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## A comparative study of brief and time-unlimited marital therapists

Sharon Kay Gilley

*College of William & Mary - School of Education*

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therapists**

**Gilley, Sharon Kay, Ed.D.**

**The College of William and Mary, 1994**

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A COMPARATIVE STUDY OF BRIEF AND TIME-UNLIMITED  
MARITAL THERAPISTS

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A Dissertation  
Presented to  
The Faculty of the School of Education  
The College of William and Mary in Virginia

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In Partial Fulfillment  
Of the Requirements for the Degree  
Doctor of Education

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by  
Sharon Kay Gilley  
December 1994

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1994

A COMPARATIVE STUDY OF BRIEF AND TIME-UNLIMITED  
MARITAL THERAPISTS


by

Sharon Kay Gilley

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Approved December 1994 by

  
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## DEDICATION

In memory of my sister, Karon Ann Gilley  
February 16, 1965 - September 16, 1984

This work is dedicated to my parents, Charlie and Mary Gilley, and my brother, Reid, who believing in me from the start, encouraged my continued education and helped me through every struggle to make my dream of completing this dissertation and doctorate a reality. They not only encouraged and supported me constantly, but contributed in so many ways that I consider this accomplishment to be theirs as much as my own.

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A COMPARATIVE STUDY OF BRIEF AND TIME-UNLIMITED  
MARITAL THERAPISTS

ABSTRACT

This was a descriptive study of 140 volunteer therapists in the Richmond, Virginia metropolitan area who identified themselves as either "brief" or "time-unlimited" in their practice of marital therapy. The sample, predominantly female and highly educated, had a mean age of 46.9 years.

For the purpose of this study, brief marital therapy was defined as eight or fewer therapeutic sessions within a 3-month period, and time-unlimited marital therapy was designated as therapy lasting longer than eight sessions or over 3 months. There were 60 self-identified brief marital therapists (BMTs) and 73 self-identified time-unlimited marital therapists (TUMTs). Subjects completed four instruments, including the "style" questionnaire, the active-directiveness subscale, and two instruments developed by the researcher. The specific variables under consideration were active-directiveness of the therapist, therapeutic goals, and duration of treatment.

Results revealed a high degree of similarity between BMTs and TUMTs regarding theoretical orientation, style, interventions, aim of therapy, and length and scheduling of sessions. Despite their similarities, therapists endorsed items consistent with their identification as either a BMT or TUMT. Thus BMTs, compared to TUMTs, were more active-directive, employed more limited, modest goals, and utilized fewer sessions. Therefore, it was concluded from the present findings that there was a significant difference between BMTs and TUMTs on the variables under scrutiny.

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A COMPARATIVE STUDY OF BRIEF AND TIME-UNLIMITED  
MARITAL THERAPISTS



## Chapter 1

### Introduction

#### Statement of the Problem

Is there a difference between self-identified brief marital therapists and self-identified time-unlimited marital therapists in their treatment of marital couples regarding time, goals, and therapist activity?

#### Justification for Study

The purpose of this study was to investigate how self-identified brief therapists differed from self-identified time-unlimited therapists when measured on the variables of time, goals, and therapist activity in their treatment of marital couples. For the purposes of this study, brief marital therapy was defined as eight or fewer therapeutic sessions within a 3-month period and time-unlimited marital therapy designated as therapy lasting longer than eight sessions or over 3 months.

Mental health consumers routinely seek help because of relationship disturbances. A survey of how Americans view mental health issues (Gurin, Veroff, & Feld, 1960) revealed 42% of all people who had sought professional help stated the issues were marital. Parad and Parad's

(1968) survey of casework and therapeutic services showed over three-quarters of patients described their presenting problems as either "interactive" (37%) or "problem posed by another family member" (39%). More recently, Budman and Gurman (1988) alleged "most 'family therapy,' in fact, is conjoint therapy with the husband-wife dyad, typically referred to as 'marital therapy' or 'marriage counseling'" (Budman & Gurman, 1988, p. 124).

The literature documents that nonbehavioral marital therapy produces beneficial outcomes in about two-thirds of cases, and their effects are superior to no treatment; and that conjoint marital therapy has a greater chance of positive outcomes than when only one spouse is treated. Also, there is some evidence of positive results of both nonbehavioral and behavioral marital therapy occurring in treatment of short duration (Gurman, Kniskern, & Pinsof, 1986). Thus in order for therapists to be prepared to meet the demands for services in this area, researchers need to further explore the effectiveness of brief treatment.

Additional justification lies in the fact that the divorce rate in the United States has risen dramatically. In the past 100 years, the divorce rate rose from 1 per 1,000 marriages to 20 per 1,000 marriages (Edwards & Saunders, 1981). At least 2.4 million people in this country divorce every year (Spanier & Thompson, 1983).

During 1990 (the latest year in which compiled statistics were available), 1,175,000 couples, or well over 2 million persons, divorced (Statistical Abstract of the United States, 1992). Considering the children and parents of divorcing persons, it is reasonable to assume over 6 million persons were directly affected by divorce that single year.

No longer stigmatized (Pais & White, 1979), divorce is readily available and has reached epidemic proportions under the no-fault 1970s legislation (Maclean, 1991). Seen as a viable alternative to an untenable marriage, divorce is a reality for many families (Pais & White, 1979), and has become a standard part of the family experience (White, 1990). Divorce replaces death as the predominant mode of terminating first marriages (Eekelaar, 1978), and history suggests divorce will continue (Riley, 1991).

Likewise, researchers predict the divorce rate will continue to rise for the foreseeable future. Among people born between 1946 and 1955, 49% are predicted to divorce in their first marriage (Glick, 1984) and 75% to 80% will remarry (Baker, Druckman, & Flagle, 1980). At least 40% of first remarriages will also end in divorce in less than 4 years (Glick & Norton, 1976). Martin and Bumpass (1989) provide the startling estimate that two-thirds of all first marriages in the United States will terminate by

divorce, and Maclean (1991) states 1 marriage in 2 is now expected to end in divorce. Thus an ever-increasing number of individuals are spending part of their lives dealing with the multiple consequences of divorce (Kitson & Morgan, 1990), including the problems of reestablishing order and continuity to a life severely disrupted by marriage dissolution (Albrecht, 1980).

Divorce and separation are considered highly stressful events as indicated by the high weighting for these items on the Holmes and Rahe Social Readjustment Rating Scale (Holmes & Rahe, 1967). A divorce is a crisis even if desired by both spouses (Rose & Price-Bonham, 1973). With the exception of death of a spouse, divorce is perhaps the single greatest life stressor the average married person is likely to experience (Walen & Bass, 1986).

Framo (1985), Kalb (1983), and Schulman (1981) identify the divorce decision as the single most crucial and perhaps the most stressful aspect of the divorce process. The literature indicates the newly divorced suffer at least some amount of personal disorganization, anxiety, unhappiness, loneliness, low work efficiency, increased drinking and other problem behaviors (Goode, 1956; Gurin et al., 1960; Rose & Price-Bonham, 1973; Weiss, 1976). During the post divorce adjustment period individuals are particularly vulnerable to a wide variety

of physical and emotional disorders (Bloom, Asher, & White, 1978; Weiss, 1976). Humphrey (1983) reports the divorced have more car accidents, more illnesses, more psychiatric hospitalizations, and more suicides than married people.

Becoming unmarried also imposes difficult and unclear demands for change. These demands can lead to psychological disturbance resulting from economic hardship, parental overload, social isolation (Pearlin & Johnson, 1977), as well as housing, legal, and former spouse issues (Buehler, Hogan, Robinson, & Levy, 1985-1986). These strains impose a resistance to rapid amelioration and over time can have deleterious psychological effects (Pearlin & Johnson, 1977). The adjustment and recovery process may take 3 to 4 years after separation (Weiss, 1975), and divorce may even exert an impact 5 to 10 years after separation (Wallerstein & Blakeslee, 1989). Hence, one of the best documented findings in the social science literature is the poorer psychological well-being of the formerly married as compared to the married, the single, and often the widowed in the United States and other societies (Bebbington, 1987).

Lastly, though many people get hurt in divorce, children may be hurt most (Felder, 1971). On the average, two children are involved in most divorces. Psychological

stress, economic hardship, guilt, discontinuity in parent-child relations (Spanier & Thompson, 1987) and changes in rules, roles, and responsibilities (Buehler et al., 1985-86) are some ways children are affected. Additionally, "each divorce sows the seeds of future divorces" (Felder, 1971, p. 31).

In conclusion, when one considers the number of couples who separate without eventual divorce, the number who divorce without prior separation, and the number who seriously contemplate separating and divorcing without doing either, it is clear that no therapist can avoid dealing with individuals or couples who have considered dissolution. Likewise, of all the possible related "clusters" of marital and family problems a therapist may face, the potential and actual dissolution of marriage will account for more clinical time than any other (Budman & Gurman, 1988).

While there is no ideal or easy solution to the ever-increasing divorce rate and its multiple consequences, Gurman (1973) found a positive relationship between brief treatments and outcome in couples therapy. His conclusion: the shorter the treatment the better the outcome. He proposed that "a crisis-intervention model may be especially relevant to the treatment of marital conflicts" (Gurman, 1973, p. 161). The goal is rapid problem resolution using "planned" brief intervention.

There have been significant advancements in the theory and technique of brief therapy in the past 20 years (Koss & Butcher, 1986). A number of research studies demonstrate its promise as an effective intervention, including findings that long and short-term treatments produce comparable gains (Fisher & Greenberg, 1977; Luborsky, Singer, & Luborsky, 1975; Smith, Glass, & Miller, 1980); that brief therapy may be effective for a variety of mental health problems (Butcher & Koss, 1978); it reduces dependency on the therapist (Budman & Gurman, 1983); and patients continue to get better after brief therapy (deShazer et al., 1986).

However, an obvious deficit is the lack of studies demonstrating the effectiveness of brief marital therapy specifically. Hence, if the results of this study are encouraging, they may have a significant impact on the utilization of brief therapy in the treatment of marital discord. Since brief therapy is the norm for reimburseable treatment (Sperry, 1989), findings could further advance brief marital therapy as an effective and cost-efficient method of preventing the crisis of divorce and its symptomatology.

#### Theoretical Rationale

Koss and Butcher (1986) classify four approaches to brief psychotherapy as psychodynamically oriented, crisis-oriented, behavioral, and other verbal

psychotherapies. Psychodynamically oriented approaches are the most numerous. Interpretations, modified for the brief format, are the major therapeutic technique. The focus is on present circumstances and positive transference is generally thought to be essential to the success of therapy.

Most behavior therapies, though treatment length is not a primary consideration, qualify as brief forms since they can be completed within the time limits of brief therapy. Likewise, crisis-oriented therapies, including environmental manipulation and general support, are effective with certain client types. Additionally, other approaches which fail to fit the categories above have been mentioned in the literature. For example, Budman and Gurman (1983) describe "Integrative Brief Psychotherapy" which includes various techniques, including family and systems approaches.

Treatment approaches that use verbal or cognitive mediation to bring about behavior change likewise fit into a brief treatment mode (Koss & Butcher, 1986). Hence a number of elements of Rational-emotive Therapy lend particular support to brief treatment and positive outcomes. These elements include: an active and direct therapist role; an emphasis on present circumstances; the development of problem-oriented goals that are limited and reality based; an emphasis on cognitive reorganization



along with emotive and behavioral procedures; the teaching of new skills; and lastly, the emphasis on hard work on the clients' part, outside of therapy, being essential to the success of therapy. Thus, Rational-emotive Therapy lends a strong theoretical and applied knowledge base supportive of early therapeutic change.

The underlying philosophy of Rational-emotive Therapy (RET) includes a version of positivism, naturalism, and classical humanism. Positivism views science as exemplary for all forms of intellectual activity. Naturalism states moral and empirical views should be linked such that ethical principles will be in harmony with the needs, desires, and capacities of the human being, as determined by empirical investigations. Ellis (1969), however, recognizes the differences between empirical propositions and value judgments and understands that "morality still has to be related to some underlying value system that is not completely determined by empirical findings" (p. 7). For Ellis, moral codes are human creations varying across cultures and historical periods and cannot be substantiated or validated beyond their situational utility. "There probably cannot ever be any absolutely correct or proper rules of morality since people and conditions change over the years and what is 'right' today may be 'wrong' tomorrow. Sane ethics are relativistic and situational" (p. 3).

Classical humanism accepts the superiority of science to all other systems of thought and views scientific objectivity as desirable in most human activities. It commits itself to the primacy of reason as a guide to conduct and opposes all arbitrary and irrational authority. It emphasizes reason, balance, restraint, and order. It views man as "the measure of all things" and enhances human freedom and happiness.

Ellis (1969) advocates a form of classical humanism, ethical humanism, that goes hand in hand with the scientific method. It postulates that until definitely proven otherwise, there is nothing beyond human existence; and for a human being to substantiate any hypothesis, it must be backed by observable and reproducible data. "Any hypothesis which cannot be backed by evidence which ordinary humans can observe and replicate is deemed to be a theological, supernatural, or magical hypothesis, and is not considered in the field of general or psychological science" (Ellis, 1973, pp. 2-3).

Ellis' RET implies a theory of personality and theory of personality change. Humans are viewed as cognitive-emotive behaving creatures, and by their very nature are alive and exist. This observable aliveness is neither good nor bad, and it is desirable that no self-evaluation be attached. Humans are expected to have limitations. Yet, they have the right to existence and the ability to

create and direct their own lives, and the choice to enjoy and fulfill themselves.

Originally postulated by Epictetus (1899, as cited in Ellis, 1973b) that humans are disturbed not by things but by the views they take of them, Ellis asserts the human being's highly organized thinking ability is responsible for emotional disturbance. RET places humans in the center of the universe and of their own emotional fate and gives them almost full responsibility for choosing to make or not make themselves seriously disturbed. Although it weighs biological and early environmental factors quite importantly in the causative factors leading to disorganization and disorder, Ellis insists that the individual can significantly intervene between one's environmental input and emotionalized output and, therefore, has an enormous amount of potential control over what one feels and does (Ellis, 1973b).

The inherent character of humans is that they make themselves disturbed by a belief system that accepts assumptions about self and others that cannot be validated. Unverifiable superstitions and myths and unsound and incongruous absolutes which humans accept, result in extreme self-evaluation and ineffective functioning. Thus, humans are demandingly perfectionistic and correspondingly error-prone.

Humans tend to avoid high-level thinking by nature. Ellis has identified three basic "irrationalities" or forms of "musturbation" which all humans hold to some degree but which disturbed individuals hold more intensely, extensively, and rigidly.

1. "I must be competent, adequate, and achieving, and I must win the approval of all the significant people in my life. When I don't, it is awful. I am a rotten person and I can't stand it."

2. "Others must treat me kindly, fairly, and properly. It is terrible when they don't."

3. "I need and must have the things I really want-- just the way I want them to be, easily, immediately, and without difficulties or hassles. It is horrible and I can't tolerate being frustrated or uncomfortable when things don't go as they should."

Thus, Ellis (1973b) makes the point that virtually all human disturbance is the result of magical thinking and can be directly eliminated by sticking rigorously to empirical reality. RET philosophy concludes that humans have the innate ability to learn how to challenge actively and remove irrational beliefs which support self-defeat. Herein lies the primary tenet of RET: it is possible to achieve maximum actualization of human potential through the use of cognitive control of illogical emotional responses (Ellis, 1973b).

Given that humans are perfectionistic and error-prone, are influenced by language indoctrinations, and live in neurosis-producing cultures, RET theory suggests that deconditioning reeducation by direct means is an appropriate way to eliminate human disturbance. The principles of RET are designed to reduce disturbability and not solely to eliminate symptoms.

RET is rigorously scientific, meaning that it is based on and consistently uses the principles of empirical validation and logical analysis rather than the principles of magic, mysticism, arbitrary definition, religiosity, and circular thinking (Ellis, 1971). The principles employed in the theory and practice of RET are stated in terms of A-B-C-D-E and are explained below.

At point **A** there is an **activity** or **action** the individual becomes disturbed about. At point **rB** the individual has a **rational** or **realistic Belief** about the **activity** at point **A**. At point **iB** the individual has an **irrational Belief** about the **action** at point **A**.

Point **rB**, the **rational Belief**, can be supported by empirical data and is appropriate to the reality at point **A**. Conversely, point **iB**, the **irrational Belief** cannot be supported by empirical evidence and is inappropriate to the reality at point **A**. Further, **irrational Beliefs** usually imply a should, ought, or must--an absolute

dictate that the individual obtain what one wants, or catastrophe results.

At point **rC** the individual experiences or feels **rational Consequences** of one's **rB's**. The individual's actions and feelings are appropriate to the situation occurring at point **A**. At point **iC** the individual experiences **irrational Consequences** of one's **iB's**. The individual's actions and feelings at point **iC** are inappropriate to the situation at point **A**, resulting in "neurotic" and "over reactive" symptoms.

The ABC's of RET are extended to D-E's which constitute the cognitive core of RET methodology. At point **D**, the individual can be taught to **dispute** one's **iB's** (**irrational Beliefs**). If the individual persistently and vigorously **disputes** the **iB's** which are creating the **iC's** (**inappropriate Consequences**), one will eventually understand they are unverifiable, unempirically based, and the individual will be able to reject and change them.

At point **cE** the individual will obtain the **cognitive Effect** of disputing one's **iB's** (**irrational Beliefs**). Thus, the catastrophic event viewed earlier at **iB** becomes a mere inconvenience at point **cE**.

At point **bE** the individual will obtain the **behavioral Effect** of disputing one's **iB's** (**irrational Beliefs**). Thus, the individual will tend to be much less anxious and significantly less "disturbed" or "neurotic."

On the cognitive level, RET largely employs direct philosophic confrontation. The therapist actively demonstrates to the individual how a dysfunctional emotion or behavior or **consequence**, at point C, indirectly stems from some **activity** or **agent** at point A, and it much more directly results from one's interpretations, philosophies, attitudes, or **beliefs** at point B.

The therapist teaches one how to scientifically **dispute** those beliefs at point D and to persist until one consistently comes to point E with a set of sensible **cognitive Effects, cE's**, and appropriate **behavioral Effects, bE's**. When the individual has remained for some period of time at point E, one has a radically changed philosophic attitude toward oneself, others, and the world. Thereafter, one is much less likely to keep convincing oneself of **iB's (irrational Beliefs)** and thereby creating **iC's (inappropriate Consequences)** or emotional disturbances (Ellis, 1973a).

Spurred by criticism of the original ABC theory and by his own clinical and research findings, Ellis (1991) has continued to add to his original RET model developed in the 1950s. More recently, Ellis has added G, which stands for the **Goals**, values, and desires people bring to their ABCs of human health and disturbance. Humans, biologically and by social learning, are goal-seeking animals and their **Fundamental Goals (FG)** are to survive,

to be free from pain, and reasonably satisfied or content. As subgoals or **Primary Goals (PG)**, they want to be happy: when by themselves; gregariously, with others; intimately, with a few selected others; informationally and educationally; vocationally and economically; and recreationally.

Ellis' ABC theory of personality now holds that when humans experience, or even think about experiencing, stimuli or **Activating events (A's)** that they interpret as aiding or confirming their **Goals (G's)**, they explicitly and/or tacitly (unconsciously) react with their **Belief system (B)** and their **Consequences (C's)** in a pleasurable manner. Thus, they preferentially (rather than demandingly) think at point B, "This is good! I like this **activating event.**" Resultingly, they experience the emotional **Consequence (C)** of pleasure or happiness and the behavioral **Consequence (C)** of approaching and trying to repeat the activating event.

However, when the experience at point A is perceived as blocking or sabotaging one's **Goals (G's)**, they normally explicitly or tacitly react at points B and C in an unpleasurable, avoiding manner. Thus, they preferentially think at point B, "This is bad! I dislike this **activating event.**" Resultingly, they experience the emotional consequence (C) of frustration or unhappiness and the



behavioral consequence (C) of avoiding or trying to eliminate the event at point A (Ellis, 1991).

In addition to Ellis' previous theory that cognitions, emotions, and behaviors are interactional and never disparate and pure, likewise "the same thing seems to go for the ABC's of RET. G, A, B, and C continually interact with each other and they all seem to be part of a collaboration with one another" (Ellis, 1991, p. 145). Hence, interactions and mutual influences among the ABC's of healthy and unhealthy functioning are multiple and almost endless.

