

Providing Therapy in the Context of
Third Party Determined Time Limits:
A Mixed Methods Study of Psychologists'
Experiences of Working in Pre-set Timeframes

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CONFERENCE PRESENTATIONS RELATING TO THIS THESIS

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- Wright, T., & Lennings, C. (2008). *Psychologists' approach to working within time limits*. Poster presented at the 6th Biennial Faculties of Health Research Conference, Blue Mountains, Australia.
- Wright, T., & Lennings, C. (2007). *Time in therapy: Psychologists' reactions to working in treatment time limits*. Paper presented at the 42nd APS Annual Conference, Brisbane, Australia.
- Wright, T., & Lennings, C. (2007). *What difference does a time limit make to psychotherapy?* Paper presented at the Faculty of Health Sciences, Postgraduate Research Student Conference, Sydney, Australia.

ABSTRACT

Psychological services in Australia are frequently provided in the context of third party payers who impose time limits based on reasons other than particular client (or therapist) characteristics. Time limits may function as a useful clinical factor in the provision of therapy, for example through accelerating treatment. Less is known about the third party *imposition* of time limits and the impact they may have on psychotherapy from the perspective of psychologists. The present study investigates the impact of time limits imposed in this manner from the viewpoint of practising psychologists.

Practising psychologists took part in a mixed methods study. Twenty seven participated in a semi-structured interview, and eighty-five completed a mailed questionnaire. Interviews were analysed thematically, while both qualitative content analysis and statistical analyses were applied to questionnaires.

The interview and questionnaire findings were congruent, both showing that a time limit makes a difference to psychologists. Psychologists are less satisfied with treatment that can be provided in the time limited as opposed to time unlimited context. However, they also perceived benefit in terms of improved client access to psychologists and improvements in the efficiency of therapy. Participants reported that the system of third party referrals had an impact on them that was over and above the impact that a time limit itself had, for example, the fact they were externally managed. The broader context therefore reportedly brought with it the need for psychologists to adapt their treatment to the context of the service. Psychologists reported that, in response to time limits, they often changed their treatment type, for example, from a psychodynamic to cognitive behavioural approach. They also made more general changes, such as moving quicker through the process of therapy and becoming more directive and less client-centred. Perceived outcomes were also affected by the time-limited context. How psychologists conceive of, report, and achieve outcomes is different in this context, and overall outcomes were perceived as weaker.

In conclusion, this study has demonstrated that time limits impact upon psychologists in important ways with regard to the process and outcomes of psychotherapy. The broader system of third party referrals has implications for the delivery of psychological services in Australia, which clinical understandings of time limitation have not accounted for. Previous research has shown that the number of sessions available makes a difference, but the present research shows that a time limit cannot be separated from the system under which it is imposed, because once it is imposed, it has implications throughout the whole process.

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LIST OF ABBREVIATIONS

ABS	Australian Bureau of Statistics
ANOVA	Analysis of Variance
APS	Australian Psychological Society
BOMHC	Better Outcomes in Mental Health
CBT	Cognitive Behavioural Therapy
COAG	Council of Australian Governments
CTL	Complex Time Limited
CTUL	Complex Time Unlimited
DASS	Depression Anxiety and Stress Scale
DoHA	Department of Health and Ageing
DSM	Diagnostic and Statistical Manual of Mental Disorders
DVA	Department of Veterans' Affairs
EAP	Employee Assistance Program
EBP	Evidence-Based Practice
EPC	Enhanced Primary Care
EST	Empirically Supported Treatment
ESW	Enhancement of Subjective Wellbeing
IPT	Interpersonal Psychotherapy
RLF	Recovery of Life Functioning
SFBT	Solution Focussed Brief Therapy
SR	Symptom Reduction
SST	Socioemotional Selectivity Theory
STL	Simple Time Limited
STUL	Simple Time Unlimited
VOC	Victims of Crime

CERTIFICATION

I, Dr Christopher Lennings, certify that the PhD thesis entitled *Providing therapy in the context of third party determined time limits: A mixed methods study of psychologists' experiences of working in pre-set timeframes*, by Tracey Wright is in a form suitable for examination.

Dr Christopher Lennings

Date

AUTHOR'S DECLARATION

I, Tracey Wright, certify that this thesis, *Providing therapy in the context of third party determined time limits: a mixed methods study of psychologists' experiences of working in pre-set timeframes* is my own work. It is based on original data gained from my own research. It contains no material that has been written or published by another person, except where acknowledgment is made. This work has not been submitted or accepted for the award of any other degree or diploma. All research practices involved with this thesis were approved by The University of Sydney Human Ethics Committee.

Tracey Wright

Date

Whoever controls the delivery of mental health care – by determining such things as the definition of mental disorder, triage criteria, and the nature and length of proper treatment – inevitably and deeply affects society-wide understandings of health and illness, abnormality and healing, the possibilities and limits of human nature, and thus what is believed to be proper and good (Cushman & Gilford, 2000, p. 985).

CHAPTER 1: INTRODUCTION

BACKGROUND TO THE RESEARCH

Mental health is increasingly recognised as an important aspect of the nation's health. In 2006 the Council of Australian Governments agreed to a National Action Plan on Mental Health that included universal funding for the treatment of common mental health disorders (COAG, 2006). The proportion of Australians seeking assistance for mental health problems was 12% in the 12 months prior to 2007 (ABS, 2007), indicating the need for readily accessible psychological services. Recent Australian Government funding trends reflect the recognition of the importance of treating common mental health conditions, and one of the more common ways in which a person may receive psychological assistance in Australia is from a psychologist in private practice.

With the increased control of healthcare systems by corporations and governments, there is a shift towards the management of mental health services by professionals outside of the client-practitioner interaction. A third party, whose rationale will include balancing the most significant improvement in mental health with the most viably restricted expense, thus often funds psychological services. There are different ways in which third party providers may contain costs in mental health. In some cases, such as bibliotherapy and psychotherapy provided over the Internet, the services do not even require the presence of a mental health professional. In most types of services, however, mental health professionals provide a personal service, and cost is controlled through the use of a time limit, which forms the focus of the present research. In Australia and abroad, one of the more common ways through which to provide psychotherapy is through a third party and with a time limit. The length of therapy in this context is therefore externally determined, rather than dependent on the needs of the client.

The current research occurred at a time when a significant new source of funding for psychotherapy was introduced by the Australian Government through the Better Access initiative. Prior to that there were a number of funded programs and initiatives on a smaller scale that funded therapy in a time limited format. It would be fair to say that most, if not all, Australian psychologists have had experience providing therapy within externally imposed time limits, yet little is known about their experiences in this context.

AIMS OF THE RESEARCH

The aim of the present study is to understand how the third party payer system with pre-determined time limits is experienced by psychologists providing therapy in this context. The specific research questions to be addressed are: *What are psychologists' perceptions of providing time limited therapy in the context of third party payer referrals? What are the perceived impacts on therapeutic processes? What are the perceived impacts on therapeutic outcome?* In this research, I wanted to uncover how third party determined time limits were experienced by psychologists, but I also wanted to gain some systematic appreciation of the extent to which a time limit may contribute to changes in therapeutic process and perceived outcomes. Therefore, the aims were addressed through the use of a mixed methods design. Semi-structured interviews were used to ask 27 psychologists their opinions of time limited therapy and provided a rich source of context-bound information. Eighty-five psychologists also participated in a questionnaire that used a repeated measures design to ask about process and outcome perceptions based upon four different conditions; therapy provided in a time limited context with a simple client presentation, therapy provided in a time limited context with a complex client presentation, therapy provided without a time limit with a simple client presentation, and therapy provided without a time limit with a complex client presentation. Time available and complexity of presentation were thus the independent variables of this questionnaire.

My initial assumptions about time limited therapy changed considerably over the course of this research. In the beginning I set out to find out about time limits and to 'isolate' them as much as possible as the research phenomenon. Over the course of data collection it became very apparent that while I was asking participants about time

limits, they were also talking about other factors associated with the third party provision of psychotherapy. The context within which third party determined time limits occurs was therefore shown to be important and in analysis could not readily be separated from the time limit.

OVERVIEW OF THE THESIS

The thesis is structured in the following way: Chapter Two outlines our current knowledge concerning the length and limitation of psychotherapy. I also consider the context under which time limitation most frequently occurs – under the auspice of a third party provider. The methodological approach, including the need to use a mixed methods design, is described in Chapter Three. Chapter Four presents the findings of this research in terms of the inputs of time limited therapy. Factors relating to the broad system of third party time limited services are considered, as well as therapist and client factors that act to influence the provision of therapy in this context. Findings relating to the therapeutic process and perceived outcomes of time limited therapy are presented in Chapter Five. This chapter describes the changes psychologists report making to their therapeutic process when time is limited. It also describes perceived outcomes in time limited psychotherapy in comparison to perceived outcomes in other contexts of therapy provision. In Chapter Six I discuss the meaning and relevance of these findings and consider the implications for practice and policy.

CHAPTER 2: CONTEXTUALISING THE RESEARCH

INTRODUCTION

Many psychotherapeutic settings in Australia today offer their services with a pre-determined limit on the number of sessions. Time limits, or a restriction on the number of sessions available for therapy, have been used for many years by psychologists and have been based on varied justifications. There are clinical indications to use time limits as well as economic reasons. Research has shown that the amount of time available for therapy makes a difference, and also that limiting the amount of time makes a difference. Less is known about the processes through which this might be the case. Recent Australian Government funding changes for the provision of mental health services have meant that the majority of clients seeking psychological services will now have a limited funding framework through which they receive their treatment. Given the lack of knowledge about the processes involved in time limited therapy as well as the prevalence of providing treatment in this context, the present research aims to consider, from the perspective of psychologists, how treatment occurs in this context and what the important determinants to its success are.

This chapter will consider background issues to therapy in light of the use of time limits as well as review the available evidence for the use of time limits. This chapter will firstly consider the issues involved in brief and time limited therapy and review the evidence for its effectiveness. It will then go on to examine the mechanisms of effectiveness and the role of a time limit in determining this, as well as considering how psychologist and client factors may contribute. The second section of this chapter will consider therapy in the context of third party payers with externally determined time limits. It will look at the aims of third party systems and consider the implications of externally managing the number of sessions, and how this impacts upon psychologists. The Australian context of third party determined time limits will also be considered

here. This chapter will conclude by outlining the research questions this study aims to address.

SECTION I. BRIEF AND TIME LIMITED THERAPY

Limiting the number of therapy sessions has been occurring in therapy for over half a century and with different justifications. This section will firstly consider the relevant historical factors involved in time limited psychotherapy and go on to examine the evidence for its effectiveness. The mechanisms of change involved in time limits will then be considered and result in the identification of the acceleratory effects of a time limit. Psychologist and client factors that relate to a time limit will then be examined, followed by consideration of the therapeutic process in time limited therapy.

History of Brief and Time Limited Therapy

The notion that therapy could be made brief developed around the end of World War II (Strasser & Strasser, 1997), when it became necessary to treat large numbers of returning veterans for their trauma symptoms. This was also the time that the profession of clinical psychology developed and that psychotherapy began moving from the realm of psychiatrists to psychologists (Leahey, 2000). The profession of psychology is young (O’Gorman, 2007) and the extent of knowledge that accumulated over the 20th Century has provided the impetus for significant shifts in the way psychological services are provided; including a move away from psychoanalysis and towards briefer forms of treatment, accompanied by a change in the perception of psychotherapy’s aims (Cantor & Fuentes, 2008).

The prominence of brief therapy is evident across a broad range of settings offering psychological interventions. Initially, brief therapy was different to mainstream therapy (Shapiro et al., 2003), but something that was once novel has become the norm, and a significant amount of research has been dedicated to this area. The scope of this research has recently moved away from the question of the appropriateness of brief therapy, and onto the issues involved in a world where psychotherapy is assumed to be brief.

Not only is brief therapy prominent in therapeutic settings, but its very definition has changed since its inception as a concept. When the term 'brief therapy' was initially developed it was taken to mean something different from its current meaning. Shapiro et al. (2003) define brief therapy as "no more than about 25 sessions" (p. 214), although others contend that therapy today is unlikely to be labelled as brief if it is over ten sessions (Key & Craske, 2002). An implication of this is an industry that is increasingly headed towards minimising the time spent on psychotherapy while aiming to maximise and generalise the benefit attained. For example, one of the more recent ways to maximise this benefit is through the use of targeted cognitive behaviour therapy (CBT) that only uses techniques to target a specific maladaptive behaviour common in that particular disorder (Hazlett-Stevens & Craske, 2002).

Regardless of how brief therapy is defined, the length of treatment in naturalistic treatment settings has consistently been shown to be low on average. For example, Carey (2006) used a rigorous stratified sampling strategy to identify 3,021 patients and retrospectively found that they attended for an average of four sessions. Hansen, Lambert, and Forman (2002) found that a large sample of over 6,000 patients attended therapy for an average of five sessions, while another large pilot study found the average to be 5.6 sessions (FHSA, 1994, cited in Scott, 2004). Despite the advocacy for longer therapy by treatment manuals that usually prescribe upwards of 10 sessions, use of therapy in the 'real world' is on average low. Within this average, a smaller number of clients utilise a larger number of sessions, which can be considered a 'utilisation paradox' (Shapiro et al., 2003).

