy.

The investigation of specific and nonspecific variables in this study

evolved from Wexlar's (1974) assertion that the curative effect of the therapeutic relationship is believed to accrue from the therapists establishing an "understanding" atmosphere which permits "growth and change" (p.95). It also evolved from the premise brought forward by Firth (1966) who attributed the influence of the therapeutic relationship on the process of change to the therapists' development of "specialized techniques" (p. 196) that enable them to plan their role effectively.

This is a quantitative correlational (passive-observational) study of short-term psychotherapy clients treated by therapists in a national EAP. Sixty-three clients of twelve therapists voluntarily participated in the study. By the use of a comparative approach, two level of functioning measures, the CLF and the LOF/GAS, measured the clients' level of functioning from the perspective of the clients (CLF) and the perspective of the therapists (LOF/GAS).

As indicated, the study involved two stages. Stage one identified and defined the criterion variable, the client's level of functioning at the completion of therapy. A summary of the comparison of the client's level of functioning from the perspective of the client as measured on the CLF and from the perspective of the therapist as measured on the LOF/GAS is presented and discussed. The criterion variable, client level of functioning, was measured by the pretest and posttest of the CLF and the LOF/GAS measures to determine the degree of change in level of functioning. The results of the difference between the pretest and posttest

scores will be discussed in relation to the effectiveness of the short-term psychotherapy model utilized by the therapists in this study.

The second stage involved the multiple regression analyses of the influence of the predictor variables on the client's level of functioning. A summary of the multivariate model explaining the influence of the predictor variables on the client's level of functioning following the completion of therapy will be discussed.

Level of Functioning

Analyses of the t tests for each outcome measure show that t values for the pretest and posttest differences were significant at the $p < .001$ level of significance (Table13 and Table 14). The magnitude of the pretest and posttest differences indicate that short-term psychotherapy treatment had a significant positive effect on level of functioning. This finding is consistent with other outcome studies (Koss & Butcher, 1986; Koss & Shiang, 1994; Strupp, 1980; Luborsky, Mintz, Auerbach, Christoph, Bachrach, Todd, Johnson, Cohen & O'Brien, 1980) .

Determinants of Level of Functioning

Pearson correlation coefficients between level of functioning and specific and nonspecific variables were computed. The CLF was found to be in significant association with the nonspecific predictor variables, except therapeutic relationship and encouragement. The CLF did not have

a significant association with any of the specific variables. The LOF/GAS did not result in any significant association with the predictor variables. In order to explore the relative effects of the predictor variables in explaining level of functioning, multiple regression was employed.

It is notable that in Table 18 the r is negative for each of the nonspecific variables except therapeutic relationship and encouragement. This indicates that the criterion variable CLF and the nonspecific variables are negatively correlated, in that those clients with high CLF scores have low scores for these predictor variables. The negative correlation for these variables was an unexpected result given this study's hypothesis assumed and the literature review indicated a positive relationship between level of functioning and nonspecific variables.

The correlation coefficient, does not indicate causality. What it does indicate is that one can predict the value of one variable if the value of the other variable is known. Since one variable is not causing the variation in the other variable, quite possibly some third variable is responsible for the variation in both. Therefore one could not state that low scores on nonspecific variables are responsible for high outcome scores. What can be interpreted is the strength of the relationship.

Guilford (1950, p. 165) provides a definition of the strength of the relationship between variables that covary. The nonspecific variables working alliance with a r= -.270, empathic resonance with a r=-.324 and openness with a r=-.281 indicates a low correlation with the relationship

being described as definite but small. The nonspecific variable mutual affirmation with a r=-.174 indicates a slight correlation with the relationship being described as negligible.

As indicated in the methods chapter, the data was analyzed in the following way. First, the total sample of cases was analyzed employing a series of backward multiple regressions. Each set of nonspecific and the specific variables were analyzed separately and then together on each level of functioning measure.

Next, the level of functioning groups were also analyzed employing a series of backward multiple regressions. Each set of variables were again analyzed separately and together. The results of the multiple regression analyses were then compared to discern if there were any identifiable differences in the percentage of variance accounted for in level of functioning between each level of functioning group and in comparison to the total sample.

Multiple Regression Analyses of the Total Sample of Cases

The Influence of Predictor Variables on Level of Functioning

Results of the multiple regression of the separate entry of nonspecific variables with the CLF indicate that the variable empathic resonance remained in the regression equation accounting for 10% of the variance in level of functioning and contributing significantly to the regression equation at p=.010. As indicated empathic resonance resulted

in an unexpected negative correlation with level of functioning.

The results of the separate entry of specific variables into the regression equation with the CLF resulted in a R^2 of .000. That is no specific variables remained in the regression equation.

Results of the joint entry of the nonspecific and specific variables indicate that only the nonspecific variable empathic resonance remained in the regression equation accounting for 10% of the variance in level of functioning and contributing significantly to the regression equation at p=.010. Not only were the results the same as the separate entry of nonspecific variables the remaining variable empathic resonance resulted in a negative correlation. The joint entry of the predictor variables did not improve the degree of variance accounted for in level of functioning when the CLF was the criterion variable.

Results of the multiple regression of the predictor variables and their effect on the criterion variable as measured by the LOF/GAS indicate that when entered separately the nonspecific variable empathic resonance remains in the regression equation accounting for 12% of the variance in level of functioning, while no specific variables remain in the regression equation. Empathic resonance remained negatively correlated and was still an unexpected result.

The joint entry of the predictor variables results in the specific variables psychodynamic/past-focused in combination with the nonspecific variables therapeutic relationship and empathic resonance

accounting for 16% of the variance in level of functioning. Both empathic resonance and psychodymanic/past-focused resulted in a negative correlation while therapeutic relationship was positively correlated. The negative correlation continued to be an unexpected result.

The nonspecific variable empathic resonance was the consistent variable to remain in the regression equation for each outcome measure. Therapeutic relationship and psychodynamic/past-focused remained in the regression equation for only the regression analysis of the joint entry of predictor variables on the LOF/GAS. Similar to the pearson correlation results, the negative Beta (partial coefficient) score for the nonspecific variable empathic resonance was an unexpected result. The literature on nonspecific variables and psychotherapy outcome clearly indicates a positive rather than negative association. As indicated, given that the relationship is predictive in multiple regression and not cause and effect, it is possible that other variables not measured are responsible for the negative correlation identified between empathic resonance and the criterion variable level of functioning. This negative correlation result remains unexplainable and contrary to current assumptions about the relationship between nonspecific variables and psychotherapy outcome. Certainly, it would be inaccurate to interpret or claim as a result of this analysis that a high degree of empathic resonance inhibits or detracts from a higher level of functioning.

The joint entry of the predictor variables does indicate that the

interaction between specific and nonspecific variables increases the percentage of variance accounted for in level of functioning when measured on the LOF/GAS. When measured by the LOF/GAS the increase was from a R^2 of .118 to a R^2 of .166, compared to the CLF where both the separate and joint entry of the predictor variables resulted in a R^2 of .106.

The analysis of the data on the total sample clearly indicates that neither specific variables nor nonspecific variables on their own account for any appreciable proportion of the variance in the criterion variable (level of functioning) as measured by the CLF and the LOF/GAS. The results of the analysis on the total sample of cases instills little confidence in employing either separate regression models or a joint regression model of nonspecific and specific variables to predict level of functioning. Measuring level of functioning on the LOF/GAS resulted in a more powerful explanation than the CLF, however, the joint entry of the predictor variables (R^2 = .166 on the LOF/GAS) is at best a minimum explanation of the percentage of variance that the predictor variables account for in level of functioning.

The limited degree of variance explained by the predictor variables may be directly attributable to the measurement of the predictor variables after the last session of therapy. The last session may not be representative of other therapy sessions. That is, the last session of therapy may involve therapists' employing techniques differently, as well

as, a change in the therapeutic relationship in anticipation of termination of therapy.

In addition, the measure of specific variables by the Therapeutic Procedures Inventory may have resulted in eliciting a general focus of therapy based on the therapists' theoretical orientation (Affective, Psychodynamic/past-focused, Directive/Behavioral) rather than the therapeutic techniques actually employed by the therapist. Utilizing more specific measures of identifiable specific therapy techniques may have yielded different findings. For both the specific and nonspecific variables different results may have been found if the predictor variables were measured in an earlier session.

In actuality, what this study has measured is the degree that the predictor variables were present in the last therapy session and the degree of variance these last session predictor variables account for in the criterion variable, level of functioning. Still, the negative associations between client outcome and nonspecific variables in the last session are difficult to explain.

It was notable that empathic resonance surfaced as one of the most important factors which has the greatest amount of explanatory power as a last session predictor variable concerning level of functioning. It was very surprising that empathic resonance resulted in a negative correlation with level of functioning. One would expect that a high quality of communication between the therapist and the client would promote a high

level of functioning. One would also assume that the quality of the communication between the client and the therapist should continue to improve over the course of therapy if therapy resulted in improvement.

It would be a mistake to conclude that the clients who report a high degree of empathic resonance do less well in therapy than those clients who report a lower degree of empathic resonance. As indicated the results may have been influenced by the measurement of the variables in the last session and by some other variables that may be exerting influence on the variance between the predictor variables and level of functioning. What the results do raise is a question in relation to the general assumption about the therapeutic process that nonspecific variables that promote the strength of the relationship are a major predictor of outcome. It is generally accepted that a strong positive relationship is critical to a positive outcome. Therefore, these results seem counter intuitive, that is, could a client experience less empathic resonance in their relationship with their therapist and still do better in therapy than a client who experiences a high degree of empathic resonance. One explanation may be that the client can't know and therefore can't report if any other experience of life pursuit contributed to their report of improved level of functioning more than the therapy experience. This may also be indicative that empathic resonance on its own, despite being identified as a high score, is not enough to promote a higher outcome score.

Another explanation offered by Frank and Frank (1991) argues that

therapy is effective not as a result of it's specific theories or methods but as a result of clients "coming to believe" in those theories and methods. Some clients may indeed believe that they been helped and that their level of functioning has improved despite reporting a low degree of empathic resonance because of their belief that what the therapist knows and does will create change.

Therapeutic relationship, the degree of investment of the therapist in role of helper, surfaced as one of the other most important last session predictor variables which has the greatest amount of explanatory power concerning level of functioning. This nonspecific variable was measured by the therapist where as the other nonspecific variables were measured by the client.

In contrast to the unexpected negative correlation of empathic resonance, therapeutic relationship was positively correlated and significant at p= .031. The alliance between the client and the therapist is considered to be the glue that binds the therapeutic process. A productive open, and trusting relationship is considered by most theorists and therapists as the vehicle for therapeutic change (Beutler & Consoli, 1992).

The positive association of therapeutic relationship with level of functioning in this study is congruent with the consensus in the field. There are, however, a number of critics of the importance of the influence of the therapeutic relationship on psychotherapy outcome. Dineen (1996) criticizes therapists for acting like experts in the absence

of demonstrable expertise and for promoting their effectiveness in absence of supporting evidence. Her major criticism is that their practice is based on trained intuition and expert judgement which "presumably allows them to transcend scientific principles and ignore research findings" (p.164). She argues that the therapeutic relationship is no more influential than the client's hope and belief in the perceived curative power of the therapist. Watters and Ofshe (1999) describe the influence of the therapeutic relationship on outcome to be the result of a dance of confidence portrayed by therapists and their belief in the power of the curative effects of their own therapy and techniques as opposed to the influence being the result of an open, honest and trusting relationship between the client and the therapist.

If Lambert's (1992) analysis of the outcome research is accurate, extratherapeutic factors such as client characteristics and fortuitous incidents in the client's life account for 40% of the variance in psychotherapy outcome. It would be interesting to evaluate their influence on outcome in relation to nonspecific and specific variables as a potential set of interactive variables. This may provide an explanation for the results of this study and identify extratherapeutic factors as the possible variables that influenced the negative correlation.

This is conjecture, however, one wonders why the majority of research including this study continue to focus on nonspecific variables which account for an estimated 30% and specific variables that account

for an estimated 15% (no more than the 15% attributed to a placebo effect) and not the extratherapeutic factors which account for an estimated 40%.

This study, similar to current psychotherapy outcome studies, did not address the resilience of the client. That is, 'the self', who clients are and to what degree the internal and external resources that they may incorporate into the process of change account for the variance in level of functioning. These extratherapeutic factors may be a partial explanation for the results of this study and may be an indication clients bring with them a repertoire of life experience strengths and skills that assist them to progress through the process of change with more or less success. It would be interesting for future research to measure the resilience and capability of the client as a predictor variable of level of functioning. That is, despite a client's distress, does their worldview, their interpretation of self, of their own acts of perception, thought, volition, feeling and doing account for improvement in level of functioning and therefore what is the relationship to the criterion and predictor variables identified in this study. It may well be as Jaspers (1963) points out, that the process of therapeutic change is so complex that we are likely never to understand fully what happens and why, nor will we ever reduce it's essence to a few skills, concepts or variables.

Multiple Regression Analysis of Predictor Variables by Level of Functioning Groups

The Influence of Nonspecific and Specific Variables on Level of Functioning

As noted in chapter four, the investigation of this second objective is intended to be exploratory given the following caveat. That is, the attrition of cases over the data collection period resulted in fewer cases than the recommended 10 cases to 1 variable ratio (Craft, 1991, p 157). Without this minimum ratio the regression results can get unusually large R^2 by chance alone. When the sample was categorized into the three level of functioning groups the ratio of cases to variables was 21 to 9, therefore, by chance alone the R^2 would be .3. Caution is expressed in interpreting the results given that the ratio of the number of cases to variables is low.