Similarly, the interaction among the ABC's of two or more people in an intimate relationship may be immense and profound. A couple's A's may strongly influence their B's, and their B's can significantly influence their A's. Likewise, two people's C's often powerfully influence each other's A's. Despite the seeming complexity, RET does not address all of the couples' interactions, only those creating disturbance in the relationship. Those crucial to disturbance usually involve thoughts, feelings, and actions that overtly or tacitly involve musts and demands. Thus, the theory and practice of RET proposes that if the partners fully understand the ABC's of their own and the other's life, they will have a much better view of what is happening, and what they are making happen, in their relationship. Beyond this, a clear understanding of their

preferences and their demands about their own and each other's cognitive-emotive ABC's is needed. According to Ellis (1991), "If their own cognitive-emotive B's are preferential, they will most probably not be disturbed, while if they are distinctly musturbatory, they most probably will be" (p. 153). The role of the RET therapist then is to help the couple change their irrational musturbatory beliefs and replace them with preferential ones.

In summary, according to RET, all behavior includes a combination of learned and innate factors. Likewise, a multiplicity of innate and environmental factors maintain our personalities. While Ellis agrees with many humanistic psychologists that we have strong, innate tendencies to act rationally, self-fulfillingly, and self-actualizingly, we likewise have strong inborn tendencies to defeat ourselves. People largely create their emotional problems by accepting and inventing irrational and illogical ideas. Further, they also have the capacity to understand, change, or eliminate their irrational Beliefs (iB's), their inappropriate emotions, and self-sabotaging behaviors. Showing people how they can change their irrational Beliefs (iB's) that directly create their disturbed emotional Consequences constitutes the essence of RET.

Whereas emotive and behavioral procedures play important roles in change, it is the underlying cognitive reorganization that motivates and directly "causes" these changes. Thus, philosophic reconstruction works best in changing disturbed thoughts and feelings. Based on Ellis' (1991) premise that cognitions, emotions, and behaviors are interactional and collaborate with one another, a positive change in faulty cognitions will facilitate positive and vital changes regarding emotional and/or behavioral Consequences.

The theory and practice of RET and the practice of brief therapy, which was the focus of the present investigation, share many common elements. These include: (a) a problem-oriented focus regarding goals; (b) a direct approach; (c) parsimony of treatment, thus the aim to decrease disturbability versus "cure" and elimination of all symptoms; (d) the emphasis on cognitive reorganization with emotive and behavioral procedures playing important roles; and lastly, (e) the importance of deconditioning and reeducation. Hence, RET provides an appropriate theoretical support for the present exploration of brief therapy as it is applied in the treatment of marital discord.

#### Definition of Terms

The following definition of terms will clarify some of the major constructs of this study:

1. **Active-Directiveness** - refers to the therapist's degree of activity in the therapeutic session.

2. **Brief Marital Therapy** - marital intervention in which time is rationed so that maximum benefit is gained with the lowest investment of therapist time and patient cost. The time limit is set at the start of therapy with a plan to accomplish agreed upon therapeutic goals within the specific time frame. For purposes of this study, brief marital therapy was defined as eight or fewer therapeutic sessions within a 3-month period.

3. **Goals** - specific, well-defined objectives, agreed upon by the therapist and a couple at the outset of therapy, to be accomplished within the designated time frame.

4. **Therapist** - a licensed behavioral health professional (including counselors, nurses, social workers, and psychologists), who was self-identified as either a brief therapist or time unlimited therapist based upon their perception of their marital therapy practice.

5. **Therapist Activity** - the specific behaviors and use of therapeutic interventions in the treatment of marital couples.

6. **Time** - the specific number of therapeutic sessions in which the therapist and couple engage in marital treatment; also referred to as duration of treatment.

7. **Time-Unlimited Marital Therapy** - marital intervention in which time is not rationed. In this study, time-unlimited marital therapy was designated as therapy lasting longer than eight sessions or over 3 months.

#### Research Hypotheses

1. Self-identified brief marital therapists will report being more active-directive in their therapeutic treatment of marital couples when compared to self-identified time-unlimited therapists.

2. Self-identified brief marital therapists will report employing more limited and more modest goals in their therapeutic treatment of marital couples when compared to self-identified time-unlimited therapists.

3. Self-identified brief marital therapists will report utilizing fewer therapeutic sessions in their treatment of marital couples when compared to self-identified time-unlimited therapists.

#### Sample Description and General Data

##### Gathering Procedures

The population under investigation was 140 therapists in the Richmond, Virginia metropolitan area who conducted marital therapy in private or agency settings. All respondents were volunteers and their names and addresses were obtained from the telephone directory yellow pages.

This was a descriptive study that employed a survey for data collection. No "treatment" was given. Participants were mailed four self-report inventories for completion (total of 82 items) and included:

1. The Therapist Personal Data Questionnaire (demographic questionnaire).
2. The "style" questionnaire.
3. The active-directiveness subscale.
4. The Specific Therapist Behaviors Questionnaire.

The latter inventory and the demographic questionnaire were developed by the researcher to gather specific information related to the targeted areas to be studied and to provide a picture of the population under investigation. All respondents remained anonymous. A cover letter accompanied the mailed questionnaires to: explain the purpose of the study; to elicit participation; and to provide written instructions for returning the unidentified confidential materials in the enclosed stamped envelope to the researcher. The researcher contacted each respondent by telephone prior to mailing the questionnaires to facilitate participation.

Additionally, the researcher contacted five practicing professionals to participate in a pilot study of the four tools to: (a) promote standardization and strengthen the validity of the instruments; (b) ensure the

desired information was obtainable; and (c) determine the approximate time required to complete the instruments.

#### Limitations of the Study

Since the instruments employed in this study were all self-report inventories, there may be some question as to the subjects' objectivity in responding to items relating to themselves.

All participants in this study were volunteers. This raises the potentiality of a biased sample, as volunteers may respond differently than nonvolunteers.

No special considerations or adjustments were made for the demographic variables of gender, degree obtained, level of experience, or volume of marital cases. The study took place in Richmond, Virginia, and the sample employed was not a random one.

## Chapter 2

### Review of Literature

#### Historical and Theoretical Development

Gurman (1973), Manus (1966), and Beck (1966) agree that marriage counseling is a technique in search of a theory. As far as a theory base is concerned, marriage counseling seems to be eclectic and pragmatic. Cognitive theory has made its greatest contribution to the field of individual psychotherapy, but cognitive principles also apply to marital problems (Ellis, 1958). Likewise, several cognitive behavior therapies fit into a brief treatment mode (Koss & Butcher, 1986). In Rational-emotive Therapy (RET) specifically, the active role of the therapist, the direct intense use of various techniques that foster early therapeutic change, and the accomplishment of limited goals provide a strong theoretical and applied base of knowledge with which this study's results can be compared. Rational-emotive psychotherapy is based on the assumption that cognition and emotion are not independent. Emotional upset and disturbed interpersonal interactions result not from external events, but from illogical, irrational thinking. Thus, what an individual tells himself about an external event determines his emotional response.



A growing body of research suggests that RET can be an effective therapeutic approach with a variety of behavioral and emotional problems. One area in which RET may be directly employed is marital counseling, since a major portion of marital counseling evolves around disruptive interpersonal interaction and emotional disturbances. RET assumes that most couples enter marriage with two general expectations: the enjoyment of secure and intimate companionship and love, and the hope for regular sexual satisfaction. The two expectations are intimately related to each other and "to the general personality patterns and life expectations of the married partners" (Ellis & Harper, 1961, p. 17). If the expectations are relatively open-minded and rational, the behavior of the couple will tend to be relatively reasonable and undisturbed. However, if the expectations are illogical, unrealistic, and prejudiced, the resulting behavior will tend to be disturbed and unreasonable.

According to Ellis, the foremost cause of disturbed interactions is the totally unrealistic expectations resulting from irrational ideas which husbands and wives tend to have about others and the marriage relationship. Partners stubbornly cling to and absolutely refuse to work at eliminating their self-defeating value system (Ellis, 1966). This is partly because they are not

aware of their philosophical stand and partly because they have become convinced of their position. Before change can take place, spouses must honestly express their feelings, and more importantly, work hard at changing the irrational ideas that create and perpetuate such feelings (Human Development Institute, Inc., 1964).

Thus, Ellis presents an approach to marriage counseling and psychotherapy that views cognition as a cause of man's emotional behavior. Given that marital difficulties arise from neurotic disturbances on the part of either or both spouses, RET views the disturbed interaction as simply an extension of the disturbed individual and is dealt with accordingly. One is not required to seek dynamics underlying disturbed marriage partners as opposed to disturbed, unmarried individuals. Therefore, separate theoretical frameworks and procedures are unnecessary.

While RET tends to provide a generally applicable tool for marital discord, the view that irrational ideas are a crucial variable in disturbed marital relationships is still in need of experimental support. To explore the relationship between irrational ideas and marital discord, Eisenberg and Zingle (1975) attempted to answer the question: Do individuals who are having difficulties with their marital relationship adhere to

irrational ideas to a greater extent than do individuals not having such difficulties?

The study involved two finite populations of married individuals. One sample of 52 individuals, designated the agency sample, was involved in marital counseling through various agencies. A second sample, the nonagency sample, was comprised of 98 subjects who were not being seen for marital counseling. The majority of subjects in both groups were husband-wife pairs, Caucasian (one couple being Black), and primarily Protestant.

The Irrational Ideas Inventory (Zingle, 1965) derived from Ellis' 11 irrational ideas, and a measure of marital-adjustment, the Locke and Wallace Inventory (Locke & Wallace, 1959), were given to both groups. To reduce between group differences due to possible counseling effects, only those agency subjects who were in therapy 2 weeks or less participated.

The hypothesized relationship between irrational ideas and marital discord was supported. The Locke and Wallace Inventory demonstrated that the samples clearly differed as to the level of marital adjustment, and the Irrational Ideas Inventory indicated that the agency sample was functioning on a statistically significant, more irrational level than the nonagency sample.

Further, if one partner possessed irrational ideas, it had a noticeable effect on the marital relationship.

In a control study, Munjack et al. (1984) randomly assigned 16 males with erectile failure to either 12-biweekly sessions (6 weeks duration) of RET or a 6-week waiting list control group. All subjects were married or living with a partner and sought outpatient treatment for secondary erectile failure. Treatment was administered by a psychology graduate student with special training in RET. The major effort of therapy was to dispute subjects' irrational beliefs and develop more rational attitudes resulting in reduced anxiety and increased erectile ability.

Subjects were given a battery of instruments, including the Obler Sexual Anxiety Scale (Obler, 1972), the Shorkey-Whiteman Rational Beliefs Inventory (Shorkey & Whiteman, 1977), and the Munjack-Oziel Sexual Anxiety Scale (Munjack & Oziel, 1974) when they applied for treatment and again after 6 weeks of active treatment or 6 weeks on the waiting list. Findings indicated that patients in the treatment group made significantly more sexual intercourse attempts, reported significantly reduced sexual anxiety, and had a significantly higher number of successful intercourse attempts than the control group. A 6-to-9 month follow-up of the treated subjects revealed most had fallen back toward the

pretest baseline (lower rates of successful intercourse). However, group means as a whole were still significantly higher than pretreatment success rates.

While the results are somewhat encouraging, further replication is needed. The small number of patients, the use of only one therapist, and the occasional use of other interventions in addition to RET, make it difficult to attribute with certainty the differences between the treatment group and control group to RET.

In a similar study, Dekker, Dronkers, and Staffeleu (1985) used RET, masturbation exercises, and social skills training to treat 40 men in male-only groups with the complaint of sexual dysfunction. The Sexuality Experience Scales (Frenken & Vennix, 1981), a measure of sexual function, and the Willems Social Anxiety Scale (Willems, Tuender-de Haan, & Defares, 1973), a measure of social functioning, were administered upon intake and following the final group session.

Subjects were patients at an outpatient sexual dysfunction clinic and were treated in eight groups of 4 to 6 subjects, each for 2-hour sessions on a weekly basis. RET, one of the major treatment components, was used to analyze cognitions, feelings, and behaviors, and suggestions for more effective sexual functioning were

given. In each group, treatment was provided by two male therapists.

The combination of RET, masturbation training, and social skills training proved to be a successful method to improve sexual functioning and social anxiety in sexually dysfunctional males. Treatment was also successful according to the therapists' assessment. A large number of subjects showed a complete cure, and many showed unmistakable improvement, but not a complete cure. However, the researchers asserted that male-only groups are not a panacea.

The above data were combined with previously reported data (Everaerd et al., 1982) to predict treatment outcome. The following effects were found: sexual functioning of men with a steady partner and men with varying partners improved; and inhibited sexual desire was associated with a poor outcome. However, several other variables such as type of dysfunction, social anxiety, age, and educational level did not predict improvement of sexual functioning. Thus, the ability to predict treatment outcome proved limited. The researchers concluded that while a combination of RET with other treatments seems to provide adequate treatment for various complaints of men with quite different backgrounds, further research using "pure"

treatment methods may produce more clearly differentiated results.

In comparison to the above study, Everaerd and Dekker (1985) used "pure" treatment methods in their treatment of 32 couples with male psychogenic sexual dysfunction. Only couples with at least a 6-month history of male dysfunction were included and patients were treated in an outpatient setting. Couples were randomly assigned to one of two unique treatment groups: (a) RET or (b) an adaptation of the Masters and Johnson method of sex therapy (ST). A structured form of RET was used in which RET principles were explained to couples orally and in printed form. Couples were instructed to make "rational analyses" of problem situations at home. The therapists initially helped them, but later confined themselves to analyses made by the couple.

Four assessment instruments were administered after intake, 3 weeks after the final session, and 6 months to 1 year after the final session. These included the Sexuality Experience Scales (Frenken & Vennix, 1981); a measure of sexual functioning, the Marital Attitude Evaluation Scale (Schutz, 1967); the Self-Esteem Scale (Rosenberg, 1969); and the Willems Social Anxiety Scale (Willems et al., 1973). The number of therapeutic

sessions ranged from 12 to 31 for ST and 9 to 29 for RET.

Of the 32 couples, 16 dropped out after an average of five sessions. In a comparative analysis of males who completed treatment and males who dropped out, it seems the drop-outs had less serious sexual problems and therefore were probably less motivated for treatment. Because of random assignment in combination with the drop-out phenomenon, 10 couples received ST and 6 received RET.

In couples completing therapy both RET and ST led to improvement of sexual functioning. RET seemed to be effective especially in the dysfunctional partner. A striking finding was that satisfaction with the relationship improved in RET but not in ST. This effect was not significant at follow-up, but follow-up data were available on only two couples. Jeopardized by the small number of patients that remained in treatment and resulting methodological problems, significant differences between ST and RET could not be demonstrated in a valid way.

Gooch (1985) reported preliminary findings on a 10-session "course" of marriage counseling based on RET principles that was offered to psychiatric inpatients in a rural Veterans Administration Medical Center. The choice of a 10-session model was arbitrary. Ellis



(1956), in his cognitively oriented marriage counseling, estimates 6 to 10 sessions are sufficient for most cases.

In the proposed model, the couple met daily with the therapist who attempted to quickly relieve tension between the partners. Additionally, the basic principles of RET were explained as well as specific irrational beliefs that contribute to marital discord. The model did not propose to resolve all marital problems in therapy. The goal was to teach cognitive principles and techniques to enable the couple to more effectively resolve their own problems after discharge.

The model was used with only three couples. In all three cases the couples reported improvement in their relationship and there was no recurrence of the Axes I symptoms. While credit for improvement in these cases cannot be attributed entirely to RET, there is some indication that improvement in the marital relationship had been a factor in the patient's recovery. Studies employing a larger number of subjects, more rigorous methodologies, and specific assessment instruments are needed. Nevertheless, preliminary results indicate its promise.

Further, though not specifically noted by the researcher, the proposed RET marital therapy model included several principles of brief marital therapy

endorsed by Budman and Gurman (1988). Quickly identifying and vigorously working on the source of problems in the relationship; an intense, active-directive and highly structured approach; a present-oriented focus; teaching skills and techniques to enhance other problem areas; and the intention not to resolve all the marital problems in therapy are all characteristic of brief marital therapy. Thus, the preliminary results of the aforementioned RET marital intervention also indicate promise for the use of RET as a form of brief marital therapy.

#### Critique

A growing body of research suggests that RET can be an effective therapeutic approach with a variety of behavioral and emotional problems. Studies have shown that it can be effective for anxiety and depression (Kujoth & Topetztes, 1977), Type A behavior (Jenni & Wollersheim, 1979), and assertiveness (Carmody, 1978). A review of the literature suggests that RET appears promising in the treatment of marital difficulties as well. However, studies reported a number of methodological deficiencies which precluded definitive conclusions. These deficiencies included a limited number of subjects, use of predominantly white subjects, predominance of a particular religious denomination, high drop-out rates, large differences in the number of

subjects in comparative samples, and the lack of control studies using pure treatments. While one preliminary study (Gooch, 1985) indicated promising results using RET marriage counseling with psychiatric inpatients, there is need for additional empirical data to support the clinical observations made by Gooch, and particularly in nonclinical outpatient subjects.

The current study investigated therapists' self-reports of their practice of either brief marital therapy or time-limited approach, versus a long-term or time-unlimited approach on outpatient clients. Although there are no conclusive studies in the literature reporting the use of RET specifically as a brief marital intervention, the theoretical framework appears suitably flexible for application to a wide variety of specific situations. Also, Ellis' delineation of irrational ideas tends to be of a generalized nature (Gooch, 1985). Further, RET has much in common with the practice of brief marital therapy as mentioned earlier. Thus, this study expanded the body of research and subsequent utilization of RET as a flexible and effective treatment method in brief marital therapy.

#### Time as a Variable of Brief Therapy

Recent interest in brief psychotherapy has been an explosion of interest in "planned" brief therapy--or brief therapy "by design," as opposed to unplanned brief

therapy "by default." Lacking a reliable and universally accepted definition and model of practice of brief therapy, it is best described as an intervention in which the time allotted to treatment is rationed.

"The therapist hopes to help the patient achieve maximum benefit with the lowest investment of therapist time and patient cost, both financial and psychological" (Budman & Gurman, 1988, p. 6).

In essence, according to Shlien, Mosak, and Dreikurs (1962), time limits place the emphasis where it belongs: on quality and process rather than quantity. "Time does not heal, because it cannot. Only activity can heal, and the more activity, the shorter the time required" (Shlien et al., 1962, p. 31). Thus, time limits increase energy, choice, wisdom and courage and thereby heighten the essential process while they reduce the largely unessential time.

To test the prediction that clients in time-limited counseling with a predetermined termination date would demonstrate greater improvement than clients in undetermined-time counseling, within the same period, Munro and Bach (1975) randomly assigned 24 college students to either an 8-week time-limited (TL) or an undetermined-time (UT) treatment condition. Subjects were seeking help at the university counseling center for emotional or personal-social problems. Subjects in

the TL condition were informed at the beginning of the first and each subsequent session of the time limitation. Subjects in the UT group were seen in the usual manner and the time of termination was left open-ended. The Personal Orientation Inventory (Shostrom, 1966) and a modified version of Strupp's pre- and post-assessment of therapy (Strupp, Fox, & Lessler, 1969) were administered to all subjects prior to treatment and following the eighth session. Counselors also completed a modified version of Strupp's therapist questionnaire on which they evaluated client improvement at the completion of the eighth session.

Although both groups exhibited positive change on the assessment measures, the TL group increased significantly more in independence and self-acceptance, demonstrated greater tendencies toward improvement in "living in the present" and self-regard, and felt in less need of further treatment than the UT group. Likewise, counselors were in agreement with the clients' perceptions of improvement, which is a result not often found (Horenstein, Houston, & Holmes, 1973). Thus, the results suggested that time-limited counseling affected client progress in a much more positive direction than did undetermined-time counseling.

Although the small sample size limits generalizability of the findings, there is an additional

concern. In neither the TL nor the UT groups was there any implicit or explicit expectation that counselors would modify their behaviors or techniques in treatment. Thus, this raises the question of time-limited treatment being viewed a shorter version of time-unlimited treatment, in other words, "less of the same."

Although brief therapy is widely practiced today, many still consider it to be a second-rate form of treatment whose effects are palliative and temporary (Malan, 1976). Presently, little research evidence exists to support this conservative view. To challenge criticism of the limited effectiveness of brief treatment, Fisher (1984) did a 1-year follow-up on a previous study of brief family therapy.