Brief therapy frequently involves the use of a time limit, but it encompasses much broader considerations than this alone. Brief therapy is about the very control of time (Eckert, 1993), that is, an emphasis on achieving the maximum outcome in the minimum amount of time. Indeed, Eckert (1993) proposes four catalysts that can be used in brief therapy to accelerate client changes, which are planning, collaboration, timing, and empowerment. Eckert's notion of the influence of timing on therapeutic changes includes "rapid initial intervention, followed by control of number, frequency, and duration of therapy sessions: treatment stages; intersession activity; and intermittency" (Eckert, 1993, p. 1). Included in this is the suggestion that setting a specific time limit on therapy accelerates the rate of improvement achieved, so that

fewer sessions are required for equivalent outcomes. This notion is explored in more detail later in this chapter.

Brief and time limited therapy are thus firmly established in the profession of psychology today, and are predicted to be on the rise in the future of psychotherapy (Norcross, Hedges, & Prochaska, 2002). The terms ‘brief therapy’ and ‘time limited therapy’ sound similar, but in fact they refer to different things. The former relates to a relatively (to the current standard) brief timeframe with flexibility, whereas the latter relates to a specified and pre-determined number of sessions available for treatment. Thus time limited therapy is not necessarily brief¹. Although this thesis differentiates between the length of therapy and the use of a time limit, this chapter will review notions of the length of therapy in order to locate the relevant phenomenon of the time limit.

Outcomes of Therapy Based on Time

The issue of how much psychotherapy is necessary for adequate outcomes is an important question, and time limits have been examined for over 30 years (e.g., Malan, 1976). Overall, an extensive review has revealed that 100 out of 106 research studies between 1950 and 1992 have shown a positive correlation between treatment length and outcome (Orlinsky, Grawe, & Parks, 1994). A significant body of research has considered the outcomes that can be achieved in time limited and brief therapy, as well as how much therapy is in fact enough. Shapiro et al. (2003) discussed the “fall and rise” of brief therapy research and acknowledged the increasing importance of research surrounding this area given the current climate of brief therapy.

The dosage of psychotherapy

The Dose Response model of psychotherapy offers partial insight into the impact of time course and limitation on therapy outcome. The model suggests that significant therapy gains are achieved within the early stages of treatment, and that exponentially more treatment is needed to achieve similar increments of therapeutic gain (Howard,

¹ For example, the Victims of Crime service in New South Wales (NSW) offers compensatory psychological treatment to people who have been the victim of a crime. Psychologists are required to complete a report following the first session, which asks them to specify the amount of sessions they believe will be necessary for the client. After a two hour assessment, the maximum number of sessions available for one act of crime is 20 hours.

Kopta, Krause, & Orlinsky, 1986). In general, the model shows that improvement occurs most steadily up to the eighth session, so that 50% of clients are significantly improved at that stage (Howard et al., 1986). This model provides some (averaged out) information about how long therapy should go for and was an important initial study on the 'dosage' of therapy. While the dose response model was a landmark finding, several criticisms and limitations have been levelled against it. One of these limitations was that the model was ascertained in a research setting. To address this limitation, Hansen and Lambert (2003) looked at the dose response in a naturalistic treatment setting and also considered the clinical significance of gains that were deemed more meaningful than in the initial Howard et al. (1986) study and with a large sample of clients (4,761 participants, mostly from Employee Assistance Programs). They also identified a dose response relationship but that 15 to 19 sessions are needed for a 50% recovery rate. Kadera, Lambert, and Andrews (1996) found that instead of 50% being improved by the eighth session, only 22% were adequately recovered. Therefore, change may in fact take longer than the predictions of the original Dose Response model would suggest.

After reviewing evidence from studies that have considered dose-response relationships, Hansen et al. (2002) suggested that time limits should be a minimum of 20 sessions given that research in this area suggests more than 20 sessions is needed for more than 50% of clients to experience clinically meaningful improvement. This research was critiqued by Sanderson (2002) who suggested that the use of evidence-based treatments may have led to findings more in line with clinical trials, where fewer sessions have been shown to be adequate. An interpretation of this finding does not however justify the unquestionable use of brief therapy or time limited therapy. Firstly, like most findings surrounding clinical psychological research, the findings are confounded by many external variables such as therapy type, presenting problem, and problem severity (Shapiro et al., 2003). Secondly, a finding that implicates only 50% of its participants still leaves another 50% unaccounted for. Kadera et al. (1996) further critique the dose-response model for its lack of consistent outcome measurement, predominantly psychodynamic and interpersonal approach, assumption of a linear progression throughout therapy, and the classification of clients according to diagnosis.

How effective psychotherapy is considered to be depends on the criteria for measuring a successful outcome. The Phase Model (Howard, Lueger, Maling, & Martinovich,

1993) was developed from the initial findings of the Dose Response model and proposes that clients move through three sequential stages in therapy; enhancement of subjective well-being (remoralisation), symptom reduction (remediation), and recovery of life functioning (rehabilitation). The stages of the Phase Model are accumulative, thus remediation cannot be achieved until remoralisation is achieved, and the rehabilitation phase can only be reached once remoralisation and remediation have been reached. The Phase Model associates the decelerating curve of outcome improvement shown in the Dose Response model to the escalating complexity of treatment goals across these phases (Shapiro et al., 2003). This is different to the assumption that the Dose Response model suggests whereby the slowing down of improvement across later sessions implies therapy is less useful at this stage. The definition of an appropriate outcome can therefore be seen to influence how outcome research is interpreted; if remoralisation is the aim of treatment then fewer sessions will be needed, but if rehabilitation is considered a successful outcome then more treatment will be required, and the tapering off of the dose response curve suggests that exponentially more time will be needed.

Utilising the Phase Model is said to provide the means for adapting therapy to the stage at which the client is at; remoralising the distressed patient, followed by developing coping skills for symptomatic relief, followed by learning new skills to enable the client to function in an improved way (Lueger et al., 2001). The Phase Model has been supported in other settings, for example in a training clinic (Callahan, Swift, & Hynan, 2006) and using short-term psychodynamic psychotherapy (Hilsenroth, Ackerman, & Blagys, 2001). Further, the initial treatment response appears to be a determining factor to the success of therapy. Lueger et al. (2001) found that the longer clients took to reach the phases proposed in the phase model, the less likely clients would be reliably improved by the end of therapy. This suggests that assessment of therapy in the early stages of therapy can lead to an indication of the likelihood of further sessions being helpful. A study considering the length to reach each stage found that for subjective well-being, improvement was most rapid around the second session; for symptom remediation, it was most rapid around the sixth session; and for overall life functioning, improvement was most rapid around the tenth session (Lueger, 1998). Each stage may therefore be reasonably reached in brief lengths of treatment. Part of the present

research questionnaire is informed by the Phase Model, and this will be further discussed in Chapter Three.

The efficacy and effectiveness of time limited therapy

In terms of efficacy², time limited and time unlimited treatments have been demonstrated to be comparably efficacious in some studies (Orlinsky, Ronnestad, & Willutzki, 2004); however other studies found that arbitrary time limits can produce outcomes that are not clinically meaningful for the majority of clients (Wolgast, Lambert, and Puschner, 2003). In an effectiveness study, Seligman (1995) showed that longer therapy was associated with better treatment outcomes and that poorer treatment outcomes were linked with artificially timed therapy delivered through managed care and insurance funding. In a prospective study on therapeutic outcome, Carter (2005) concluded that time limited therapy was effective for clients presenting at a Community Mental Health Team. Research looking at the effectiveness or efficacy of time limited treatment needs to be able to isolate the time limit from other factors (at least to some extent even in effectiveness studies) in order to be able to validly conclude that it is the time limit operating as an independent variable. Because Carter (2005) had no control of the time limit per se, the research question of the effectiveness of time limited therapy is not able to be answered. Furthermore, the measurements that Carter (2005) used to ascertain the effectiveness of therapy focus on symptoms, which is suggested by some to be only part of the picture of the effectiveness of therapy (e.g., Hansen & Lambert, 2003; Norberg, Calamari, Cohen, & Riemann, 2008). Similarly, the only indication of long-term effectiveness in this study was given by whether clients reported back to the service, which is by no means conclusive. Importantly, without a control or comparison group, it is difficult to claim that the time limit was isolated enough as a variable to conclude that it is effective compared with unlimited therapy that may end up being brief anyway.

A key question when looking at the effectiveness or efficacy of time limited treatment is whether rapid benefit (for example as demonstrated in Carter, 2005) is equal to enough benefit. A randomised trial comparing short-term and long-term psychotherapy found that while short-term psychotherapies produced quicker benefits, long-term

² 'Efficacy' relates to the utility of a treatment shown in a controlled treatment setting, while 'effectiveness' refers to the success of psychotherapy shown in naturalistic settings.

therapy produced more durable gains (Knekt et al., 2008). The aim of investigating the effectiveness and efficacy of psychotherapy is to build on the scientific basis of therapeutic interventions as legitimate ways to reduce healthcare problems and minimise costs. Reliance on experimental methods in order to achieve this has been questioned (e.g., Speer, 1994). Understanding how effective treatment is achieved may be better understood through understanding the facets of psychotherapy that are best applied in particular circumstances (Beutler, 1999). Flexibility with both the length of therapy and the use of time limits may therefore be tools to adapt therapy to a particular context and client presentation (Beutler, 1999).

Mechanisms of Change brought about by Time Limits

A considerable body of research has considered the role of time in determining changes in internal experiences such as motivation. This section will consider the potential mechanisms through which time limits make a difference; including the role they may play in time limited psychotherapy.

Time and motivation

There are several contexts in which time and motivation have been shown to be implicitly linked. Time perspective is a psychological variable that differentiates people through their perception of time, how they think about it and how they use it. The concept of time perspective includes the degree to which people can structure time in their day to day life (Lennings & Gow, 1997). Time perspective is a malleable trait, and it can be influenced by experiences such as education level (Lennings, 2000). Motivation is linked with time and may be changed by the introduction of a time limit. For example, Amabile, DeJong, and Lepper (1976) found that the use of a time constraint was linked with decreased interest in the task at hand and argued that the use of time deadlines resulted in goals becoming extrinsically motivated, and as such interest in the task was undermined. The results of this research are examined through the lens of the “over justification” hypothesis, which states:

As a theoretical proposition, the over justification hypothesis predicts - other things being equal - a decrease in intrinsic motivation, in situations where subjects do not expect extrinsic rewards, when subjects are presented with an activity of initial intrinsic interest under

conditions which make salient to the subject the instrumentality of engaging in that activity as a means to some ulterior end. (Lepper & Greene, 1976, p. 33)

The implications from such research suggest that intrinsic motivation is a malleable state that can be affected without changing the task or activity for which the intrinsic motivation is held. Furthermore, one way to achieve this manipulation of intrinsic motivation is to introduce time constraints. Time limits are also shown here to be distinct from time length; Amabile et al. (1976) intended and confirmed the time limit to be functionally superfluous, because the deadline affected participants' motivation but not the actual time taken in doing the task at hand.

Time perspective is linked with motivation and goal setting. For internal objects to have a temporal sign they necessarily predominantly relate to motivational or affective factors (Nuttin & Lens, 1985). Conti (2001) suggests that time perception is an important dimension of motivation, and demonstrated that participants scoring higher on intrinsic motivation were more likely to think about time less often, feel that time passed more quickly, and to lose track of time than participants scoring low on intrinsic motivation. Conti's (2001) findings are important in that they demonstrate that intrinsic and extrinsic motivation are differentially influential on the experience of time. Motivation that is enjoyable and productive is linked with a lack of attention to time (Conti, 2001). It is suggested that "by intentionally shifting one's focus of attention away from how long an activity is taking, rewards inherent in that activity may become apparent" (Conti, 2001, p. 22), however Conti's 'cause and effect' are not necessarily clear in this research. A study looking at the effect of time deadlines on goal revision found that goal revision was stronger towards the end of the deadline when there was a discrepancy between goals and actual behaviour (Donovan & Williams, 2003). There is therefore evidence to suggest that time limitation and motivation are inherently linked; while intrinsic motivation may be undermined by time constraints, revision of goals can be increased to meet the demands of a deadline.

Socioemotional Selectivity Theory (SST) relates limitations placed on time to impacts on motivation. SST specifically relates the limitation of time in life to the type of goal setting undertaken. It proposes that when time is limited individuals select different

types of goals to when time is open-ended. The theory argues that “the perception of time as constrained or limited as opposed to expansive or open-ended has important implications for emotion, cognition, and motivation” (Carstensen, Isacowitz, & Charles, 1999, p. 2). The foremost prediction of SST is that when time is perceived as limited, ‘emotionally meaningful’ goals become more important as they are associated with short-term rewards, and that when time is perceived as unlimited, ‘knowledge related’ goals become more important as they are associated with long-term benefits (Lang & Carstensen, 2002). It should be noted that ‘time’ as construed in SST spans the life course, and the theory is not based on time intervals such as therapy that is limited or unlimited. An important question to be gained from SST is whether the theory retains its aptness when applied to discrete time components of the life span, such as a period of therapy; Carstensen et al. (1999) suggest that it might be the case that SST applies in the therapeutic context. Either way, the implications that SST has contributed to the field of time and motivation research provide the information that time perception has a significant impact upon goal selection. Time limits and motivation are therefore linked, because “[b]oundaries on time provide the framework within which individuals select and prioritise goals” (Carstensen et al., 1999, p. 17).