The low score level of functioning group had an R^2 of .408 at a level of significance p =.035 for the combination of predictor variables compared to a R^2 of .270 for the separate entry of nonspecific variables and a R^2 of .439 for the separate entry of specific variables when measured by the LOF/GAS. When measured by the CLF the separate entry of the predictor variables resulted in a R^2 =.159 for the nonspecific variables and a R^2 =.367 for the specific variables. The joint entry of the predictor variables resulted in a R^2 of .367 at p=.020.

The medium score level of functioning group had an R^2 of .169 at level of significance p= .064 for the combination of predictor variables

compared to the separate entry of specific variables (R^2 =.000) and nonspecific variables (R^2 =.169) when measured by the CLF. When measured by the LOF/GAS the combination of predictor variables resulted in a R^2 of .318 at a level of significance p= .032 compared to a R^2 of .318 for the separate entry of nonspecific and a R^2 .000 for the separate entry of the specific variables.

The high score level of functioning group had an R^2 of .282 at level of significance p= .123 for the combination of predictor variables compared to the separate entry of specific variables (R^2 =.000) and nonspecific variables (R^2 =.000) when measured by the CLF. When measured by the LOF/GAS the combination of predictor variables resulted in a R^2 of .000 compared to a R^2 of .000 for the separate entry of nonspecific and a R^2 .000 for the separate entry of the specific variables.

Analyses of the level of functioning groups did not support the hypothesis that nonspecific variables in combination with specific variables are interactive and improve the percentage of variance accounted for in level of functioning except for the high score group when measured with the CLF. This of course could be directly attributable to the small ratio of sample size to variables.

Methodological Problems

In the course of collection of the data several methodological problems arose. The major question raised was the extent to which the results found here might be artifacts of the measures used.

Both clients and therapists complained that the measures involved more time than they expected. This may be part of the explanation for the number of therapists that dropped out of the study and the number of final instruments with incomplete data or missing post therapy measures.

It would have been helpful to have the instruments administered by someone other than the therapists. They experienced a significant amount of difficulty organizing their time and their caseload to promote completion of the instruments. An external administrator would have significantly increased the potential number of therapists and cases with a complete set of data. This however was financially prohibitive for this researcher.

The instruments are self-report inventories that provide a measure of how the participants feel and are used because the participants are able to report on his or her own thoughts. These types of instruments permit assessment of several domains of functioning across a range of different situations which has the advantage of providing a comprehensive portrait of the participants' experience. Kazdin (1992) indicates that there are two general categories of problems "that characterize many self-report

measures: (a) the biases on the part of the participants and (b) the lack of evidence that the measures assess the characteristic of interest" (p. 238).

In relation to the biases on the part of the participants the results may have been influenced by the clients and therapists need to appear in the best possible light. For clients this tendency towards social desirability may lead to endorsing more socially condoned behaviors (Crowne & Marlow, 1964). Similarly, therapists may endorse what they perceive to be the more theoretically condoned technique and not the intervention they actually used.

Another source of bias related to self-report measurement of problems is that clients may rate symptoms and presenting problems more seriously if they believe that this will ensure access to therapy or promote a more prompt response to offering service. Conversely at the completion of therapy they may overestimate the degree of improvement responding in a more socially desirable fashion. Matzloff and Kornreich (1970) have referred to this as the 'hello-goodbye' effect.

As much effort as possible was attempted to minimize the distortion of the social desirability effect on this study. As Kazdin (1992) recommends, clients and therapists were guaranteed anonymity in that their names would not be included in the testing material and that their therapist would not have access to the outcome of clients' specific ratings. Confidentiality was guaranteed by the signing of an informed consent document for both client and therapist. Lastly, it was conveyed to

the client and therapist that his or her best interests are served by honest self-evaluation. As Kazdin (1992) highlights there is no indication of the degree of influence these measures have on decreasing the influence of social desirability.

In relation to the predictor variable measures the major question raised is also the extent to which the results formed in this study are artifacts of the time at which the measures were used. Specifically, the measurement of the predictor variables following the completion of therapy is questionable. This resulted in the clients' and therapists' reporting on the presence of the predictor variables in the last session. Therefore the regression equation measured the variance accounted for in the criterion variable by last session predictor variables. Employing the predictor variable measures as post therapy measures raises the external validity question as to whether the same results would have been obtained had measurement been taken at another time. Given that psychotherapy is generally comprised of a number of stages (i.e., the engagement of the client, implementation of the treatment plan and termination of treatment) the last session is not likely representative of the other stages of therapy. In order to better assess the influence of the predictor variables on level of functioning the predictor measures would need to be administered in a session (or sessions) this (are) representative of the working stage of therapy.

One way to strengthen the design of this study, albeit prohibitively

expensive, would have been to have the therapy sessions recorded (with the clients' consent) and evaluated by a designated judge who would evaluate the presence of specific and nonspecific variables. This would then be compared to the participants' evaluation of the presence of nonspecific and specific variables.

Of the original 40 therapists who indicated an intent to participate in the study 20 dropped out of the study for the variety of reasons. It became apparent that history and maturation significantly impacted on the outcome of this study by hindering the completion of cases. Therapists who agreed to participate and then failed to complete the study had the best of intent and hoped that the research tasks they were asked to complete would come together. The majority of this group did not want to formally drop out of the study because of the commitment they made and generally did not want to disappoint the researcher.

Limitations of the Study

The results of therapist influence on short-term psychotherapy may have emerged more statistically robust if the number of clients per therapist had been higher. The fact that therapists and clients self-selected (volunteered) to participate in the research may not have resulted in as diverse a sample of therapists and clients as desired and therefore may not support any generalization to the population of short-term therapists.

The external validity of this design may have been affected by an

interaction of the pretest with the treatment, that is, the treatment may produce significant effects only because a pretherapy measure was administered. In this study, there may not be a significant enough period of time between the pretest and the post test to minimize the effect of this interaction. This may, however, promote internal validity due to the change in level of functioning not being fully attributable to maturation.

Instead of a correlational (passive-observational) design, the study may have been more enlightening if the design was a time series whereby predictor variable measures were administered after a number of sessions. This may have led to the identification of a number of patterns and trends of what happens at what stage of therapy and may have highlighted whether or not there are identifiable patterns between the predictor variables and the stage of therapy. The lack of identifiable patterns or trends in which combinations of specific and nonspecific variables that might predict level of functioning is directly attributable to the small sample size of this study.

Overview

This study was based on an emerging consensus in the literature that the specific versus nonspecific distinction seems irrelevant and that to promote the training of technically good therapists in the absence of deeply felt positive responses to the client (nonspecific variables) is a contradiction in terms. It was also based on the premise posited by

Orlinsky and Howard (1986) that nonspecific variables likely have a "double barreled" (p.351) effect compared to specific variables. They proposed that a good relationship not only had a direct impact on outcome through the enhancement of client morale but also was a major precondition for clients' openness to specific therapeutic interventions.

Unfortunately the results of this study, particularly the negative correlation of a number of the predictor variables with client outcome, do not support the emerging consensus in the literature and the cumulative results of previous research identified in the literature review. The measurement of the presence of these variables in the last session of therapy and the possibility that other variables outside of the therapy experience could have influenced the variance accounted for in the variables that are part of the regression solution provides a possible explanation. As the critics of psychotherapy argue, what we believe to be the essential components of the psychotherapy process, nonspecific and specific variables, may not be the most salient predictors of improvement in client outcome.

Despite methodological problems this study's design had a number of strengths: the use of rigorous outcome data, that is, multiple outcome measures from the perspective of both the client and the therapist were used; the study was multi-site; it used experienced therapists from a variety of orientations and training and clients presenting with a variety of presenting problems; and, it was a natural study of experienced

therapists and clients from the general population who access mental health services.

Future Research

Methodologically, it would seem more relevant to run a time series study rather than the post therapy design of this study. A time series design may provide more detail about the process of therapy given that therapy is a process of reciprocal interactions between the therapist and client that involve the distinct phases of engagement, the invitation to change (implementation of the treatment plan) and termination.

This study raises a number of suggestions for further research:

1. Replicating this study by employing a time series design in other clinical settings utilizing a larger sample.

2. Investigating the influence of therapists on short-term psychotherapy outcome by comparing good outcome cases with poor outcome and dropout cases, may assist in identifying more specifically which therapist variables contribute to the success of therapy.

3. Utilizing technique variable measures that identify specific therapeutic techniques as opposed to the general strategies of the three theoretical orientations measured by the Therapeutic Procedures Inventory.

4. Exploring of the influence of extratherapeutic factors such as client characteristics or life incidents outside of the therapy experience in

relation to an interaction with specific and nonspecific variables. (particularly the impact of pre-therapy expectations and resilience within the client).

It is hoped that this study will promote future interest in the influence that therapists have on short-term psychotherapy outcome and in particular in the investigation of those therapist factors that improve and promote client well-being.

Anecdote

A homeowner awoke to discover that his basement was flooding. Shortly after calling the plumber both were standing knee deep in water. As the level of the water continued to rise the plumber pushed back his hat, scratched his head and surveyed the pending disaster. He reached into his toolbox and withdrew his hammer at which point he waded into the rushing water and banged forcefully on a pipe. The water immediately stopped flowing and the level began to recede.

The plumber closed his toolbox and handed the homeowner the bill. The surprised homeowner confronted the plumber exclaiming," how can you possibly charge me two hundred dollars when all you did was hit the pipe with the hammer. I could have done that for nothing!" The plumber confidently replied, "its only twenty-five dollars for the house call and one hundred and seventy-five dollars for knowing where to hit the pipe with the hammer".

BIBLIOGRAPHY

Alexander, F., & French, T.M. (1946). Psychoanalytic therapy? Principles and application. New York: Ronald Press.

Alexander, J.F., Barton, C., Schiavo, R.S., & Parsons, B.V. (1976). Systems-behavioral interventions with families of delinquents: Therapists characteristics, family behavior, and outcome. Journal of Consulting and Clinical Psychology,17, 656-664.

Ames, G. M. (1989). Alcohol-related movements on drinking policies in the american workplace: An historical overview. Journal of Drug Issues, 19, 489-510.

Auer, A. H. & Johnson, M. (1977). Research on the therapist's level of experience, in Gurman, A. S. and A. M. Razin (Eds.), Effective psychotherapy (pp. 84-104). New York: Pergamon.

Annbuhl, H. & Grawe, K. (1988). Therapy outcome as a result of the interaction between therapeutic offer and patient openness. Zeitschreftfur Klin ische Psychologie, Psychopathologie und Psychotherapie, 36, 308-327.

Auerbach, A.H., & Johnson, M. (1977). Research on the therapist's level of experience. In A.S. Gurman and A.M. Razin (Eds.) Effective Psychotherapy: A handbook of research (pp. 84-102). Elmsford, NY: Pergamon.

Baekeland, F., & Lundwall, M.A. (1975). Dropping out of treatment: A critical review. Psychological Bulletin,82, 738-783.

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). Cognitive therapy of depression. New York: Guilford Press.

Bellack, A. S., & Hersen M. (1980). Introduction to clinical psychology. New York: Oxford University Press.

Bergin, A. E. (1971). The evaluation of therapeutic outcomes. In A.E. Bergin and S.L. Garfield (eds.), Handbook of psychotherapy and behavior change: An empirical analyses (pp.11). New York: Wiley.

Bergin, A. E. & Garfield, S. L. (1994). Handbook of psychotherapy and behavioral change (4th ed.). New York. Wiley.

Bergin, A. E., & Lambert, M. J. (1978). The evaluation of therapeutic outcomes. In S.L. Garfield and A.E. Bergin (Eds.), Handbook of psychotherapy and behavioral change: An empirical analysis (2nd ed.). New York: Wiley.

Berkman, A. S., Brassos, C. A., & Post, L. (1988). Managed mental health care and independent practice: A challenge to psychology. Psychotherapy, 25, 434-428.

Berman, J.S., & Norton, N.C. (1985). Does professional training make a therapist more effective? Psychological Bulletin, 98, 401-407.

Beutler, L.E., & Crago, M. (1983). Self-report measures of psychotherapy outcome. In M.J. Lambert , E. R. Christensoen, and S. De Julio (Eds.), The assessment of psychotherapy outcome (pp. 453-497). New York: Wiley.

Beutler L. E., Machado P.D., & Neufelt, S.A. (1994). Therapist variables. In Garfield & Bergin (Eds.), Handbook of psychotherapy and behavioral change (4th edition). New York: Wiley and Sons.

Beutler, L.E., Crago, M., & Arzmendi, T.G. (1986). Therapist variables in psychotherapy process and outcome. In S.L. Garfield and A.E. Bergin (Eds), Handbook of psychotherapy and behavior change (3rd edition, pp. 257-310). New York: Wiley.

Blatt, S.J., Sanislow, C.A. 111, Zuroff, D.C., & Pilkonis, P.A. (1996). Characteristics of effective therapists: Further analysis of data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. Journal of Consulting and Clinical Psychology, 64, 6, 1276-1284.