In the original study (Fisher, 1980), 6-session, 12-session, and unlimited treatment sessions were compared to a waiting list control group. Upon termination, families who received treatment showed greater improvement than the controls, but there were no significant differences among the three therapy conditions. Despite small sample size making it difficult to draw firm conclusions, results suggested that very brief treatment of 6-sessions could be as effective as longer treatment. To assess the durability of reported improvement, the researcher did a 1-year

follow-up of the families of the original study which is described below.

Each of the 37 families in the original study had sought help at a child guidance clinic for difficulties with a child 8 to 12 years old. Follow-up questionnaires were returned by 24 families: 6 out of 9 in the 6-session, time-limited treatment (6TL); 6 out of 10 in 12TL; 7 out of 8 in treatment without time limits (UL); and 5 out of 10 in the waiting list control group (WL). Returnee families included a significantly higher proportion of lower-class and one-parent families, and consistent with the original study, consisted largely of white male children referred by the schools.

Questionnaires were completed by the parents(s) and included the Individualized Problem Behavior Scales; Louisville Behavior Check List, Form E2; Child Problem Areas, Family Concept Semantic Differential; Improvement in Presenting Problems and Improvement in Family Relationships; and Additional Help Questionnaire.

Results of the 1-year follow-up study demonstrated no significant changes from termination to follow-up, nor any significant differences among the four groups of families. Results also provided no evidence for deterioration in any of the three groups of families that received treatment originally. This evidence is consistent with the position that brief family treatment

can produce more than temporary improvement in an unselected child clinic sample. However the small sample size, which severely reduces the probability of detecting valid group differences, and obtaining data only from the parent(s), limit the drawing of firm conclusions regarding these follow-up results. Also, as in the original study, the results do not support the argument that time limits contribute to increased therapeutic effectiveness. However, it is obvious that setting a time limit can shorten the length of therapy, apparently without diminishing effectiveness.

In a series of field and laboratory studies conducted at a university counseling center, Keilson, Dworkin, and Gelso (1983) assessed the outcomes of time-limited therapy (TLT) by randomly assigning 42 noncrisis students to an 8-session, time-limited condition (TLT), a time-unlimited condition, and a waiting list control group. Students were seeking counseling for personal-social problems but were probably within the normal, moderately neurotic, range of adjustment. Subjects assigned to the time-limited condition were informed of the limit during their first session. Time-unlimited subjects were serviced by the center in the usual manner, with the termination date left open-ended. Control group subjects were placed on the waiting list for 8 weeks. The Bills' Index of



Adjustment and Values (IAV) (Bills, Vance, & McLean, 1951) was administered prior to treatment, upon termination, and approximately 2½ years after the beginning of the experiment. The IAV provides a measure of adjustment-maladjustment and is sensitive to the effects of brief treatments as well as long-term counseling (Berman, Gelso, Greenfeig, & Hirsch, 1977).

The results of the investigation suggested that 8-session TLT is a viable treatment, at least for clients who are not severely disturbed. It seemed to produce as much change as open-ended treatment in a university counseling center setting, and the change it stimulated appeared to be durable. However, limitations reduce the confidence we can place in the results. Researchers employed only one criterion measure, a paper-and-pencil inventory assessing the discrepancy between real and ideal self. Also, only 18 of the original sample could be reached for follow-up. However, all of those reached completed the questionnaire (43%).

Interestingly, when comparing the actual number of sessions of time-limited subjects to time-unlimited subjects (the controls received open-ended counseling), the mean number of sessions was 7.5 (SD = 1.2) and 11.66 (SD = 6.4), respectively. Thus, the time-limited subjects received an average of 4.1 fewer sessions.

Many studies fail to report on such data (Johnson & Gelso, 1980).

Second in a series of investigations, Gelso, Spiegel, and Mills (1983) compared therapists' and clients' reactions to three different therapy structures: 8-session, time-limited therapy (TLT); 16-session TLT; and time-unlimited therapy (TUT). Seventy-eight students who sought psychotherapy at a university counseling center were randomly assigned to one of the treatment conditions. Subjects in the two time-limit conditions were informed by their therapists of the time limits during the first session. TUT subjects received counseling according to the standard counseling center procedure.

Subjects were given the Bills' Index of Adjustment and Values (IAV) (Bills et al., 1951) prior to treatment to determine pretreatment adjustment level. Additionally, all subjects were mailed the Counseling Center Follow-up Questionnaire (CCFQ) for completion at 1 month and 18 months after termination. The CCFQ is a slight modification of a follow-up device employed at the center for over a decade. It contains 50 items that elicit specific reactions to diverse aspects of counseling, such as subjects' personal growth, the quality of treatment, and their satisfaction.

Four counselor-completed forms were employed.

Following the first interview with each client, therapists completed a 5-item Pre-Counseling Assessment Blank to determine if subjects were initially comparable among the treatment conditions and to discern if certain factors predict client and therapist outcome evaluations. Upon termination, therapists responded to the 7-item Post Counseling Assessment Blank to assess their self-perceptions on factors distinguishing TLT from TUT. Both the pre- and post counseling devices were constructed specifically for the study.

A third self-rating scale devised specifically for the study was the 17-item Time-Limited Therapy Questionnaire. It asks questions ranging from theoretical orientation to reactions to the TLT conducted. Finally, the most recent revision of the Therapist Orientation Questionnaire (TOQ) (Sundland, 1972) was completed by all therapists. The 104-item instrument measures theoretical orientation, and reliability and validity data are generally quite supportive of its utility (Howard, Orlinsky, & Trattner, 1970; Sundland, 1972; Sundland & Barker, 1962).

Results of the investigation evidenced that 1 month after counseling had terminated, subjects exhibited a weak but consistent tendency to make more favorable ratings of themselves and their therapy when they received TUT as opposed to either 8- or 16-session TLT.

Therapists exhibited the same pattern, although to an extent even greater than subject ratings. Their ratings contained individual differences so great they clearly overshadowed possible treatment effects. It should be noted here that therapists, on the whole, felt most comfortable conducting moderately long-term counseling (6 to 12 months) and possessed a "guarded optimism" regarding the value of TLT upon beginning the project.

The pattern of clients' ratings seemed to increase 18 months after termination. Thus, while subjects in all three treatments viewed themselves as improving, subjects in TUT, to a greater extent than those in TLT, saw the improvement as due to counseling and, in fact, as occurring during the time of counseling. The finding that subjects tended to evaluate individual counseling with a time-limited format less positively than TUT, especially some time after termination, is contrary to existing literature as revealed by a review of studies comparing the effects of TLT and TUT (Johnson & Gelso, 1980).

Additionally, the researchers reported interesting exploratory findings upon using a more liberal definition of alpha to inspect initial adjustment by treatment group interactions. While caution must be exercised in generalizing from these data, the analysis suggested that TUT was more favorably evaluated than

TLT, and 16-session TLT more positively rated than 8-session TLT when subjects were poorly adjusted. However, when subjects were better adjusted, TLT yielded more favorable reactions than open-ended counseling. This finding was especially interesting considering the difference between the number of sessions attended by subjects in the 8-session and 16-session treatment groups was only 2.61 (means 6.0 and 8.61, respectively). Thus, this finding along with the aforementioned findings contrary to existing research, and the fact only therapist and client reports were examined, preclude the drawing of any firm conclusions concerning clients' reactions to TLT versus TUT.

Budman and Gurman (1983) proposed that there are major divergencies in the value systems of long-term and short-term therapists. They suggested one of the critical criteria for defining the nature of brief therapy is "a state of mind of the therapist and the patient" (Budman & Gurman, 1983, p. 278), rather than the number of sessions or length of treatment. Further, they stressed that "attitudinally, planned brief therapy requires that the therapist and patient agree to accept a set of values as to what therapy can and cannot do" (p. 278). Thus, Budman and Gurman identified eight dominant values pertaining to the ideal manner in which long-term therapy is practiced and contrasted these with

corresponding ideal values pertinent to the practice of short-term therapy. One of the ideal value differences involves the idea of "cure." While the long-term therapist seeks basic character change or "therapeutic perfectionism" (Malan, 1963), the short-term therapist does not ascribe to the notion of "cure" and prefers pragmatism, parsimony, and the least radical intervention. Seven other proposed value differences between short-term and long-term therapists include: the nature of psychological change; the focus on patients' strengths versus weaknesses; psychological change occurring during or after therapy; time factors; economic issues; negative consequences of therapy; and the importance of therapy in the patient's life. Although Budman and Gurman (1988) recognized that their proposed divergences may not be as dichotomous in actual clinical practice, their purpose was to convey the essence of the subject by presenting value "ideals" of the short-term versus the long-term therapist. Additionally, Budman and Gurman (1983) did not present brief therapy as a specific school or model of treatment, rather they seemed to suggest that the differences in values they identified transcend specific schools or brief-treatment orientations.

Bolter, Levenson, and Alvarez (1990) investigated Budman and Gurman's (1983) proposal that short-term and

long-term therapists hold different values systems relating to the nature and practice of psychotherapy. They constructed two questionnaires specifically for the study: Background Data Questionnaire and Beliefs and Attitudes Toward Therapy Questionnaire (BAT). The BAT consists of two scales, the Value Scale and the Attitude Scale. The focus of this study was the 13-item Value Scale. Items on the scale represented the eight dominant therapy-related values and were worded as closely as possible to the phrasing used by Budman and Gurman (1983).

Subjects were 222 licensed psychologists practicing in private and institutional settings in California. Two-thirds of the sample were male, almost all (96%) held doctorates, their mean age was 45, and they had been practicing psychotherapy an average of 16 years. More than half (54%) of the respondents indicated a preference for long-term therapy, about one-third (32%) indicated a preference for short-term therapy, and a small group of respondents (14%) did not indicate a strong preference for either approach.

Findings indicated that, overall, therapists who preferred a short-term approach were more likely to endorse the values of the short-term therapist than were therapists who preferred a long-term approach. This finding held even after researchers controlled for the

significant contributions of the variables of therapeutic practice and theoretical orientation. However, upon examination of individual values, short- and long-term therapists were found to differ significantly in only 2 of the 8 areas identified by Budman and Gurman. Therapists differed most in their values associated with the limitation of time in therapy. Long-term therapists seemed to value a "timeless" quality in therapy, whereas short-term therapists valued an awareness of limited time.

Therapists also differed in their values pertaining to the nature of psychological change. Long-term therapists were more likely to view personality as static and immutable, thus requiring a therapeutic relationship to overcome resistance to change. In contrast, short-term therapists seemed to take more of an adult developmental perspective, which holds that the overall thrust in most people's lives is toward growth and development. Hence, only those interventions aimed at resuming growth are necessary.

Despite the use of a self-administered questionnaire and the small number of items which limit the scale's reliability and generalizability, the researchers' findings provided some empirical support for Budman and Gurman's (1983) proposal that there are fundamental value differences between short- and long-



term therapists. This finding has implications for the future practice of psychotherapy, particularly since the majority of therapists appear to prefer a long-term approach.

### Critique

The notion that important therapeutic change can be achieved only in the context of long-term treatment has been popular among therapists throughout the history of modern psychotherapy (Wolberg, 1965). However, this belief has never been shared by the majority of psychotherapy patients (Garfield & Wolpin, 1963; Parad, 1971). Most expect improvement to occur rapidly (Gurman, 1981) and to remain in treatment for only a short period of time. In studies of individual and marital/family therapy, the median treatment tends to fall in the range of 6 to 10 sessions. Thus, Gurman (1981) points out there is nothing new about brief therapy, but it is only recently that much attention has been paid to "planned" brief treatment, that is, brief therapy "by design" as opposed to "by default."

While the data presented above is at least consistent with the position that time-limited brief therapy is an effective and durable approach, the studies are plagued by a number of limitations and deficiencies. The use of small samples; the preponderance of studies of individuals, particularly

college students; a lack of significant differences in the numbers of treatment sessions used to compare short- and long-term groups; findings regarding subjects' evaluation of time-limited versus time-unlimited therapy (Gelso, Spiegel, & Mills, 1983) that contrast with earlier findings (Johnson & Gelso, 1980) and thus lead to controversy; and the obvious lack of studies addressing brief marital therapy, all of the above point to the need for further research in the domain of brief treatment.

The present study added to the inconclusive data on brief therapy by investigating therapists' self-perception of their use of the time variable in the treatment of brief marital couples. Similar to Bolter et al. (1990), the study investigated differences between short- and long-term therapists.

#### Limited Goals as a Variable of Brief Therapy

Budman and Gurman (1988) define brief therapy by its planned character, attitudes of the therapist about therapy objectives, maintenance of clear and specific foci, high level of therapist activity, and flexible use of interventions and time. Thus, brief therapy is a matter of efficiency and focus and involves targeted interventions (Levine & Sandeen, 1985). The time limitations of brief therapy make many of the goals of traditional psychotherapy, such as extensive personality

reconstruction or dynamic insight into psychogenetic origins of behavior impossible (Koss & Butcher, 1986). Brief treatment requires that "therapeutic perfectionism" (Malan, 1963) and "prejudices of depth" (Wolberg, 1965) be abandoned.

Most brief therapists strive to accomplish one or more of the following goals: removal or amelioration of the patient's most disabling symptom as rapidly as possible; prompt reestablishment of the patient's previous emotional equilibrium; and development of the patient's understanding of the current disturbance and increased coping ability in the future. Additionally, the patient should have major input in choosing the goals of limited therapy (Koss & Butcher, 1986). Hence, setting and maintaining limited and realistic goals are important in the brief therapy process. Budman and Gurman (1988) place much emphasis upon the development and maintenance of therapeutic focus. "The attitude of 'not having to do it all right now' allows the therapist to centralize a particular problem or set of problems without becoming mired in the task of total personality reconstruction" (Budman & Gurman, 1988, p. 17).

Only rarely has short-term psychotherapy been referred to as an addition to the psychotherapist's armamentarium and not a "second best" alternative to long-term psychotherapy (Sifneos, 1967). The assumption

that the short-term patient receives "supportive" therapy and the long-term patient "exploratory" therapy is common. However, there are a few notable exceptions to this tendency. Errera, McKee, Smith, and Gruber (1967) provided evidence that this assumption was not true in their population and suggested it would only be true in clinics with either a limited staff or strong treatment bias.

Ursano and Dressler (1974) addressed the above issue in an investigation of specific factors influencing the clinician's decision for brief individual psychotherapy (BIP) versus long-term individual psychotherapy (LIP) in a community mental health center. The sample of 99 subjects was predominantly white (91%); female (65%); never married (48%); and ranging in age from 20 to 34 years. The typical center procedure was followed and all patients were evaluated at intake by a clinician on the multidisciplinary team. Based upon their assessment, the clinician made the decision for the patient to receive either BIP (12 hours or less) or LIP (more than 12 hours).

Upon outset of the study, participating clinicians completed the Therapist Attitude and Experience Questionnaire (TAE). The questionnaire elicited therapists' responses regarding their experience and attitudes toward BIP and LIP. Additionally, clinicians

completed the Clinician Evaluation Form (CNEF) following evaluation of the subject and at the time a decision for treatment was reached. This questionnaire assessed clinical variables including diagnoses, severity of illness, length of illness, prior treatment, the clinician's expectation of success, and an estimate of the subject's motivation and ego strength.

In contrast to Errera et al. (1967) who found no differences in either diagnosis or previous treatment, the findings of this study indicated significant differences in these two variables. Significant differences in duration of the presenting problem and severity of illness were also found. Thus, in the present study, subjects with discrete problems with recent onset of functional impairment (more often diagnosed situation adjustment disorder) were more likely referred to BIP. LIP was more likely the treatment recommended for pervasive problems of longer duration, affecting basic personality function (More often diagnosed as neurosis or psychosis). The researchers' findings provided negative evidence in support of the support-exploratory model as it applies to the clinical decision-making process involved in recommending brief or long-term psychotherapy. The concept of brief therapy as focal and long-term therapy

as nonfocal (or multifocal) seems more explanatory of the clinicians' decisions.

Although Ursano and Dressler (1974) found that the focal nature of brief therapy was the essential difference between brief and long-term psychotherapy, they noted several limitations to their study. The underrepresentation of Blacks (N = 3) and psychotic diagnoses limit the generalizability of findings. Additionally, the researchers noted that clinical decision-making is also determined by other factors not measured in their study, such as the clinician's skill in BIP, time availability for new patients, and their relationship with the patient. Lastly, the lack of conformity of definitions across studies that clearly differentiates brief and long-term treatments, prevents meaningful comparisons to previous research.

To determine if goal setting could be a sensitive measure of outcome, Burton and Nichols (1978) studied a sample of 20 university and community clients who were treated with brief therapy by seven advanced graduate students and one faculty member. The sample of 14 women and 6 men, ranging in age from 18 to 33 years, were randomly assigned to therapists and either the experimental goal-setting condition or the nongoal-setting reference group. Each consisted of 10 subjects.

Immediately prior to the first therapy session, all subjects completed two measures. First, a modified version of the Expectancy Questionnaire (Strupp et al., 1969) was given to determine subjects' expectancy of successful treatment. Second, the Adult State-Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970) was administered to assess general anxiety and anxiety at the specific time of testing. During the first session, therapists elicited further information using the Personal Satisfaction Form (Nichols, 1975) in which subjects described their satisfaction in eight areas of everyday life. The experimental group also completed the Behavioral Target Complaints Form in which subjects' specific target complaints as goals for therapy were operationally defined by specific behavioral criteria. Therapists did not discuss goals with reference group subjects.

At the end of the first session, all subjects again completed the Expectancy Questionnaire. In the seventh session experimental group subjects discussed progress toward achieving their goals, and all subjects were readministered the outcome measures.

Results indicated the experimental subjects set significantly more goals ( $M = 2.71$ ) than the reference clients ( $M = .57$ ). Likewise, the mean goal-specificity rating of 4.71 for the experimental group was

significantly more than the mean of 1.71 for the reference group. While both groups showed significant improvement on the Personal Satisfaction Form and the State-Trait Anxiety Inventory, the experimental group did not show significantly greater improvement than the reference group on either measure. Thus, the researchers concluded that setting explicit behavioral goals at the beginning of therapy had no effect on the outcome of treatment. However, progress toward achieving goals was strongly correlated with other measures of outcome. Taken together these two findings indicated that setting explicit goals is a sensitive measure of improvement but not a reactive one.

The above findings contrasted with those of La Ferriere and Calsyn (1978) and Smith (1976) whose investigations showed that, when compared with nongoal-setting controls, clients who collaborated with their therapists in establishing treatment goals showed significantly better improvement on several standard outcome indices. The discrepancy in findings and a small, predominantly female sample reduces the confidence we can place in the results.

An additional methodological issue relates to goals being set only at the beginning of therapy and checked only at the end. Further research in which goals are not only set but provide the focus for treatment and are



frequently reviewed during the course of therapy could enhance the investigation of goal attribution in brief treatment.

Greer (1980) attempted to identify the type(s) of goals most likely to be attained, and most predictive of improvement on independent criteria using a sample of 19 randomly selected, first-time participants in brief therapy at a community mental health clinic. At intake the sample of 14 females and 5 males were administered an updated version of the Jefferson Goal Scaling Form (Edwards, 1974). This instrument permits therapists and subjects to write individualized goals for therapy within four areas: (a) personal (feelings, attitudes, behaviors); (b) family; (c) social; and (d) others. Therapists and subjects were to agree mutually on the goals in the first hour of therapy.

Goal attainment was rated by both therapists and subjects 4 weeks into therapy using a standardized 9-point rating scale which ranged from "impossible to reach" to "completely attained." Improvement was also assessed by posttest measures administered at 4-week follow-up (mean visits were about three). These included five items from the 22-item Dupuy General Well-Being Scale (Dupuy, 1974); the Anxiety Subscale of the Hopkins-Symptom Checklist (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974); a 12-item measure of social status improvement (Edwards,

Yarvis, & Mueller, 1979); and eight outcome items concerning overall improvement (Edwards, 1974). Therapists' ratings of subjects were also obtained for the measures of general outcome and well-being.

Results indicated that each of the four goal categories produced positive attainment rates with no significant differences among them. Correlational analyses indicated that improvement was not limited to any specific type of goal. While the findings from this small sample suggested that goal attainment and corresponding improvement are not necessarily tied to specific types of goals, further research in other types of clinical settings is needed. Additionally, further differentiation of goal content, the assessment of therapists' contribution to the success of treatment goals, and an evaluation of the focus of goals in each session would expand the research effort in the continued search for brief and effective therapeutic strategies.