Motivation for therapy

Time and motivation are implicitly connected and time limits can increase particular types of motivation in some settings. The structure and predetermined length of brief therapy may lead to increased client motivation (Bor, Gill, Miller, & Parrott, 2004). A pre-determined end to therapy is also said to increase the efficiency of therapy (Yalom, 1989) and can increase motivation for further change (Hazlett-Stevens & Craske, 2002). One of the disadvantages of brief and time limited therapy is that it leaves little time to develop treatment motivation, and assumes that clients will be in a place where they are ready to make changes (Hazlett-Stevens & Craske, 2002). Key & Craske (2002) suggest that client motivation be assessed at the outset because of the greater commitment required from clients in brief cognitive behavioural therapy (CBT). Clinical impressions from a randomised controlled trial were that a brief CBT approach “particularly helped patients who were able to set clear achievable goals, and was less useful to those who saw their problems in global terms” (Scott, Tacchi, Jones, & Scott, 1997, p. 133). The ways in which therapeutic goals are selected may therefore have implications for the

affect of time limits, and time limited therapy may not be appropriate for clients who begin therapy with little motivation to change.

Accelerating Therapy

There are empirically established reasons to consider limiting the number of sessions in therapy. Research has identified that a time limit can act to accelerate the process of therapy, and this section will review findings in this regard and consider the range of domains that have been identified as potential and actual accelerators of therapy.

The setting of a time limit allows for a visible end to therapy, which was identified by the early pioneers of therapy such as Otto Rank and Carl Rogers (Yalom, 2005). In a study examining whether there were differences in the speed of therapeutic movement, Barkham et al. (1996) confirmed the acceleratory effects of a time limit when comparing clients given a limit of either eight or 16 therapy sessions. In line with their hypothesis as well as Eckert's (1993) suggestions, the clients with only eight sessions experienced a quicker trend toward improvement at the point of eight sessions compared with the group allocated to 16 sessions. Similarly, Reynolds et al. (1996) considered the immediate session impact in therapy lasting either eight or 16 sessions, and found that the clients designated only eight sessions of treatment experienced a quicker trend toward more positive subjective assessment of sessions than the group with 16 sessions. A significant strength of this study was the use of both CBT and Psychodynamic groups for both sets of time limits (four groups in total), which allowed theoretical orientation to be partially controlled for. The proposal that time limitation causes acceleration in therapy has therefore been empirically supported, whereby both clients and therapists are aware of the time limit and respond accordingly to create quicker treatment progress and outcomes (Shapiro et al., 2003). Reynolds et al. (1996) suggested that it may be the positive subjective assessment that contributes to accelerated changes in brief time-limited therapy. This acceleration can be seen as an advantage to therapy, in that it results in quicker treatment gains and may therefore increase both the motivation of clients and their belief in psychotherapy (Hazlett-Stevens & Craske, 2002). The benefit of a specific ending in time limited therapy has also been described as a catalyst to effective therapy (Strasser & Strasser, 1997). If a time limit can indeed be conceived of as a catalyst, then it may be a tool in itself to

improve therapy, at least for some people. Time limits, as well as the extent of limitation, have thus been shown to have some impact on therapeutic outcomes.

In summary, explicit time limits have been found to increase extrinsic motivation (Amabile et al., 1976) and change the types of goals that are valuable to people (e.g., Lang & Carstensen, 2002). Time limits may have a similarly facilitative effect in the therapeutic context. Goals may come to the forefront of time limited therapy (Strasser & Strasser, 1997), which can be viewed positively insofar as explicit outcomes are consciously worked on, or it can be viewed negatively in terms of pressure to both clients and psychologists.

Therapeutic Process in Time Limited Therapy

There is some information available regarding the therapeutic process in time limited therapy. This section will consider recommendations for time limitation on the basis of theoretical orientation, guidelines for working in time limits, and the therapeutic alliance.

Recommendations for time limitation on the basis of theoretical orientation

There are questions about whether brief therapy is a form of therapy in its own right or whether it is the timely use of therapy regardless of theoretical approach. In considering what allows therapy to be brief, Messer (2001a) suggests it differs based upon theoretical orientation. Interpersonal therapy (IPT), for example, engages in the use of a strict time limit on theoretical grounds. Treatment time suggestions for most presenting problems are 12 to 16 sessions, and importantly, there is no room for negotiation in relation to the number of sessions (Gabbard, 2009). If a client misses a session, regardless of their reason, the session is not made up for and the client still pays for the missed session. In this regard, the use of time limits in IPT form part of a theoretical approach, and are not based on the limitation of resources. IPT is recommended in the policy documents of both the Better Access initiative (DoHA, 2007) and Better Outcomes in Mental Health (BOMHC; Pirkis & Blashki, 2003), particularly for use with depression. Existential therapy is thought to be inherently conducive to a time limited approach, insofar as “[t]ime is so much part of our existence that we argue that no therapy which takes into account the existential themes can be called open-ended,

for this would imply that the temporal aspect of life which includes endings would be excluded from the therapeutic process” (Strasser & Strasser, 1997, p. 35).

CBT also makes suggestions for brief and limited timeframes, but to a less strict extent than IPT. CBT is recommended in the treatment guidelines for the Better Access initiative (DoHA, 2007) and BOMHC (Pirkis & Blashki, 2003). CBT has been extensively demonstrated to be efficacious in research trials (e.g., Gloaguen, Cottraux, Cucherat, & Blackburn, 1998). CBT assumes that there is a core element responsible for the symptoms that present in therapy, and that identification of this core element can therefore lead to a straight-forward treatment of it (Hazlett-Stevens & Craske, 2002). Working within this theoretical framework therefore lends itself quite readily to limited timeframes (McGinn & Sanderson, 2001). However, when diagnosis of the core problem is not clear or symptoms are more diffuse, working briefly with CBT may become problematic (Hazlett-Stevens & Craske, 2002). CBT need not be time limited officially, but when it is Wright, Basco, & Thase (2006) suggest it is best suited for the “prototypically easy-to-treat person (i.e., an adult in good health with relatively acute anxiety or a nonpsychotic depressive disorder, who has good verbal skills and some past success in relationships and who is motivated to make use of therapy)” (p. 47). The flexible use of time, as opposed to a predetermined timeframe, may also be an important determinant in making CBT brief (McGinn & Sanderson, 2001). The role of the therapist in CBT, described as active and directive, is additionally responsible for the amenability of CBT to brief timeframes because of the increased control the therapist has over time (McGinn & Sanderson, 2001).

Solution-focussed brief therapy (SFBT) is a therapeutic approach defined as a brief treatment in its very nature. The establishment of concrete goals is important in the practice of SFBT (de Shazer et al., 1986). The theory of SFBT draws a distinction between “(a) brief therapy defined by time constraints and (b) brief therapy defined as a way of solving human problems” (de Shazer et al., 1986, p. 207). Brevity of therapy is therefore consistent with the aims of SFBT. It is thus the philosophy of SFBT, which includes its emphasis on solutions rather than problems, which allows it to be brief (de Shazer et al., 1986).

Brief Dynamic psychotherapy has a long history of existence before the advent of pressure from managed care (Levenson & Strupp, 1999). Henry, Strupp, Butler, Schacht, and Binder (1993) investigated the effects of brief manual-based training on experienced psychodynamic therapists. One of the premises of the Time-limited Dynamic Therapy manual that was used in this study was the use of a time limit and its emphasis on “early determination of focus and greater therapist activity as keys to time-limited clinical work” (Henry et al., 1993, p. 438). Certain interpersonal and interactional aspects of therapy were found to deteriorate as a result of the manual-based training. In a survey sent to members of the American Psychological Association (APA), 25% of respondents identified themselves as psychodynamic in orientation, and of these 82% indicated working in brief timeframes (Levenson & Davidovitz, 2000), demonstrating the extent to which psychodynamic therapists work in short timeframes, at least in the United States (US). One of the features that might allow for the effectiveness of brief psychodynamic therapy is “a deliberate time limit that adds a sense of intensity and urgency and sets in motion therapist and patient expectancies as to when change will occur” (Messer, 2001b, p. 5). A meta-analysis of studies on the efficacy of brief psychodynamic therapy showed significant and large effect sizes for both the immediate and long-term benefits of treatment (Leichsenring, Rabung, & Leibing, 2004).

Theoretical orientation thus provides some understanding of the role of time in therapy, however the justification for certain numbers of sessions is rarely specified based upon a particular theory. Furthermore, despite the existence of different theoretical positions, the name or branding of a therapy (e.g., CBT, Psychodynamic) is thought by some to be an inaccurate representation of what actually happens in therapy (Beutler, 1999). While theoretical orientation provides some information regarding time in therapy, it also leaves some gaps. This research will therefore consider time in therapy in a meta-theoretical way aside from where reference to a particular orientation is relevant.

Guidelines to Working in Time Limits

As brief therapy has become so common, there is an abundance of guidelines for ways to implement therapy that is brief. One such source describes their approach as “ethically driven yet commercially aware” (Bor et al., 2004, p. 1). The extent to which time limited therapy is thought to be a different type of therapy from that without a time

limit varies in the literature. Strasser & Strasser (1997) suggest that “working within a time limitation brings out a different emphasis and therefore gives different results” (p. 2). Some sources suggest that for therapy to work briefly, therapists need to ‘intervene’ from the beginning, and that “[b]rief therapy does not mean ‘doing less’ but rather ‘doing differently’” (Bor et al., 2004, p. 16). Awareness of the entire process of therapy also appears to increase according to the literature. Corey (2001), for example, asserts that the final part of the therapeutic process is “always in the background” (p. 7) when working in a short-term framework. Some, but not too much, experience with longer term therapy is thought to be effective before training in brief dynamic psychotherapy should take place (Levenson & Strupp, 1999). Therapy provided in time limits therefore has implications for the way in which it is delivered; Broskowski (1991) suggests that clinicians should develop skills in behavioural approaches to common disorders because they are lower cost in terms of the timeframe needed to provide them in. The use of CBT, SFBT, and brief strategic therapy are applicable to managed care type settings because of their primary focus on symptom reduction (Cushman & Gilford, 2000). Despite the prevalence of providing therapy in limited timeframes, a survey of a sample of psychologists in the US found that only half of these psychologists had received training in brief therapy (Levenson & Davidovitz, 2000).

Patients and therapists may have different expectations regarding the length of therapy. In a study examining expectations of length, most therapists were found to expect treatment to last more than 15 sessions, while most patients expected shorter treatment (Pekarik & Wierzbicki, 1986). Such differences between ideas about the expectations of treatment length by psychologists and clients questions the use of therapy that designates a certain number of sessions that is usually above 10 (Carey, 2006). A survey of psychologists providing services through the BOMHC program found that psychologists had different ideas about how much time was necessary for therapy; 37% believed six sessions to be enough while 40% did not, and 75% believed 12 sessions to be enough while 25% did not (Pirkis et al., 2006). It is clear that the time considered necessary for therapy is somewhat inconsistent and no doubt conflicting between psychologists as well as within psychologists (that is, their idea of the time necessary will vary in some way, for example depending on client type). The Australian Psychological Society (APS) suggests that most clients will need between four and ten

sessions for treatment (APS, 2006). It is also suggested that the client should be advised of how long treatment should take; “Patients should expect the psychologist to estimate the number of sessions and the type of therapy that is likely to lead to an effective outcome for their problem” (APS, 2006). This is in line with the APS code of ethics (APS, 2007).

Having a time limit may impact upon the therapeutic process over and above considerations for the length of therapy. Reflecting on the experience of being a therapist in a randomised controlled trial, one psychologist describes the experience of pressure that was somehow different to the usually brief timeframe of therapy she worked in anyway.

Despite the fact that, as systemic therapists, we were accustomed to fairly brief work, we had felt some anxiety about having to stop at the end of the period of time laid down by the research design (twenty sessions or nine months), since the circumstances of many of our clients, and our anxiety about being scrutinized, made us often feel doubtful about the clients’ capacity to maintain changes that had been established, without at least some occasional therapeutic input. (Jones, 2003, p. 353)

There is some information available in the literature regarding how psychologists react to time limits. Torrente, Harf, Trica, & Hirsch (2006) found that therapists, when working briefly, were congruent with their preferred therapeutic model; however they made adjustments based on individual aspects of each case. Working in time limits puts psychologists under a degree of pressure that is not felt without these limits (Ellis, 2002). The way that therapy is delivered may be different in a number of ways, for example Cantor and Fuentes (2008) suggests that managed care “changes the role of the psychologist from informed listener to active director” (p. 640). It is unclear whether the quality of psychotherapy may be impeded by time limits, but Herron (1992) suggests that quality may be more readily assured without the use of time limits. However, while the danger of working within pre-determined treatment time limits has been acknowledged, it is also argued that therapy need not lose its depth or sophistication when time is brief and limited (Curran, 1999). Scott et al. (1997)

concluded after a randomised controlled trial using brief CBT that brief treatment may be more difficult to conduct than more traditional timeframes of 12-20 sessions, and that the level of experience of the therapist therefore needed to be taken into account.