Bloom, B.L. (1981). Focused single-session therapy: Initial development and evaluation. In S. Budman (Ed.), Forms of brief therapy (pp. 167-216). New York: Guilford Press.

Blum, T. C., & Roman P. M. (1985). The social transformation of alcoholism intervention. Journal of Health and Social Behavior, 26, 365-378.

Bracht, G. H., & Glass, G. V. (1968). The external validity of experiments. American Educational Research Journal, 5, 437-474.

Brandes S. D. (1970). American welfare capitalism. Chicago: University of Chicago Press.

Budman, S.H. (1981). Forms of brief therapy. New York: Guilford.

Budman, S.H., & Gurman, A.S. (1988). Theory and practice of brief therapy. New York: Guilford.

Burlingame, G.M., & Furhriman, J.A. (1987). Clinician attitudes towards time-limited and time-unlimited psychotherapy. Professional Psychology: Research and Practice, 18, 61-65.

Burlingame, G.M., & Fuhriman, A. (1987a). Conceptualizing short-term treatment: A comparative review. The Counseling Psychologist, 15, 557-595.

Busch, E. J. (1981). Developing an employee assistance program. Personnel Journal,60, (9), 708-711.

Butcher, J.N., & Koss, M.P. (1978). Research on brief and crisis-oriented psychotherapies. In S. L. Garfield and A.E. Bergin (Eds.), Handbook of psychotherapy and behavioral change (2nd ed., pp. 725-786). New York: Wiley

Canadian Association of Social Workers. (1995) Code of ethics. CASW.

Carter, I. (1977). Social work in industry: A history and a viewpoint. Social Thought, 3,(winter), 7-11.

Carter, D. E., & Newman, F.L. (1980). A client-oriented system of mental health service delivery and program management: A workbook and guide. National Institute of Mental Health.

Coady, N. F. (1991). The association between complex types of therapist interventions and outcomes in psychodynamic psychotherapy. Research on Social Work Practice, Vol 1,(3), 257-277.

Cohen, J. (1988). Statistical power analysis for the behavioral sciences (2nd ed.). Hillsdale, N. J : Erlbaum.

Consumer Report (1995, November). Mental Health: Does therapy help? pp.734-739.

Cook, T.D. & Campbell, D.T. (1979). Quasi-experimentation: Design and analysis issues for field settings. Chicago: Rand McNally.

Craft, J.L. (1990). Statistics and data analysis for social workers, (2nd ed.). Itasca, IL: F.E. Peacock Publishers.

Crits-Christoph, P. (1992). The efficacy of brief-dynamic psychotherapy: A meta-analysis. The American Journal of Psychiatry, 149, 151-158.

Crits-Christoph, P., Baranackie, K., Kurcias, J., & Beck, A.T. (1991). Meta-analysis of therapist effect in psychotherapy outcome studies. Psychotherapy Research,1, 81-91.

Crits-Christoph, P., & Mintz, J. (1991). Implications of therapist effects for design and analysis of comparative studies of psychotherapies. Journal of Consulting and Clinical Psychology, 59, 20-26.

Crowe, D. P., & Marlowe, D. (1964). The approval motive:Studies in evaluation dependence. New York: John Wiley & Sons.

Cunningham G. (1990). Short-term counselling. EAP Digest (3), 21-25.

Dasher, P.W. (1989). Type of treatment, client characterisitcs, and outcomes in an employee assistance program. (Doctoral dissertation, Fordham University, 1989). UMI Dissertation Services, 90071176.

Dawes, R. M. (1994). House of cards: Psychology and psychotherapy built on a myth. New York: Free Press.

Dickman, J. F., and Emener,W. G. (1982). Employee assistance programs-basics concepts, attributes and an evaluation. Personnel Administrator,27, (8), 55,56,58-61.

Dickman, J. F., Emener, W.G., & Hutchison Jr. (1985). Counseling the troubled person in industry. Springfield, IL.: Charles C. Thomas.

Derogatis, L.R. (1977). SCL-90: Administration and Procedures Manual-I for the R (revised) Version. Clinical Psychometrics Research: Baltimore.

Derogatis, L. P., & Melisaratos, N. (1983). The brief symptom inventory: An introductory report. Psychological Medicine, 13, 595-605.

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

Efran, J.S., Lukens, M.D., & Lukens, R.J. (1990). Language, structure and change: Frameworks of meaning in psychotherapy. New York: W.W. Norton and Co.

Eisenstein, S. (1986). Franz Alexander and short-term dynamic psychotherapy. International Journal of Short-term Dynamic Psychotherapy, 1, 179-191.

Endicott, J., Spitzer, R..L., Fleiss, L.J., and Cohen, J. (1976) The Global Assessment Scale: A procedure for measuring overall severity of psychiatric disturbances. Archives of General Psychiatry, 33, 766-771.

Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. Journal of Consulting Psychology, 16, July, pp. 319-324.

Eysenck, H. J. (1966). The effects of psychotherapy: An evaluation. New York: Basic Books.

Eysenck, H. J. (1978). An exercise in mega-silliness. American Psychologist, 33, 517-539.

Eysenck, H. J. (1993). Forty years on: The outcome problem in psychotherapy revisited. In T. Giles (Ed.), Handbook of effective psychotherapy. (pp. 11). New York: Plenum.

Ferguson, C. A. & Fersing, J. E. (1965). The legacy of neglect. Fort Worth: Industrial Mental Health Associates.

Flegenheimer, W.V. (1982). Techniques of Brief Psychotherapy. New York: Jason Aronson.

Foreman, S., & Marmar, C.R. (1985). Therapist actions that address initially poor therapeutic alliances in psychotherapy. American Journal of Psychiatry, 142, 9-22-966.

Frank, A.D. (1959). The dynamics of the psychotherapeutic relationship: Determinants and effects of the therapist's influence. Psychiatry, 22, 17-39.

Frank, J. (1961). Persuasion and healing: A comparative study of psychotherapy. Baltimore, MD: John Hopkins University Press.

Frank, J. (1973). Persuasion and healing: A comparative study of psychotherapy (2nd ed.). Baltimore, MD: John Hopkins University Press.

Frank, J. (1984a). Therapeutic components of all psychotherapies. In J. M. Meyers (ed.), Cures by psychotherapy: What effects change (pp. 15-27). New York: Praeger.

Frank, J. (1984b). Therapeutic components of psychotherapy. A 25-year progress report of research. The Journal of Nervous and Mental Disease, 159, 325-342.

Freud, S. (1937/1957). Analysis terminable and interminable. In J. Strachey (ed), The standard edition of the complete psychological works of Sigmund Freud, Vol. 11, pp. 139-151. London: Hogarth.

Furhriman, A., Paul, S.C., & Burlingame, G.M. (1986). Eclectic time-limited therapy. In J. Norcross (Ed.), Handbook of eclectic psychotherapy (pp.226-259.) New York: Brunner/Mazel.

Garfield, S.L. (1989). The practice of brief psychotherapy. New York: Paragon.

Garfield, S.L., and Bergin, A.E. (1978). Handbook of psychotherapy and behavior change: An empirical analysis (2nd ed.). New York: Wiley.

Garfield, S.L., & Bergin, A.E. (1986a). Handbook of psychotherapy and behavior change: An empirical analysis (3rd ed.). New York: Wiley.

Garfield, S.L., & Bergin, A. E. (1986b). Introduction and historical overview. In S.L. Garfield and A.E. Bergin (Eds.), Handbook of psychotherapy and behavioral change (3rd ed., pp. 3-22). New York: Guilford.

Gaston, L., Marmar, C. R., Gallagher, D., & Thompson, L. W. (1991). Alliance prediction of outcome beyond in-treatment symptomatic change as psychotherapy processes. Psychotherapy Research, 1, 104-113.

Gelder, M.G., Marks, I. M., & Wolff, H.H. (1967). Desensitization and psychotherapy in phobic states: A controlled inquiry. British Journal of Psychiatry, 103, 53-73.

Gelso, C.J., & Johnson, D.H. (1983). Explorations in time-limited counseling and psychotherapy. New York: Teachers College Press.

Gelso, C.J., Mills, D.H., & Spiegel, S.B. (1983). Client and therapist factors influencing the outcomes of time-limited counseling one month and eighteen months after treatment. In C.J. Gelso and D.H. Johnson (Eds.), Explorations in time-limited counseling and psychotherapy (pp. 87-114). New York: Teachers College Press.

Goldberg, C. (1992).The seasoned psychotherapist: Triumph over adversity. New York: W.W. Norton and Company.

Gomes-Schwartz, B. (1978). Effective ingredients in psychotherapy: Prediction of outcome from process variables. Journal of Consulting and Clinical Psychology, 46, 1023-1035.

Gravetter, F. J., & Wallnau, L. B. (1992). Statistics for the behavioral sciences (3rd ed.). New York: West.

Greenberg, J. (1994). Psychotherapy research: A clinician's view. In P. Talley, H. Strupp, and S.Butler (Eds.), Psychotherapy research and practice: Bridging the gap. (pp. 11). New York: the Guilford Press.

Grinnell, R. M. Jr. (1993). Social Work research and evaluation. Itasca, IL: F.E. Peacock Publishers, Inc.

Grissom, R.J. (1996). The magical number .7+ .2: Meta-mets-analysis of the probability of superior outcome in comparisons involving therapy, placebo, and control. The Journal of Consulting and Clinical Psychology, 64, 92-103.

Gurman, A.S., & Razin, M. (Eds.) (1977). Effective psychotherapy: A handbook of research. Elmsford, N.Y.: Pergamon Press,.

Haley, J. (1963) Strategies of psychotherapy. New York:

Hattie, J.A.,, Sharpley, C.F. and Rodgers, H.J. (1984). Comparative effectiveness of professional and paraprofessional helpers. Psychological Bulletin, 95, 534-541.

Henry, W.P., Schact, T. E., & Strupp, H.H. (1986). Structural analysis of social behavior: Application to a study of interpersonal process in differential psychotherapeutic outcome. Journal of Consulting and Clinical Psychology, 54, 27-31.

Hill, C. E., Carter, J. A., and O'Farrell, M.K. (1983). A case study of the process and outcome of time-limited counseling. Journal Counseling Psychology, 30, 3-18.

Hill, C. E., Helms, J. E., Tichner, V., Spiegel, S. B., O'Grady, K. E., & Perry, E. S. (1988). Effects of therapist response modes in brief psychotherapy. Journal of Counseling Psychology, 33, 222-233.

Holloway, E.L., & Wampold, B.E. (1986). Relation between conceptual level and counseling-related tasks: A meta-analysis. Journal of Counseling Psychology, 33, 310-319.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analyses. Journal of Counseling Psychology, 38, 139-149.

Howard, K. I. (1988). Current Life Functioning. Evanston, Il.: Department of Psychology, Northwestern University.

Howard, K. I., Orlinsky, D. E., & Bankoff, E. A. (1988-1993). The research project on long-term psychotherapy: Patients, processes, and outcomes. Northwestern University-University of Chicago Psychotherapy Research Program.

Howard, K.I., Kopta, S.M., Krause, M.S., & Orlinsky, D.E. (1986). The dose-effect relationship in psychotherapy. American Psychologist, 41, 159-164.

Imber, S.D., Nash, E.H., Hoehn-Saric, R., Stone, A.R., & Frank, J.D. (1968). A ten year follow-up study of treated psychiatric outpatients. In S. Lesse (Ed.), An evaluation of the results of the psychotherapies. Springfield, Ill.: Charles C. Thomas.

Jaspers, K. (1963). The nature of psychotherapy. Chicago: University of Chicago Press.

Jensen, J. P., Bergin, A. E., & Greaves, D.W. (1990). The meaning of eclecticism: New Survey and analysis of components. Professional Psychology: Research and Practice,21, 124-130.

Jerrell, J. M., & Rightmeyer, J. F. (1982). Evaluating employee assistance programs. Evaluating Program Planning, 5, 255-267.

Jones, E.E., Cumming, J.D., & Horowitz, M.J. (1988). Another look at the nonspecific hypothesis of therapeutic effectiveness. Journal of Consulting and Clinical Psychology, 56, pp. 48-55.

Johnson, H., & Gelso, C. (1980). The effectiveness of time limits in counseling and psychotherapy. The Counseling Psychologist, 9, (1), 70-83.

Karloy, P. (1985). Measurement strategies in health psychology. John Wiley and Sons, Inc.

Kazdin, A.E. (1986). Comparative outcome studies in psychotherapy: Methodological issues and strategies. Journal of Consulting and Clinical Psychology, 54, (1), 95-105.

Kazdin, A.E. (1992). Research design in clinical psychology (2nd edition). Boston: Allyn and Bacon.

Kiesler, D.J. (1966). Some myths of psychotherapy research and the search for a paradigm. Psychological Bulletin, 42, 110-136.

Kolden, G.G., Howard, K.I., & Maling, M.S. (1994). The counseling relationship and treatment process and outcome. The Counseling Psychologist, 22, (1), January, pp. 82-89.

Koss, M.P., & Butcher, J.N. (1986). Research on brief psychotherapy. In S.L. Garfield and A.E. Bergin (Eds.) Handbook of psychotherapy and behavior change (3rd ed., pp. 627-670). New York: Wiley.

Koss, M. P., & Shiang, J. (1994). Research on brief therapy. In S. L. Garfield and A. E. Bergin (eds.), Handbook of psychotherapy and behavior change (4th ed., pp. 664-701). New York: Wiley.