Expounding upon previous findings suggesting that changes accruing in brief time-limited therapy (TLT) persist well beyond the end of therapy (Adelstein, Gelso, Haws, Reed, & Spiegel, 1983a; Gelso, Spiegel, & Mills, 1983; Keilson et al., 1983), Adelstein et al. (1983b) investigated the specific developments that emerged in the client and/or treatment situation that were detectable by

the therapist and predictive of continued growth after termination. This study presented a 1-year follow-up evaluation of 21 original therapists who treated 38 subjects in a university counseling center with a minimum of eight TLT sessions.

At the time of the subject follow-up, therapists were given their clients' case folders containing intake evaluation, case notes, test results, and termination summary to stimulate recall. After reexamining the folder, the therapist was asked to complete two inventories based upon recollections of subjects' progress in counseling. The 4-item Counseling Change Measure asked therapists to rate, on 7-point Likert scales, the degree of improvement during counseling in subjects' feelings, behavior, self-understanding, and overall change. The Client Change Inventory (CCI) was devised by the researchers as a therapist-completed form containing items that might be predictive of change during treatment and continued growth after termination. It consisted of 30 items reflecting areas of therapeutic improvement, process, and psychological health. In addition to the therapist-completed forms, clients' evaluation of changes in feelings, behavior, and self-understanding during therapy and between termination and the 1-year follow-up were collected previously on all 38 subjects (Adelstein et

al., 1983a) using the 9-item Client-Rated Counseling Outcome Questionnaire.

Analyses of the data revealed three factors, in combination with each other or with additional factors, that seemed most predictive of continued growth after brief treatment ended. Findings suggested that client insight, communication skills, and self-concept may form a constellation of indices that lend themselves to long-term change. This finding was additionally supported by interview data collected by researchers at the 1-year follow-up of subjects (Adelstein et al., 1983a).

Upon examination of factors not related to subjects' continued growth was the surprising finding that the early establishment and maintenance of a central focus in TLT seemed inconsequential to durable change as a result of that treatment. Conversely, it appeared that TLT in which the participants did not focus on one central issue was just as effective as TLT that employed a central focus. This finding is in contrast to clinical theory in TLT (Mann, 1973) and previously cited studies relating the setting of specific goals to improvement on outcome measures (La Ferriere & Calsyn, 1978; Smith, 1976). However, the fact that therapists' ratings were made approximately 1 year after termination makes for cautious generalizations. Future studies would do well to obtain such ratings soon after termination and also include

evaluation of specific and individualized goals agreed upon by therapist and subject at the outset of brief treatment.

To determine whether and in what ways counselors initially approach time-limited therapy (TLT) and time-unlimited therapy (TUT) with different goals, outcome expectancies, and role expectancies, Johnson (1983) utilized a laboratory setting and included 32 counselor subjects who had experience in both TLT and TUT. The sample of 20 females and 12 males were working at a university counseling center where approximately three-fourths of all clients received TLT. Eighteen subjects averaged 7 years postdoctoral counseling experience and 14 were predoctoral interns, all of whom had at least 3 years counseling experience.

Three measures were employed. First, the Therapist Orientation Questionnaire (TOQ) (Sundland, 1972), a measure of counselors' philosophies and strategies, was used to derive a 14-item active-directiveness subscale using a face-validity approach based on experts' judgments. Second, the 30-item Goal Statement Inventory (GSI) (McNair & Lorr, 1964) was used to measure and classify counseling goals according to three empirically independent factors: Reconstructive Goals (personality and behavior change); Stabilization Goals (maintenance of current functioning); and Situational Adjustment Goals

(coping with the presenting situation). Third, the Counselors' Expectancies Questionnaire was used to measure counselors' role and outcome expectancies.

Stimulus materials included two sets of written intake notes and two 5-minute videotapes simulating a client talking at the beginning of an initial counseling session. Two different client problems were portrayed: Problem A, fear of intimacy; and Problem B, unhealthy dependency. The materials described clients who needed counseling, could conceivably benefit from TUT, and had enough ego strength to benefit from TLT.

Subjects first completed the TOQ and were categorized as high active-directive or low active-directive on the basis of their active-directiveness scores. Subjects were then randomly assigned to type of counseling structure (TLT, TUT). Subjects were further randomly assigned to actresses playing each part. Thus, the experimental design consisted of two between-subjects variables (active-directiveness and type of counseling structure) and one within-subjects variable (client problem type).

Subjects were tested individually according to the following procedure. Subjects first read the intake notes for the first client. Both the intake notes and experimenter stressed the counseling structure (TLT or TUT) to which the client was assigned. Subjects were then instructed to watch the videotape, thinking of it as the

beginning of the first counseling session. Afterwards, counselors reacted to the client under the given counseling structure by responding to the GSI and Counselors' Expectancies Questionnaire. The procedure was then repeated for the second client presentation.

Only those results relating to goals will be reported. It was hypothesized that goals for TLT would be fewer in number and less extensive than goals for TUT. Results indicated that the hypotheses regarding differences in the number of goals was not statistically borne out. The mean total number of goals for TLT ( $M = 12.78$ ) was somewhat less than TUT ( $M = 15.12$ ), but not significantly so.

Regarding types of goals, TLT and TUT did not differ regarding the less extensive types: Stabilization Goals and Situational Adjustment Goals. However, subjects did have fewer of the more Reconstructive Goals for TLT ( $M = 7.72$ ) than for TUT ( $M = 9.97$ ). Thus, it was only in the most extreme case of attempting personality reconstruction that subjects approached TLT with lessened goals as compared to TUT. Thus, the researcher concluded that the difference between TLT and TUT in terms of goals appears to be more qualitative than quantitative. However, caution must be exercised in generalizing findings that occurred in a laboratory setting to actual counseling settings.

### Critique

Much of the theoretical literature (Posin, 1969; Wright, Gabriel, & Maimowitz, 1961) suggests that time-limited therapy (TLT) is characterized by a less extensive number and more delimited types of goals than time-unlimited therapy (TUT). Hence, TLT is portrayed as focusing more on supporting existing defenses (overcoming situational problems by drawing on client strengths) while TUT works toward uncovering defenses and changing the personality structure. While there is some recent support for this conceptualization (Johnson, 1983), there have been conflicting findings (Ursano & Dressler, 1974) and the issue remains controversial.

Further, in contrast to previous findings and cited theoretical views, there is evidence that TLT need not exclude personality change as a goal. The empirical literature demonstrates that when differences in personality change have been found between the two therapy structures, the TLT structure is favored (Johnson & Gelso, 1980). Similarly, Sifneos (1967) takes the view that TLT can appropriately be anxiety-provoking, working to change personality dynamics rather than just supporting existing defenses.

Thus, in light of the inconsistencies in findings and limitations of the aforementioned studies, including use of small, predominantly white samples in clinic, college,



or laboratory settings; lack of concordance in differentiating brief and long-term treatments; and the obvious exclusion of studies of brief marital therapy; all preclude the drawing of firm conclusions regarding the role of delimited goals in brief therapy. The present study provided further evidence for the practice of brief therapy in an area which has been somewhat neglected by researchers. The researcher investigated the issue of goal setting as it is perceived by therapists in their practice of brief marital therapy. The study was not limited to a particular setting or therapist level.

#### Active-Directiveness as a Variable of Brief Therapy

Maintaining a focus in brief therapy requires that the therapist participate more actively in the therapeutic process than is characteristic of many long-term approaches (Koss & Butcher, 1986). Being "active" means talking more, directing the conversation when necessary, actively exploring areas of interest, offering support and guidance, formulating plans of action, assigning homework, teaching problem solving and encouraging a constructive life philosophy. Wolberg (1980) noted that passivity is "anathema" in brief therapy. A more active style is reported to be especially helpful with lower-class patients. Gelb and Ullman (1967) concluded that a well-trained therapist can guide clients toward behavior and

interaction different from their customary modes, and lead them to more satisfactory and productive lives.

Further, Budman and Gurman (1983) emphasized the importance of a patient's real life, outside-therapy behavior over the importance of in-session behavior. Hence, brief therapists often actively foster behavior change through the use of homework assignments, involvement of significant others in treatment, and by using adjunctive aids to therapy, such as self-help organizations.

As part of a larger investigation cited earlier (Gelso, Spiegel, & Mills, 1983), which compared therapists' and clients' reactions to three different therapy structures (8-session TLT, 16-session TLT, and TUT), the researchers collected additional data on counselor and subject characteristics that influenced outcome across the treatments. To briefly summarize, 78 students who sought therapy at a university counseling center were randomly assigned to one of the three therapy structures. Subjects in the two time-limit conditions were informed by their therapists of the time limits during the first session. Clients in the TUT condition received counseling according to the usual center procedure. Subjects completed the Bills' IAV (Bills et al., 1951) prior to treatment to establish high and low adjustment groups. Subjects also completed the Counseling

Center Follow-up Questionnaire (CCFQ) approximately 1 month and 18 months after termination to elicit reactions to diverse aspects of their treatment.

In sum, the 15 therapists (7 female, 8 male) who participated represented a wide range of experience. While they had only a modest amount of experience with TLT prior to the project, they did have more experience with structured, short-term therapy. They were theoretically eclectic and there was a clear personal preference for doing moderately long-term therapy versus brief work. At the beginning of the project, therapists possessed a guarded but positive view of the potential of brief TLT.

The therapist-completed forms included the Therapist Orientation Questionnaire (TOQ) (Sundland, 1972) and the Time-Limited Therapy Questionnaire, both of which function to describe the therapist sample and assess how therapist factors influence outcome. Additionally, therapists completed two assessment devices constructed specifically for the study: the Pre-Counseling Assessment Blank was completed after each initial subject interview; and the Post Counseling Assessment Blank was completed at the end of therapy. The latter 7-item instrument assessed therapists' self-ratings on activity level, structure, and the use of historical material, items often viewed in the TLT literature as distinguishing TLT from TUT.

Pertinent findings included therapists reported being equally active with their 8- and 16-session cases, and significantly more active with those cases than their TUT clients. Further, therapists imposed more structure in 8-session TLT than in TUT. The degree of structure in 16-session TLT was intermediate, but did not differ significantly from that in either 8-session TLT or TUT. There were miniscule differences regarding the use of historical material across treatments.

While these findings provided some evidence for increased therapist activity in brief therapy, some caveats exist regarding generalization of the results. The use of self-reports and the actual difference of only 2.61 sessions between the two TLT treatments, limit the drawing of firm conclusions. Also, therapists reported greater comfort with and experience in moderately long-term counseling (6 to 12 months) and "guarded optimism" about the value of TLT. This reduces likewise the confidence one can place in the results.

Using the aforementioned methodology explained above, and expounding upon their earlier findings that therapists report being more active in TLT versus TUT (Gelso, Spiegel, & Mills, 1983), Gelso, Mills, and Spiegel (1983) further explored the relation of therapists' orientation to brief TLT outcome. Six of the 15 therapists in the above study who counseled an equal number of clients in

the three conditions (8- and 16-session TLT and TUT) served as subjects. All subjects were senior staff counselors with 2 to 16 years postdoctoral experience ( $M = 5.7$  years). Subjects varied widely in their reported theoretical orientation and none was strongly wedded to one persuasion. When asked to express various theoretical influences on their counseling in terms of percentages, one therapist each expressed the primary influence as rational-emotive, psychoanalytic, behavioral, Gestalt, and phenomenological/existential/Rogerian. One felt an equal influence of three different orientations.

The instruments employed were of two types: 3 predictors (the Pre-Counseling Assessment Blank; the Therapist Orientation Questionnaire (TOQ); and the Time-Limited Therapy Questionnaire); and 3 outcome measures, 1 from therapist ratings and 2 from clients (1 month after termination and the other 18 months after termination). Regarding the outcome predictors, therapists completed the TOQ (Sundland, 1972; Sundland & Barker, 1962), which measures theoretical orientation along several empirically derived dimensions, previous to the study. The Pre-Counseling Assessment Blank was completed by the therapists after the first client interview. Within a month after each therapist terminated with his/her client in the study, the Time-Limited Therapy Questionnaire was completed.

Regarding the outcome criteria, immediately following termination with each client the therapists completed the Post Counseling Assessment Blank to evaluate clients' personality, behavior and feeling change as a consequence of treatment. Lastly, client-judged outcomes were derived from the Counseling Center Follow-up Questionnaire (CCFQ), both 1 month and 18 months after termination.

From the three predictor instruments a total of 30 items representing therapists' orientation, experience and attitudes, and expectations and judgments after the first counseling session were drawn. These were correlated with (a) therapists' evaluations of clients' personality, behavior, and feeling change due to counseling; and with (b) clients' ratings of satisfaction with and changes due to counseling. Therapist outcome evaluations were made shortly after termination; clients' outcome ratings were completed both at 1 and 18 months after termination. All correlations between predictor and outcome criteria were computed separately for clients in 8-session TLT, 16-session TLT, and TUT.

Results revealed that few of the correlations between theoretical orientation items and therapist-rated outcome attained significance. However, a notable pattern emerged for therapist directiveness to be related to client change in the 8-session TLT, but not in the 16-session TLT or TUT. Using the TOQ definition of directiveness (Howard et

al., 1970), therapist-rated change in brief TLT was greatest for therapists who tended to prescribe an actively guiding, instructing, confronting therapeutic approach to improve the patient's social adjustment. However, this relationship did not hold up as the length of treatment increased. Interestingly, while directiveness was positively related to therapist ratings of client change in TLT, it was clearly unrelated to clients' perceptions of outcome. Hence, the researchers' expectation that those who were generally more directive would be more effective in TLT than those who reported being generally less directive was only partially evidenced.

Thus, based on the data collected from this small sample and from therapist self-report measures, which may reflect beliefs rather than behaviors, one cannot conclude that therapists should be more directive in TLT than in TUT. Findings suggested that directiveness has little, if any, influence on outcome. Further studies involving therapists trained and experienced in TLT would do much to enhance the present findings.

In a previously cited study, Johnson (1983) investigated the differences in therapists' goals, outcome expectancies, and role expectancies in their approach to TLT and TUT in a laboratory setting. Secondarily, the researcher explored some client and therapist variables

that might moderate the relationship between counseling structure and counselors' goals. Because it had generally been thought that the more active, directive counselor orientations were especially appropriate for TLT (Butcher & Koss, 1978), the counselor variable studied was general active-directiveness.

To briefly summarize the methodology explained previously, 32 counselor subjects were exposed to written intake notes and two 5-minute videotapes simulating a client talking in an initial counseling session regarding either a "fear of intimacy" or "unhealthy dependency." Subjects completed the 14-item active-directiveness subscale of the Therapist Orientation Questionnaire (TOQ) (Sundland, 1972; Sundland & Barker, 1962) prior to the study. The subscale was specifically derived for the purpose of this study through a face-validity approach based on experts' judgments. Counselors were categorized as either high active-directive or low active-directive according to their TOQ active-directiveness scores.

Subjects, tested individually, read the intake notes for the first client. Both the intake notes and the experimenter stressed the client's assigned counseling structure (TLT or TUT). Subjects then watched a videotape simulating the beginning of the initial therapy session. Next, they reacted to the client and the given structure by responding to the Goal Statement Inventory (GSI)



(McNair & Lorr, 1964) and the Counselors' Expectancies Questionnaire. The GSI measured and classified goals as Reconstructive Goals, Stabilization Goals, and Situational Adjustment Goals. The procedure was repeated for the second client presentation.

The experimental design consisted of two between-subjects variables (active-directiveness and type of counseling structure) and one within-subjects variable (client problem type). After grouping counselors according to active-directiveness scores (high, low), they were randomly assigned to either the TLT or TUT structure, and further randomly assigned to actresses playing each part.

The hypothesis was based on the premise that a counselor whose general theoretical orientation was more active and directive might have similar goals for TLT and TUT, while a less active counselor might lessen the goals for TLT. Thus, the researcher hypothesized that counseling structure would have an interactive effect with counselor orientation on the dependent measure of goals. Results, however, showed no such interaction on either overall number of goals, Situational Adjustment Goals, or Reconstructive Goals. On these three measures, both the high and low active-directive counselors shared similar approaches to TLT and TUT. Contrastly, Stabilization Goals did show an interaction, but different than expected.

High active-directive counselors had more Stabilization Goals in TUT ( $M = 3.87$ ) than in TLT ( $M = 2.31$ ) rather than the hypothesized equal number in TUT and TLT. As hypothesized, low active-directive counselors had the opposite pattern: they had more Stabilization Goals for TLT ( $M = 3.87$ ) than TUT ( $M = 2.50$ ).

Thus, as a moderator of goals, counselor active-directiveness might not be as potent as hypothesized in the literature, which emphasizes the necessity for an active, directive counselor role in TLT (Butcher & Koss, 1978). This lack of effect was reminiscent of the Gelso, Mills, and Spiegel (1983) finding in which the TOQ Directiveness Scale was unrelated to client and counselor-judged outcomes. Hence, the current study added confirmatory evidence to the Gelso, Mills, & Spiegel (1983) hypothesis that general theoretical beliefs may not extend to behavior enough to differentially affect TLT and TUT.

The TOQ used by Johnson in the current study and Gelso, Mills, and Spiegel (1983), focused more on counselors' beliefs and tolerances rather than their actual behavior. Further research in actual counseling settings, using larger samples, and investigating specific therapist behaviors, would add more confidence to the above findings.

Based on prior family interaction studies and a systems conceptualization of deviant behavior, Alexander and Parsons (1973) utilized a specific, short-term behaviorally-oriented family approach in a study of delinquent, court-referred teenager-families. Families were assigned to either the treatment or one of the comparison conditions.

Forty-six families were randomly assigned to the short-term behavioral family intervention designed to increase family reciprocity, clarity of communication, and contingency contracting. In the treatment condition, therapists actively modeled, prompted, and reinforced in all family members (a) clear communication of substance and feelings; and (b) clear presentation of "demands" and alternative solutions, to facilitate negotiation. Additionally, the therapist trained the family in solution-oriented communication patterns. Verbal and nonverbal praise was given to reinforce appropriate behaviors.

Thirty families were randomly assigned to 1 of 3 comparison conditions. Nineteen families were assigned to the client-centered family groups program, a basically didactic group discussion context focusing on attitudes and feelings about family relationships and adolescent problems. The group was based on the client-centered model. Eleven families were referred to the psychodynamic

family group based on an eclectic psychodynamic model with an emphasis on insight. Lastly, 10 randomly selected families, who received no treatment, comprised the control group.

The first 20 of the 46 treatment families completing their short-term intervention, the 10 client-centered families, and the 10 no-treatment controls were tested on family interaction tasks upon completion of their programs. Each family was given a series of three tasks including (a) a behavior specificity phase, (b) vignette phase, and (c) interaction phase. Family interactions were recorded and three dependent measures found in the literature to differentiate adaptive from nonadaptive families were examined. Thus it was hypothesized that families in the treatment condition would demonstrate (a) more quality of interaction; (b) less silence, reflecting greater family activity; and (c) greater frequency of interruptions. As an additional measure of outcome, juvenile court records were examined following termination at a 6- to 18-month interval for recidivism. It was hypothesized that treated families would demonstrate a significant reduction in recidivism.

As hypothesized, statistically significant differences were found on each dimension for families that received the short-term behavioral intervention. They demonstrated significantly more equality in talk time,

less silence, and more interruptions. Further, the treatment group also demonstrated the lowest recidivism rates.

While the researchers concluded that the results clearly demonstrated the efficacy of an active therapist in a short-term, specific, behavioral family treatment program for delinquent teenagers, a number of limitations are noted. The use of small samples for group comparisons, therapists were graduate students who had little previous training in family therapy, and the failure to report the actual number of sessions the treatment group received, all make for cautious generalizations. Further research correcting for these deficiencies and including different contexts is needed to make firm conclusions regarding therapist activity and specific interventions in brief treatment.

Resistance to psychological treatment of the elderly has given way to new interest in utilizing short-term treatment in this population. In a pilot study, Sholomskas, Chevron, Prusoff, and Berry (1983) reported their use of a short-term intervention, Interpersonal Psychotherapy (IPT), in the treatment of elderly outpatients suffering from depression. IPT was developed specifically for ambulatory, depressed patients (Klerman, Rounsaville, & Chevov, 1979) and its efficacy has been

demonstrated in two clinical trials (Weissman, Klerman, & Paykel, 1974; Weissman, Klerman, & Prusoff, 1981).

IPT is based on the premise that depression occurs in a psychosocial and interpersonal context. It claims understanding and renegotiating the interpersonal context associated with the onset of symptoms is important to the person's recovery and prevention of relapse. IPT facilitates recovery by relieving depressive symptoms and helping the patient develop more productive strategies for dealing with problems.