Issues of Eclecticism

Psychotherapy conducted in the real world is diverse. The finding that most psychologists in practice consider themselves eclectic is not new (e.g., Jensen, Bergin, & Greaves, 1990; Levenson & Davidovitz, 2000), which is problematic for the use of treatment manuals that work within a single theory (Beutler, 1999). Therapy operating within a particular theoretical orientation is also variable, although less so for cognitive therapies (Malik, Beutler, Alimohamed, Gallagher-Thompson, & Thompson, 2003). It has been suggested that the tailoring of treatment to relevant characteristics of clients is beneficial to outcome, for example the level of complexity in the client presentation (Groth-Marnat, Roberts, & Beutler, 2001). It should be noted though that there are differences in the opinions between the mental health professions of General Practitioners, psychiatrists, and clinical psychologists on the treatment of common disorders (Jorm, Korten, Jacomb, Rodgers, & Pollitt, 1997).

The diversity of understandings that come with different theoretical orientations may be beneficial for the practice of psychotherapy (Lazarus, 1996). Integrating different types of theoretical perspectives may be achieved in three broad ways; unsystematic eclecticism, theoretical integrationism, and technical eclecticism (e.g., Lazarus & Beutler, 1993). Technical eclecticism assumes a single, coherent model informing assessment and the development of therapy, but the borrowing of empirically validated techniques from other models, whilst theoretical eclecticism assumes no commitment to any specific model and is based on what seems to work at the time for a particular client. Although it might be possible to determine the theories that are used by eclectic therapists, understanding the actual implications on practice is more complex (Jensen et al., 1990). The role of eclecticism in influencing the impact of a time limit is thus unknown.

Client factors to consider in time limited therapy

The notion of tailoring therapy to suit client type is one that has promise for the efficiency and effectiveness of psychotherapeutic interventions. Non-diagnostic client

characteristics may provide hope for predicting the outcome of psychotherapy to a greater extent than Diagnostic and Statistical Manual (DSM) based diagnoses (Clarkin & Levy, 2004). Tailoring psychotherapeutic interventions to client characteristics is proposed by Groth-Marnat et al. (2001) to be important in achieving successful therapy. Assessment of patient characteristics may help to differentiate between clients whose needs require long-term therapy or time limited therapy (Beutler, 1999). In actual practice, the length of treatment may be better determined by factors associated with the combination of psychologist, client, and treatment setting (Shapiro et al., 2003). There is also evidence that clients are not only capable of determining their length of treatment, but that length ends up being similar to that found in studies considering treatment length in naturalistic settings (Carey, 2005; Carey & Mullan, 2007). Flexibility, rather than external control of therapy length is thus an important determinant to therapeutic success according to some sources.

Research to date has provided some insight into what might be influencing factors distinguishing between what, if any, effect a time limit of psychotherapy has on clients. For example, a study found that perfectionism in clients presenting for treatment of depression had important implications for treatment (Blatt et al., 1998). Specifically, pre-treatment levels of perfectionism moderated the effect of a time limit of 16 sessions through a negative effect in the latter half of the treatment process. Clients who scored higher on perfectionism were disrupted by the imposition of an arbitrary and abrupt termination to their therapy. The complexity of a client's presentation may also impact upon therapy conducted in limited amounts of time. Instigating change in disorders that are not identifiable through a core feature is more challenging and less amenable to brief CBT (Key & Craske, 2002). Similarly, Axis II disorders are less appropriate for brief CBT interactions (Key & Craske, 2002). Complexity can be defined as "[t]he degree to which the problem is narrow (i.e., specific phobia, pure panic disorder) versus broad (personality disorder, dual diagnosis)" (Groth-Marnat et al., 2001, p. 117), and the same authors suggest that complexity is a factor that treatment needs to be tailored to because of its ability to predict treatment outcome. Having a clear conceptualisation of the client's problem in therapy is necessary for brief CBT to be effective, while a less specific or comorbid presentation could render brief approaches disadvantageous (Hazlett-Stevens & Craske, 2002). In addition to complexity, it has been suggested that

severity and chronicity are indicators that a brief model of therapy is not appropriate (Scott, 2004), which was also the opinion of a group of psychologists treating clients through BOMHC with chronic symptoms (Barr & Pegg, 2006). While external stressful factors in a client's life are always likely to impede on the process of therapy, these become particularly problematic when time is limited (Key & Craske, 2002).

The therapeutic alliance in time limited therapy

The therapeutic relationship has been demonstrated to be a key ingredient for successful psychotherapy (e.g., Baldwin, Wampold, & Imel, 2007; Horvarth, 2001). The extent to which the therapeutic alliance contributes to variance in outcome has been found to range between 7% (Horvarth & Symonds, 1991) and 30% (Wampold, 2001). Rogers (1957) explains the therapeutic relationship as something which is an enhanced version of the type of engagement which might be found elsewhere in a person's life:

[T]he therapeutic relationship is seen as a heightening of the constructive qualities which often exist in part in other relationships, and an extension through time of qualities which in other relationships tend at best to be momentary. (p. 101)

Given the importance of the alliance, potential impacts on the therapeutic alliance due to time constraints are therefore imperative to understand. In a study considering the interaction between the alliance and time limits, it was found that the therapeutic alliance was not enhanced by the use of explicit time limits in therapy (Kamin, Garske, Sawyer, & Rawson, 1993). Flexibility has been shown to be a positive contributor to the development of the therapeutic alliance (Ackerman & Hilsenroth, 2003), which suggests that the limited flexibility that comes with time limits may be problematic. The goal oriented and time limited nature of therapy under systems of managed care "runs the risk of becoming increasingly instrumental" (Cushman & Gilford, 2000, p. 991) if there is less scope for exploring the therapeutic alliance.

The therapeutic alliance may be particularly important for clients presenting with complex treatment needs and be undermined by brief timeframes of treatment. In referring to treatment for complexly traumatised clients, the following is recommended regarding the therapeutic alliance; "Far from being the nonspecific placebo effect or inert ingredient suggested by some advocates of short-term therapy, the relationship

between client and therapist can be seen as directly and specifically curative” (Briere & Scott, 2006, p. 55). The counter-conditioning (re-experiencing negative feelings in the context of a positive relationship) that can occur due to the therapeutic relationship is able to address emotional responses in a way that briefer treatment approaches cannot. The therapeutic relationship can thus be said to be a powerful tool in therapy at least with particular types of problems and therapeutic approaches. One of the reasons for the importance of the relationship is that it can serve the function of interpersonal triggers and allow clients to be exposed and experience disparity and counter-conditioning (Briere & Scott, 2006). For complex clients, the therapeutic alliance may therefore have an even more important role than for clients with more straightforward presentations.

Time limits may be accompanied by other types of limitations that have implications for the outcome of therapy. Herron et al. (1994) argue that time limits may leave clients with the expectation that they should recover in the given timeframe. In a study on patients’ perceptions on entitlement to time, Pollock and Grime (2002) found that patients took on time pressure, expressed anxiety about time, and reported being limited in their sense of freedom in discussing their problems. This increased management and rationing of time by clients raises issues about what might be limited for clients of psychotherapeutic services when working in time limits. A survey of a group of patients receiving psychotherapy through the BOMHC initiative found that the main concern expressed was the limited number of sessions available (Barr & Pegg, 2006), so there is some evidence to suggest that clients may be impacted by the use of time limits.

Literature regarding the impact of time limitation on the therapeutic process has been considered in this section. It has been shown that there are many justifications for limiting the number of sessions in therapy, and these broadly relate to those on the grounds of theoretical orientation and in relation to the effect of time on the speed of therapy. A broader consideration of the role of time has shown that limiting time is established as a way to change certain types of experience such as motivation. The following section will consider the context within which time limitation usually occurs in contemporary Australian practice; under the management of a third party provider.

SECTION II: THE EXTERNAL IMPOSITION OF TIME LIMITS BY THIRD PARTY PAYERS

Throughout the development of psychotherapy in the 20th century, health organisations and government departments have become involved in the distribution of psychological services. The form this takes in Australia is Government and non-Government third parties – through their funding mechanisms – controlling the permitted number of sessions. This section will consider the influence of the external management of psychotherapy with a particular focus on the use of time limits.

Third Party Funding of Psychological Services

The push towards briefer psychological interventions operates within a broader context of ‘managerialism’. The management of knowledge and power was initially identified by Foucault (1979) as a strategy to govern populations through the need for self-management, and is evident in the healthcare system (Gilbert, 2005). The most notable influence on psychology in this regard has been through third party providers, sometimes known as ‘managed care’.

Managed care has had a significant impact on the research and practice of psychotherapy (Lambert & Ogles, 2004; Sanchez & Turner, 2003). Bor et al. (2004) describe the most important influence of managed care as being that “the preconditions for and the extent of therapy is neither likely to be determined by the practitioner nor by someone directly involved with the client” (p. 186). It is a system for controlling health care costs, whereby control is exercised from forces external to the treating practitioner. Managed care in the US began in 1973 and is currently the main vehicle for the delivery of mental health care (Cushman & Gilford, 2000; Herron et al., 1994; Sanchez & Turner, 2003). Australian psychological services do not operate under the same degree of managed care despite some similarities such as session limits and the use of “gatekeepers” to the provision of services³. The Australian context will be referred to in more detail further on.

From the perspective of third party funding of psychological services, Mander (2003) suggests that time-limited therapy does not necessarily constitute a one-off therapeutic

³ For example, General Practitioners need to refer patients to a psychologist in order for the patient to be eligible for a Medicare rebate.

encounter. Rather, each time-limited therapy block forms a specific focus whereby therapy becomes “a series of necessary repair jobs during the ups and downs of life” (Mander, 2003, p. 489). Mander’s suggestion appears to be forming the basis of a theoretical approach to effectively distribute psychological services, rather than justifying a rationing of resources to clients who would benefit more if time limited therapy was not utilised. It can thus be acknowledged that the use of a time limit might not only impact on the resources of psychotherapy, but may also have a role in encouraging clients to utilise services throughout their lives in a problem-focused format. Of course, like many other facets of psychotherapy, this approach is not likely to suit every type of client presenting for therapy.

There are other ways to increase the efficiency of therapy besides the minimisation and capping of therapeutic length. For example, working closely with emotion can accelerate therapy (Magnavita, 2006), while group therapy and other ways that minimise therapist input such as self-help (e.g., bibliotherapy) and computer-assisted therapy programs can reduce the resources needed for therapy (Hazlett-Stevens & Craske, 2002). There is more room for understanding the efficacy of bibliotherapy (Jack & Ronan, 2008; Redding, Herbert, Forman, & Gaudiano, 2008), although there is evidence that points to its therapeutic effectiveness (e.g., Den Boer, Wiersma, & Van Den Bosch, 2004; Gregory, Canning, Lee, & Wise, 2004). Use of minimal interventions may be unsuited to patients who expect to understand the ‘cause’ of their psychological distress (Macdonald, Mead, Bower, Richards, & Lovell, 2007), which has been identified as an important expectation from clients towards psychotherapy (Lewis, 1995). These methods of increasing efficiency may also be used as a way around the potential impediment of a time limit.

Issues of access

Externally managing the provision of psychological services is argued by some to increase access to these services yet argued by others that certain groups of people are disadvantaged in terms of access. For example, limiting psychological services is disadvantageous to ethnic minorities from lower socioeconomic groups because their circumstances are more likely to be associated with higher and more chronic levels of mental illness (La Roche & Turner, 2002). Clients with complex presentations may also be disadvantaged by the restrictions of third party providers (Sanchez & Turner, 2003).

The problem with the equitable distribution of psychological services may be related to its aim for the “lowest common denominator rather than to the best possible treatment” (Cantor & Fuentes, 2008, p. 643). Even to reach functioning in line with ‘necessity’, more resources may be required for certain groups of people (Herron et al., 1994), indicating that different resources are required for different groups in order to achieve the same level of access and equity. However, access may be improved through limitations such as time limits because there is greater scope to provide access to a greater number of people (Sanchez & Turner, 2003). Shapiro et al. (2003) suggest that the population as a whole may benefit from time limited psychotherapy;

From a utilitarian perspective of seeking the greatest good for the greatest number, placing limits on the number of sessions taken up by individual patients would appear to promise greater aggregate health gain within the population served. (p. 213)

While overall access may be improved through managed care type arrangements, certain groups of individuals such as those already marginalised and/or those with more severe or complex presentations may not experience this as access to appropriate psychological care.

The effectiveness of third party provider systems

There is conflicting evidence regarding how effective third party systems of psychotherapy provision are at achieving adequate outcomes. In a study testing the hypothesis that the introduction of managed care to a children’s outpatient service would result in the use of fewer sessions and less improvement in clinical outcomes, it was found that while treatment length reduced, clinical outcomes did not change (Armbruster, Sukhodolsky, & Michalsen, 2004). However, in a large effectiveness study, Seligman (1995) found that there were poorer outcomes associated with therapy delivered in managed care settings with time limitations.

How psychological problems and adequate outcomes are defined will impact upon how third party providers structure their aims and evaluate their outcomes. The very way in which psychological disorders and treatments are conceptualised may be in favour of “behavioral descriptions of patient symptoms, treatment formulations focused on symptom relief, psychotropic medication, and concrete, opportunistic, directive

interventions within a radically short-term format” (Cushman & Gilford, 2000, p. 986). This leaves little scope for understanding issues such as quality of life and long-term functioning (Halpern, 1999). Managed care companies can also be seen as a source of ‘invisible rationing’ (Miller, 1996c), referring to a form of subtle substitution, introduced by managed care companies, that replaces longer term and unlimited therapy for brief therapy with the intention of rationing their services. Miller (1996b) performs a critical review of research supporting time limitation, concluding that it has been erroneously interpreted and that time limits are simply a way to allocate resources that are limited. From this, Miller (1996a) proposed that if services are to be rationed in the manner they currently are by Health Management Organisations (in the US context), then for ethical and liability reasons, it is necessary to inform clients of the economic, not clinical, nature of this rationing. Lambert and Ogles (2004) acknowledge that managed care has brought with it a business attitude to psychotherapy that aims to reduce the cost of mental health services. One of the implications of reducing psychotherapy costs is that the service becomes limited in some way - most notably for the present research through the implementation of a limit on the number of sessions funded for treatment.