Kurtz, N. R., Googins B., & Howard W. C. (1984). Measuring the success of occupational alcoholism programs. Journal of Alcohol Studies, 45, (1), 44-49.

Kurzman, Paul. (1987). Industrial Social Work. Encyclopedia of Social Work, Vol. 1,(18). pp.899-910.

Lafferty, P., Beutler, L.E., & Crago, M. (1989). Differences between more or less effective psychotherapists: A study of select therapist variable. Journal of Consulting and Clinical Psychology, 57, (1), pp. 76-80.

Lambert, M. J. (1989). The individual therapist's contribution to psychotherapy process and outcome. Clinical Psychology Review, 9, 469-485.

Lambert, M.J. (1992). Implications of outcome research for psychotherapy integration. In J.C. Norcross and M. R. Goldstein (Eds.), Handbook of psychotherapy integration. (pp. 11). New York: Basic books.

Lambert, M. J., & Bergin, A. E. (1983). Therapist characteristics and their contribution to psychotherapy outcome. In C. E. Walker (Eds.), The hanbook of clinical psychology (pp. 205-241). Homewood, Il: Dow-Jones Irwin.

Lambert, M. J., & Bergin, A. E., (1994). The effectiveness of psychotherapy. In A.E. Bergin, and S.L. Garfield (Eds.), Handbook of psychotherapy and behavioral change (4th ed.). New York: Wiley.

Lambert, M. J., Bergin, A. E., & Collins, J.L. (1977). Therapist induced deterioration in psychotherapy. In A. S. Gurman and A.M. Razin (Eds.), Effective psychotherapy: A handbook of research (pp. 452-481). New York: Pergamon Press.

Lambert, M.J., Shapiro, D.A., & Bergin, A.E. (1986). The effectiveness of psychotherapy. In S.L. Garfield and A.E. Bergin (Eds.) Handbook of psychotherapy and behavior change (2nd ed., pp.122-157). New York: Wiley.

Land, T. (1981). Global strategy: Confronting alcoholism at the workplace. Alcoholism, 1 , (6), 41-42.

Leham, R. S. (1991). Statistics and research design in the behavioral sciences. Pacific Grove, CA: Brooks/Cole Publishing Company.

Levene, H., Breger, L., & Patterson, V. (1972). A training and research program in brief psychotherapy. American Journal of Psychotherapy, 26, 90-100.

Levenson, H., Speed, J., & Budman, S. H. (1995). Therapist's experience, training, and skill in brief therapy: A bicoastal survey. American Journal of Psychotherapy, 49, (1), 95-117.

Liberman, B.L., (1978). The maintenance and persistence of change: Long-term followup investigations of psychotherapy. In J. D. Frank, R. Hoehn-Sarix, S. D. Imber, B.L. Liberman, and A.R. Stone (Eds.), Effective ingredients of effective psychotherapy. New York: Brunner/Mazel.

Liberman, M., Yolom, Y.D., & Miles, M. (1973). Encounter groups: First facts. New York: Basic Books.

Lindemann, E. (1976). "Symptomatology and management of acute grief". In H. J. Porad (Ed.) Crises Intervention: Selected Readings. New York: Family Service Association of America, pp. 7-21. (originally published in American Journal of Psychiatry, 1944, p. 101.)

Lipsey, M. W. (1990). Design Sensitivity. Newbury Park, CA: Sage.

Lipsey, M., & Wilson, D. (1993). The efficacy of psychological educational and behavioral treatment: Confirmation from meta-analysis. American Psychologist, 48, 1181-1209.

Lorr, M., McNair, D. M., Michaux, W.W., & Rankin, A.(1964). Frequency of treatment and change in psychotherapy. Journal of Abnormal Social Psychology,64, 281-292.

Luborsky, L., & Auerbach, A.H., (1985). The therapeutic relationship between working alliance and outcome in psychotherapy: The research evidence and its meaning for practice. In R. F. Hales & A.J. France (Eds.), Annual Review, Vol. 4, pp. 550-561. Washington DC: American Psychiatric Press.

Luborsky, L., Auerbach, A.H., Chandler, M., Cohen, J., & Bachrach, H.M. (1971). Factors influencing the outcome of psychotherapy: A review of quantitative research. Psychological Bulletin, 75, 145-185.

Luborsky, L., Crits-Christoph, P., McLellan, T., Woody, G., Piper, W., Liberman, B., Imber, S. & Pilkonis, P. (1986). Do therapists vary much in success? Findings from four outcome studies. American Journal of Orthopsychiatry,56, 501-512.

Luborsky, L., Diquer, L.A., McLellan, A.T., & Woody, G. (1995). The psychotherapist as a neglected variable: New Studies of each therapist's benefits to their patients. Journal of Counseling Psychology, 31, 13-27.

Luborsky, L., Mclellan, A.T., Woody, G.E., O'Brien, C.P., & Auerbach, A. (1985). Therapist success and it's determinants. Archives of General Psychiatry, 42, 602-611.

Luborsky, L., Mintz, J., & Christoph, P. (1979). Are psychotherapeutic changes predictable? Comparison of a Chicago Counseling Center project with a Penn psychotherapy project. Journal of Consulting and Clinical Psychology, 47, 469-473.

Luborsky, L., Mintz, J., Auerbach, A., Christoph, P., Bachrach, H., Todd, T., Johnson, M., Cohen, M., & O'Brien, P. (1980). Predicting the outcome of psychotherapy: Findings of the Penn Psychotherapy Project. Archives of General Psychiatry, 37, 471-481.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of Professional Psychology. Research and Practice,14, 277-292.

Luborsky, L., Woody, G., McLellan, A.T., O'Brien, C.P., & Rosenzweig, J. (1982). Can independent judges recognize different psychotherapies? Journal of Consulting and Clinical Psychology, 50, 49-62.

Lyons, L.C. & Woods, P.J. (1991). The efficacy of rational-emotive therapy: A quantitative review of the outcome research. Clinical Psychology Review, 11, 357-370.

Maiden, R. P. (1987). Ethical issues in occupational Social Work: Implications for practice. Journal of Independent Social Work .

Malan, D.H. (1963). A study of brief psychotherapy. London: Tavistock.

Mann, J. (1973). Time-limited psychotherapy. Cambridge, MA: Harvard

Marmor, J. (1971). Dynamic psychotherapy and behavior change. Are they reconcilable? Archives of General Psychiatry, 24, 22-28.

Martindale, C. (1978). The therapist-as-fixed-effect fallacy in psychotherapy research. Journal of Consulting and Clinical Psychology,46, 1526-1530.

Marziali, E. (1984). Three viewpoints on the therapeutic alliance: Similarities, differences, and associations with psychotherapy outcome. Journal of Nervous and Mental disease, 172, 417-423.

Masi, D. A. (1982). Human services in industry. Baltimore, MD: Sheppard Pratt.

Masi, D. (1994). Evaluating your employee assistance and managed behavioral care program. Troy, MI: Performance Press.

Mayo, E. (1923). Irrationality and reverie. Journal of Personnel Research, 1, 477-483.

McGuire,T.G. &. Freseman L.K. (1983). Reimbursement policy and cost-effective mental health care. American Psychologist, 38, 935-940.

McLellan, T., Woody, G.E., Luborsky, L. & Goehl, L. (1988). Is the counselor and "active ingredient" in substance abuse rehabilitation? An examination of treatment success among four counselors., The Journal of Nervous and Mental Disease,176, 423-430.

McNeilly,C., & Howard, K. I. (1991). The Therapeutic Procedure Inventory: Psychometric properties and relationship to phase of treatment. Journal of Psychotherapy Integration, 1, 223-235.

Meltzoff, J., & Kornreich, M.(1970). Research in psychotherapy. New York: Aldine-Atherton.

Miller, R.C., & Berman, J.S. (1983). The efficacy of cognition behavior therapies: A quantitative review of the research evidence. Psychological Bulletin, 94, 39-53.

Miller, S. D., Duncan, L., & Hubble, M.A. (1997). Escape from babel: Toward a unifying language for psychotherapy practice. New York: W.W. Norton and Company.

Miller, W.R., Taylor, C.A., & West, J. C. (1980). Focused versus broad-spectrum behavior therapy for problem drinkers. Journal of Consulting and Clinical Psychology, 48, 590-601.

Mum, E.W., & Spiegel, W. R. (1962). Mental health in industry. Personnel study no. 15. Houston: Universtiy of Texas Bureau of Business Research.

Munroe, B.H., & Page, E.B. (1993). Statistical methods for health care research. Evanston, IL: J.B. Lippincott.

Nagy, T. (1995). Ethical standards with particular relevance to media psychology. Unpublished manuscript.

Najavits L.M., & Strupp, H.H. (1994). Differences in the effectiveness of psychodynamic therapists: A process outcome study. Psychotherapy,31, 114-123.

Norcross, J. C., & Goldfried, M.R. (Eds.) (1992). Handbook of psychotherapy integration. New York: Basic Books.

O'Malley, S. S., Suh, C. S., & Strupp, H. H. (1983). The Vanderbilt Psychotherapy Process Scale: A report on the scale development and a process-outcome study. Journal of Consulting and Clinical Psychotherapy, 51, 581-586.

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy-Noch einmal. In In S.L. Garfield and A.E. Bergin (Eds.), Handbook of psychotherapy and behavior change (4th ed., pp. 271-376). New York: Wiley.

Orlinsky, D. E., & Howard, K. I. (1966). Therapy session report. Patient form. Chicago: Institute for Juvenile Research.

Orlinsky, D. E., and Howard, K. I. (1975). Varieties of psychotherapeutic experience. New York: Teachers College Press: Columbia University.

Orlinsky, D. E., & Howard, K. I. (1980). Gender and psychotherapeutic outcome. In A. M. Brodsky and R. T. Hare Mustin (Eds.), Women in psychotherapy, (vol.1), pp.275-297. New York: Guilford.

Orlinsky, D.E., & Howard, K.I. (1986). Process and outcome in psychotherapy. In S.L. Garfield and A.E. Bergin (Eds.), Handbook of psychotherapy and behavior change (pp. 311-381). New York: Wiley.

Orlinsky, D. E., Lundy, M., Howard, K. I., Davidson, C. V., & O'Mahoney, M. T. (1987). Therapeutic Procedures Inventory. Chicago: Northwestern Memorial Hospital.

Orne, M. (1962). On the social psychology of the psychological experiment: With particular reference to demand characteristics and their implications. American Psychologist, 17, (10), 776-783.

Ozawa, M. N. (1980). Development of social service in industry: Why and how? Social Work, 80, 167-172.

Pardes, H., & Pincus, H.A. (1981). Brief therapy in the context of national mental health issues. In S.H. Budman (Ed.), Forms of brief therapy (pp. 7-22). New York: Guilford Press.

Parloff, M. (1982). Psychotherapy research evidence and reimbursement decisions: Bambi meets godzilla. American Journal of Psychiatry, 139, (6), p.719.

Parloff, M., Waskow, I., & Wolfe, B. (1978). Research on therapist variables in relation to process and outcome. In S.L. Garfield and A. Bergin (Eds.). Handbook of psychotherapy change (pp. 232-282). New York: John Wiley and Sons Inc.

Patterson, C.H. (1973). Theories of counselling and psychotherapy (2nd edition.) New York: Harper and Row.

Pekarik, G. & Wierzbicki, M. (1986). The relationship between clients' expected and actual treatment duration. Psychotherapy, 23, 532-534.

Phillips, E. L. (1990). The delivery system as prime therapeutic determinant. In J.K. Zeig, and W. M. Munion (Eds.), What is psychotherapy? Contemporary perspectives. San Francisco: Jossey-Bass Publishers.

Pinkerton, R.S. (1986). Brief individual counseling and psychotherapy with students. In J.E. Talley and W.J.K. Rockwell (Eds.), Counseling and psychotherapy with college students: A guide to treatment (pp. 1-30). New York: Preager.

Piper, W.E. (1984). A comparative study of four forms of psychotherapy. Journal of Consulting and Clinical Psychology, 52, 268-279.

Rachman, S.J., & Wilson, G.T. (1980). The effects of psychological therapy (2nd ed.). New York: Pergamon.

Reid, W. D., & Epstein, L. (1977). Task centered practice. New York: Columbia University Press.

Reid, W. J., & Smith A. D. (1989). Research in social work (2nd ed.). New York: Columbia University Press.

Ricks, D. F., (1974). Supershrink: Methods of a therapy judged successful on the basis of adult outcomes of adolescent patients. In D.F. Ricks, A. Thomas and M. Roff. (Eds.), Life history research in psychopathology (vol.3), (pp.275-297). Minneapolis: University of Minnesota Press.

Robinson, L. A., Berman, J.S., & Neimeyer, R. A. (1990). Psychotherapy for the treatment of depression: A comprehensive review of controlled outcome research. Psychological Bulletin, 100, 30-49.

Roethlisberger, F.J., & Dickson, W.J. (1939). Management and the worker. Cambridge, MA: Harvard University Press.

Rogers, C. R. (1942). Counseling and psychotherapy. Boston: Houghton-Mifflin.

Rogers, C. R. (1951). Client-centered therapy. Boston: Houghton Mifflen.