In their pilot study of elderly subjects, Sholomskas et al. (1983) reported that the role of the therapist was active. The therapist was seen as a patient advocate who was very active in helping subjects identify, focus, and work toward problem-oriented specified goals. Findings revealed that subjects' dependency needs were expressed with greater frequency and requests for advice and support were more explicit than with younger patients. Also, elderly patients had little tolerance for passivity and neutrality in the therapist, and the active stance used in IPT helped offset this problem. The researchers indicated from results of their pilot study that IPT was a viable treatment for elderly patients.

Results of IPT reported in a previous paper (Rothblum, Sholomskas, & Prusoff, 1982) showed 61% of patients accepted for treatment improved significantly

from baseline on measures of depressive symptomatology and global ratings. The mean Hamilton Depression Rating Scale was 22.7 (out of a possible 65, significantly above the cut off score of 18 for depression) at baseline and 7.3 after treatment.

The previous findings and the present preliminary results suggest active, brief interventions may be a promising treatment for depression in the older population. However, rigorously designed, well-controlled research is needed to further support the efficacy of IPT and other brief psychotherapies.

Friedman (1989) described a model of brief psychotherapy for children and families in which the therapist was active, directive, optimistic about change, respectful of the presenting problem and tailored interventions to the individual's or family's needs. The therapist actively directed change and constantly encouraged members to "do something different" in regard to the problem (de Shazer, 1985).

Friedman (1989) presented four case studies reporting successful outcomes utilizing this active model. He additionally reported that based on a group of 156 families he treated consecutively in an 18-month period, 80% were seen for six or fewer sessions. The median number of sessions was three, with a range of 1 to 20.

It is impossible to draw any conclusions based on these subjective findings. As in the aforementioned pilot study, rigorously designed, well-controlled research with testable hypotheses is indicated. Additionally, a clear description of the therapist active-directiveness variable as it is specifically used and measured in the study is imperative for meaningful inferences to be drawn.

#### Critique

In recent years, partly because of design, brief psychotherapy has become a treatment of choice. Comparative studies of brief and unlimited therapies show essentially no difference in results (Koss & Butcher, 1986). Consequently, brief therapy results in a great saving of available clinical time and can reach more people in need of treatment. However, brief therapy does not mean less therapy; it means more efficient therapy (Cummings, 1986).

The role of time limitation and the uses to which temporal awareness is put is important in brief therapy. Time limitation keeps the patient tuned in to the need for rapid goal attainment. While behavior change does require time, evidence suggests that the time does not have to be spent in continuous treatment (Koss & Butcher, 1986).



Likewise, most brief therapies place a great emphasis on directiveness and a high therapist activity level. These techniques keep the sessions moving at a productive pace and facilitate the attainment of the patient's limited goals, a third salient feature of brief therapy. According to Cummings and VandenBos (1978), you have to give up the concept of cure.

While there is some evidence that brief therapy may be an effective and durable approach, there are many limitations noted in reported studies. First, brief therapy or time-limited therapy is often discussed as if it were a unitary treatment, while in fact approaches vary widely. Among studies, the time limit alone has varied from 4 to 30 sessions. Likewise, researchers fail to provide a detailed description of the variables they are measuring, such as time limits, limited goals, and therapist activity, which prohibit the drawing of firm conclusions. It is also not uncommon for researchers to employ therapists who are not trained, experienced, or comfortable in administering brief interventions. Other noted deficiencies include the use of small sample sizes, inconsistencies in findings across studies, and a lack of investigation of brief marital treatment.

The present study added some insight into the practice of brief marital therapy. Therapists who described themselves as either brief or long-term

practitioners responded to issues salient in brief treatment, including time limitation, limited goals, and active-directiveness. Findings portrayed brief marital intervention as it is actually practiced, thus adding to the now nondescript definition of brief marital therapy. Additionally, therapists responded to items regarding their formal training, experience, and comfort level in brief marital therapy. This provided significant background information of those practicing brief marital therapy.

## Chapter 3

### Methodology

#### Population and Selection of the Sample

The subjects for this study were 140 volunteer therapists in the Richmond, Virginia metropolitan area who conduct marital therapy. Volunteers included private practitioners and therapists employed within agencies and practice groups. Names and addresses of participants were obtained from the telephone directory yellow pages. There were no selection requirements regarding degree obtained, level of experience, or volume of marital cases.

#### Data Gathering Procedure

Four different data gathering instruments were used. These included a demographic questionnaire (Therapist Personal Data Questionnaire) and the following self-report measures: the "style" questionnaire (Rice, Fey, & Kepecs, 1972); the active-directiveness subscale of the Therapist Orientation Questionnaire (TOQ) (Sundland, 1972); and a third questionnaire developed by the researcher, the Specific Therapist Behaviors Questionnaire. There were 82 items in total and respondents remained anonymous.

The researcher contacted five practicing therapists in the Richmond, Virginia and Birmingham, Alabama areas to participate in a pilot study of the four questionnaires to: (a) estimate time required for completion of instruments; (b) strengthen the validity of the questionnaires; and (c) to provide feedback about the relevancy of the questions as they relate to the purposes of the study. The pilot participants were not included in the proposed study.

The four questionnaires, accompanied by a cover letter explaining the purpose and procedures of the study were mailed to respondents. To ensure anonymity, participants were directed to mail unidentified completed forms in the enclosed stamped envelope addressed to the researcher. Additionally, all respondents were directed to return the enclosed stamped postcard addressed to the researcher upon completion of the questionnaires, separate from the completed instruments. Respondents were asked to indicate on the postcard their desire to receive a copy of the findings upon completion of the study. The postcards were coded by the researcher to identify respondents. The researcher made follow-up telephone calls and repeat mailings as requested to enhance participation. The goal was to obtain at least 100 completed protocols.

The cover letter explained that participation in the study was strictly voluntary and respondents were guaranteed the right to decline to participate or to withdraw in part or in whole at any time without penalty. Likewise, the participants' anonymity was assured and only the researcher had access to all data collected in this study, which was kept strictly confidential. Only group data was used for analysis.

The cover letter also included the approximate time required to complete the questionnaires based upon results of the pilot study. Participants were encouraged to return the completed forms by the date specified in the cover letter, allowing about 2 weeks upon receiving the mailed materials. The name, address, and telephone number of the researcher and the investigator responsible were provided and respondents were encouraged to contact either with questions. Since the return of completed forms implied consent, no consent form was utilized.

Prior to the mailing of questionnaires, the researcher called each respondent to explain the study and elicit participation. Only those agreeing to participate were mailed packets.

#### Instrumentation

Three instruments were employed to measure therapist style and in-therapy behavior.

### The "Style" Questionnaire

The "style" questionnaire (Rice et al., 1972) is a 23-item, self-report of therapists' in-therapy behaviors. Respondents were asked to mark a 5-point rating scale ranging from 1 ("never") to 5 ("always"). For each item subjects indicate the degree of endorsement of each behavior as characteristic of their "style in general, the picture of you which a panel of observing therapists would get from watching you work, over time, with a variety of cases." Representative items are: talkative; supportive, reassuring; guided by theory; critical, disapproving; businesslike, "in charge"; patient, willing to wait; working toward definite goals.

Early factor analysis of the questionnaire yielded six orthogonal factors or different therapeutic "style" of in-therapy behavior (Rice et al., 1972). The six "styles" and the key self-descriptive phrases (items which "load" highly on that factor) include: (a) blank screen (passive, unchanging, unprovocative, anonymous, and cautious); (b) paternal (businesslike, patient, interpretive, interested in patient's history, and impartial); (c) transactional ("here-and-now," casual, relationship-oriented, interpretive, spontaneous); (d) authoritarian (theory-oriented, persistent, definite, goal-oriented, guiding, businesslike); (e) maternal (talkative, explanatory, supportive, guiding,

interpretive); and (f) idiosyncratic (critical, nonprovocative, talkative). No data are provided on the distribution of the answers to the 23 items, or their means, only the means of "transformed scores" on the factors.

In a later study (Rice, Gurman, & Razin, 1974), factor analysis yielded eight orthogonal factors accounting for 66.90% of the total variance. The styles that emerged and the corresponding loading items included: (a) low activity level (cautious, passive, and talkative [negative loading]); (b) directed focus (focus on the relationship, challenging, interpretive, and guiding); (c) cognitive goal emphasis (goal-oriented, guided by theory, and explanatory); (d) traditional (interested in history, patient/willing to wait, and interpretive); (e) rigid/mechanical (consistent during session, anonymous, and businesslike); (f) feeling-responsiveness (casual, spontaneous, and provocative); (g) judgmental (critical/disapproving, encourage conformity, and persistent); and (h) supportive (supportive, businesslike, and guided by theory [negative loading]). Each of the six previous factors had a corresponding factor in the later analysis. Although the individual items did not always match, the similarity suggested the corresponding factor in each analysis was tapping similar therapist behaviors (Rice et al., 1974).

In both analyses the factor contributing the greatest amount of variance had to do with the therapist's reported activity level. In close order, as measured by the amount of factor variance, was the amount of focusing and directing done by the therapist. Thus, the results supported cross-sample reliability of the "style" questionnaire (Rice et al., 1974).

Therapist Orientation Questionnaire:

Active-Directiveness Subscale

In an attempt to provide a measure of explicit differences between therapists, Sundland and Barker (1962) made an intensive study of the literature and identified 252 points of difference among therapeutic orientations. The original Therapist Orientation Questionnaire (TOQ) was composed of 133 items designed to reflect evenly both poles of 13 scales on attitudes and methods about which psychotherapists disagreed. Results were based upon the replies of 139 subjects.

The 13 attitudinal scales included (Sundland, 1977):

1. Frequency of activity (talkative, active).
2. Type of activity (depth of interpretation).
3. Emotional tenor of the relationship (impersonal versus a warm, personal approach).
4. Structure of the relationship - the intercorrelations of these items indicated a split into the following three groups: spontaneity in the



therapeutic relationship (spontaneous, unreasoned); planning of the therapeutic relationship (planned behavior of the therapist); and conceptualization of the therapeutic relationship (therapist thinks about the patient's relationship with him).

5. Goals of therapy (has goals).

6. Therapist's security (therapist's own security in the therapy situation).

7. Theory of personal growth (a "life force" urging to mental health).

8. Nature of therapeutic gains - this is another subtest which, from the table of intercorrelations, it was decided to divide into two parts: cognitive therapeutic gains (understanding is important); and learning process in therapy (process is verbal and conceptual).

9. Topics important to therapy (discussion of childhood is important).

10. Theory of neurosis (ineffectual conscience versus a too strong one).

11. Criteria for success (social adjustment is important).

12. Theory of motivation (unconscious processes are important).

13. Curative aspect of the therapist (training versus personality).

The 13 original scales yielded 16 scores due to splitting of the two scales. These 16 scores in turn gave 6 first-order factors and 1 second-order factor. A most interesting and surprising finding of the analysis was it yielded a general factor which cut across the majority of scales. Thus, this general factor was considered the most significant single continuum upon which to compare therapists. One pole of the general factor was labeled the "analytic" pole, in the broad sense of attending and responding and not as an abbreviation for "psychoanalytic." The other pole was labeled "experiential," congruent with its emphasis upon nonrationalized, nonverbal experiencing. The "analytic" pole stressed conceptualizing, the training of the therapist, planning of therapy, unconscious processes, and a restriction of therapist spontaneity. The "experiential" pole de-emphasized unconscious processes and accepted therapist spontaneity (Sundland, 1977).

As an expansion of the original study (Sundland & Barker, 1962), the researchers obtained 100 questionnaires from each of three professional groups, including psychologists, psychiatric social workers, and psychiatrists. The findings evidenced a repetition of the general factor reported above. In brief, the experientialists (experiential eclectic and experiential) differed from most everybody else and the

orthodox Freudians were at the other extreme, also holding views that differed from all the rest (Sundland, 1977). Later research by McNair and Lorr (1964) and Howard et al. (1970), generally supported Sundland and Barker's finding despite differences in samples as well as differences resulting from revision of the original questionnaire.

The third revision of the TOQ contained 104 items. Subjects completed the TOQ by responding to each statement in terms of a 5-point Likert scale, ranging from 1 ("strongly disagree") to 5 ("strongly agree"). The items sampled orientation to such areas as training, planning, and conceptualization; use of desensitization; and informal behavior. Representative items included:

1. A therapist should never interrupt a patient while he is talking.
2. A good therapist occasionally makes a patient angry.
3. A good therapist treats the patient as an equal.

Although many subscales of the TOQ have been derived through factor analysis (Dougherty, 1976; Howard et al., 1970; McNair & Lorr, 1964; Sundland & Barker, 1962), Johnson (1983) derived an active-directiveness subscale through a face-validity approach based on experts' judgments. Three experienced, doctoral-level counselors rated the TOQ items on a 7-point Likert scale measuring

the extent to which each item characterized an active, directive counselor. Items rated by all three raters as either "quite characteristic" (6 or 7 on the 7-point scale) or "quite uncharacteristic" (1 or 2) were chosen to comprise the active-directiveness subscale. The resulting scale consisted of 14 items (6 negatively and 8 positively loaded). Representative items include:

1. The patient should be directly confronted with evidence of his irrational thoughts and behavior.

2. I am a fairly active, talkative therapist, compared to most therapists.

3. The more effective therapists do things during the therapeutic hour for which they have no reasoned basis, merely a feeling that it is right (negatively loaded item).

Due to the absence of norms for the TOQ and its subscales, the only frame of reference is the actual 5-point Likert scale used to rate each item. Nonetheless, subjects' means can be examined in terms of their location on the rating scale and some generalizations can be made regarding their activeness, directiveness, and planfulness in their therapy.

#### Specific Therapist Behaviors Questionnaire

This questionnaire, devised by the researcher, consisted of 30 items common to the practice of brief therapy. Subjects were asked to choose one of the

following 5-point Likert responses most typical of their style or approach in their practice of marital therapy: (a) "almost always," (b) "usually," (c) "typically" (about 50% of the time), (d) "only occasionally," and (e) "never." Items consisted of short phrases and focused on the variables of brief treatment emphasized in the study. Representative items included: (a) parsimony of treatment, (b) modest goals, (c) the first session is mostly data collection, (d) maintain a clear and specific focus, (e) highly structure all therapy sessions, and (f) teach new skills. The aim of the questionnaire was to obtain extensive and varied information regarding specific therapists' behaviors in a timely manner, thereby illuminating the practice of marital therapy.

#### Research Design

The research design for this study was descriptive. Statistical considerations were dependent upon the data obtained from the study and comparisons were made only among the respondents' information and were not compared with any outside group. The data from the demographic questionnaire and the three instruments employed were analyzed to determine what significant differences, if any, existed between the two groups; and also to portray a picture of the population. In general, the analysis was dependent upon the significance of the items

depicting the variables under study that differentiated the two groups.

#### Specific Hypothesis

1. There will be no significant difference in the reported level of therapist activity between therapists who identify themselves as brief marital therapists and those who do not, as assessed by the active-directiveness subscale, and specific items on the "style" questionnaire and Specific Therapist Behaviors Questionnaire.

2. There will be no significant difference in the reported use of therapeutic goals between therapists who identify themselves as brief marital therapists and those who do not, as assessed by the "style" questionnaire and Specific Therapist Behaviors Questionnaire.

3. There will be no significant difference in the reported number of treatment sessions between therapists who identify themselves as brief marital therapists and those who do not, as assessed by the Therapist Personal Data Questionnaire.

#### Statistical Analysis

Specific answers to the questionnaire items were quantified for each respondent. Responses of therapists who identified themselves as brief marital therapists were compared to those identified as time-unlimited marital therapists using t-tests, multivariate tests of

significance, and univariate analysis when appropriate. Differences between the group means were considered significant only if they exceeded the .05 alpha level. Additionally, a Chi-square was utilized for categorical data, and the mean, standard deviation, and range were computed for relevant items.

#### Ethical Considerations

Procedures as outlined by the Human Subjects Research Committee of the College of William and Mary were followed. There was no foreseen possibility of causing harm to subjects associated with this study. The major ethical considerations were to ensure anonymity and confidentiality for all respondents; therefore, all data were collected and reported without reference to specific names. Only the researcher had access to all individual test data and questionnaires which were treated as confidential materials. All participants were volunteers. They were informed of the purpose and procedures of the study in writing and were guaranteed the right to decline to participate or withdraw in part or in whole at any time without penalty. After the analyses of the data, all respondents who so requested will receive a summary of the findings. Participants were encouraged to contact the researcher or the investigator responsible at any time with questions.

## Chapter 4

### Analysis of Data

#### Description of Sample

One hundred-forty subjects participated in the study. Most notably, this was a predominantly female, highly educated sample with an age range of 30 to 80 years. There were 78 females (55.7%) and 62 males (44.3%) in the study. The mean age of participants was 46.9 years. The mean age of male and female subjects was 48.1 and 46.0 years, respectively.

As to the highest degree obtained by therapists in the sample, 75 (54%) had masters degrees, 63 (45.3%) had doctoral degrees, and 1 (.7%) had a specialist degree. Regarding current licensure: 56 (40%) were licensed as clinical social workers (LCSW); 49 (35%) as clinical psychologists (LCP); 27 (19.3%) as professional counselors (LPC); 5 (3.6%) as registered nurses (RN); 3 (2.1%) as social workers (LSW); and 6 (4.3%) chose the designation "other" which included 1 medical doctor and 5 subjects with advanced certification in their professions. Interestingly, three participants were licensed in two professional areas with the combinations including LCP and LPC, RN and LPC, and RN and LCSW.



Additionally, two "other" RN subjects had advanced certification beyond their masters degree, one being a certified clinical nurse specialist. Likewise, one LCSW reported additional certification in that profession. As to type of practice or setting, 129 (94.2%) therapists reported being in private practice, 4 (2.9%) worked in the public sector, and 4 (2.9%) reported working in both.

One additional descriptive characteristic critical in this study was based on subjects' perception of their involvement in marital therapy. The options included "no marital therapy"; "brief marital therapy," defined as "not more than 8 sessions within 3 months"; and "time unlimited marital therapy," defined as "therapy lasting longer than 8 sessions or over 3 months." Of the 140 subjects: 2 (1.4%) indicated they did not do marital therapy; 73 (52.1%) identified themselves as time-unlimited marital therapists (hereafter known as TUMTs), and 60 (42.9%) identified themselves as brief marital therapists (hereafter known as BMTs). Although subjects were asked to choose one of the above options, 5 (3.6%) indicated they did both time unlimited and brief marital therapy about equally in their practice.

#### Analysis of Nonrespondents

One hundred fifty-eight therapists agreed by telephone to participate in the study and were mailed a packet containing the questionnaires. One hundred-forty

questionnaires were returned (89% response rate) as well as 128 postcards verifying participation in the study. The researcher made a follow-up telephone call to 30 therapists who did not return the postcard acknowledging participation in the study. Of these 30, 8 indicated they had already mailed the completed questionnaires and 4 stated they never received the packet in the mail. The researcher mailed a second packet to these four therapists. Since more questionnaires (140) were returned than postcards (128), it is difficult to determine exactly who were the nonrespondents. However, the response rate of 89% is sufficient to ensure representative response.

#### Description of Subsamples

Excluding respondents who did not practice marital therapy (2) and those who stated they did both brief and time-unlimited marital therapy equally in their practice (5), 133 subjects identified themselves as either BMTs or TUMTs. There were 73 (54.9%) TUMTs and 60 (45.1%) BMTs. The predominance of females in both groups was consistent with the finding for the entire sample. Thus, 35 (58.3%) of the BMTs were female and 25 (41.7%) were male. Likewise, 37 (50.7%) of the TUMTs were female and 36 (49.3%) were male. Using a Chi-square, there was no significant difference between the two groups regarding gender (.3784).

However, a t-test revealed a significant difference ( $p < .001$ ) between the two groups regarding age. The mean age was 44.1 for the BMTs and 48.2 for the TUMTs. The standard deviations for the BMTs and TUMTs were 5.0 and 9.5, respectively.

As to the highest degree obtained (see Table 1), there was no significant difference between the two groups using a Chi-square (.0576). Interestingly, a masters degree was the highest obtained by the majority of BMTs (63.3%) and a doctorate the highest degree obtained by the majority of TUMTs (54.2%).