Psychology has the potential to act within the boundaries of three different types of approaches to mental healthcare: ‘necessity’, ‘improvement’, and ‘potentiality’ (Herron et al., 1994). Herron et al. propose that the managed care scenario endorses a level of mental healthcare in line with their concept of necessity. Here, basic adaptation and the absence of symptoms that prevent clients from functioning in their day to day lives are focussed on. In addition to psychotherapy, psychological assessment is also ‘rationed’ through managed care (Beutler, 1999; Stout & Cook, 1999), though targeted assessment may in fact increase the cost effectiveness of therapy (Groth-Marnat, 1999). Separating assessment from treatment is problematic because it does not allow therapists to integrate the results from assessment into their intervention (Beutler, 1999). One of the gaps between the definitions of quality care provided by psychologists and managed care companies may relate to the focus on Axis I diagnoses by managed care companies but the frequent encounter of Axis I plus Axis II presentations in clinical practice, rendering treatment more complex than that defined by the provider of funding (Rupert & Baird, 2004). How much assessment should be conducted when time is limited is an

important question (Carey, Rickwood, & Baker, 2009), but it is suggested, for example in the Better Access initiative, that it not go beyond the initial consultation (Littlefield & Giese, 2008).

The cost-effectiveness of psychotherapy

The introduction of managed care to psychology brought with it a notion of the necessity for psychotherapy to be cost-effective (Broskowski, 1991). A focus on cost necessarily involves evaluations of the effectiveness of services and introduces the possibility of cost-motivated compromises to services. How the cost-effectiveness of psychotherapy is determined will depend on the criteria for assessing the effectiveness of its outcomes (Halpern, 1999). One of the ways used to cut the cost of psychotherapy is to put some type of limit on its availability (Sanchez & Turner, 2003) and identify target areas for treatment (Herron et al., 1994). However, there are two arguments which question the applicability of short-term cost-effectiveness to psychotherapy practice.

Firstly, there is a need to distinguish between long-term and short-term mental health care costs, and who pays for these costs. If providing a limited number of sessions to clients is a form of tailoring a cost-effective approach to providing therapy, then the question remains as to what the short and long-term implications of this will be. Docherty (1999) suggests that a multiyear responsibility for individual clients could accommodate a more long-term, and hence overall effective, model for assessing the cost effectiveness of psychotherapy. If, for example, cost effectiveness is measured on the basis of the entire life of a client as opposed to a discreet period of the life of the client, it is likely that a clearer perspective of cost effectiveness can be gained. So although time limited therapy may have the potential to reduce the immediate cost of providing psychotherapy, the long-term cost outcome may be different.

Secondly, there is an interaction between physical health and psychological well-being (Arnetz, 1996; Lyons & Chamberlain, 2006). Medical cost offset studies suggest that medical and psychological needs interact in such a way that those who receive psychological interventions in fact reduce their need for medical interventions more than those who do not receive psychological interventions (Chiles & Lambert, 1999; Lambert & Ogles, 2004). Working within this model, it may be that it is not only

beneficial, but financially viable, to ensure that every person receives adequate access to mental health services. However, ascertaining medical offsets is complex and therefore needs to be interpreted cautiously (Fraser, 1996).

The External Management of Psychologists

The external management of psychotherapy means that a certain amount of control over psychotherapy comes from sources outside of the treating psychologist. Losing therapeutic autonomy may have implications for service delivery; for example Slife (2004) suggests the “problem is that the economic and medical tail is now wagging the therapeutic dog” (p. 44). Involvement of a third party that manages treatment may be the main concern relating to the quality of treatment that can be provided in this system (Sanchez & Turner, 2003). A survey conducted in the US showed that the most highly ranked source of stress relating to managed care was the external constraints on services (Rupert & Baird, 2004).

There have been several studies investigating the opinions of psychologists on working in managed care type settings. In a survey of a large sample of psychologists in the US, it was revealed that 79% of the 15,918 respondents reported the impact of managed care to be negative (Phelps, Eisman, & Kohout, 1998). A more detailed survey of a smaller number of US psychologists found that managed care impacted on the ways in which treatment was provided (Murphy, DeBernardo, & Shoemaker, 1998). This study also showed that limiting the amount of time interfered to a great extent with the treatment that could be provided for 80% of participants, demonstrating that a time limit is commonly experienced as an interferer to the provision of treatment perceived as effective. Working in managed care type settings may therefore have an impact on the way that psychological services are delivered. A survey of a large sample of psychologists practicing in New Jersey, US, showed that higher managed care workloads were related to increased likelihood of reporting “changes in morale and professional identity and in having changed the approach to therapy” (Rothbaum, Bernstein, Haller, Phelps, & Kohout, 1998, p. 38), and nearly half of respondents in two surveys indicated a negative impact on their approach or technique from working in managed care (Rupert & Baird, 2004). However, research such as the above does not leave us in a position to understand the *processes* through which third party determined

timeframes may be experienced as different or interfering, and the present research aims to fill this gap.

Some information is also available regarding the theoretical orientations used in managed care settings. A survey of psychologists providing services through managed care in the US found that psychologists with higher workloads of managed care clients were more likely to have a CBT orientation and less likely to have a psychodynamic orientation than were participants with lower workloads of managed care clients (Rupert & Baird, 2004). It is unclear whether this may be as a result of managed care exposure or an indication of the types of psychologists more likely to work in managed care settings. Another survey in the US identified that the extent of ethical difficulties experienced when working in managed care did not relate to theoretical orientation (Murphy, DeBernardo, & Shoemaker, 1998).

Accountability in Third Party Payer Systems

The context of managed care also comes with the need for more visible accountability in the delivery of health care (Bor et al., 2004; Cushman & Gilford, 2000). External accountability has been identified as a facet of psychotherapy that has not existed until the time of managed care (Schultheis, 1998). Accountability is a benefit to the quality of psychological services, but it also involves threats to autonomy from the perspective of psychologists. The push for accountability has brought with it an increased focus on the need for evidence that particular therapeutic approaches produce meaningful outcomes (Bauer, 2007). One of the primary ways to achieve this accountability is through the objective identification of effective treatments, which has been called evidence-based practice (EBP). The move towards EBP has become important to psychology and health care systems in general (APA Presidential Task Force, 2006), however EBP and empirically supported treatments (ESTs) are not the same thing (Bauer, 2007). ESTs refer to treatments that have demonstrated efficacy as shown in an appropriate research trial, and hence involve limited external validity. The definition of EBP used by the APA and adopted by the Australian Psychological Society (APS) is “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force, 2006, p. 273). The definition therefore goes some way towards accounting for the complexity of

client-practitioner interactions and the variance in outcome that is currently unaccounted for.

While there has been a push for evidence that supports the benefit of psychotherapy in order to make it accountable, there is debate over how this evidence should be constituted and doubt by some that the complexity of therapeutic interactions could be understood in the traditionally manualised and controlled framework that forms the criteria for appropriate evidence (Halpern, 1999). Yet despite this push for EBP, time limits themselves do not have evidence to support them (Carey, 2006; Carey et al., 2009; Wolgast et al., 2003).

The Australian Context

The provision of psychological services in Australia has some particularities that are unique to the system in which it operates. This section will briefly describe some key aspects of the major sources of external funding for psychotherapy in Australia that come with preset time limits. It will also consider evidence of the outcomes and uptake of these services in recent years.

Many agencies including Australian Government welfare organisations and non-Government organisations in Australia offer general and specific counselling services for clients. For example, organisations such as Centacare, Anglicare, Lifeline, and other welfare agencies will offer limited sessions of counselling for general reasons or specific problems such as gambling, domestic violence, and alcohol abuse. Time limits are engaged within these settings due to a lack of resources and a subsequent rationing of the services available. Victim related services such as Victims of Crime and the Department of Veterans' Affairs also fund psychotherapy to a limited extent. Another setting familiar with the use of time limits in therapy is Employee Assistance Programs (EAPs). Here, companies pay EAP providers for a limit of sessions per employee, most commonly three or six, occasionally the extremes of one or 10. The number of sessions offered through EAPs varies according to the employer, and in some cases because of the nature of the job⁴. Initial adoption for the use of EAPs by Australian organisations was found to be linked with reactions to adverse workplace conditions, but sustained

⁴ For example, members of the Police Force are offered considerably more sessions than the average employee in Australia.

because of the outcomes that can be achieved through EAPs (Kirk, 2005). Employer funding of psychological services demonstrates that there is the recognition of benefit in providing psychotherapy over and above that which the individual may experience. Insurance companies will also manage the extent and sometimes the type of psychotherapy used when funding compensation based clients for psychotherapy.

Mental Health has been increasingly recognised as an important aspect of the nation's health, reflected through such strategies as the National Action Plan on Mental Health 2006-2011 (COAG, 2006). There are two Australian Government funded initiatives which have significantly changed the delivery and availability of psychological services; Medicare and Better Outcomes in Mental Health. The following sections will address the aims and outcomes associated with these initiatives.

Australian Government funding for psychological services

For the first time since its inception, Medicare began funding for psychological services in September 2004 through a program called Enhanced Primary Care (EPC). Funding allowed for up to five⁵ 25 minute sessions⁶ with a registered psychologist. Following EPC, the Better Access initiative – also funded through Medicare - was introduced in November 2006. Funding for psychological services by the Australian Government has been described as a major milestone for the profession of psychology (Littlefield & Giese, 2008). At present, an in-depth understanding as to the effectiveness of treatment provided by psychologists through the Better Access initiative is limited (Whiteford, Doessel, & Sheridan, 2008), although the significant uptake of this program provides the opportunity for broad based effectiveness research (Carey et al., 2009). The Better Access initiative funds an initial set of six sessions, followed by a further six sessions after a review from a General Practitioner per calendar year. In exceptional circumstances, an additional six sessions will be funded. Use of a calendar year limit rather than a lifetime limit has been described as a more feasible solution to the limited amount of funding available for mental health care (Herron et al., 1994). The intention of this limitation was to allow the use of short-term psychological strategies that have

⁵ This cap on the number of sessions was shared with other health professionals, such as physiotherapists and podiatrists. Thus, if a patient had used these other health care professionals in the course of the year the available funding for psychotherapy would be less.

⁶ Twenty-five minutes is half the usual 50 minute 'therapeutic hour', although there is little evidence to support the use of such timeframes (Carey, 2005).

been demonstrated to work with common mental disorders (Whiteford et al., 2008), however Carey et al. (2009) suggest that these three potential groups of six sessions will result in the over-servicing of some patients and the drastic under-servicing of others. The psychological services subsidised by Better Access are “embedded within the ethos of evidence-based practice” (Carey et al., 2009, p. 11), as there is a focus on psychoeducation, cognitive interventions, and IPT.

Better Outcomes in Mental Health (BOMHC) was introduced by the Australian Government in July 2001, and formed the foundations for the structure of funding in the Better Access initiative. BOMHC offers two groups of six sessions, although the funding available in divisions of General Practice will influence how much of this allowance may be accessible at different times of the financial year. The way in which BOMHC is structured has lent itself to the increased access by the public to evidence-based mental health care (Pirkis et al., 2004).

Utilisation of Australian Government initiatives

There has been a significant uptake of mental health services funded by the Australian Government. Nearly eight million mental health services have been subsidised by Medicare up until April 2009 (DoHA, 2009a). A survey of a sample of clients receiving treatment through Better Access showed that 90% of clients reported feeling either significant or very significant improvement as a result of their treatment and utilised an average of nine sessions (Giese, Lindner, Forsyth, & Lovelock, 2008). Thirty-eight percent received between one and six sessions, while 49% received between seven and 12 sessions, and 13% received between 13 and 18 sessions (Giese et al., 2008). The average of nine sessions was therefore below the limit of 12 sessions, but higher than the average uptake shown in other naturalistic studies (e.g., Carey, 2006; Hansen et al., 2002). It is unclear why this average is higher; two potential reasons could be that clients are being over-serviced as Carey et al. (2009) suggest may happen, or perhaps the time limitation is serving as a more useful guide to how much time psychotherapy should last from the perspective of clients. An analysis of uptake through the Central Sydney division of BOMHC showed that the average number of sessions utilised was five (Barr & Pegg, 2006), which is similar to uptake shown in the above mentioned naturalistic studies. Uptake of BOMHC is therefore on average lower than uptake of the Better Access initiative, although it is possible that this may be because of the limited

funding available through this scheme that sometimes meant the limit of 12 sessions was not accessible.

These programs and the Australian Government initiatives described above are the main groups which will be referred to in further chapters and encompass the broad definition of third party funding of psychological services for the purposes of this thesis. Overall, the number of patients presenting to General Practitioners in Australia with psychological problems has increased from 9,683/100,000 encounters to 11,557/100,000 encounters between 1990-1991 and 2000-2002 (Harrison & Britt, 2004). This increase is prior to the introduction of BOMHC and is therefore indicative of a trend external to funding changes. Over the same time 10-year period statistics have shown a 50% increase in the treatment of psychological problems with psychotherapeutic treatments (Harrison & Britt, 2004). There is thus a significant trend towards the utilisation of psychotherapy by the Australian public, and this is most likely to occur in the context of a third party provider.