Roman, P.M. (1981). From employee alcoholism to employee assistance. Journal of Studies on Alcohol,42, (3), 244-272.

Roman, P.M. (1982). Employee alcoholism programs in major corporations in 1979: Scope, change, and receptivity. In Prevention and intervention and treatment: Concerns and models. Rockville, MD.: U.S. Department of Health and Human Services.

Roman, P. M., & Blum T. C. (1985). The core technology of employee assistance programs. ALMACAN 15, (3), 8-12.

Roman, P. M., & Blum Terry C.. (1988). The core technology of employee assistance programs: A reaffirmation. ALMACAN 18, 17-22

Roman, P.M. (1988). Growth and transformation in workplace

alcoholism programming. In Marc Galanter (Ed.), Recent developments in alcoholism, (vol. 6, pp. 11). New York: Plenum Press.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods in psychotherapy. American Journal of Orthopsychiatry, 6, 412-415.

Rounsaville, B.J., Chevron, E.S., Prusoff, B.A., Elkin, I., Imber, S., Sotsky, S., & Watkins, J. (1987). The relation between specific and general dimensions of psychotherapy process in interpersonal psychotherapy of depression. Journal of Consulting and Clinical Psychology, 55, 379-384.

Rounsaville, B.J., Weissman, M.M. & Prusoff, B.A. (1981). Psychotherapy with depressed outpatients. Patient and process variables as predictors of outcome. British Journal of Psychiatry, 138, 67-74.

Rubin, A., & Babbie, E. (1989). Research methods for social work. Belmont, CA: Wadsworth.

Rubinstein, E. & Lorr, M. A. (1956). A comparison of terminators and remainers in outpatient psychotherapy. Journal of Clinical Psychology, 12, 345-349.

Rubinstein, E. A., & Parloff, M. B. (Eds.) (1959). Research in psychotherapy (Vol. 1.). Washington, DC: American Psychological Association.

Saunders, S.M., Howard I., & Orlinsky, D. E. (1989). The therapeutic Bond Scales: Psychometric characteristics and relationship to treatment effectiveness. Journal of Consulting and Clinical Psychology,1, (4), 323-330.

Schaffer, N.D. (1982). Multidimensional measures of therapist behavior as predictors of outcome. Psychological Bulletin, 92, 670-681.

Shatrom, E.L. (1965). Three approaches to psychotherapy. AV#82981, San Francisco State University AV/ITV Center. San Francisco, CA.

Shlien, J. M., Hunt, H. F., Matarazzo, J. D., & Savage, C. (Eds.) (1968). Research in psychotherapy, (Vol.1). Washington, DC: American Psychological Association.

Shapiro, D. A. & Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: A replication and refinement. Psychological Bulletin, 92, 581-604.

Shapiro, D. A. & Shapiro, D. (1983). Comparative therapy outcome research: Methodological implications of meta-analysis. Journal of Consulting and Clinical Psychology, 51, 42-53.

Sifneos, P. E. (1972). Short-term psychotherapy and emotional crisis. Cambridge: Harvard University Press.

Sifneos, P. E. (1987). Short-term anxiety-provoking psychotherapy. In S. Buorian (Ed.), Forms of brief therapy (pp. 45-82). New York: Guilford.

Silberschatz, G., & Curtis, J. T. (1993). Measuring the therapist's impact on the patient's therapeutic progress. Journal of Consulting and Clinical Psychology, 61, (38), 403-411.

Sledge, W. H., Moras, K., Hartley, D., & Levine, A. (1990). Effect of time-limited psychotherapy on patient drop-out rates. American Journal of Psychiatry,14, 1341-1347.

Sloane, R.B., Staples, F.R., Cristol, A.H., Yorkston, N. J., and Whipple, L. K. (1975). Psychotherapy versus behavior therapy. Cambridge, MA: Harvard University Press.

Smith, M.L., Glass, G.V. (1977). Meta-analysis of psychotherapy outcome studies. American Psychologist, 32, 752-760.

Smith, M.L., Glass, G.V., & Miller, T.I. (1980). The benefits of psychotherapy. Baltimore: The Johns Hopkins University Press.

Sperry, L., Brill, P. L., Howard, K. I. & Grisson, G.R. (1996). Treatment outcomes in psychotherapy and psychiatric interventions. New York: Brunner/Mazel.

SPSS 8.0 for Windows Base. SPSS Inc. (1997). University of Calgary.

Sonnenstuhl, W. J., & O'Donnell, J. E. (1980). EAP's: The why's and how's of planning them.Personnel Administrator,25 (11), 35-36.

Sonnenstuhl, W. J. (1986). Inside an emotional health program: A

field study of workplace assistance for troubled employees. Ithaca, N.Y.: ILR Press.

Staudenmeier, W. J., Jr. (1985). Alcohol and the workplace: a study of social policy in a changing america. Unpublished Ph.D. dissertation, Washington University.

Steele, P. D. (1988). Employee assistance programs in context: an application of the constructive broker role. Journal of Applied Behavioral Science,24, (4), 365-382.

Steenbarger, B.N. (1992). Toward science-practice integration in brief counseling and therapy. The Counseling Psychologist, 20, 403-450.

Stein, D. M., & Lambert, M.J. (1984). On the relationship between therapist experience and psychotherapy outcome. Journal of Counselling Psychotherapy,25, 96-102.

Sternberg, R. J. (1992). Psychological bulletin's top 10 "Hit Parade". Psychological Bulletin, 112, 387-388.

Stiles, W.B., Shapiro, D. A., & Elliott, R. K. (1986). Are all psychotherapies equivalent? American Psychologist, 41, 165-180.

Strupp, H.H. (1980). Success and failure in time-limited psychotherapy: A systematic comparison of two cases: Comparison 1. Archives of General Psychiatry, 37, 595-603.

Strupp, H.H. (1986). Psychotherapy: Research, practice, and public policy (how to avoid dead ends). American Psychologist, 41 (2), 120-130.

Strupp, H. H. (1993). Psychotherapy research. Evolution and current trends. In T. K. Fagan and G.R. Vandenbos (Eds.), Exploring applied psychology: Origins and critical analyses (pp.61-193). Washington, D.C. : American Psychological Association.

Strupp, H. H. (1998). The Vanderbuilt I study revisited. Psychotherapy Research, 8, (1), 17-29.

Strupp, H.H., and Binder, J.L. (1984). Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy. New York: Basic Books.

Strupp, H. H., and Hadley, S. S. (1977). A tripartite model of mental health and therapeutic outcomes. American Psychologist, 32, 187-196.

Strupp, H. H., & Luborsky, L. (Eds.) (1962). Research in psychotherapy (Vol.2). Washington, DC: American Psychological Association.

Subotnik, L. (1972). Spontaneous remission: Fact or artifact? Psychological Bulletin, 77, 32-48.

Suh, C.S., Strupp, H.S., & O'Malley, S.S. (1986). The Vanderbilt process measures: Th Psychotherapy Process Scale (VPPS) and Negative Indicators Scale (VNIS). In L.S. Greenberg & W.M. Pinsof (Eds.), The psychotherapeutic process: A research handbook (pp. 285-324). New York: Guilford.

Svartberg, M., & Stiles, T. C. (1991). Comparative effects of short-term psychodynamic psychotherapy: A meta-analysis. Journal of Consulting and Clinical Psychology, 59, 704-714.

Svartberg, M., & Stiles, T. C. (1994). Therapeutic alliance, therapist competence, and client change in short-term anxiety-provoking psychotherapy. Psychotherapy Research, 4, (1), 20-33.

Tabachnick, B. G., & Fidell, L. S. (1996). Using multivariate statistics (3rd ed.). New York: HarperCollins College Publishers.

Talley, J.E. (1992). The predictors of successful very brief psychotherapy. Springfield, IC: Charles C. Thomas.

Talmon, M. (1990). Single-session therapy.: Maximizing the effect of the first (and often the only) therapeutic encounter. San Francisco: Jossey-Bass.

The standard edition of the complete psychological works of Sigmund Freud, v. 23, 9, (pp.211-253). London: Hogarth Press and Institute for Psychoanalysis.

Tanner R.M. (1991). Social work: The profession of choice for eaps. Employee Assistance Quartetly, 6, (3). The Haworth Press.

Tracey, T.J., and Ray, P.B. (1984). The stages of successful time-limited counseling. Journal of Counseling Psychology, 31, 13-27.

Tichenor, V., & Hill, D. E. (1989). A comparison of six measures of working alliance. Psychotherapy: Theory, research, and practice, 26, 195-199.

Trice, H. M., & Beyer, J. M.. (1984). Employee assistance programs: Blending performance-oriented and humanitarian ideologies to assist emotionally disturbed employees. In James R. Greenly (Ed.), Research in community mental health vol.4. Greenwich, Conn.: JAI Press.

Trice, H. M., & Sonnenstuhl W. J. (1981). Drinking behavior and risk factors related to the workplace: Implications for research and prevention. Journal of Applied Behavioral Science, 24, 327-346.

Wampold, B.E., Modin, G. W., Stitch, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes." Psychological Bulletin, 22, 203-215.

Wechsler, H., Reinherz, H. Z., & Dobbin, D.D. (1981). Social work research in the human services (2nd ed.). New York: Human Sciences.

Weinbach, R.W., & Grinnel, R.M., Jr (1991). Statistics for social workers (2nd ed.). New York:Longman.

Weinbach, R.W., and Grinnel, R.M., Jr (1996). Statistics for social workers (3rd ed.). New York:Longman.

Wells, R. A., & Giannetti, V. J. (1990). Handbook of brief psychotherapies. New York: Plenum Press.

Wexlar, D. (1974). A cognitive theory of experiencing, self-actualization, and therapeutic process. In D. Wexler and L. Rice (Eds.), Innovations in Client-Centered Therapy (pp. 11). New York: John Wiley and Sons.

Weyl, H. (1949). Philosophy of mathematics and natural science. Princeton, N.J.: Princeton University Press.

Wilson, G.T., and Rachman, S.J. (1983). Meta-analysis and the evaluation of psychotherapy outcome: Limitations and liabilities. Journal of Consulting and Clinical Psychology, 51, 54-64.

Windholz, M. J., & Silberschatz, G. (1988). Vanderbilt psychotherapy process scale: A replication with adult outpatients. Journal of Consulting and Clinical Psychology,56, 56-60.

Wodarski, J. S. (1981). The role of research in clinical practice: a practical approach for the human services. Baltimore, ML: University Park Press.

Woody, G. (1983). Psychotherapy for opiate addicts: Does it help? Archives of General Psychiatry, 40, 639-645.

Wright, K., Gabriel, E., and Haimowitz, N. (1961). Time limited psychotherapy: Advantages, problems outcomes. Psychological Reports, 9, 187.

APPENDICES

APPENDIX A

Therapist Consent Form

Therapist Consent Form

THERAPIST CONSENT FORM

EAP CLINICAL PRACTICE RESEARCH STUDY

INVESTIGATOR: Brian Guthrie MSW, RSW, CEAP

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Please take the time to read this form carefully and to understand any accompanying information.

The purpose of the research study is to achieve a better understanding of the EAP therapeutic process so that we can determine the quality of service to employee and family members who access the EAP for counselling. All therapists who provide EAP services within your organization will be invited to participate in this research study. Your participation in the study is completely voluntary. You can decline to participate in this study without it affecting your position with the organization.

What It Involves

Participation involves your completing questionnaires about the EAP clinical practice process. You will be asked to complete a set of three questionnaires following your first and last session with your client. You will also be asked to give your client a set of two questionnaires prior to the first session and on completion of the last session. Each set of questionnaires following your first and following your last session will take approximately 20 minutes to complete

Confidentiality

Your responses will be kept <u>completely confidential</u>. No one within your organization, other than the researcher, will see your questionnaires. Although each individual is important for the research study, the findings will report overall patterns of responses and will not single out any individual. You will place your completed questionnaire in a sealed envelope that will be forwarded to the investigator. Although each individual is important for the research study, the findings will report overall patterns of responses and will not single out or identify any

individual. Your completed questionnaire will be coded so your name does not appear. Completed questionnaires will be kept in a locked filing cabinet in the investigators office. The completed questionnaires will be destroyed in accordance with the five year time frame of the University of Calgary. The outcome of the research will become published information and will be available as a Ph. D. Disseration through the University of Calgary.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Brian Guthrie 1-403-261-1544

If you have any questions concerning your participation in this project, you may also contact the Office of the Vice-President (Research) and ask for Karen McDermid, 1-403-220-3381.

_____ _____

Participant Date

A copy of this consent form has been given to you to keep for your records and reference.

APPENDIX B

LETTER OF PERMISSION TO CONDUCT RESEARCH IN EAP FROM DR. JACK SANTABARBARA CEO

LETTER OF PERMISSION TO CONDUCT RESEARCH IN EAP FROM DR. JACK SANTABARBARA CEO

CHC

THE EAP SPECIALISTS

MEMORANDUM

TO: CHC Counsellors

FROM: Jack Santa-Barbara

DATE: February 3, 1997

RE: **RESEARCH PROJECT ON PSYCHOTHERAPY OUTCOME**

Brian Guthrie will be conducting his Ph.D. research utilizing the CHC counselling network.

He will be contacting you over the next few weeks to describe this project, and invite your participation.