As to current licensure, the majority of therapists were clinical social workers (41.4%), followed in decreasing order by clinical psychologists (34.6%), professional counselors (19.5%), registered nurses (3%), social workers (2.3%), and those that chose "other" (3.8%). Using a Chi-square, there was no significant difference between the two groups regarding current licensure. Additional findings are summarized in Table 2.

Additional descriptive information obtained from the Therapist Personal Data Questionnaire is presented in Table 3. Therapists averaged 22.9 hours of psychotherapy weekly with sessions averaging 54.7 minutes. Using t-tests, there were no significant differences between the groups on these items. However, t-tests revealed

Table 1  
Highest Degree Obtained

	<u>Number and Percentage</u>	
	BMTs	TUMTs
Specialist	1 ( 1.7)	0
Masters	38 (63.3)	33 (45.8)
Doctorate	21 (35. )	39 (54.2)

Table 2

## Current Licensure

Profession	Total	Number and Percentage		Significance
		BMTs	TUMTs	
Clinical Psychologist	46 (34.6)	19 (31.7)	27 (37 )	.52100
Social Worker	3 ( 2.3)	2 ( 3.3)	1 ( 1.4)	.44794
Registered Nurse	4 ( 3 )	2 ( 3.3)	2 ( 2.7)	.84191
Professional Counselor	26 (19.5)	10 (16.7)	16 (21.9)	.44733
Clinical Social Worker	55 (41.4)	28 (46.7)	27 (37 )	.25930
Other	5 ( 3.8)	1 ( 1.7)	4 ( 5.5)	.25002

Table 3  
Means and Standard Deviations of  
Descriptive Characteristics

	BMT's	TUMTs	Significance
Years practicing marital therapy in chosen designation	8.5 ( 5.8)	14.6 ( 9.0)	.001*
Average number hours of psychotherapy performed weekly	22.1 ( 9.7)	23.6 ( 8.9)	.497
Average number hours of brief marital therapy performed weekly	4.0 ( 3.1)	1.7 ( 2.1)	.001*
Average number hours of time-unlimited marital therapy performed weekly	1.1 ( 1.5)	4.9 ( 3.9)	.000*
Number of sessions most typical in marital therapy practice	7.7 ( 2.2)	18.5 (12.1)	.001*
Length of marital session in minutes	54.6 ( 6.5)	54.8 ( 6.7)	.753
Extend treatment beyond time established at outset	59 (98.3)	66 (97.1)	.634

\*

p < .05

significant differences between group means on a number of items. First, TUMTs reported practicing TUMT significantly ( $p = .001$ ) longer (14.6 years) compared to BMTs in their practice of BMT (8.5 years). As expected, BMTs reported doing significantly ( $p = .001$ ) more BMT than TUMT, averaging 4.0 and 1.1 hours, respectively. Likewise, TUMTs reported doing significantly ( $p < .001$ ) more TUMT than BMT, averaging 4.9 and 1.7 hours, respectively. Also notable was the significant difference ( $p < .001$ ) in the number of sessions most typical in one's practice of marital therapy. The mean number of sessions and the standard deviations (SD) for BMTs and TUMTs were 7.7 (SD 2.2) and 18.5 (SD 12.1), respectively. Additionally, when asked if treatment was ever extended beyond the time or number of sessions established at the outset of treatment, 59 (98.3%) BMTs and 66 (97.1%) TUMTs answered in the affirmative. Using a Chi-square, the difference between the two groups was not significant (.6343).

Regarding the scheduling of appointments, a t-test revealed no significant difference between the groups on the 4-point scale. BMTs and TUMTs fell between the "weekly" and "every 2-3 weeks" options with respective means and standard deviations of 1.9 (SD 1.1) and 1.5 (SD .98). Similarly, when asked if one typically increased the time between sessions or spaced

appointments further apart as treatment proceeded, 55 (91.7%) BMTs and 59 (86.8%) TUMTs answered in the affirmative. A Chi-square revealed the difference between groups was not significant (.3752).

When asked "what theoretical orientation most influences your approach to marital therapy," 53 (40.2%) respondents chose "eclectic," followed by "other" (19.7%) and "cognitive" (18.2%). These findings were consistent within each group and are detailed in Table 4.

Using a Chi-square, there was no significant difference (.7918) between the two groups regarding theoretical orientation. However, it is interesting to note the written responses to the "eclectic" and "other" options. Regarding the "eclectic" option, the four most frequently reported responses (either reported singly or in combination) included: cognitive-behavioral (reported by 15 participants); mention of "systems" or "family systems" (9); psychoanalytic (7); and mention of Bowen, "family of origin" or "object relations" (6). Additional responses in decreasing order of frequency included: person-centered (reported by 5 participants); cognitive (4); interpersonal (4); communications (3); Imago Relationship Therapy (3); behavioral (3); psychodynamic (3); rational-emotive (2); Gestalt (2); "solution focused" (2); and Ericksonian (2). The following orientations were less frequently reported but were



Table 4  
Theoretical Orientation

Theoretical Orientation	Number and Percentage		Total
	BMTs	TUMTs	
Rational-emotive	2 ( 3.3)	3 ( 4.2)	5 ( 3.8)
Behavioral	4 ( 6.7)	2 ( 2.8)	6 ( 4.5)
Cognitive	13 (21.7)	11 (15.3)	24 (18.2)
Gestalt	3 ( 5 )	3 ( 4.2)	6 ( 4.5)
Person-centered	2 ( 3.3)	6 ( 8.3)	8 ( 6.1)
Psychoanalytic	1 ( 1.7)	3 ( 4.2)	4 ( 3.0)
Eclectic	22 (36.7)	31 (43.1)	53 (40.2)
Other	13 (21.7)	13 (18.1)	26 (19.7)

mentioned by at least one therapist: strategic, structural, "philosophical," "self as healer," existential, crisis intervention, "insight oriented," developmental and reference to Otto Rank. Thus, while most of the popular orientations were represented by the participants in the study, the majority indicated they were influenced by a combination of orientations in their approach to marital therapy.

Regarding the option designated "other," the five most frequently reported responses included: mention of "systems" or "family systems" (reported by 9); mention of Bowen, "family of origin" or "object relations" (5); Harville Hendrix's Imago Relationship Therapy (4); mention of Satir or "communications" (4); and mention of Haley or "strategic" (4). Additional responses and the number of therapists indicating them as influential in their marital therapy practice included: "interpersonal" (2); "solution focused" (2); social learning theory (2); structural (2); short-term, goal directed, problem focused (1); family therapy (1); "transpersonal" (1); existential (1); "spiritual issues" (1); and "personal responsibility healing, core healing" (1). Hence, regarding theoretical orientation, reference to "systems" and "family of origin" approaches were the most frequently consistent of the written responses to the

"eclectic" and "other" options, second only to "cognitive-behavioral."

To capture the therapists' goal of marital therapy, respondents were asked to indicate which one of the following they primarily aim to modify in their treatment: cognitions, feelings, or behaviors. The majority (52.8%) indicated they primarily aim to modify behaviors, followed by 32.8% endorsing cognitions, and 14.4% endorsing feelings. Additional details are presented in Table 5. Using a Chi-square, there was no significant difference (.0813) between the BMTs and TUMTs in their primary modification goal. However, the finding that the majority aim to modify behaviors is incongruous to the earlier finding in which a majority claimed a cognitive orientation. This raises the question whether the therapists' goal of therapy matches the goal of their chosen orientation. Although this issue cannot be resolved here, it was an interesting and unexpected finding. As to specific interventions, therapists were asked to identify the three used most frequently in treating marital couples. The most frequent intervention chosen by 84.8% was reframing, followed secondly by education (43.9%). These findings were consistent within the BMT and TUMT groups as well. Indicated third in frequency was interpretation, as reported by 31.8% of the respondents and 36.1% of the TUMTs. However, for BMTs

Table 5  
Therapists' Primary Modification Goals

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	<u>Number and Percentage</u>		
	BMTs	TUMTs	Total
Cognitions	20 (34.5)	21 (31.3)	41 (32.8)
Feelings	4 ( 6.9)	14 (20.9)	18 (14.4)
Behaviors	34 (58.6)	32 (47.8)	66 (52.8)

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role-play was reported by 28.3% as the third most frequently utilized technique. A Chi-square revealed no significant differences between the BMTs and TUMTs regarding specific interventions. Refer to Table 6 for additional findings.

In response to "specific interventions," 25.8% of the BMTs and TUMTs chose the "other" designation, thus a brief discussion follows. The five most frequent responses written in by respondents included reference to communication training (indicated by 11 subjects); homework (8); bibliotherapy (2); problem solving (2); and confrontation (2). Less frequently reported (mentioned by only one subject each) included: insight; Imago therapy interventions, "systems approaches to change," Ericksonian techniques, Gestalt experiments, support groups, mirroring, exploration, empathetic understanding, clarification, skill building, support, imagery, and nonanalytic dream interpretation.

Following is a presentation regarding participants' preference, attitude toward, comfort level, and training in brief marital therapy. Regarding preference for brief or time-unlimited marital therapy, 75 (57.3%) preferred time unlimited compared to 56 (42.7%) who preferred brief. Interestingly, 8 (14.3%) BMTs indicated time-unlimited was their preference and 6 (8%) TUMTs reported brief therapy was their preference. Thus, 14 (10.7%)

Table 6  
Interventions Used Most Frequently

Intervention	<u>Number and Percentage</u>		
	BMTs	TUMTs	Total
Encouragement	14 (23.3)	16 (22.2)	30 (22.7)
Paradoxical Intervention	2 ( 3.3)	5 ( 6.9)	7 ( 5.3)
Role-play	17 (28.3)	16 (22.2)	33 (25 )
Objective Instruments	1 ( 1.7)	1 ( 1.4)	2 ( 1.5)
Relaxation	1 ( 1.7)	3 ( 4.2)	4 ( 3.0)
Interpretation	16 (26.7)	26 (36.1)	42 (31.8)
Information/Advice giving	12 (20 )	12 (16.7)	24 (18.2)
Reframing	52 (86.7)	60 (83.3)	112 (84.8)
Education	24 (40 )	34 (47.2)	58 (43.9)
Reinforcement	13 (21.7)	11 (15.3)	24 (18.2)
Modeling	10 (16.7)	11 (15.3)	21 (15.9)
Other	15 (25 )	19 (26.4)	34 (25.8)

therapists were practicing, for whatever reason, a form of marital therapy incongruous with their preference.

As to attitude toward the efficiency of brief marital therapy, a t-test revealed a significant difference ( $p = .003$ ) between the two groups on the 7-point scale. BMTs fell between the "positive" and "somewhat positive" options with a mean of 5.9 and standard deviation of .88. TUMTs were less positive in their response and fell between "somewhat positive" and "neutral" with a mean of 4.5 and standard deviation of 1.3.

Similarly, regarding comfort level in doing brief marital therapy, a t-test revealed a significant difference ( $p = .001$ ) between the two groups on the 5-point scale. BMTs were more comfortable and fell between the "very comfortable" and "comfortable" options with a mean and standard deviation of 4.2 and .73, respectively. TUMTs were less comfortable and fell between "comfortable" and "somewhat comfortable" with a mean and standard deviation of 3.15 and 1.1, respectively.

Finally, regarding specific training in brief marital therapy: 117 (85.4%) reported books and journal articles; 114 (83.2%) indicated seminars or lectures; 67 (48.9%) reported supervision; 59 (43.1%) indicated course work, and 15 (10.9%) chose "other." Interestingly, the

most frequent "other" responses written in by participants included: "doing it" (reported by 3 subjects); consultation with peers (2); co-therapy (2); and workshops (2). Other less frequent responses included peer supervision, internship, "intensive training," papers, conventions, and "training program."

#### Results of Specific Hypotheses

Hypothesis 1. Hypothesis 1a stated there would be no significant difference in the reported level of therapist activity between therapists who identified themselves as brief marital therapists and those who did not, as assessed by the active-directiveness subscale.

Individual scores within groups were obtained by adding the numerical values based on the 5-point Likert scale. Of the 14 items, 8 were positively loaded and 6 negatively loaded. The numerical values for the negatively loaded items were reversed to generate the subject's score. A t-test revealed there was no significant difference ( $p = .293$ ) between the means of the BMTs and TUMTs on the active-directiveness subscale items. This indicates groups were more similar than dissimilar in their self-report of therapist activity. Thus, the results of Hypothesis 1a were not significant. Refer to Table 7 for full presentation of results.

Hypothesis 1b stated there would be no significant difference in the reported level of therapist activity



Table 7  
Mean, Standard Deviation, and Standard Error  
for TOQ Active-Directiveness Subscale

	Number of Cases	Mean	SD	Standard Error
BMTs	57	53.30	5.92	.784
TUMTs	69	50.00	6.79	.817

between therapists who identified themselves as BMTs compared to those identified as TUMTs, as assessed by specific items on the "style" questionnaire.

A multivariate test of significance was used to analyze responses to the 23-item self report scale. Based on the Hotellings t-test and resulting significance value of .209, there was no significant difference between the two groups. This indicated groups were similar in their report of behaviors related to style and activity level. Thus, the results of Hypothesis 1b were not significant. See Table 8 for a full presentation of results.

Hypothesis 1c stated there would be no significant difference in the reported level of therapist activity between BMTs and TUMTs as assessed by specific items on the Specific Therapist Behaviors Questionnaire. A multivariate test of significance was used to analyze responses to the 30-item self-report that employed a 5-point scale. Based on the Hotellings t-test, there was a significant difference between the two groups ( $p = .001$ ). Further univariate analysis revealed a significant difference between groups on 19 of the 30 items.

There were 19 items related specifically to therapist active-directiveness, 11 of which revealed significant differences between BMTs and TUMTs. See

Table 8  
Style Questionnaire Items and Significance

Item	Significance
1. Talkative	.510
2. Passive	.052
3. Explanatory	.296
4. Businesslike, "in charge"	.502
5. Supportive, reassuring	.194
6. Emphasizes "here-and-now" interaction	.222
7. Unchanging, consistent during hour	.030*
8. Guiding, directing obliquely	.402
9. Provocative, challenging	.705
10. Guided by theory	.649
11. Anonymous, inscutable	.767
12. Patient, willing to wait	.018*
13. Interpretive, inferential	.252
14. Persistent, unyielding	.701
15. Interested in patient's history	.084
16. Casual, informal	.990
17. Critical, disapproving	.424
18. Objective, impartial	.266
19. Spontaneous, intuitive, improvising	.804
20. Working toward definite goals	.021*
21. Focusing upon relationship(s)	.660
22. Encouraging conformity	.224
23. Cautious, premeditated interventions	.601

\*

p < .05

Table 9 for presentation of results. Findings revealed that BMTs, in comparison to TUMTs, assess couples more rapidly, are more structured, activate outside supports quicker, do more educating and teaching of new skills, are more demanding of clients, discuss time limits and termination more frequently, facilitate improvement quicker--starting in the first session, place more emphasis on outside therapy work, and place more emphasis on quick changes in behaviors, thoughts, and feelings.

Thus, there is evidence that the results of Hypothesis 1c were significant, differentiating the two groups regarding therapist activity. Hence, Hypothesis 1, stated as a null hypothesis, is not supported.

Hypothesis 2. Hypothesis 2a stated there would be no significant difference in the reported use of therapeutic goals between therapists who identified themselves as BMTs and those who did not, as assessed by the "style" questionnaire. As indicated in Hypothesis 1, the Hotellings t-test of the "style" questionnaire did not reach significance ( $p = .209$ ). This indicated the groups were similar in their self-report of in-therapy behaviors related to goals. Refer to Table 8 for "style" items and significance values.

Hypothesis 2b stated there would be no significant difference in the reported use of therapeutic goals between therapists identified as BMTs and those

Table 9  
 Specific Therapist Behaviors Questionnaire Items  
 Related to Active-Directiveness (Mean, Standard  
 Deviation, and Significance)

	BMTS		TUMTS		Significance
	Mean	(SD)	Mean	(SD)	
1. Early and rapid assessment.	4.48	(.70)	4.08	(.92)	.009*
2. Negotiate in first session clearly defined treatment goals.	N/A		N/A		.455
3. Maintain a clear and specific focus each session related to treatment goals.	N/A		N/A		.285
4. Highly structure all therapy sessions.	3.02	(.75)	2.56	(1.11)	.025*
5. Active-directive in each session, especially the first.	N/A		N/A		.336
6. Early activation of outside supports (family, support groups, etc.).	3.54	(1.07)	3.03	(1.09)	.025*
7. Early and frequent homework assignments, specific to couple's goals.	N/A		N/A		.231

Table 9 (cont.)

	BMTS		TUMTS		Significance
	Mean	(SD)	Mean	(SD)	
8. Emphasis on education and teaching new skills.	4.37	(.69)	4.14	(.79)	.050*
9. Insist at beginning that partners are active participants.	4.68	(.50)	4.47	(.87)	.047*
10. Discuss time limits or termination.	3.88	(1.04)	2.74	(1.19)	.000*
11. First session is mostly data collection.	N/A		N/A		.130
12. Use a variety of techniques.	N/A		N/A		.532
13. Facilitate some immediate improvement in the couple's condition in first session.	4.13	(.77)	3.56	(.97)	.004*
14. Assessment and treatment begin almost simultaneously.	N/A		N/A		.068
15. Emphasize the "real work" of therapy takes place outside of therapy.	4.33	(.82)	4.11	(.97)	.049*
16. Time limitation and termination date is mentioned each session.	2.83	(.96)	1.79	(.80)	.000*

Table 9 (cont.)

	<u>BMTs</u> Mean (SD)	<u>TUMTs</u> Mean (SD)	Significance
17. Intervention begins in the first session.	4.66 (.66)	4.40 (.86)	.013*
18. Cognitive reorganization is a frequently used technique.	N/A	N/A	.121
19. Emphasis on quick change of behaviors, thoughts, and feelings.	3.83 (.85)	2.84 (1.05)	.000*

\*

p &lt; .05

identified as TUMTs, as assessed by specific items on the Specific Therapist Behaviors Questionnaire. As indicated in Hypothesis 1, the Hotellings t-test revealed a significant difference between the two groups ( $p = .001$ ) on 19 of the 30 items. Fifteen items were specifically related to therapeutic goals, and of these 9 revealed significant differences between BMTs and TUMTs. Refer to Table 10 for full presentation of results.

Findings revealed that BMTs, in comparison to TUMTs, are more parsimonious and use more modest, limited goals, place more emphasis on "here and now" issues, are more content with enhancement, restoration, and improvement versus "cure," "think small" regarding treatment, and place more emphasis on couples' outside-therapy work. Additionally, findings revealed that TUMTs, compared to BMTs, place more emphasis on historic details and believe in extensive evaluation and treatment of all identified areas of conflict.

Thus, there is evidence that results of Hypothesis 2b were significant, and discriminate between the groups regarding the use of therapeutic goals. Hence, Hypothesis 2, stated as a null hypothesis, is not supported.

Hypothesis 3. Hypothesis 3 states there would be no significant difference in the reported number of treatment sessions between therapists who identified



Table 10  
 Specific Therapist Behaviors Questionnaire Items Related to Goals  
 (Mean, Standard Deviation, and Significance)

	BMTS		TUMTS		Significance
	Mean	(SD)	Mean	(SD)	
1. Belief in parsimony of treatment.	3.92	(.88)	3.49	(.99)	.039*
2. Negotiate in first session clearly defined treatment goals.	N/A		N/A		.455
3. Belief in modest, limited goals.	4.10	(.84)	3.30	(.98)	.000*
4. Emphasis on "cure."	N/A		N/A		.181
5. Extensive exploration of past issues and historic details.	2.47	(.79)	2.79	(.93)	.036*
6. Maintain a clear and specific focus each session related to treatment goals.	N/A		N/A		.285
7. Emphasis on "here" and "now."	4.03	(.64)	3.78	(85)	.044*
8. Early and frequent homework assignments specific to couple's goals.	N/A		N/A		.231

Table 10 (cont.)