SUMMARY AND RESEARCH QUESTIONS

The literature reviewed thus far leaves several important questions unanswered. While there is information regarding time limited psychotherapy, there is a lack of research addressing the reality of these time limits in practice. It has been shown that there are both theoretical and financial justifications for time limits, but it remains unknown what actually happens when therapy is delivered in this context from the perspective of those psychologists providing it. The literature does not address the issue of how psychologists as practitioners are impacted by time limits, whether it affects their therapy, and how this might be the case. Whilst there exists a broad understanding of time limits in therapy and we know about the management of psychological services, we do not know about the experiential side of therapists when these two situations combine. Time limits are often used in randomised controlled trials designed to assess the efficacy of particular treatments in controlled settings. Time limits used in this context are a by-product of the need to have methodological control over variables, which includes how much time is used (Koss & Shiang, 1994). However, when considering time limits in naturalistic settings where clients are more complex and

treatment is more eclectic, less is known. The perspective of psychologists has also been left out of the literature.

Despite the identified importance of evidence supporting psychotherapeutic effectiveness, researching psychotherapy is difficult given the complexity of the therapeutic process (Andrews, 2001; Lerner, 2001) and its unclear relation to outcomes (Krause & Lutz, 2009; Stiles, 2009). Only particular treatments conform to the structure of a therapy that can be subjected to the type of testing that constitutes evidence. Evidence for therapy has traditionally been derived from research making some kind of assessment as to the clinical utility of particular treatments on carefully selected patients with a specific disorder (Halpern, 1999). Whether and by how much therapy works is a contentious issue and one that has had significant research devoted to it (e.g., Eysenck, 1952; Seligman, 1995; Smith & Glass, 1977; Westen & Morrison, 2001). Whilst today the evaluation of therapy effectiveness is essential to its very existence because of the accountability needed to ensure funding, the objectivity of evaluating therapy has failed to evolve into a firmly established tradition within the field of psychology. Many debates exist on the legitimacy and methods of evaluating treatment interventions (e.g., Gaskovski, 1999; Lambert & Ogles, 2004; Lerner, 2001; Seligman, 1995; Westen & Morrison, 2001). Throughout psychotherapy evaluation history there has been a tendency to assess therapy through the lens of efficacy, and the scientist-practitioner model that has become dominant has brought with it a focus on experimental and clinical trial research (Lerner, 2001). However, there has been a push from proponents of effectiveness research to accompany empirical validation with the demonstration of real effectiveness in the clinical setting (e.g., King, 1998). The difference between efficacy and effectiveness becomes an important issue in this light (Seligman, 1995). In order to establish the efficacy of a treatment, experimental control is needed. This is a necessary evil in order to make the scientific method applicable to psychotherapy; as extraneous variables need to be excluded. In reality, this means that the evidence thus demonstrated cannot be applied to clients with, for example, a comorbid presentation that is not accounted for in the original research. Research that claims a particular disorder can be successfully treated in a certain way and within a particular time-frame (e.g., Bower et al., 2000) is therefore not inherently applicable to client presentations in the 'real world' (Briere & Scott, 2006). However, the reality of psychological service

provision may mean that empirical evidence is not the only driver to the use of specific techniques. As Andrews (2001) suggests, "...new techniques often are used (and are effective) in therapeutic practice long before they are empirically investigated or proven" (p. 113).

Furthermore, while the need for a scientific understanding of therapy is warranted, consideration of the 'art' that clinicians utilise is also an important consideration (Gaskovski, 1999). Some question the notion that therapy can be reduced to an objective practice, and that the "idea of pure therapeutic systems that produce unclouded effects is largely a fantasy" (Andrews, 2001, p. 112). The claim of science is not necessary for clinicians to have a position of authority and supply benefit to clients (Leahey, 2000). Despite this, opinions regarding EBP are diverse and in some cases strong. For example, Doessel, Williams, & Nolan (2008) suggest that using therapy without scientific evidence is akin in physical medicine to "giving an insulin injection for arthritis instead of a cortisone injection because the practitioner believes his/her choice of injection works better" (p. 65). Understanding therapy by considering responsive processes may be a more logical way to assess how successful therapy is achieved than focusing on the idea of 'active ingredients' (Stiles & Shapiro, 1995). Research that does not allow for the complexities and interpersonal processes involved in therapy may give a misleading picture, as therapy cannot be reduced to a single technique (Larner, 2001).

In order to understand the impact of time limits on therapeutic practice and client outcomes, this study has focussed on the perspectives of practising psychologists as they have reflected upon their practice within this research context. Such an approach is justified for several reasons: Much of the literature on treatment outcomes has been client-focussed, with less attention being paid to the perspectives of practising psychologists. In addition, the decision to ask psychologists about hypothetical, rather than actual, practice is warranted, since the reported behaviour of healthcare providers has been found to correspond closely with actual behaviour (Eccles et al., 2006); in other words, what these psychologists *say* about their practice is likely to reflect what they actually *do*. And finally, the value of naturalistic research that examines client-practitioner interactions *in situ* is well-established, yet research that is conducted 'off-line', as it were, provides a different, but equally valuable, perspective. This is because

psychologists are able to consider their therapy outside of the context of a particular client, providing a meta-understanding of the context of time limited therapy occurring within a third-party referral context.

The frame of this thesis is therefore how psychologists adapt to providing therapy within third party payer systems with particular attention to imposed limits on the number of sessions. This is therefore the basis for the research questions of the present study.

1. What are psychologists' perceptions of providing time limited therapy in the context of third party payer referrals?
2. What are the perceived impacts on therapeutic processes?
3. What are the perceived impacts on therapeutic outcome?

In order to answer these research questions the following needs to be done. Firstly, an in-depth understanding of psychologists' perceptions needs to be attained, which is most readily suited to a qualitative approach. These research questions also raise the hypothesis of whether time limited treatment is different from treatment without a time limit, and this will be addressed through the development of four conditions in a questionnaire. The four conditions will not only account for temporal conditions but will also account for the complexity of clients in order to ascertain the extent to which this particular client factor may account for the influence of a time limit.

These are important practical questions for the field of psychology to understand given the push for accountability in the provision of psychological services. The present research will aim to fill the gap of knowledge regarding the provision of third party determined time limited therapy and provide an exploratory understanding of the issues involved for Australian practising psychologists in this context. The following chapter will outline the methods undertaken in achieving these aims.

CHAPTER 3: METHODOLOGY

INTRODUCTION

This chapter describes the methodology used to understand the experiences of psychologists working in third party determined time limits, as well as their perceptions of therapeutic process and outcome in this context. The way that research questions were conceptualised led to the use of a mixed methods design that allowed for a deep understanding, as well as the ability to know the extent to which this understanding could be generalised. The research sought to find out information from the perspective of participants, so a qualitative design was warranted. However, the research also aimed to understand, and to be able to quantify, the extent to which psychologists might see differences between time limited and time unlimited work. Therefore, the overall approach is mixed methods.

This chapter will outline the methodology for an interview and questionnaire and justify the mixed methods approach that has been taken. In order to understand the methods used, the philosophical assumptions behind the research design will firstly be discussed and result in the identification of a specific theoretical position to the development of knowledge. This chapter will then go on to outline the research design, methods undertaken, the representation of data, and the quality of research methods.

THEORETICAL CONSIDERATIONS

All research is conducted under certain assumptions, including epistemological and ontological ones. It is important to consider the philosophical assumptions behind research methodology (Crotty, 1998; Ponterotto, 2005), because it influences the way research questions are framed, the way data is collected, and the way data is interpreted. This section will consider the assumptions underpinning the present research and identify the theoretical framework as interpretivist.

Theoretical Framework

In considering the perspectives of psychologists on third party determined time limits, it occurred to me that the process and perceived outcomes of psychotherapy in this context may be different to other contexts of psychotherapy. Because I was interested in how psychologists made sense of their therapy in terms of the inputs, processes, and outcomes involved, an interpretive study using interviews and questionnaires with vignettes was considered the most appropriate theoretical framework.

The theoretical framework of interpretivism formed part of a reaction to positivism's attempt to understand human behaviour in scientific terms (Dilthey, 1976), and can be seen as a shift away from objectivism and the positivist paradigm (Ponterotto, 2005). Working within an interpretivist framework will allow me to ascertain an understanding of third party determined time limits from the perspective of participants without imposing a pre-determined framework upon them. The theoretical perspective of interpretivism is linked with the epistemology of constructionism, hence I assume that knowledge is not separate from its interpretation (Crotty, 1998). This theoretical framework is, like other frameworks, accompanied with limitations, which include my own subjectivity influencing the interpretation of findings. This limitation will be addressed in the section of this chapter on research quality.

An interpretive focus was also chosen for the research because there exists no deep understanding of the research questions available in the literature and its key dimensions remain unknown, while the literature simultaneously points to the significance of answering such questions. Therapy itself has been acknowledged as a subjective and complicated phenomenon (e.g., Lambert & Baldwin, 2009). While movements towards evidence-based practice have attempted to pin down the essential elements of therapy, subjectivity still largely encircles the discipline's definition.

As therapists we know, subjectively, that the process of psychotherapy is constituted by a multiplicity of interactions, tentative invitations to change, mutual construction of new and old meanings, exploration of difference, resources, creativities, fears and blocks, feedback from previous communications, and so on into an infinity of complexity for which we have some technical description and some explanation, but

much of which still resides outside our capacity to capture it and pin it down. (Jones, 2003, p. 350)

If therapy, and its processes, are said to be partially unique to both therapists, clients, and their interactions, then in researching time limited therapy I needed to choose a theoretical framework that was appropriate for these multiple interactions. Therefore, the type of data that will allow the present research question to be answered must be able to account for this complexity, indicating the appropriateness of an interpretivist framework.

Theoretical Considerations in Design

The design of this study was ‘mixed methods’, and used both qualitative and quantitative approaches to data collection, analysis, and representation. Although quantitative research is often associated with a positivist theoretical perspective, “quantification is by no means ruled out within non-positivist research” (Crotty, 1998, p. 15). The assumptions embedded in any individual research method, such as epistemological and ontological assumptions, can be accounted for in mixed methods designs because of the combination of different data collection techniques; mixed methods can therefore be considered more scientific (Slife & Gantt, 1999). Mixed methods designs “rooted in diverse philosophical paradigms” (Haverkamp, Morrow, & Ponterotto, 2005, p. 123) are in an ideal position to enhance understandings of complex phenomena.

The use of a qualitative component in this research involves epistemological assumptions also. Qualitative methodology has a rich history in social research. The application of qualitative methodologies to psychological research, while more recent (Rennie, Watson, & Monteiro, 2002; Slife & Gantt, 1999), has undergone extensive consideration (e.g., Elliott, Fischer, & Rennie, 1999; Morrow, 2005; Ponterotto, 2005; Smith, 1995). One of the key issues to arise in the literature on the use of qualitative research methods to psychology is the application of what has been called postpositivism to an essentially constructivist or interpretivist paradigm (Ponterotto, 2005). Examples of “postpositivizing” qualitative research methods include:

...the use of semi-structured interviews that are literature driven, detailed, and standard from participant to participant; the selection of

the complete sample before the study rather than the incorporation of theoretical sampling; the establishment of theme categories before the study and the attempt to code interview data into these categories; or the calculation of the number of participants who are represented in each theme. (Ponterotto, 2005, p. 127)

To address the potential for such criticisms, the present research aims to work in a qualitative framework simpatico with the epistemological assumptions involved. Therefore, use of parallel criteria will not be used as an estimation of the trustworthiness of this research.

The present research draws on the fundamentals of qualitative research proposed by such well-known authors as Silverman (2006) and Miles & Huberman (1994), as well as considering more contemporary and specifically psychological references such as Morrow (2005), Braun and Clarke (2006), and Polkinghorne (2005). In discussing the application of qualitative research to studying psychotherapy process, Hill and Lambert (2004) state that “[u]nfortunately, each researcher seems to use a slightly different method, making it difficult even to count the number of extant methods [of qualitative research]” (p. 102). The lack of order in qualitative research therefore means that the approach taken in the present research was inspired by previous researchers and theorists but not strictly based upon a particular frame of reference⁷.

The social sciences have traditionally been engaged in the use of multiple research methods; however the discipline of psychology has been slow to adopt qualitative and mixed methods research (Haverkamp et al., 2005). Slife (2004) suggests that psychology has moved away from the theoretical pluralism that accompanies the social sciences in order to benefit from the economic advantages of being accountable. Producing evidence in the form of randomised controlled trials, for example, increases the accountability of psychotherapy (Lambert, Garfield, & Bergin, 2004). Reliance on the type of information produced in such studies is problematic to the development of understanding psychotherapy (Bohart, O’Hara, & Leitner, 1998), but psychology research is in the process of shifting towards a more balanced view that includes mixed

⁷ An alternative qualitative approach that would have been appropriate for the present topic is consensual qualitative research (Hill, Thompson, & Williams, 1997); however the requirement for a team of researchers making decisions by consensus renders it inapplicable to the requirement of independent research for a PhD.

methods approaches (Ponterotto, 2005). There is a growing awareness of the value of qualitative research, and Thomas et al. (2004) suggest that qualitative research can be accompanied by research trials to inform systematic reviews; previously the domain of quantitative research only. The discipline of psychology has thus experienced a paradigm shift to account for the type of knowledge that qualitative and mixed methods research can deliver (Ponterotto, 2005; Rennie et al., 2002).