Given the level of expertise of our CHC counselling team, and the depth of experience in providing short-term therapy, your participation and contribution to the outcome of this research will be of great benefit to furthering the understanding of the effectiveness of psychotherapy.

Your participation is confidential and voluntary. Although each individual is important for the research study, the findings are intended to report overall patterns of the responses, and will not single out or identify any individual. Your responses will be completely confidential. Only the researcher, Brian Guthrie, will see the questionnaire responses.

Thank you for your cooperation in this worthwhile effort by Brian. I am sure he will appreciate whatever participation you are willing to offer.

JSB:clc

APPENDIX C
CLIENT CONSENT FORM

Client Consent Form

CLIENT CONSENT FORM

EAP CLINICAL PRACTICE RESEARCH STUDY

INVESTIGATOR: Brian Guthrie, MSW, RSW, CEAP

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Please take the time to read this form carefully and to understand any accompanying information.

The purpose of the research study is to achieve a better understanding of the EAP therapeutic process so that the program can determine the quality of service to employee and family members who access the EAP for counselling. All employees who access the EAP will be asked to participate in this research study. Your participation in the study is completely voluntary. You can decline to participate without it affecting your continuing treatment at the EAP.

What It Involves

Participation involves your completing questionnaires about your life circumstances which prompted you to access the EAP and your treatment experience (the outcome of your treatment) at the EAP. A questionnaire will be given to you by your therapist at your first session and then again upon completion of your treatment. Each of the two questionnaires prior to your first and following your last session will take approximately 20 minutes to complete. Some emotional discomfort maybe associated with the completion of these questionnaires, if so, you can omit answering any questions that are upsetting to you. Your therapist will be available to address any emotional issues raised by the questionnaire.

Confidentiality

Your responses will be kept completely confidential. No one on the clinical staff including your therapist, will see your questionnaires. You will place your completed questionnaire in a sealed envelope that will be forwarded to the investigator. Although each individual is important for the research study, the findings will report overall patterns of responses

and will not single out or identify any individual. Your completed questionnaire will be coded so your name does not appear. Completed questionnaires will be kept in a locked filing cabinet in the investigators office. The completed questionnaires will be destroyed in accordance with the five year time frame of the University of Calgary. The outcome of the research will become published information and will be available as a Ph. D. Disseration through the University of Calgary.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Brian Guthrie 1-403-261-1544

If you have any questions concerning your participation in this project, you may also contact the Office of the Vice-President (Research) and ask for Karen McDermid, 1-403-220-3381.

_____ _____

Participant Date

A copy of this consent form has been given to you to keep for your records and reference.

APPENDIX D

Current Life Functioning

Current Life Functioning

Current Life Functioning

Below are some ways in which people's emotional or psychological problems interfere with their functioning. Please read each item carefully and *circle* the response which best describes your present situation.

My emotional/psychological problems interfere with my:	Not applicable	Not at all	A little Bit	Moderately	Quite a bit	Extremely
1 Ability to perform routine tasks.	0	1	2	3	4	5
2 Interactions with friends.	0	1	2	3	4	5
3 Interactions with people at work.	0	1	2	3	4	5
4 Interactions with my spouse/romantic partner.	0	1	2	3	4	5
5 Ability to maintain my personal appearance.	0	1	2	3	4	5
6 Interaction with my parents.	0	1	2	3	4	5
7 Interaction with my sibling.	0	1	2	3	4	5
8 Ability to concentrate and complete tasks.	0	1	2	3	4	5
9 Performance at work or school.	0	1	2	3	4	5
10 Carrying out family responsibilities.	0	1	2	3	4	5
11 Participation in physical activities.	0	1	2	3	4	5
12 Participation in social activities.	0	1	2	3	4	5
13 Ability to function as an independent person.	0	1	2	3	4	5
14 Developing or managing my career.	0	1	2	3	4	5
15 Ability to manage my finances.	0	1	2	3	4	5
16 Planning and enjoying leisure time activies.	0	1	2	3	4	5
17 Being the kind of person I would like to be.	0	1	2	3	4	5
18 Ability to form or sustain intimate relationships.	0	1	2	3	4	5
19 Enjoyment of sexual activities.	0	1	2	3	4	5
20 Maintaining good health habits.	0	1	2	3	4	5
21 Creative activities.	0	1	2	3	4	5
22 Ability to control myself and stay out of trouble.	0	1	2	3	4	5
23 Attending work or school or getting there on time.	0	1	2	3	4	5
24 Ability to be comfortable with people	0	1	2	3	4	5

THE FOLLOWING QUESTIONS PERTAIN TO YOUR CURRENT LIFE SITUATION. PLEASE *CIRCLE* THE RESPONSE WHICH BEST DESCRIBES YOUR CURRENT SITUATION?

1. At the present time, how upset or distressed have you been feeling?

   1. Not at all distressed.
   2. Slightly distressed.
   3. Pretty distressed.
   4. Very distressed.
   5. Extremely distressed.

2. At the present time, how energetic and healthy have you been feeling?

   1. Not at all energetic and healthy.
   2. Slightly energetic and healthy.
   3. Pretty energetic and healthy.
   4. Very energetic and healthy.
   5. Extremely energetic and healthy.

3. At the present time, how well do you feel that you are getting along emotionally and psychologically?

   1. Quite poorly; I can barely manage to deal with things.
   2. Fairly poorly; life is pretty tough for me at times.
   3. So-so; I manage to keep going with some effort.
   4. Fairly well; I have my ups and downs.
   5. Quite well; I have no important complaints.
   6. Very well; much the way I would like to.

4. At the present time, how satisfied have you been feeling with your life?

   1. Not at all satisfied.
   2. Slightly satisfied.
   3. Pretty satisfied.
   4. Very satisfied.
   5. Extremely satisfied.

HOW WELL DO EACH OF THE FOLLOWING STATEMENTS DESCRIBE YOUR CURRENT RELATIONSHIP WITH YOUR THERAPIST? (*Complete following last session*)
MY THERAPIST:

1. Has warm, positive feelings for me.

   0 — I don't know yet; 1 — Not at all; 2 — Some; 3 — Pretty much; 4 — A lot; 5 — Completely

2. Is someone I can talk to about my private feelings and concerns.

   0 — I don't know yet; 1 — Not at all; 2 — Some; 3 — Pretty much; 4 — A lot; 5 — Completely

3. Respects me.

   0 — I don't know yet; 1 — Not at all; 2 — Some; 3 — Pretty much; 4 — A lot; 5 — Completely

4. Cares about my happiness and well being.

   0 — I don't know yet; 1 — Not at all; 2 — Some; 3 — Pretty much; 4 — A lot; 5 — Completely

5. Really knows and understands me.

   0 — I don't know yet; 1 — Not at all; 2 — Some; 3 — Pretty much; 4 — A lot; 5 — Completely

6. Is someone I turn to for support and comfort when I am feeling bad.

   0 — I don't know yet; 1 — Not at all; 2 — Some; 3 — Pretty much; 4 — A lot; 5 — Completely

AT THE PRESENT TIME, TAKING EVERYTHING INTO CONSIDERATION, HOW CLOSE DO YOU FEEL TO YOUR THERAPIST?

1. Not at all close.
2. Somewhat close.
3. Pretty close.
4. Very close.
5. Extremely close.

EAP Clinical Practice Research Study

(Client Pre 1st session/post last session)

The purpose of this research study is to achieve a better understanding of the EAP counselling process so that we can continue to provide a high quality of service to employee and family members who access the EAP for counselling.

Your responses will be kept completely confidential. No one on the clinical staff including your therapist will see your questionnaires. Although each individual is important for the research study, the findings will report overall patterns of responses and will not single out any individual.

Before beginning your participation in the research program, you will be asked to read and sign a Research Consent Form. If you choose not to participate, this will in no way affect your treatment at the EAP.

CURRENT LIFE FUNCTIONING

Howard K. I., Orlinsky D. E., & Beckett E. A. (1993) The research project on long-term therapy. Patients, interviews, and outcomes. Chicago: Northwestern Memorial Hospital

Therapist ID_____Client ID_____

Session #____

1. How important to you is it to be in counselling at this time? (*circle response*)

   1. It is absolutely essential to me.
   2. It is very important to me.
   3. It is moderately important to me.
   4. It is somewhat important to me.
   5. It is not important to me at all.

2. How confident are you that counselling will be successful in helping you with your problems?

   1. Not at all confident.
   2. Slightly confident.
   3. Pretty confident.
   4. Very confident.

3. What is your best guess as to how long counselling will last?

   1 to 2 weeks; 4 to 8 weeks; 2 to 6 months; 6 to 12 months; 1 to 2 years

Presenting Problem

Below are examples of problems for which people often seek counselling. Please rate the extent to which each of these problems is a reason for seeking counselling at this time. Please *circle* the appropriate response for each question. (*If this is your last session indicate how much the problem has improved*).

I AM SEEKING COUNSELLING BECAUSE OF:	Not at all	A little	Some	A lot	Very much
1. Problems with spouse or romantic partner.	1	2	3	4	5
2. Difficulty forming or maintaining an intimate relationship.	1	2	3	4	5
3. A sexual problem.	1	2	3	4	5
4. Problems getting along with a friend or friends.	1	2	3	4	5
5. An unsatisfactory social life.	1	2	3	4	5
6. Difficulties getting along with family members (not spouse).	1	2	3	4	5
7. Problems getting along with people at work or school.	1	2	3	4	5
8. Feeling uncomfortable with people in general.	1	2	3	4	5
9. Not getting things done at work or school.	1	2	3	4	5
10. Problems handling family responsibilities.	1	2	3	4	5
11. Not having a sense of direction or goals in life.	1	2	3	4	5
12. Not managing life well in general.	1	2	3	4	5
13. Low self-esteem.	1	2	3	4	5
14. Not understanding myself.	1	2	3	4	5
15. Reacting too emotionally to events.	1	2	3	4	5
16. Feeling distress, anxiety, depression or anger.	1	2	3	4	5
17. A physical problem, such as illness, pain or medical	1	2	3	4	5
18. Alcohol or drug problems.	1	2	3	4	5
19. An eating problem or weight problem.	1	2	3	4	5
20. Problems developing or managing my career.	1	2	3	4	5
21. Missing work or school or not getting there on time.	1	2	3	4	5
22. Difficulties caused by the substance abuse or emotional problems of a family member.	1	2	3	4	5
23. Another problem (specify):	1	2	3	4	5

Current Symptoms

Below is a list of problems and complaints that people sometimes have. Read each item carefully and *circle* the response that best describes :

How often you have had each experience in the past month:

	Not at all	Once or twice	Several times	Often	Most of the time	All of the time
1. Having repetitive thoughts that I cannot get rid of.	0	1	2	3	4	5
2. Problems at work or school because of my alcohol or drug use.	0	1	2	3	4	5
3. Thoughts that seemed to race through my mind.	0	1	2	3	4	5
4. Avoiding places that seemed too closed in.	0	1	2	3	4	5
5. Headaches.	0	1	2	3	4	5
6. Feeling sad most of the day.	0	1	2	3	4	5
7. Trying to push thoughts out of my mind.	0	1	2	3	4	5
8. Guilt or remorse over my alcohol or drug use.	0	1	2	3	4	5
9. Being sluggish or lethargic.	0	1	2	3	4	5
10. Thoughts about ending my life.	0	1	2	3	4	5
11. Muscular tension or aches.	0	1	2	3	4	5
12. Feeling hopeless about the future.	0	1	2	3	4	5
13. Difficulty concentrating.	0	1	2	3	4	5
14. Feeling blocked at work or school.	0	1	2	3	4	5
15. Being irritable and easily angered.	0	1	2	3	4	5
16. Afraid of leaving my home.	0	1	2	3	4	5
17. Engaging in repetitive behaviors to calm myself.	0	1	2	3	4	5
18. Dizziness.	0	1	2	3	4	5
19. Feeling ill or rundown.	0	1	2	3	4	5
20. Trouble falling asleep.	0	1	2	3	4	5

HOW OFTEN HAVE YOU HAD EACH EXPERIENCE IN THE PAST MONTH	Not at all	Once or twice	Several times	Often	Most of the time	All of the time
21. Feeling worthless.	0	1	2	3	4	5
22. Shortness of breath or rapid heartbeat.	0	1	2	3	4	5
23. Not enjoying things as much as I used to.	0	1	2	3	4	5
24. Very strong mood swings (highs and lows).	0	1	2	3	4	5
25. Difficulty making decisions.	0	1	2	3	4	5
26. Troubling events in my daily life.	0	1	2	3	4	5
27. Bothered by a fear of something specific.	0	1	2	3	4	5
28. Problems with my health because of my alcohol or drug use.	0	1	2	3	4	5
29. Needing very little sleep.	0	1	2	3	4	5
30. Problems resulting from the loss of an important person or relationship.	0	1	2	3	4	5
31. Feeling tense or anxious.	0	1	2	3	4	5
32. Sleeping too much.	0	1	2	3	4	5
33. Fear of rejection.	0	1	2	3	4	5
34. Feeling that I, or a situation I was in, was not real.	0	1	2	3	4	5
35. Having to avoid certain places or situations because of fearfulness.	0	1	2	3	4	5
37. Doing things that could have caused trouble for me or my family.	0	1	2	3	4	5
38. Experiencing a great deal of stress.	0	1	2	3	4	5
39. Periods of intense fear that seem out of place or out of proportion.	0	1	2	3	4	5
40. Problems with my family or friends because of my alcohol or drug use.	0	1	2	3	4	5

APPENDIX E

Level of Functioning Scale

Level of Functioning Scale

Level of Functioning

Carter, D.E., & Newman, F.L. (1980). A client-oriented system of mental health service delivery and program management: A workbook and guide. National Institute of Mental Health, Series FN, No. 4, DHHS Publication No. (ADM). 80-307, Washington, DC: US Government, Printing Office.