	BMTs		TUMTs		Significance
	Mean	(SD)	Mean	(SD)	
9. Emphasis on underlying pathology.	N/A	N/A	N/A	N/A	.102
10. Content with enhancement, restoration, and improvement versus cure.	4.41	(.65)	4.19	(.70)	.009*
11. Think small.	3.63	(1.00)	2.99	(1.01)	.000*
12. Emphasize "real work" of therapy takes place outside of therapy.	4.33	(.82)	4.11	(.97)	.049*
13. Belief in extensive evaluation of couple's problems.	2.28	(.80)	2.78	(1.08)	.022*
14. Deal with all identified areas of conflict.	1.98	(.91)	2.84	(1.26)	.002*
15. Character change is one of the goals for one or both partners.	N/A	N/A	N/A	N/A	.085

\*  
p < .05

themselves as brief marital therapists and those who did not, as assessed by the Therapist Personal Data Questionnaire. This hypothesis was specifically addressed in item 8 of the questionnaire and stated: "Indicate the number of therapeutic sessions that is most typical of your practice of marital therapy." The mean number of sessions was 7.7 for BMTs and 18.5 for TUMTs which is a significant difference ( $p < .001$ ) between the groups. Hence, Hypothesis 3 is not supported. See Table 11 for additional details.

#### Additional Analysis of Data

Question 15 on the Therapist Personal Data Questionnaire invited additional comments by participants and yielded three types of responses regarding brief marital therapy: positive, negative, and a combination of the two. Positive comments included: "For some it works"; and "It is very positive, couples are 'relieved' to know they are not 'terminal.'" This model reinforces hope and 'doing things that work.'"

Other responses expressed the limitations of brief marital therapy, but not in a totally discrediting manner. A representation of these comments included: "Some brief approaches are great and appropriate, but sometimes people need more intense work to deal with each other and relationships in general"; "I prefer brief therapy if the level of pathology warrants it, but often

Table 11  
Typical Number of Marital Therapy Sessions  
(Mean, Standard Deviation, Standard Error)

Group	Number of Cases	Mean	SD	Standard Error
BMTs	58	7.7	2.17	.285
TUMTs	69	18.5	12.10	1.46

it does not"; "Brief marital therapy can be used if there are no Axis II behaviors or tendencies in either partner"; "It can be used in very early marriage"; and "It can be used with individuals too fragile to tolerate more dynamic, longer teamwork." Two additional comments implied the limits of brief marital therapy in addressing "secrets or intense, prolonged conflict" and "with ingrained patterns of behaviors with serious consequences such as spouse abuse and substance abuse issues."

Negative comments included: "It does not work well"; "Not all couples can be squeezed into a brief format"; "Brief models are OK for training and education"; "The essence of treatment is change and it does not seem possible or workable to put limits on that process, although some changes can be brief"; and "Rarely does brief marital therapy work to improve the marriage relationship. If treatment is brief, it is because the decision was already made to dissolve the marriage or the couple is too resistant to proceed with the emotional work of improving the relationship."

Additionally, three respondents made reference to brief therapy being advocated by insurance companies for reimbursement; one stated therapy is brief "if I cannot help them or they do not come back." One sex therapist among the respondents suggested that frequently the presenting marital problem is actually a sexual

dysfunction problem. However, the comment "both short- and long-term therapies have value" appeared to express the sentiments of most respondents.

## Chapter 5

### Conclusion

#### Discussion

While it is alleged in the literature that brief psychotherapy is a unique craft and a developing science and not just "less of the same" (Peake, Borduin, & Archer, 1988), it is also alleged that "numerous therapists practice both long-term and short-term therapy and that few pure examples of either species exist" (Budman & Gurman, 1988, p. 11). The purpose of the present study has been to explore how 60 self-identified brief marital therapists (BMTs) differed from 73 self-identified time-unlimited marital therapists (TUMTs) (using definitions delineated in Chapter 1) on the variables of therapist activity, goals, and time in their treatment of marital couples.

While it is difficult to accurately ascertain the amount of brief therapy conducted within current clinical practice (Wells, 1993), some findings of the present study resonate those of previous studies. In the present sample, 45% identified themselves as BMTs and 54.9% as TUMTs. Regarding preference, 41.5% preferred brief marital therapy (BMT) and 58.5% favored time-unlimited

marital therapy (TUMT). Similarly, in a recent study by Bolter, Levenson, and Alvarez (1990), 34% of their random sample of 550 clinical psychologists practicing in California favored brief approaches, in contrast to 54% who preferred long-term therapy. Twelve percent indicated no preference. Comparatively, a review by Wells and Phelps (1990) reported a minority position of brief psychotherapy and estimated utilization by 20% to 30% of practitioners.

In the present study, although there was a significant difference between the BMTs and TUMTs in age (means 44.1 and 48.2, respectively), and a significant disparity in the number of years practicing either BMT or TUMT (means 8.5 and 14.6 years, respectively), there were no significant differences between the groups regarding methodology, with one exception. The exception was the average number of marital sessions most characteristic of one's marital therapy practice and will be discussed later. However, the two groups were similar concerning logistical issues of their practice including: the length of each session; scheduling of appointments; increasing time between sessions as treatment proceeded; and extending treatment beyond the time or number of sessions established at the outset.

Likewise, as mentioned in Chapter 4, there was no significant difference between BMTs and TUMTs regarding



their theoretical approach to marital therapy. The majority of BMTs and TUMTs stated they were **eclectic** (36.7% and 43.1%, respectively), followed secondly by the **"other"** designation (21.7% and 18.1%, respectively), and thirdly, **cognitive** (21.7% and 15.3%, respectively).

Budman and Gurman (1988) state that most therapists who do brief therapy are rarely theoretical or technical purists. Rather, "they are pragmatic and eclectic, if not integrative, in method and technique" (p. ix). Despite numerous professional workshops, books, and journal articles on brief therapy, few practitioners faithfully use a single model or approach. Further, Gurman (1973), Manus (1966), and D. F. Beck (1966) agree that marriage counseling is a technique in search of a theory and "a lot of marriage counseling seems to be eclectic and pragmatic as far as a theory base is concerned" (Gooch, 1985, p. 30). Findings in the present study revealed that while the majority (40.2%) claimed to be eclectic, 59.8% reported allegiance to a particular orientation, thus lending little support to the above assertions. Likewise, the following documentation is only partially supported by the current study: "While school identifications exist in brief psychotherapy, most approaches are considerably more eclectic in the choice of interventions than is true of long-term therapy" (Koss & Butcher, 1986, p. 644; Horowitz et al., 1984). The

present study evidenced the majority of both BMTs and TUMTs were theoretically eclectic, with a greater percentage of TUMTs claiming eclecticism (43.1% of TUMTs versus 36.7% of BMTs). Further in terms of theoretical perspective, the salience of cognitive approaches was highlighted by 18.2% of the present sample endorsing **cognitive** and 28.3% of the eclectics endorsing **cognitive-behavioral**. According to Koss and Butcher (1986), several cognitive behavior therapies, treatment approaches that use verbal or cognitive mediation to bring about behavior change, fit into a brief treatment mode. Inclusive among these approaches would be Rational-emotive Therapy (Ellis & Grieger, 1977) and others that assume an active therapist role and employ techniques to encourage cognitive mediation and early therapeutic change (Koss & Butcher, 1986). The principal objective of cognitive theory is to teach people to think rationally (Gooch, 1985). This dovetails nicely with Ellis' assertion that humans tend to avoid high-level thinking by nature and are disturbed not by things but by the views they take of them (Ellis, 1973b).

Although cognitive theory has made its greatest contribution to the field of individual psychotherapy, its principles also apply to marital problems and the literature is replete with articles and books on cognitive theory in marriage counseling (Gooch, 1985).

Eisenberg and Zingle (1975) experimentally demonstrated a relationship between irrational ideas and marital discord. They found that if one partner possessed irrational ideas it had an effect on the marital relationship. Thus, their findings supported the direct employment of RET in marital counseling. Likewise, Gooch (1985) avowed that cognitive theory and treatment methods, such as RET, were well suited to providing marriage counseling to psychiatric inpatients. Additionally, Werner (1982) asserts: "Insight alone is not enough to improve one's mental health unless it is accompanied by the capacity to put it to use in the real world" (p. 1-2).

Although previous documentation alludes to the efficacy of RET in treating marital couples using a brief model (Eisenberg & Zingle, 1975; Gooch, 1985), only five (3.8%) respondents in the current study reported RET as most influential in their therapy approach. Thus, while the present study offers some support for the relevance of cognitive approaches in BMT, a majority of respondents combine a variety of approaches. There remains the issue of experimentally demonstrating which therapeutic approach is the most clinically efficacious in treating marital discord within a brief model. This question cannot be resolved in the present study and would perhaps

be best addressed in an outcome study utilizing trained BMTs in their actual treatment of marital clients.

In terms of specific interventions therapists used most frequently, the two groups were similar, differing (although not significantly) only on the third most frequently used technique. Thus, following **reframing and education**, BMTs chose **role-play** (28.3%), whereas TUMTs chose **interpretation** (36.1%). There appears to be some logic and consistency with the chosen interventions and those documented in the literature as characteristic of brief therapists (Koss & Butcher, 1986). The literature, however, also documents that "most brief psychotherapists consider **interpretation** to be the therapist's key change-producing behavior" (Koss & Butcher, 1986, p. 650). In contrast, in the present study **interpretation** was endorsed more frequently by TUMTs (36.1%) than BMTs (26.7%). Although lending no support to this previously documented finding, the findings of the present study call for prudent generalizations due to the small number of volunteer therapists.

Up to this point, the BMTs and TUMTs have been more similar than dissimilar. Likewise, there was no significant difference between groups regarding their primary aim in therapy of modifying either cognitions, feelings, or behaviors. Findings were consistent among groups and the most frequent response by BMTs and TUMTs

was **behaviors** (58.6% and 47.8%, respectively); followed second by **cognitions** (34.5% and 31.3%, respectively); and third, **feelings** (6.9% and 20.9%, respectively). The emphasis on **behaviors** was somewhat surprising. As mentioned in Chapter 4, second to eclecticism, the sample was predominantly cognitive in their approach. Thus, it is speculative if the therapists' aims match the goals of their reported orientation.

Before discussing specific hypotheses, a discussion regarding training in brief therapy is warranted. It is noted repeatedly in brief therapy process studies that therapists who participated, even though experienced, had no training in brief therapy (Koss & Butcher, 1986). Budman (1981) suggests that therapists well trained in the practice of long-term psychotherapy lack the specific skills to practice brief therapy and even possess skills that interfere in time-limited therapy. In the present study, 85.4% of respondents acknowledged exposure to BMT through books and journal articles, 83.2% indicated seminars or lectures, 48.9% reported supervision, and 43.1% reported course work. Some additionally reported consultation with peers, co-therapy, and "intensive training." With the exposure to BMT reported above, one may wonder why TUMTs outnumbered BMTs in the study. An increasing demand for therapists to use briefer approaches due to complex social and economic issues

(Bolter et al., 1990), and the assertion it may be the treatment of choice for most (Garner, 1970), has not seemed to impact the preference for, nor practice of, TUMT over BMT in the present sample.

### Hypothesis 1

Hypothesis 1 was designed to differentiate between BMTs and TUMTs regarding active-directiveness. Findings revealed a significant difference between the two groups regarding this characteristic, thus the null hypothesis was rejected. Eleven of 19 items related to active-directiveness on the Specific Therapist Behaviors Questionnaire discriminated between BMTs and TUMTs. Some of these items will be discussed below.

Regarding active-directiveness, Budman and Gurman (1983) emphasized: the importance of a patient's real life, outside-therapy behavior over in-session behavior; using adjunctive aids to therapy; and assigning homework. Only the two former items reached a level of significance in the present study. Koss and Butcher (1986) offered further characteristics of brief therapy including: setting time limitations in advance; focusing on the "here and now"; early, rapid assessment; and prompt, early intervention. Five of the 6 representative items reached significance in the current study. Koss and Butcher (1986) also alleged: "Most brief therapists tend to be both active and directive to maintain direction and

organization of sessions" (p. 646). This statement, key to the active-directiveness issue, was measured by the item "active-directive in each session, especially the first" and did not demonstrate a significant difference between groups. Hence, inconsistencies in findings preclude the drawing of firm conclusions.

There are some consistencies with the present findings and those of previous studies. Gelso, Spiegel, and Mills (1983) assessed therapists' self-ratings on activity level, structure, and use of historical material using the Therapist Orientation Questionnaire (TOQ) (from which the active-directiveness subscale in the current study was derived) and other instruments. Findings included therapists reported being equally active with their 8- and 16-session cases, and significantly more active with those cases than their time-unlimited clients. Also, therapists imposed more structure in 8-session time-limited therapy (TLT hereafter) than in time-unlimited therapy (TUT hereafter). The degree of structure in 16-session TLT did not differ significantly from the other treatments. In the present study, there was a significant difference ( $p = .025$ ) between BMTs and TUMTs (means 3.0 and 2.6, respectively) on the item "highly structure all therapy sessions," but not on the item "maintain a clear and specific focus each session related to treatment goals."

Regarding the use of historical material, the researchers reported miniscule differences across the three treatments. This contrasts with the present significant ( $p = .036$ ) finding in which TUMTs endorsed "extensive exploration of past issues and historic details" more so than BMTs.

Interestingly, Gelso, Mills, and Spiegel (1983) further explored the relation of therapists' orientation to brief TLT outcome using the same treatments above. No significant difference between theoretical orientation items and therapist-rated outcome was demonstrated. However, a notable pattern emerged for therapist directiveness to be related to client change in 8-session TLT, but not in 16-session TLT or TUT. Thus, therapist-rated change in brief TLT was greatest for therapists who actively guided, instructed, and confronted clients, but, this relationship did not hold up as the length of treatment increased. The researchers' findings suggested that directiveness has little, if any, influence on outcome. Thus, one cannot conclude that therapists should be more directive in TLT than TUT. However, conclusiveness is limited due to small sample size.

Similarly, Johnson (1983) studied high and low active-directive counselors on three measures in an experimental laboratory setting and found the two groups shared similar approaches to TLT and TUT. The lack of



effect was reminiscent of the Gelso, Mills, and Spiegel (1983) finding and added confirmatory evidence that general theoretical beliefs may not extend to behavior enough to differentially affect TLT and TUT. One possible explanation for the lack of effect evidenced above, may be the active-directive counselor role in TLT is not as potent as hypothesized in the literature (Butcher & Koss, 1978). However, the present study complements Johnson's (1983) conclusion by revealing that one's theoretical perspective may not extend or match one's goal of therapy.

To summarize the issue of active-directiveness as related to the present study, BMTs were found to: assess couples rapidly; use more structure; activate outside supports quicker; do more teaching; be more demanding; discuss time limits and termination more frequently; facilitate improvement quicker; emphasize outside-therapy work; and emphasize quick changes in behaviors, thoughts, and feelings. Although the findings discriminated between BMTs and TUMTs regarding therapist activity, limitations of the present and previous studies preclude firm conclusions. Additional research is necessary to address the issue more adequately.

### Hypothesis 2

Hypothesis 2 was intended to discriminate between BMTs and TUMTs regarding their reported use of

therapeutic goals. Setting and maintaining limited and realistic goals are paramount in the brief therapy process. Small (1971) believes "achievement and maintenance of a focus can be regarded as the single most important technical aspect of brief psychotherapy" (p. 121). Budman and Gurman (1983) concluded that failure to structure of focus sessions is the major technical error related to negative outcomes in brief therapy.

The present study demonstrated a significant difference between BMTs and TUMTs regarding therapeutic goals, and the null hypothesis was rejected. Nine of the 15 items relevant to goals on the Specific Therapist Behaviors Questionnaire reached significance distinguishing between groups. Following is a discussion of previous studies related to present findings.

Ursano and Dressler (1974) investigated specific factors influencing clinicians' decision for brief individual psychotherapy (BIP) versus long-term individual psychotherapy (LIP) in a community mental health center. Findings evidenced that subjects with discrete problems with recent onset of functional impairment (i.e., situational adjustment disorder) were more likely referred to BIP. LIP was more likely recommended for pervasive problems of longer duration, affecting basic personality function (i.e., neurosis or

psychosis). Their findings provided negative evidence in support of the supportive-exploratory model that postulates short-term patients receive "supportive" therapy and long-term patients receive "exploratory" therapy. Instead, the researchers claimed the clinical decision-making process regarding brief therapy versus long-term therapy is a **focal** versus **nonfocal** (or **multifocal**) issue, respectively. In the current study, although lacking specific data, several respondents alluded to the limitations of brief therapy in treating complex marital cases with multiple issues. The "multifocal" issues of marital counseling may be one explanation for the predominance of TUMTs in the present study.

Additionally, Johnson (1983) used the TOQ and two other instruments in a laboratory experiment to determine the different goals of 32 counselor subjects assigned to either TLT or TUT. It was hypothesized that goals for TLT would be fewer in number and less extensive than those for TUT. Findings indicated that the mean total number of goals for TLT ( $m = 12.78$ ) was somewhat less than TUT ( $m = 15.12$ ), but not significantly so. Regarding extensiveness of goals, TLT and TUT did not differ regarding the less extensive goals (i.e., Stabilization and Situational Adjustment Goals). However, subjects did have fewer of the more

Reconstructive Goals for TLT ( $m = 7.72$ ) than for TUT ( $m = 9.97$ ). Thus, only in the most extreme case of attempting personality reconstruction did subjects approach TLT with lessened goals compared to TUT. Although caution must be exercised in generalizing findings obtained in a laboratory setting, the researcher concluded the difference between TLT and TUT in terms of goals may be more qualitative than quantitative. In the present study there were few "pure" items relating to either qualitative or quantitative issues, most included connotations of both. However, findings revealed BMTs used more modest, limited goals.

Further, although the issue remains controversial, there is evidence that the goal of personality change is not limited to TUT. The empirical literature has evidenced that when differences in personality change have been found between the two therapy structures, the TLT structure is favored (Johnson & Gelso, 1980). In the present study, the item "character change is one of the goals for one or both partners" did not reach significance. However, BMTs significantly differed from TUMTs evidenced by their more frequent endorsement of the items: "belief in parsimony of treatment"; "belief in modest, limited goals"; "emphasis on 'here and now'"; "content with enhancement, restoration and improvement versus cure"; and "think small." Thus, the present study

offers little support to previous evidence that TLT need not exclude personality change as a goal.

To conclude the issues concerning therapeutic goals, the present study demonstrated a significant difference between groups in the context of marital therapy. BMTs were found to: be more parsimonious; use more modest, limited goals; emphasize the "here and now"; be content with enhancement versus "cure"; "think small"; and emphasize couples' outside-therapy work. TUMTs were found to emphasize historic details and evaluate and treat all areas of conflict. Due to limitations of the present and previous studies, however, as well as inconsistencies among studies, the drawing of firm conclusions is precluded. Additional research to augment the role of delimited goals in brief therapy is warranted.

### Hypothesis 3

Hypothesis 3 was designed to differentiate between BMTs and TUMTs regarding the number of treatment sessions most typical of their practice of marital therapy. Time is one of the major variables distinguishing brief approaches from other forms of psychotherapy (Koss & Butcher, 1986). Budman and Gurman (1983) avow "whatever else is focused on during treatment, the brief therapist must maintain a constant ancillary focus on the time issue" (p. 284). In the present study, a significant

difference was demonstrated between BMTs and TUMTs regarding the typical number of sessions (means were 7.7 and 18.5, respectively). Therefore, one might conclude there is a difference between the groups on this issue. However, interpretation of this finding calls for circumspection. Ninety-eight percent of the BMTs and 97% of the TUMTs acknowledged extending treatment beyond the time or number of sessions established at the outset of treatment. Thus, it is speculative if the "typical" number of sessions reported by respondents is a true representation of their practice. Additionally, research has demonstrated that as many as 60% of brief treatment patients return for additional therapy (Budman, Demby, & Randall, 1982; Patterson, Levene, & Breger, 1977). Nevertheless, Hypothesis 3 was not supported based on the "typical" number of sessions reported by therapists.

Moreover, the above finding offers some support regarding the time issue to previous documentation and studies. Smith, Glass, and Miller (1980) concluded that the major impact of psychological treatment occurs in the first 6 to 8 sessions. Ellis (1956), in his cognitively oriented marriage counseling, estimates that 6 to 10 sessions are sufficient for most cases. Regardless of stated time limitations, a major portion of the change

attributable to psychotherapy appears to occur early (Koss & Butcher, 1986).

Similar to the current study, Bolter et al. (1990) investigated Budman and Gurman's (1983) proposal that short-term and long-term therapists hold different value systems. The sample of 222 licensed psychologists was somewhat similar to the present sample: two-thirds were male; almost all held doctorates; mean age of 45, 16 years on average practicing psychotherapy; and more than half indicated a preference for long-term therapy. Overall, findings indicated therapists who preferred a short-term approach were more likely to endorse the values of the short-term therapist than were therapists who preferred a long-term approach. However, examination of individual values evidenced the two groups only differed significantly on 2 of the 8 values. Comparatively, in the present study therapists endorsed items consistent with their identification as a BMT or TUMT which differentiated the groups on the measured variables. Additionally, the present findings lend credence to the researchers' finding that long-term therapists seem to value a "timeless" quality in therapy; whereas short-term therapists value an awareness of limited time.