RESEARCH DESIGN

A mixed methods research design was used to answer the present research questions. The design draws on semi-structured interviews as well as a questionnaire that utilises both quantitative and qualitative methodology. This section will describe the research design that was used.

Why This Study is Suited to a Mixed Methods Design

I initially believed that the research phenomenon (time limits used in psychological therapy) would induce frustration in psychologists, while increasing both psychologists' and clients' motivation. I included questions regarding difference of practice mostly as a sideline, and this was not the focus of my research questions. I expected different advantages and disadvantages to emerge, and I also suspected that issues would arise through the research process that were not pre-empted. This was largely my reason for including the open-ended qualitative research methodology, as I felt that to focus on specific quantitative hypotheses would take away from the possibility of uncovering phenomena not contemplated. Use of a mixed methods design was therefore ideally suited to the types of questions I was asking. The overall design is conceptualised in Table 3.1.

Table 3.1. *Data types in interview and questionnaire*

		Data Type	
		Quantitative	Qualitative
Data Collection Technique	Interview		√
	Questionnaire	√	√

This research uses both qualitative and quantitative methodologies. The interview is semi-structured, and hence is entirely qualitative. The interview was largely exploratory in nature, while the questionnaire was hypothesis testing as well as exploratory. The benefits of utilising a mix of methods in research is increasingly being recognised (Onwuegbuzie & Leech, 2005), and a mix of qualitative and quantitative methods can help provide even more understanding of the issues at hand (Rao & Woolcock, 2004). The perspective of pragmatism allows for the different epistemological and theoretical underpinnings of qualitative and quantitative research to coexist (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005). Qualitative research is aided by quantitative because “[d]uring analysis quantitative data can help by showing the generality of specific observations, correcting the “holistic fallacy” (monolithic judgments about a case), and verifying or casting new light on qualitative findings” (Miles & Huberman, 1994, p. 41). Mixing qualitative and quantitative approaches can therefore be seen as a way to understand the generalisability of qualitative findings as well as providing additional information that may inform the interpretation of qualitative findings. Similarly, qualitative findings aid quantitative data through an in-depth appreciation of the patterns that quantitative data suggests. Silverman (2006) suggests that of three main ways to combine qualitative and quantitative research, one is “engaging in a qualitative study which uses quantitative data to locate the results in a broader context” (p. 48). The present research attempts to adopt and apply this approach.

The interview stage of this project can largely be seen as inductive in nature, as it sought to develop an understanding from the bottom up. The questionnaires, however, are deductive in nature and attempt to test the hypothesis that time limited therapy will be perceived to be approached differently to time unlimited therapy, and that this difference is more pronounced for complex client presentations. The questionnaire also uses qualitative data collection techniques. Information from the questionnaire aims to provide triangulation when used in conjunction with findings obtained throughout interviews. In this way, the questionnaire has the ability to provide an indication of the validity of interpretations made in analysing the interviews.

Interview Design

The design of the interview is semi-structured and it aimed to investigate psychologists' perceptions of and experiences with working within treatment time limits in the context of third party providers. A semi-structured interview accounted for the need to approach participants with specific questions while allowing information to be gathered from the perspective of participants. An advantage of semi-structured interviewing is that it allows a more complete picture of the research phenomenon to emerge and it allows the participant to take some responsibility in the direction of the interview (Smith, 1995).

Qualitative methodology is most appropriate when research seeks deep and enriching understanding of issues (Elliott et al., 1999), and when exploring issues of process in-depth (Rao & Woolcock, 2004). Understanding of the specific process of interviewing in qualitative research was drawn from such sources as Patton (2002), who suggests that interviewing allows for an understanding of participants' perspectives while assuming that this perspective is "meaningful, knowable, and able to be made explicit" (p. 341).

The present research questions focus on an exploration of processes and perceptions, which can most readily be achieved through methods that can account for the complexities involved in understanding these phenomena. Qualitative research techniques such as interviewing, which build from the bottom up, therefore provide a means to ascertaining a type of knowledge that is from the perspective of participants.

Questionnaire Design

The questionnaire was informed by a 'repeated measures' design. A repeated measures design allowed each participant to be asked the same question in different conditions. Participants were presented with two case vignettes, and were asked to respond to

questions regarding their hypothetical therapeutic approach and predicted outcomes based upon four conditions. The conditions used were ‘time limited with a simple client’, ‘time limited with a complex client’, ‘time unlimited with a simple client’, and ‘time unlimited with a complex client’. The location of analysis is therefore *within* participants; responses to each condition of the questionnaire were compared to see the effects of time limits and complexity upon participant’s responses.

The questionnaire was developed in such a way to ensure that data could be captured that reflected the ways in which psychologists might be working differently (or not working differently) between limited and unlimited timeframes. Therefore, the extent of difference (quantitative analysis) and the type of difference (qualitative analysis) were the key factors that this questionnaire attempted to elucidate. Two case vignettes were included with presentations of ‘typical’ clients. One case was of a relatively simple client presentation and the other case represented a complex client presentation. The impact of client complexity on perceptions of time limits could thus be assessed. Complexity is an issue of relevance in the real world application of treatment provision and is introduced as a variable for this reason. There are therefore two levels of the independent variables of time (time limited and time unlimited) and complexity (simple and complex), leaving four conditions and indicating a repeated measures design as participants were required to respond to each question in each of these four conditions. Repeated measures designs increase power by reducing variability due to individual differences, and are generally thought to be an experimental method (Polgar & Thomas, 2008). This design is therefore in a position to capture information relating to *individual differences* in therapeutic approach brought about by a time limit and level of complexity.

Ethical Considerations

Approval for this research was granted from the University of Sydney Human Ethics Committee in March 2006 (Reference number: 9006). Ethical considerations included the protection of participants’ identities and informed consent. Participants in the questionnaire study were promised anonymity, which was achieved through the lack of identifying information on returned questionnaires. Participants in the interview study were promised confidentiality, which was attained through the use of pseudonyms and the protection of participant information in a locked filing cabinet. Consent forms were

signed by all interview participants and questionnaire consent was automatic with the completion and return of the questionnaire.

METHODS

This section will describe the sampling, data collection, and data analysis methods as they relate to the interview and questionnaire in the present study.

Sampling

The present methodology locates psychologists working in private practice in Australia as the relevant participants to help understand the research phenomenon. Psychologists working in private practice are ‘naturally’ working in the research setting of providing time limited services in the context of third party providers and thus have exposure and experience from which to answer the research questions. Psychologists registered with the EPC⁸ and BOMHC initiatives were thought to represent the majority of the desired population of psychologists providing time limited services through third party referrals. Purposeful sampling was used to access psychologists providing these services.

Sampling procedures overlapped between the interview and the questionnaire, and criteria to participate in both data collection techniques were the same. Participants needed to be registered psychologists in the state in which they were practicing, and to be providing therapy through time limited programs in the context of third party referrals in private practice.

Participant Recruitment

Purposeful sampling (Patton, 1990) was used to attain a sample of participants for this project. Purposeful sampling is also sometimes referred to as purposive (Merriam, 2002), and can be defined as sampling that allows for the inclusion of participants who illustrate something important about the phenomenon of interest (Silverman, 2006). In this research, I wanted to ask a specific group of psychologists about their experiences, so it was necessary to be able to sample in a way that could account for this. Sampling for the interview study was in the bounds of convenience insofar as the population for

⁸ At the time this research was designed the Better Access initiative had not yet been announced.

the interview study only included psychologists in the Sydney metropolitan area, whereas the population for the questionnaire study extended to the whole of Australia as it did not require one-on-one contact with participants.

Letters of invitation were sent to registered psychologists in Sydney for interview recruitment, and to the whole of Australia for questionnaire recruitment. Contact information about potential participants who met the selection criteria was accessed through the APS website and the websites of divisions of General Practice in Australia. Specifically, the APS website gave contact information about psychologists registered with EPC and the websites of divisions of General Practice gave information about psychologists registered to provide services through BOMHC.

There were two waves of recruitment in this study. The first wave aimed to recruit interview participants in the Sydney area until saturation was reached. A second aim of the first wave of recruitment was to also seek questionnaire participants in the Sydney area, through requesting participation in *either or both* the interview and questionnaire. The second wave of recruitment aimed to recruit questionnaire participants and extended to the whole of Australia.

In the first wave of recruitment, 167 potential participants in the Sydney area were contacted and asked to participate in either an interview or questionnaire. Potential participants received an envelope containing a letter of invitation (Appendix A), a participant information sheet for the interview (Appendix B), a participant information sheet for the questionnaire (Appendix C), a consent form (Appendix D), and a reply-paid envelope. Potential participants had the option of participating in the interview, questionnaire, or both the interview and questionnaire. Participants who consented to the interview were then contacted by phone to organise a time for the interview. Telephone numbers were accessed through the same sources that provided addresses and were publicly available. Participants who consented to the questionnaire were posted a questionnaire and a reply paid envelope for the return of the questionnaire.

The second wave of recruitment was for questionnaires only and extended to the whole of Australia. The contact information of potential participants was accessed in the same way as for the first recruitment wave; through relevant websites that contained psychologist contact details. In the second wave of recruitment, 338 potential participants were mailed a letter of invitations (Appendix E), a participant information

sheet (Appendix C), a questionnaire, and a reply paid envelope. Return of the questionnaire in the reply paid envelope was an indication of their consent to participate.

Sample Size

Interview

Sample size in qualitative research is generally small (Miles & Huberman, 1994), and this is because the number of participants is not as important when seeking to develop an understanding of a particular phenomenon (Polkinghorne, 2005). Multiple participants are needed however in order to allow for some comparison and contrast between the perspectives of different participants (Polkinghorne, 2005). The present research will compare the different perspectives of participants and specifically seek out discrepant results (Morrow, 2005). This will be discussed in further detail in the data analysis section following.

A total of 167 potential participants were contacted in the Sydney area to request participation in this wave of recruitment. Of these 167 people, 15 letters were returned to sender and 30 people returned consent forms to participate in an interview. Three of these people were not contactable or had circumstances arise that meant they could no longer participate. This left a total of 27 interview participants, and a response rate for interviews of 18%. Recruitment for interviews occurred simultaneously with questionnaires until a sufficient number of participants were attained for interviews, after which time recruitment for questionnaires only continued. Twenty-seven interviews were deemed to be a sufficient number insofar as no new ideas were being conveyed towards the end of the interview data collection⁹.

Because sampling was purposive and because a thematic analysis was taking place, ideally data collection would continue until saturation took place. When new information results in little to no change in coding this is thought to be the point at

⁹ Despite the attainment of saturation, the current study cannot claim the use of a pure grounded theory approach (Glaser & Strauss, 1967) as its methodological design. Grounded theory requires data collection and analysis to occur simultaneously, such that each new interview aims to develop on the information already attained. While some analysis occurred throughout the data collection stage, it cannot be asserted that this was to the extent that grounded theory requires.

which data saturation has been achieved (Guest, Bunce, & Johnson, 2006). The same authors determined through an experiment on data saturation that 12 interviews were deemed to be a suitable sample size, however the present study found a notable saturation to have taken place after the 22nd interview. Five more interviews had already been organised, so these also took place, leaving a total of 27 interview participants for the present study.

Questionnaire

The sample size of the questionnaire involves different considerations to that of the interview study. While sampling for the interview continued until an adequate number of participants was reached, sampling for the questionnaire continued until all accessible and eligible psychologists had been contacted in Australia to request their participation. Of the 505 psychologists contacted for participation in the questionnaire (167 in the first wave and 338 in the second wave), 30 questionnaires were returned undeliverable, leaving a total of 475 potential participants. Out of these, 85 psychologists consented to participate, which leaves an overall questionnaire response rate of 18%. The sample of 85 participants was considered to be sufficient because of the experimental nature of the repeated measures design of the questionnaire.

Procedure

This section will consider the procedures involved in the collection of data for the interviews and questionnaires. It will firstly outline the instruments used and then go on to describe the specific steps taken in the collection of data.

Instruments

Interview Guide

The interview guide was developed based on the research questions. A copy of the interview guide can be found in Appendix F. The use of an interview guide allowed for the same broad topic areas to be covered in each interview while ensuring that probing for further information could also take place (Patton, 2002).

A reflective journal was used to improve the interview guide over the course of data collection. This improvement consisted of the addition of sub-questions and the adjustment of some questions to become more open and allow the participants to

provide answers with greater depth. During the interviews, I felt that some of the demand characteristics of the interview were communicated non-verbally by particular participants and it was observed that some interview questions led participants to adopt a 'defensive positioning' (Dallos & Vetere, 2005). This led to further re-wording and re-ordering of the interview guide in order to get the most out of the interviews and minimise the potential for 'defensive positioning'. Dallos and Vetere (2005) suggest that it is important to be aware of non-verbal cues in research interviews, and as such changing the interview guide to suit this observation can be seen as an improvement in the research process.