- Using the areas of physical functioning, interpersonal relationships, social role performance and psychological signs and symptoms, please rate the client's ability to function autonomously in the community.
- *CIRLCLE* the *LEVEL* which most nearly applies. If following criteria do not apply, (e.g., ability to work or go to school, ability to live with family and friends) disregard them in your rating.

LEVEL 0 ***Unknown.***

LEVEL 1 ***Dysfunctional in all four areas*** and almost totally dependent upon others to provide supportive protective environment.

LEVEL 2 Not working or going to school; ***family/friends cannot or will not tolerate the client;*** can perform minimal self-care functions but cannot assume most responsibilities or tolerate social encounters beyond restrictive settings (e.g., in group, play or occupational therapy).

LEVEL 3 Not working or going to school; ***living and/or getting along with family or friends but not without considerable strain on the client and/or others.*** Symptoms are such that movement in the community should be restrictive or supervised. Therapeutic intervention should be maintained at an intense level.

LEVEL 4 Not working or going to school, although may be capable of doing either in a very restrictive setting. ***Client*** BARELY ***able to live and/or get along satisfactorily with family/friends/others.*** Can assume responsibility for all personal self-care. Therapeutic intervention needed.

LEVEL 5 ***Emotional stability and stress tolerance is low.*** Client marginally capable of going it work or school in a non-protective setting. ***Marginally*** able to live and /or get along satisfactorily with family/friends/others. Therapeutic intervention needed.

LEVEL 6 ***Interpersonal relationships and social role performance are stable.*** Client ***CAPABLE*** of going to work or school in a non-protective setting; able to live and/or get along with family/friends/others. The presence of psychological symptoms and their severity, however, are probably sufficient to be both noticeable and somewhat disconcerting to the client and/or others. Therapeutic intervention needed.

LEVEL 7 ***Functioning well;*** however, psychological signs and symptoms are present to the degree that regular therapeutic intervention is needed even though these ***symptoms are not disconcerting to family/friends/others.***

LEVEL 8 ***Functioning well in all four areas*** with little evidence of distress present. However, a history of symptom recurrence suggests the need for periodic contact with the therapist.

LEVEL 9 Functioning well in all areas and ***does not need further services at the EAP.***

Therapist ID #_____ Client ID #_____ Session #_____

APPENDIX F

Global Assessment Scale

Global Assessment Scale

EAP Clinical Practice Research Study
Global Assessment Scale

- Rate this client's lowest level of current functioning by selecting the lowest range which describes his/her functioning on a hypothetical continuum of mental health-illness.
- For example, a client whose behavior is considerably influenced by delusions (range 21-30) should be given a rating in that range even though he/she has "major impairment in several areas" (range 31-40).
- Use intermediary levels when appropriate (e.g., 35, 58, 62).
- Rate actual functioning independent of whether or not the client is receiving and may be helped by medication or some other form of treatment. (*CIRCLE the number that reflects the lowest level of current functioning for each category).*

> ***Superior functioning*** in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his/her warmth and integrity. ***No symptoms.***
>
> 91 92 93 94 95 96 97 98 99 100

> ***Good functioning*** in all areas, many interests, socially effective, generally satisfied with life. There may or may not be transient symptoms and "everday" worries that only occasionally get out of hand.
>
> 81 82 83 84 85 86 87 88 89 90

> ***No more than slight impairment*** in functioning, varing degrees of "everday" worries and problems that sometimes get out of hand. Minimal symptoms may or may not be present.
>
> 71 72 73 74 75 76 77 78 79 80

> ***Some mild symptoms*** (e.g., depressive mood, mild insomnia), OR some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider him/her "sick".
>
> 61 62 63 64 65 66 67 68 69 70

> ***Moderate symptoms***, OR generally functioning with some difficulty (e.g., few friends and flat affect, depressed mood and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).
>
> 51 52 53 54 55 56 57 58 59 60

> Any ***serious symptomatology*** or impairment in functioning that most clinicians would think obviously requires treatment or attention (e.g., sucidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking, mild but definite manic syndrome).
>
> 41 42 43 44 45 46 47 48 49 50

> ***Major impairment*** in several areas, such as work, family relations, judgment, thinking, or mood (e.g., depressed person avoids friends, neglects family, unable to do normal tasks), OR some impairment in reality testing or communication (e.g., speech is at times obscure, illogical or irrelevant), OR single suicide attempt.
>
> 31 32 33 34 35 36 37 38 38 40

> ***Unable to function*** in almost all areas (e.g., stays in bed all day), OR behavior is considerably influenced by either delusions or hullucinations, OR serious impairment in communication (e.g., sometimes incoherent or unresponsive) OR judgement (e.g., acts grossly inappropriate).
>
> 21 22 23 24 25 26 27 28 29 30

> ***Needs some supervision*** to prevent hurting self or others or to maintain minimal personal hygiene (e.g., repeated suicide attempts, frequently violent, manic excitement, smears feces), OR gross impairmant in communication (e.g., largely incoherent or mute).
>
> 11 12 13 14 15 16 17 18 19 20

> ***Needs constant supervision*** for several days to prevent hurting self or others, OR makes no attempt to maintain minimal personal hygiene, OR serious suicide act with clear intent and expectation of death.
>
> 1 2 3 4 5 6 7 8 9 10

Therapist ID #_____Client ID#_____ Session #_____

Endicott, J., Spitzer, R.L., Fleiss, J.L. & Cohen, J. (1976). The Global Assessment Scale: A procedure for measuring overall severity of psychiatric disturbance. Archives of General Psychiatry, 33, 766-771.

THERAPIST:complete following 1st & last session

COMPLETE LEVEL FUNCTIONING SCALE ON OTHER SIDE

APPENDIX G

Therapy Session Report (Client Self-Report)

Therapy Session Report

I. How did your therapist seem to feel during your last session?	Not at all	Some	A Lot
1. Pleased.	0	1	2
2. Thoughtful.	0	1	2
3. Annoyed.	0	1	2
4. Bored.	0	1	2
5. Sympathetic.	0	1	2
6. Cheerful.	0	1	2
7. Frustrated.	0	1	2
8. Involved.	0	1	2
9. Playful.	0	1	2
10. Demanding.	0	1	2
11. Apprehensive.	0	1	2
12. Effective.	0	1	2
13. Perplexed.	0	1	2
14. Detached.	0	1	2
15. Attracted.	0	1	2
16. Confident.	0	1	2
17. Relaxed.	0	1	2
18. Interested.	0	1	2
19. Unsure.	0	1	2
20. Optimistic.	0	1	2
21. Distracted.	0	1	2
22. Affectionate.	0	1	2
23. Alert.	0	1	2
24. Close.	0	1	2
25. Tired.	0	1	2
26. Other.(specify)		1	2

J. How helpful do you feel your therapist was in your last session?

1. Completely helpful.
2. Very helpful.
3. Pretty helpful.
4. Somewhat helpful.
5. Slightly helpful.
6. Not at all helpful.

K. How much progress do you feel you made in dealing with your problems last session?

1. A great deal of progress.
2. Considerable progress.
3. Moderate progress.
4. Some progress.
5. Didn't get anywhere last session.
6. My problems seemed to get worse.

L. Since your last session, has it been easier or harder for you to get along and deal with things?

1. Much harder.
2. Somewhat harder.
3. Slightly harder.
4. Slightly easier.
5. Somewhat easier.
6. Much easier.

M. During your last session, how much:	Slightly or not at all	Some	Pretty Much	Very Much
1.Did your therapist talk?	0	1	2	3
2.Was your therapist attentive to what you were trying to get across?	0	1	2	3
3.Did your therapist tend to accept or agree with your ideas?	0	1	2	3
4.Was your therapist negative or critical towards you?	0	1	2	3
5.Did your therapist take initiative in bringing up things to talk about?	0	1	2	3
6.Did your therapist try to get you to change your point of view or way of doing things?	0	1	2	3
7.Was your therapist friendly and warm towards you?	0	1	2	3
8.Did your therapist show feeling?	0	1	2	3

N. What do you feel that you got out of your last session?	No	Some	A lot
1. Got a chance to let go and get things off my chest.	0	1	2
2. Hope. A feeling that things can work out for me.	0	1	2
3. Help in talking about what was really troubling me.	0	1	2
4. Relief from tensions or unpleasant feelings.	0	1	2
5. More understanding of the reasons behind my behavior and feelings.	0	1	2
6. Reassurance and encouragement about how I am doing.	0	1	2
7. Confidence to try do do things differently.	0	1	2
8. More ability to feel my feelings, to know what I really want.	0	1	2
9. Ideas for better ways of dealing with people and problems.	0	1	2
10. More of a person-to-person relationship with my therapist.	0	1	2
11. Better self control over my moods and actions.	0	1	2
12. A more realistic reevaluation of my thoughts and feelings.	0	1	2
13. Nothing in particular; I felt the same as I did before the session.	0	1	2
14. Other.	0	1	2

EAP Clinical Practice Research Study

(client post 1st/3rd & last session)

The purpose of this research study is to achieve a better understanding of the EAP counselling process so that we can continue to provide a high quality of service to employee and family members who access the EAP for counselling.

Your responses will be kept completely confidential. Only the researcher will see your questionnaires. No one, including your therapist, will see your questionnaires. Although each individual is important for the research study, the findings will report overall patterns of responses and will not single out any individual.

Before beginning your participation in the research program, you will be asked to read and sign a Research Consent Form. If you choose not to participate, this will in no way affect your treatment at the EAP.

THERAPY SESSION REPORT

Orlinsky D., & Howard K. (1986). Therapy session report, Forms and T. Chicago: Institute for Juvenile Research.

Session #___

Therapist ID_____ Client ID_____

Please *circle* the response that best reflects your experience.

If this is your final session with your therapist do not complete this section go to (A) inside page.

1. To what extent are you looking forward to your next session?

1. Intensely; wish it were much sooner.
2. Very much; wish it were sooner.
3. Pretty much; will be pleased when the time comes.
4. Moderately; it is scheduled and I guess I'll be there.
5. Very little; I'm not sure I will want to come.

2. How long will it be until your next therapy session?

1. Don't know.
2. Less than a day.
3. One or two days.
4. Three or four days.
5. Five or six days
6. A week or more.

3. Comments:

A. How do you feel about your last session? (*Please circle response*)

THE LAST SESSION WAS:

1. Perfect.
2. Excellent.
3. Very Good.
5. Fair.
6. Pretty Poor.
7. Very Poor.

B. How did you feel about coming to therapy last session?

1. Eager;.could hardly wait to get there.
2. Very much; looked forward to coming.
3. Somewhat looked forward to coming.
4. Was neutral about coming.
5. Somewhat reluctant to come.
6. Unwilling;.I didn't want to come at all.

C. What did you want to get out of your last session? (circle appropriate response)	Not at all	Some	A lot
1. Get a chance to let go and get things off my chest.	0	1	2
2. Learn more about what to do in therapy, and what to expect.	0	1	2
3. Get help in talking about what is really troubling me.	0	1	2
4. Get relief from tensions or unpleasant feelings and behavior.	0	1	2
5. Understand the reasons behind my feelings and behavior.	0	1	2
6. Get some reassurance about how I'm doing.	0	1	2
7. Get confidence to try new things, to be a different kind of person.	0	1	2
8. Find out what my feelings really are and what I really want.	0	1	2
9. Get advice on how to deal with my life and with other people.	0	1	2
10. Have my therapist respond to me on a person-to person basis.	0	1	2
11. Get better self-control.	0	1	2
12. Get straight on which things I think and feel are real and which are mostly in my mind.	0	1	2
13. Work at a particular problem that's been bothering me.	0	1	2
14. Get my therapist to say what he (she) really thinks.	0	1	2
15. Other.		1	2

D. How well did you feel you were getting along emotionally and psychologically, when you had your last session?

1. Very well; much the way I would like to.
2. Quite well; no important complaints.
3. Fairly well; was having my ups and downs.
4. So-so; managed to keep going with some effort.
5. Fairly poorly; life got pretty tough for me at times.
6. Quite poorly; could barely manage to deal with things.