The findings of the present study also echo those of Kielson, Dworkin, and Gelso (1983). They investigated

TLT outcomes by randomly assigning 42 noncrisis students to either 8-session TLT, TUT, or a waiting list control group. TLT subjects received an average of 4.1 fewer sessions, which reduces confidence in the results. Nonetheless, findings suggested that 8-session TLT is a viable treatment at least for clients who are not severely disturbed. Although lacking specific data, respondents in the present study resonated strongly the above finding when asked for additional comments regarding their practice of marital therapy.

Finally, Munro and Bach (1975) tested the prediction that clients in TLT with a predetermined termination date would demonstrate greater improvement than clients in undetermined-time therapy (UT). Results suggested that TLT affected client progress in a much more positive direction than UT. These findings are suspect, however, since in neither of the treatment conditions was there any implicit or explicit expectation that counselors would modify their behaviors or techniques in treatment. This study resurrected the ongoing question regarding TLT being viewed a shorter version of TUT. The present study, in which BMTs and TUMTs significantly differed in their active-directiveness, goals, and duration of treatment, offers support to the argument that brief therapy is not just a shorter version nor "less of the same."



In sum, the present study has been an attempt to empirically differentiate between self-identified BMTs and TUMTs based on their endorsement of items related to style and in-therapy behaviors. Overall, results revealed a high degree of similarity between groups regarding theoretical orientation, style, interventions, aim of therapy, and length and scheduling of sessions. Despite similarities in orientation and therapeutic practice, therapists endorsed items consistent with their identification as either a BMT or TUMT. Thus BMTs, compared to TUMTs, were more active-directive in their treatment, employed more limited and modest goals, and utilized fewer sessions. Therefore, one can conclude from the findings of the present study that there was a significant difference between BMTs and TUMTs regarding the variables of active-directiveness, therapeutic goals, and duration of treatment. These findings were also consistent with the literature that asserts the salience of these variables in distinguishing brief and long-term treatments (Koss & Butcher, 1986).

The above findings are also consistent with the position of Shlien et al. (1962) that the more active the therapist the shorter the time required. Time limits increase energy and heighten the essential process while reducing the unessential time. However, present findings do not lend support to Budman's (1981) inference that

clinicians suffer from a skill deficit in TLT. Nor do findings add confirmatory evidence to Budman and Gurman's (1988) assertion that few pure examples of short- and long-term therapists exist. Likewise, findings provide little support for Malan's (1976) claim that many consider brief therapy a second-rate form of treatment. More noteworthy, the results of the present study add confirmatory evidence to the dictum that brief therapy is not just "less of the same." However, due to the dearth of research and limitations of studies, this issue remains a moot point.

#### Limitations of Study

There were two primary limitations inherent in the present study. First, the sample was nonrandom and was limited to volunteer therapists in the Richmond, Virginia metropolitan area. No adjustments were made for variables related to gender, degree obtained, level of experience, volume of marital cases, or training in brief therapy. Second, instruments employed were self-report inventories. Previous research (Rice, Gurman, & Razin, 1974) has shown that therapists' self-descriptions agree very strongly with their co-therapists' independent descriptions of their partners' in-therapy behavior. Nonetheless, objectivity in self-report instruments remains a pertinent issue. Since the above qualifications limit the generalizability and

conclusiveness of present findings, professionals need to continue efforts to discover the most effective methods for assisting those in marital distress.

#### Recommendations for Future Research

Having opened the door to the viewing of a unique population in the arena of brief therapy, the present study is only the beginning and suggestions for further research are discussed below.

An obvious next step would be an outcome study comparing clients having received brief marital therapy with long-term marital therapy clients, using self-report inventories, objective measures, in-depth interviews, or any combination of the above. An experimental design, comparing perceived improvements of the two groups, would be facilitative in detecting what, if any, major differences discriminated the groups. Likewise, follow-up interviews with couples would provide comparison information regarding the duration of treatment effectiveness. Further, a longitudinal study comparing return rates of BMT versus TUMT clients for the first year after termination would provide evidence possibly differentiating the groups on the long-term effects of treatments.

Knowing when and how to stop treatment is one of the most important but least discussed aspects of brief psychotherapy (Wells, 1993). An experimental design

comparing brief clients in which an explicit time limit for treatment was set in the initial session to brief clients in which time limits were not set would provide information regarding premature dropout rates. The overall objective would be the development of clinical guidelines for proactively managing the termination stage of brief treatment.

Two additional concerns remain regarding future research in brief psychotherapy. First, sufficient attention should be paid to ensure that the therapy process subjected to analysis represents exemplary or even prototypic brief psychotherapy. In other words, what needs to be examined is "planned" brief therapy, or brief therapy "by design" not "by default." Likewise, only those therapists with specific training in brief treatments and meeting specific criteria established at the outset should be included as participants. Such scrupulous research will add to the embryonic body of knowledge of BMT in the overall goal of addressing Paul's (1966) famous dictum: "What treatment, by whom, is most effective for which client. . . ."

#### Final Considerations

Marital relationships are fundamentally different from other relationships, in that they are expected to provide the most intimate, trusting, and emotionally safe relationships in life (Budman & Gurman, 1988). Americans

expect a great deal out of the state of wedlock and when a particular marriage proves unsatisfactory, they seek to dissolve it and try again (Davis, 1972). Couples are more likely to agonize over the decision to separate than over the decision to marry (Walen & Bass, 1986). It is likely that the final decision to divorce is the outcome of a long series of smaller decisions made by the individual along the way to the final decision-making point (Donovan & Jackson, 1990). Perlman (1982) suggests it takes up to two or more years for an individual to reach a divorce decision. Hence, the application of brief marital therapy early in the decision-making process might alleviate the trauma and, for some, cataclysmic consequences of divorce.

Brief therapy now represents the cutting edge in the theory, research, and practice of psychotherapy (Good, 1987). Not only is it becoming a standard component of conventional mental health practice, "evidence accumulates that 'brief therapy' may be the treatment choice in most patients" (Garner, 1970, p. 119). Thus, it has been the goal of the present study to evaluate brief treatment in the context of marital therapy. Hopefully, it will spur further exploration and assessment of the role of brief therapy in those representing a significant part of therapists' caseloads, thus constituting a population worthy of investigation.

Finally, the researcher was impressed with the responsiveness of the professional community to the present survey. The salience of their participation in this and future research for the prevention of "marital suicide" cannot be overstated.

**APPENDICES**

**PLEASE READ BEFORE COMPLETING QUESTIONNAIRES**

Date

Respondent's Address

Dear

Thank you for your willingness to participate in a research study conducted by Sharon Gilley, a doctoral student at The College of William and Mary in Williamsburg, VA. The purpose of the study is to investigate how self-identified brief marital therapists differ from time-unlimited marital therapists in their treatment of marital couples. The answers you provide are very important to the success of this study, and your help is greatly appreciated. Even if marital counseling is not your specialty, your responses are still important.

Participation involves completing the four enclosed questionnaires, a total of 82 items. The questionnaires have been tested with a group of professionals and the average time required for completion of the survey instruments was 17 minutes.

It will be appreciated if you will complete the enclosed forms prior to \_\_\_\_\_ and return them in the stamped envelope enclosed. Please do not put your name on any of the questionnaires. Please return the enclosed stamped postcard separately from your forms upon completion of the survey. Indicate on the postcard your desire to receive a summary of the research results which will be mailed to you upon completion of the study.

Participation in this study is strictly voluntary. You are guaranteed the right to decline to participate or to withdraw in part or in whole at any time without penalty. Please be assured all respondents will remain anonymous. Only the researcher will have access to all data collected in this study, which will be kept strictly confidential. Only group data will be used and reported in the final research paper.

You are encouraged to contact the researcher or the investigator responsible with any questions or concerns at the following: **Sharon K. Gilley**, 571 Rochelle Road, Richmond, VA 23233 (telephone: 804-784-5426); or **Dr. Kevin Geoffroy**, College of William and Mary, School of Education, Williamsburg, VA 23185 (telephone: 804-221-2331). Again, your participation is greatly appreciated. Thank you.

Sincerely,

Sharon K. Gilley

Attachments



## THERAPIST PERSONAL DATA QUESTIONNAIRE

**Directions:** Please respond to the following items according to your actual behaviors and specific practice of marital therapy.

1. A. Age \_\_\_\_  
 B. Sex Male \_\_\_\_ Female \_\_\_\_  
 C. Type of practice or setting (check one): \_\_\_\_ Private \_\_\_\_ Public  
 D. Highest degree obtained (check one):  
    \_\_\_\_ Bachelors                     \_\_\_\_ Master's  
    \_\_\_\_ Specialist                    \_\_\_\_ Doctorate  
 E. Current license (check all that apply):  
    \_\_\_\_ LCP \_\_\_\_ LSW \_\_\_\_ RN \_\_\_\_ LPC \_\_\_\_ LCSW Other: \_\_\_\_\_
2. Which of the following best describes you in your practice: (Check one):  
    \_\_\_\_ No marital therapy (**IF YOU CHOOSE THIS OPTION SKIP THE REMAINDER OF THIS FORM AND PLEASE COMPLETE THE OTHER THREE FORMS.**)  
    \_\_\_\_ Brief marital therapy (not more than 8 sessions within 3 months).  
    \_\_\_\_ Time-unlimited marital therapy (therapy lasting longer than 8 sessions or over 3 months).
3. What is your preference? (Check one):  
    \_\_\_\_ Brief marital therapy  
    \_\_\_\_ Time-unlimited marital therapy
4. How many years have you been practicing marital therapy in the designation you chose in #2 above? \_\_\_\_ years.
5. What is the average number of yours you do psychotherapy weekly?  
    \_\_\_\_ hours.  
    What is the average number of yours you do brief marital therapy weekly? \_\_\_\_ hours.  
    What is the average number of hours you do time-unlimited marital therapy weekly? \_\_\_\_ hours.
6. What is your attitude toward the efficiency of brief marital therapy? (Check one):  
    \_\_\_\_ Very positive                     \_\_\_\_ Somewhat negative  
    \_\_\_\_ Positive                            \_\_\_\_ Negative  
    \_\_\_\_ Somewhat positive                \_\_\_\_ Very negative  
    \_\_\_\_ Neutral
7. What is your comfort level in doing brief marital therapy? (Check one):  
    \_\_\_\_ Very comfortable                 \_\_\_\_ Somewhat uncomfortable  
    \_\_\_\_ Comfortable                        \_\_\_\_ Very uncomfortable  
    \_\_\_\_ Somewhat comfortable

Therapist Personal Data Questionnaire (cont.)

8. Indicate the number of therapeutic sessions that is most typical of your practice of marital therapy. \_\_\_ sessions.
- Do you ever extend treatment beyond the time or number of sessions established at the outset of treatment? \_\_\_ Yes \_\_\_ No
9. How long is your average marital session? \_\_\_ minutes.
10. How often do you schedule appointments? (Check one):
- |  |  |
|--|--|
| <input type="checkbox"/> Weekly          | <input type="checkbox"/> Once a month                                    |
| <input type="checkbox"/> Every 2-3 weeks | <input type="checkbox"/> Intermittently as needed or requested by couple |
- Do you typically increase the time between sessions or space appointments further apart as treatment proceeds? \_\_\_ Yes \_\_\_ No
11. What theoretical orientation most influences your approach to marital therapy? (Check one):
- |   |  |
|---|--|
| <input type="checkbox"/> Rational-emotive | <input type="checkbox"/> Person-centered             |
| <input type="checkbox"/> Behavioral       | <input type="checkbox"/> Psychoanalytic              |
| <input type="checkbox"/> Cognitive        | <input type="checkbox"/> Eclectic (please describe): |
| <input type="checkbox"/> Gestalt          | _____  |
|   | <input type="checkbox"/> Other (please describe):    |
|   | _____  |
12. Which of the following do you primarily aim to modify? (Check one):
- Cognitions \_\_\_ Feelings \_\_\_ Behaviors
13. Identify 3 specific interventions you use most frequently in your treatment of married couples. (Check or list 3 techniques):
- |   |  |
|---|--|
| <input type="checkbox"/> Encouragement            | <input type="checkbox"/> Information and advice giving |
| <input type="checkbox"/> Paradoxical intervention | <input type="checkbox"/> Reframing                     |
| <input type="checkbox"/> Role-play                | <input type="checkbox"/> Education                     |
| <input type="checkbox"/> Objective instruments    | <input type="checkbox"/> Reinforcement                 |
| <input type="checkbox"/> Relaxation               | <input type="checkbox"/> Modeling                      |
| <input type="checkbox"/> Interpretation           | <input type="checkbox"/> Other (please describe):      |
|   | _____  |
14. What specific training have you had in brief marital therapy? (Check all that apply):
- |   |   |
|---|---|
| <input type="checkbox"/> Course work      | <input type="checkbox"/> Books, journal articles  |
| <input type="checkbox"/> Seminar/lectures | <input type="checkbox"/> Supervision              |
|   | <input type="checkbox"/> Other (please describe): |
|   | _____   |
15. Any additional comments about your practice of marital therapy, particularly in relation to brief treatment, would be appreciated.

## TOQ ACTIVE-DIRECTIVENESS SUBSCALE ITEMS

Indicate your agreement or disagreement. Circle one of the following:

5 Strongly agree 5  
 4 Agree 4  
 3 Undecided 3  
 2 Disagree 2  
 1 Strongly disagree 1

1. Primary emphasis should be placed on the patient's manifest behavior.  
 5 4 3 2 1
2. People can be understood without recourse to the concept "unconscious determinants of behavior."  
 5 4 3 2 1
3. The patient's coming to experience his feelings more fully is not the most important therapeutic result.  
 5 4 3 2 1
4. With most patients I do analytic dream interpretation.  
 5 4 3 2 1
5. I instruct most patients to free associate.  
 5 4 3 2 1
6. I am a fairly active, talkative therapist, compared to most therapists.  
 5 4 3 2 1
7. The patient should be directly confronted with evidence of his irrational thoughts and behavior.  
 5 4 3 2 1
8. It is possible to make sense of a patient's behavior without assuming motives of which he is unaware.  
 5 4 3 2 1
9. For a patient to improve his current way of life, he must come to understand his early childhood relationships.  
 5 4 3 2 1
10. It is important to analyze the transference reactions of the patient.  
 5 4 3 2 1
11. I am a fairly passive, silent therapist, compared to most therapists.  
 5 4 3 2 1
12. The more effective therapists do things during the therapeutic hour for which they have no reasoned basis, merely a feeling that it is right.  
 5 4 3 2 1

TOQ Active-Directiveness Subscale Items (cont.)

13. For a patient to improve his current way of life, he does not necessarily have to come to understand his early childhood relationships.
- 5    4    3    2    1
14. Effective therapists almost always know what they are doing, and why, and where they are heading.
- 5    4    3    2    1

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**Source:** Sundland, D. M. (1972, June). Therapist orientation questionnaire, up-to-date. Paper presented at the Third Annual Meeting of the Society for Psychotherapy Research, Nashville, TN.

## SPECIFIC THERAPIST BEHAVIORS QUESTIONNAIRE

The following items refer to specific issues in the practice of psychotherapy. Please check the appropriate column for each item to indicate what is most typical of your style or approach in your practice of marital therapy and SPECIFICALLY REGARDING YOUR IDENTIFICATION AS A BRIEF MARITAL THERAPIST OR TIME UNLIMITED MARITAL THERAPIST.

	Almost <u>Always</u>	<u>Usually</u>	Typically (about 50% of time)	Only Occas- ionally	Never
1. Belief in parsimony of treatment	_____	_____	_____	_____	_____
2. Early and rapid assessment	_____	_____	_____	_____	_____
3. Negotiate with couple in first session regarding clearly defined treatment goals	_____	_____	_____	_____	_____
4. Belief in modest, limited therapeutic goals	_____	_____	_____	_____	_____
5. Emphasis on "cure"	_____	_____	_____	_____	_____
6. Extensive exploration of past issues and historic details	_____	_____	_____	_____	_____
7. Maintain a clear and specific focus each session related to treatment goals	_____	_____	_____	_____	_____
8. Highly structure all therapy sessions	_____	_____	_____	_____	_____
9. Active/directive in each session, especially the first	_____	_____	_____	_____	_____
10. Early activation of outside supports (family, support groups, etc.)	_____	_____	_____	_____	_____
11. Emphasis on "here" and "now"	_____	_____	_____	_____	_____
12. Early and frequent homework assignments, specific to couple's goals	_____	_____	_____	_____	_____
13. Emphasis on underlying pathology	_____	_____	_____	_____	_____

Specific Therapist Behaviors Questionnaire (cont.)

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	<u>Almost Always</u>	<u>Usually</u>	<u>Typically (about 50% of time)</u>	<u>Only Occas- ionally</u>	<u>Never</u>
14. Emphasis on education and teaching new skills	_____	_____	_____	_____	_____
15. Content with enhancement, restoration and improvement versus cure	_____	_____	_____	_____	_____
16. Insist from the beginning that partners are active participants	_____	_____	_____	_____	_____
17. Discuss time limits or termination date in first session	_____	_____	_____	_____	_____
18. The first session is mostly data collection	_____	_____	_____	_____	_____
19. Use a variety of techniques	_____	_____	_____	_____	_____
20. Facilitate some immediate improvement in the couple's condition in the first session	_____	_____	_____	_____	_____
21. Assessment and treatment begin almost simultaneously	_____	_____	_____	_____	_____
22. Think small	_____	_____	_____	_____	_____
23. Emphasize to couple the "real work" of therapy takes place outside of therapy	_____	_____	_____	_____	_____
24. Time limitation and termination date is mentioned each session	_____	_____	_____	_____	_____
25. Intervention begins in the first session	_____	_____	_____	_____	_____
26. Belief in extensive evaluation of couple's problems	_____	_____	_____	_____	_____
27. Deal with all the couple's identified areas of conflict	_____	_____	_____	_____	_____

Specific Therapist Behaviors Questionnaire (cont.)

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	<u>Almost Always</u>	<u>Usually</u>	<u>Typically (about 50% of time)</u>	<u>Only Occas- ionally</u>	<u>Never</u>
28. Character change is one of the goals for one or both partners	_____	_____	_____	_____	_____
29. Cognitive reorganization is a frequently used technique	_____	_____	_____	_____	_____
30. Emphasis on quick change of behaviors, thoughts and feelings	_____	_____	_____	_____	_____

## STYLE QUESTIONNAIRE

**Instructions:** Let's agree that, as therapists, we vary our behavior to suit different kinds of patients, different stages with the same patient, etc.; thus, no one photo does us justice. Yet beneath these variations, you may have some sense of your style in general-- that picture of you which a panel of observing therapists would get from watching you work, over time, with a variety of cases. Would you try to provide that sketch by responding rapidly, intuitively, to the following items? Encircle the appropriate number at left.

DEFINITELY NOT or NEVER					
Not much, not very or Rarely, occasionally					
Moderately or Cannot say;					
Quite a lot or Frequently, often					
DEFINITELY YES or ALWAYS					
1	2	3	4	5	talkative
1	2	3	4	5	passive
1	2	3	4	5	explanatory
1	2	3	4	5	businesslike, "in charge"
1	2	3	4	5	supportive, reassuring
1	2	3	4	5	emphasizes "here-and-now" interaction
1	2	3	4	5	unchanging, consistent during hour
1	2	3	4	5	guiding, directing obliquely
1	2	3	4	5	provocative, challenging
1	2	3	4	5	guided by theory
1	2	3	4	5	anonymous, inscrutable
1	2	3	4	5	patient, willing to wait
1	2	3	4	5	interpretive, inferential
1	2	3	4	5	persistent, unyielding
1	2	3	4	5	interested in patient's history
1	2	3	4	5	casual, informal
1	2	3	4	5	critical, disapproving
1	2	3	4	5	objective, impartial
1	2	3	4	5	spontaneous, intuitive, improvising
1	2	3	4	5	working toward definite goals
1	2	3	4	5	focusing upon relationship(s)
1	2	3	4	5	encouraging conformity
1	2	3	4	5	cautious, premeditated interventions

**Source:** Rice, D. G., Fey, W. F., & Kepecs, J. S. (1972).  
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