E. What problems or topics were you concerned about in your last session?	Not at All	Some	A Lot
1. Being dependent on others.	0	1	2
2. Meeting my obligations.	0	1	2
3. Being assertive or competitive.	0	1	2
4. Living up to my conscience: shameful or guilty feelings.	0	1	2
5. Being lonely or isolated.	0	1	2
6. Sexual feelings and experiences.	0	1	2
7. Expressing or revealing myself; letting others really know me.	0	1	2
8. Loving; being able to give of myself.	0	1	2
9. Angry feelings or behavior.	0	1	2
10. Who I am and what I want.	0	1	2
11. Fearful or panicky experiences.	0	1	2
12. Meaning little or nothing to others: being worthless or unlovable.	0	1	2
13. Other.		1	2

F. During your last session, how much:	Slightly or not at	Some	Pretty much	Very much
1. Did you talk?	0	1	2	3
2. Were you able to focus on what was of real concern to you?	0	1	2	3
3. Did you take the initiative to bring up the subjects that were talked about?	0	1	2	3
4. Were you logical and organized in expressing yourself?	0	1	2	3
5. Were your emotions or feelings stirred?	0	1	2	3
6. Did you talk about what you were feeling?	0	1	2	3
7. Were you angry or critical towards yourself?	0	1	2	3
8. Did you have difficulty thinking of things to talk about?	0	1	2	3
9. Were you friendly or respectful towards your therapist?	0	1	2	3
10. Were you free and spontaneous in expressing yourself?	0	1	2	3
11. Did you try to persuade your therapist to see things your way?	0	1	2	3
12. Were you attentive to what your therapist was trying to get across to you	0	1	2	3
13. Did you tend to accept or agree with what your therapist said?	0	1	2	3
14. Did you have sense of control over your feelings and behaviors?	0	1	2	3
15. Were you negative or critical towards your therapist?	0	1	2	3
16. Were you satisfied with your own behavior?	0	1	2	3

G. How well did your therapist seem to understand what you were feeling and thinking during your last session?

1. Understood exactly how I thought and felt
2. Understood very well how I thought and felt
3. Understood pretty well, but there were some things he/she did not seem to grasp.
4. Didn't understand too well how I thought and felt.
5. Misunderstood how I thought and felt.

H. What were your feelings during your last session?	Not at all	Some	A Lot
1. Confident.	0	1	2
2. Embarrassed.	0	1	2
3. Relaxed.	0	1	2
4. Withdrawn.	0	1	2
5. Helpless.	0	1	2
6. Determined.	0	1	2
7. Grateful.	0	1	2
8. Relieved.	0	1	2
9. Tearful.	0	1	2
10. Close.	0	1	2
11. Impatient.	0	1	2
12. Guilty.	0	1	2
13. Strange.	0	1	2
14. Inadequate.	0	1	2
15. Likable.	0	1	2
16. Hurt.	0	1	2
17. Depressed.	0	1	2
18. Affectionate.	0	1	2
19. Serious.	0	1	2
20. Anxious.	0	1	2
21. Angry.	0	1	2
22. Pleased.	0	1	2
23. Inhibited.	0	1	2
24. Confused.	0	1	2
25. Discouraged.	0	1	2
26. Accepted.	0	1	2
27. Cautious.	0	1	2
28. Frustrated.	0	1	2
29. Hopeful.	0	1	2
30. Tired.	0	1	2
31. Ill.	0	1	2
32. Thirsty.	0	1	2
33. Attracted.	0	1	2
34. Other.		1	2

APPENDIX H

Therapeutic Procedures Inventory (Therapist Measure)

Therapeutic Procedures Inventory

DURING THIS SESSION TO WHAT EXTENT:	ALL		MUCH	MUCH
41. Did you point out flaws or errors in your client's reasoning or assumptions?	1	2	3	4
42. Did you actively support your client's transference determined experience of you?	1	2	3	4
43. Did you work on the interpretation of a dream?	1	2	3	4
44. Did you have your client imagine and converse with a particular person?	1	2	3	4
45. Did you acknowledge your client's gains in therapy or reassure him or her that gains will be forthcoming?	1	2	3	4
46. Did you discuss the effect of recent experiences in therapy on your client's behavior outside of therapy?	1	2	3	4
47. Did you point out ways in which your client seeks to avoid anxiety (i.e., interpret defenses)?	1	2	3	4
48. Did you train your client in assertiveness, social skills, or other task relevant skills?	1	2	3	4
49. Did you link your client's reactions to you to his or her present or past reactions to parents?	1	2	3	4
50. Did you and your client develop specific assignments for the client to carry out between sessions?	1	2	3	4
51. Did you help your client express unexpressed feelings?	1	2	3	4
52. Did you encourage your client to keep a record of thought, feelings and/or activities between sessions?	1	2	3	4
53. Did you engage in social conversation about activities or current events?	1	2	3	4
54. Did you pay attention to your own reactions as a way of better understanding your client?	1	2	3	4
55. Did you directly teach or demonstrate a new way of responding to or acting with another person?	1	2	3	4
56. Did you use a guided fantasy technique?	1	2	3	4
57. Did you attempt to correct your client's transference determined experience of you?	1	2	3	4
58. Did you point out behaviors on the part of your client that interfere with the work of therapy?	1	2	3	4
59. Did you explore the meaning of your client's fantasies?	1	2	3	4
60. Did you use relaxation training?	1	2	3	4
61. Did you explore the meaning or function of your client's symptoms?	1	2	3	4
62. Did you encourage your client to engage in a dialogue between conflicting parts of his or her self?	1	2	3	4
63. Did you remind your client of material that had been discussed in previous sessions?	1	2	3	4
64. Did you explore possible practical solutions to your client's current life problems?	1	2	3	4
65. Did you have your client imagine traumatic, anxiety producing images?	1	2	3	4
66. Did you encourage your client to suppress or avoid certain feelings or ideas?	1	2	3	4
67. Did you help your client understand how childhood experiences influence his or her current life?	1	2	3	4
68. Did you help your client resolve conflicting or incompatible wants, needs or goals?	1	2	3	4
69. Did you encourage your client to examine meanings of his or her thoughts, behaviors or feelings?	1	2	3	4
70. Did you try to convey a sense of non-judgmental acceptance?	1	2	3	4
71. Did you explore your client's reactions to procedural changes in treatment (eg. vacation,fees,etc)?	1	2	3	4
72. Did you discuss the desirability or effect of psychoactive medication with your client?	1	2	3	4
73. Did you discuss your client's reactions and feelings regarding termination?	1	2	3	4

EAP Clinical Practice Research Study

Therapeutic Procedures Inventory-R

(therapist post 1st/3rd & last session)

Orlinsky, D.E., Lundy, M., Howard, K.I., Davidson, C., O'Malley, M.T.(1987). Therapeutic procedures inventory. Chicago: Northwestern Memorial hospital.

Therapist ID _____ **Client ID** _____ **Session #**_____

The purpose of this research study is to achieve a better understanding of the EAP therapeutic process so that we can continue to provide a high quality of service to employee and family members who access the EAP for counselling.

Your responses will be kept completely confidential. Each questionnaire will be coded to ensure confidentiality. No one in your organization except the researcher will see your questionnaires. Although each individual is important for the research study, the findings will report overall patterns of responses and will not single out any individual.

Before beginning your participation in the research study, you will be asked to read and sign a Research Consent Form. If you choose not to participate, this will in no way affect your employment with your organization.

A. How well do you feel that therapy with this client is going at the present time? *(circle your response)*

1. Very well; making excellent progress on important issues.
2. Fairly well; progressing steadily.
3. So-so; making some progress.
4. Fairly poorly; seem to be really stuck.
5. Very poorly; client seems to be getting worse.

B. How much longer do you feel your client needs to be in therapy?

1. 1-3 weeks.
2. 4-6 weeks.
3. 2-6 months.
4. 6 months to a year.
5. 1-2 years.
6. 2-5 years.
7. more than 5 years.

C. How much longer do you expect to be working with this client in therapy?

1. 1-3 weeks.
2. 4-6 weeks.
3. 2-6 months.
4. 6 months to a year
5. 1-2 years.
6. 2-5 years.
7. more than 5 years.

D. Which of the following best describes your assessment of the current working (therapeutic) relationship you have with this client?

1. Very poor.
2. Pretty poor.
3. Fair.
4. Quite a bit.
5. Very good.
6. Excellent.

E. At the present time, how strong an emotional connection do you feel with this client?

1. None at all.
2. A little.
3. A moderate amount.
4. Quite a bit.
5. A great deal.

F. Does the strength of your emotional connection seem right to you?

1. May not be strong enough.
2. Seems about right.
3. May be too strong.

G. How much are you looking forward to your next session with this client?

1. I definitely anticipate a meaningful and/or pleasant session.
2. I have some pleasant anticipation.
3. I feel neutral about seeing this client next session.
4. I anticipate a somewhat trying and/or unpleasant session.
5. I anticipate a very trying and/or unpleasant session.

DURING THIS SESSION HOW MUCH: (circle appropriate response)	NOT AT ALL	SOME	PRETTY MUCH	VERY MUCH
1. Did you talk?	1	2	3	4
2. Were you attentive to what your client was trying to get across?	1	2	3	4
3. Did you tend to agree with or accept your client's ideas and suggestions	1	2	3	4
4. Were you critical or disapproving towards your client?	1	2	3	4
5. Did you take initiative in defining the issues that were talked about?	1	2	3	4
6. Did you try change your client's point of view or way of doing things?	1	2	3	4
7. Were you warm and friendly towards your client?	1	2	3	4
8. Did you express feeling?	1	2	3	4
9. Were you in rapport with your client's feelings?	1	2	3	4
10. Did you feel an emotional connection with this client?	1	2	3	4

DURING THIS SESSION I WAS WORKING TOWARD:	NOT AT ALL	SOME	PRETTY MUCH	VERY MUCH
11. Helping my client feel accepted in our relationship.	1	2	3	4
12. Getting a better understanding of my client, of what was really going on.	1	2	3	4
13. Helping my client talk about feelings and concerns.	1	2	3	4
14. Helping my client get relief from tensions or unhappy feelings.	1	2	3	4
15. Helping my client understand the reasons behind her/his reactions.	1	2	3	4
16. Supporting my client's self-esteem and confidence.	1	2	3	4
17. Encouraging attempts to change and try new ways of behaving.	1	2	3	4
18. Moving my client closer to experiencing emergent feelings.	1	2	3	4
19. Helping my client learn new ways for dealing with self and others.	1	2	3	4
20. Establishing a genuine person-to-person relationship with my client.	1	2	3	4
21. Helping my client get better self-control over feelings and impluses.	1	2	3	4
22. Helping my client realistically evaluate reactions and feelings.	1	2	3	4
23. Sharing empathically in what my client was experiencing.	1	2	3	4
24. Getting my client to take a more active role and responsibility for progress in therapy.	1	2	3	4

DURING THIS SESSION TO WHAT EXTENT:	NOT AT ALL	SOME	PRETTY MUCH	VERY MUCH
25. Did you reframe your client's formulation of a problem/try to provide a different perspective on the problem?	1	2	3	4
26. Did you try to help your client stay focused on a particular theme or problem?	1	2	3	4
27. Did you try to reflect your client's feelings?	1	2	3	4
28. Did you try to calm or comfort your client?	1	2	3	4
29. Did you suggest changes in your client's behavior?	1	2	3	4
30. Did you offer explicit guidance or advice?	1	2	3	4
31. Did you confront or challenge your client's attitudes or reactions?	1	2	3	4
32. Did you try to direct your client's attention to patterns or themes in his or her experience?	1	2	3	4
33. Did you try to facilitate the client's focusing on inner feelings and experiences?	1	2	3	4
34. Did you work actively with your client's nonverbal communications (eg., posture, gestures)?	1	2	3	4
35. Did you tell your client about relevant personal experiences of your own?	1	2	3	4
36. Did you employ therapeutic paradox?	1	2	3	4
38. Did you use behavioral rehearsal techniques?	1	2	3	4
39. Did you explore your client's childhood experiences?	1	2	3	4
40. Did you use role playing?	1	2	3	4
37. Did you encourage your client to identify his or her emotional reactions to this session?	1	2	3	4

APPENDIX I

Consent to use instruments letter from Dr. Ken Howard.

Consent to use instruments letter from Dr. Ken Howard.

NORTHWESTERN UNIVERSITY

27 Feb 97

Department of Psychology
2029 Sheridan Road
Evanston, Illinois 60208-2710
Telephone (708) 491-5190
Fax (708) 491-7859
PSYCHOLOGY@NWU.EDU

February 11, 1997

Brian Gutherie
CHC The EAP Specialists
#2310, 140, 4th Ave. S.W.
Calgary, Alberta
CANADA T2P 3N3

Dear Brian:

Congratulations on being admitted to candidacy for the Ph.D.

You have my permission to use the following instruments in your dissertation research project: Symptom Checklist, Current Life Functioning, Therapeutic Procedures Inventory, and Therapy Session Report. It is my understanding that these instruments will be used solely for your research and will not be used in any commercial way.

Best of luck with your project.

Sincerely,

Ken Howard

Kenneth I. Howard
Professor

APPENDIX J

Certificate of Approval

by the

Research Ethics Committee

Faculty of Social Work

The University of Calgary

Certificate of Approval

THE UNIVERSITY OF
CALGARY
Faculty of Social Work

CERTIFICATE OF APPROVAL

by the

RESEARCH ETHICS COMMITTEE
FACULTY OF SOCIAL WORK
THE UNIVERSITY OF CALGARY

The DISSERTATION entitled:

Variance in the Effectiveness of Short-term Therapists: Factors that Differentiate High Effective from Low Effective Therapists

of Brian **Guthrie**

in the judgment of this Committee has met The University of Calgary's ethical requirements for research with human subjects.

Dec 10 1996
Date

James Hawkes, PhD
Director, Research Unit
Faculty of Social Work

C:\WP51\PHD\GUTHRIE2.ETH

2500 University Drive N.W., Calgary, Alberta T2N 1N4
Telephone: (403) 220-5942 Fax: (403) 282-7269