Questions for the interview guide were developed with a view to remaining neutral while trying to uncover the research phenomenon. To achieve this, most questions were open-ended in nature. The topics covered in the interview were participant's opinions of third party determined time limits, their perceptions of their therapeutic process in this context and their perception of therapeutic outcomes. Questions regarding treatment planning and assessment were also asked. Additionally, demographic information was collected including age, years of experience, 'type' of psychologist (registered or clinical) and the services through which they provide time limited therapy.

The Questionnaire

The questionnaire tested a series of within-participant hypotheses and utilised a repeated measures design (see Appendix G for version one of the questionnaire, and Appendix H for version two of the questionnaire). Questions that were able to be quantified in some way were designed accordingly; some were a nominal level of measurement and others interval¹⁰. Questions in the questionnaire required psychologists to consider their approach to a hypothetical client with either five sessions or an unlimited number of sessions, based firstly on a simple vignette and secondly on a complex vignette. The use of vignettes to elicit psychologists' treatment or diagnostic responses has been used elsewhere (e.g., Jorm et al., 1997; Pottick, Kirk, Hsieh, & Tian, 2007).

¹⁰ Technically, the Likert scales used to collect data in this questionnaire are an ordinal level of measurement. However, it is the convention in the discipline of psychology to treat Likert data as interval rather than ordinal, and this convention is followed in the present research.

Validation of the questionnaire took place through two separate processes. Firstly, a panel of psychologists was used to obtain feedback regarding the questionnaire. Secondly, there were two different versions of the questionnaire that differed in terms of the case vignettes.

Panel of psychologists

A panel of three psychologists was used to assist in validating the questionnaire. This panel consisted of one registered and two clinical psychologists who were treating clients within various private practices in Australia, and was selected on the basis of convenience. Feedback from the panel was used to adjust questions in the questionnaire. Considerable time was spent on some questions in this process, and subsequent debate over the best way to ask questions meant that consensus was reached regarding the choice of wording. The panel of psychologists made minor changes to the case studies within the questionnaire. Feedback was mostly indicative of a need to ensure that symptoms were clearly defined and that psychologists could identify quickly with the clients presented in the cases. The 'simple' and 'complex' cases were also discussed and agreed as to what should determine the simplicity/complexity of the cases. The cover page of the questionnaire was also altered through discussion with the panel of psychologists, through the inclusion of data regarding the time limited treatment programs for which participants were registered. It was suggested that this data would not only help with statistical analyses of this in relation to questionnaire answers, but also provide the researcher with important information regarding the nature of psychologists' registration with treatment programs in Australia. Demographic questions were also added to gather information on age, gender, and years of experience treating clients.

Two versions of the questionnaire

Two versions of the questionnaire were created in order to have an understanding of the validity of the questionnaire. Versions only differed through vignettes, that is, both versions had a simple and a complex vignette but described different clients within these vignettes. This design is demonstrated in Table 3.2 below. Validity of the questionnaire could thus be attained if responses to questions did not differ on the basis of which version of the questionnaire was being used.

The effect of version was tested through a repeated measures analysis of variance (ANOVA) of the four interval level questions in the questionnaire¹¹. The ANOVA was not significant and it was therefore taken to mean that there was no function of a particular vignette that was contributing to participants' responses over the influence of the independent variables of time and complexity.

Table 3.2. Mean responses to the two versions of the questionnaire using a Likert scale to measure predicted outcome and satisfaction (n=85)

	Version 1				Version 2			
	Simple		Complex		Simple		Complex	
	Time limited	Time unlimited						
Enhancement of subjective wellbeing (ESW)	2.47	4.08	1.39	3.66	2.65	4.17	1.36	3.57
Symptom reduction (SR)	2.79	4.13	1.74	3.84	2.65	4.09	1.43	3.47
Recovery of life functioning (RLF)	2.39	4.30	1.47	3.97	2.41	4.16	1.19	3.37
Satisfaction (SAT)	7.08	9.07	5.41	8.68	7.16	9.07	5.24	8.40

The above test of validity can only be conducted using a repeated measures ANOVA, so it was only possible for the four questions with an interval level of measurement. Despite this, the lack of significance in the contribution of 'version' to variance indicates that it is permissible to assume that both versions of the survey are similar enough to collapse into one version for all statistical and qualitative analyses, and is indicative of validity in the collection of data in the questionnaire.

¹¹ A 2(version) x 2(complexity) x 2(time) ANOVA was performed and the main effects and interaction effect for all 4 variables was nonsignificant for 'version'. The effect of ESW was nonsignificant, $F_{1,84} = 0.002$, $p > 0.05$, as was SR, $F_{1,84} = 1.962$, $p > 0.05$, RLF, $F_{1,84} = 3.066$, $p > 0.05$, and SAT, $F_{1,84} = 0.110$, $p > 0.05$.

Data Collection

Interview

Following receipt of consent forms indicating a desire to participate in the research interview, participants were contacted by telephone to make a time and place for the interview. During the contact telephone conversation, interview participants were told that the interview would take between half an hour and one hour of their time. Interviews were held at a time and in a place convenient for the participant. Most participants (25) elected to have the interview held in the rooms that they usually engage in therapy. Use of this natural setting where participants would usually be conducting the therapy they refer to can be seen as a strength of the present research (Hoyt & Bhati, 2007).

All participants consented to having their interview recorded using a digital voice recorder. At the beginning of each interview I briefly reminded participants about the research topic before beginning to ask questions from the interview guide. Throughout the interview I took some brief notes to write down questions that I wanted to come back to, or to clarify, later on in the interview. These notes were made so that I could continue concentrating on participant's responses without interrupting their flow of thought, but still allow for divergent thought processes and questions to be recorded and attended to later in the interview. As a semi-structured interview was used, I took liberty in probing areas that were not covered in the interview guide as well as addressing issues of particular importance to participants. These liberties are suggested as an appropriate means to gathering in-depth information in semi-structured interviews (Smith, 1995). I also used techniques such as 'minimal encouraging', maintaining rapport with participants, and encouraging them to continue talking (Silverman, 2006), which aided in gaining a rich understanding of participants' perspectives.

The interview focussed on opinion, belief, experience, and behaviour types of questions with some demographic/background questions used as well. Hypothetical and probing questions were also used where appropriate. The interview guide had only nine questions, which was deemed to be sufficient to explore the present topic and allow for a depth of understanding to be obtained. Sources such as Morrow (2005) suggest that "the fewer questions one asks, the more likely one is to elicit stories and deeper meaning from participants" (p. 255).

In line with a semi-structured approach, questions were tailored to the participant's previous responses. The order of questions was flexible as it was important to stay with the participant rather than stick to a strict schedule of questions (Smith, 1995). The following section of an interview transcript shows how probing was used to develop a rich understanding of the perspective of participants.

Amy: And that doesn't feel comfortable for some people but there's not much choice if you want to get into the core issue and you want to try to move them on sometimes, or sometimes you can't touch that issue because you know it's too sensitive and you just have to leave it alone, which is another difficult thing.

Tracey: You say some people, you don't think that process works well for them, are you saying that some people it does work well for?

Amy: I think there are probably a few, a percentage that will probably progress fairly quickly anyway for issues that aren't as historically driven or that are more recently developed, you know a relationship issue that's just popped up, that you just have to go through various procedures and it will respond quite well.

Tracey: Because of the structure or just because they don't need more time anyway?

Amy: I think because they don't need more time anyway. I think you'd probably be that structured and you'd do it that quickly anyway. You're probably more cognizant that you're following it in that shorter period of time because of the limitation. But I would imagine it would have gone that way anyway.

Towards the end of the interview process I engaged in some hypothesis testing with participants, generated from the analysis of earlier interviews. Hypothesis testing in this context meant the asking of closed-ended questions in order to ascertain the participant's stance on a particular issue. For example, the question was posed to the last few participants along the lines of "Do time limits make you feel like you need to be more directive in your therapy compared with when you don't have time limits?"

Hypotheses were asked towards the end of the interview, and they were foreshadowed by a comment indicating that I was about to ask a very directive question.

Interviews went for an average length of 42 minutes (SD = 14.3). The range was between 21 and 75 minutes, which is a considerable discrepancy that can be put down to the semi-structured nature of the interview. Some participants simply had more to say.

Role of the researcher

The role of the researcher is an important consideration in research including interviews because the researcher will always have some influence (Elliott et al., 1999). Before and during the interview I worked to establish rapport with participants, suggested as necessary by Smith (1995). I also maintained an 'open' approach when interviewing participants in order to minimise response bias and encourage the openness of participants, including, for example, a focus on open-ended questions. While the influence of the researcher in qualitative research can never be eliminated, it is important to act to minimise it (Elliott et al., 1999). This was achieved through a standard opening approach in the interview (see interview guide in Appendix F) and a standard approach in the recruitment of participants after consent forms were received. This was also achieved through aiming to have the participants' voice heard rather than imposing a framework of understanding upon them.

Questionnaire

Questionnaire data was collected through a mail out of the questionnaire. Participants returned the questionnaire via a reply-paid envelope that was included with the questionnaire. Participants were required to repeat the process twice of reading a vignette and answering six questions about their hypothetical treatment of this client. The first vignette was 'simple' and the second vignette was 'complex'. Questions related to their choice of theoretical orientation, focus of presenting problem, treatment plan, expected symptom change, expected outcomes across three domains of the Phase Model (Howard et al., 1993), and expected satisfaction with this treatment. Because of the two vignettes used, as well as the two time conditions (limited and unlimited), participants were required to answer each question four times.

Data Analysis

There were several approaches to data analysis taken in this research. This section will describe the data analytic approaches of the interview followed by the approaches taken in the analysis of questionnaire data.

Interview Analysis

Data analysis commenced while data collection was still taking place, which can be seen as part of the ongoing analysis process of qualitative research (e.g., Bailey, 2007). During the initial analysis of early interviews, some tentative hypotheses were formed and then asked of the participants who were remaining. Silverman (2005) suggests that hypotheses will be naturally developed from the early stages of research and that they should be directly tested. As qualitative research is inductive and has an iterative process, the development of questions into more focussed questions over time can be seen as inherent to the process (Glaser & Strauss, 1967). For the present research, the most logical way to approach this was to test theories developed from earlier transcriptions during interviews with later participants. Silverman (2005) asserts this to be an indication of rigorous qualitative research, and that “good research goes back to the subjects with the tentative results, and refines them in the light of the subjects’ reactions” (p. 267).

The timing over which hypothesis testing should be done is also important to consider. A certain degree of data analysis needs to occur before tentative interpretations can be developed, at which time the following participants can give an indication on their opinion of the interpretation. Miles and Huberman (1994) suggest that this process allows for a thorough development of ideas and the ability to test ideas that may arise throughout the analysis process;

Some qualitative researchers put primary energy into data collection for weeks, months, or even years and they retire from the field to “work over their notes”. We believe this is a mistake. It rules out the possibility of collecting new data to fill in gaps, or to test new hypotheses that emerge during analysis. (p. 50)

Interview Transcription

Throughout the course of data collection I transcribed the interviews. All verbal material was transcribed, and where there were inaudible words this was indicated in square brackets as [inaudible]. Some non-verbal material was also transcribed, for example emotional cues such as sarcasm or humour. Words that were emphasised by participants were underlined.

Coding the data

In order to analyse the data, a process of data reduction (Miles & Huberman, 1994) was first used to develop a coding scheme. Data was coded inductively (Braun & Clarke, 2006) based on the information attained from interviews. Patton (2002) describes this process as “reducing the volume of raw information, sifting trivia from significance, identifying significant patterns, and constructing a framework for communicating the essence of what the data reveal” (p. 432).

Initial coding categories were introduced during the analysis of the first interview and there were no a priori coding frameworks based on the literature or other theories. Coding categories were subsequently adjusted as I became more familiar with the interview content. A coding scheme was eventually developed, and edited throughout the analysis process as a means to ensuring that the most systematic understanding of the data was attained.

Over time, initial codes gradually became ‘tree codes’, resulting in the final evolution of major themes. For example, initially the idea of ‘going faster’ was coded as this, but over time it became clear that it was in fact part of the more important theme of ‘time pressure’, which was also made up of other related codes. Themes were thus composed of the codes described above, and can be defined as the combination of a range of related codes that emerged throughout analysis (Lyons et al., 2007). Axial coding (Strauss & Corbin, 1990) was introduced gradually as understanding of the data deepened, and was an indication of coding moving from descriptive to analytical (Bailey, 2007).

Methods of analysis

Thematic analysis was the main method that informed the analysis of interview data. Thematic analysis is an effective means to gaining a deep understanding of interview

data, and although derived from Grounded Theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990) can be considered a method in its own right (Braun & Clarke, 2006).

At the beginning of data analysis, early interviews were analysed in thorough detail with tentative coding schemes. This is in line with an idiographic approach to data analysis (Smith, 1995) where generalisations were slowly developed from the bases of the in-depth analysis of initial interviews. In this way, later interviews took considerably less time to analyse than earlier ones.

Data was analysed in light of a dialectical position insofar as consideration of participant contradictions were noted. A dialectical approach to data analysis assumes that social reality is inherently contradictory (Kvale, 1996) and as such any interpretation of data that does not acknowledge contradiction is invalid. Analysis of data therefore looked at the contradictions within subjects as well as between subjects and attempted to ascertain patterns of contradiction where relevant. This is described by Morrow (2005) as considering discrepant findings.

Analysis tools

NVivo 7 was chosen as a data analysis tool because it was the most recent version of the program offered and was readily available from the University of Sydney. It is also an Australian program and as such was convenient to attain technical support for. Using NVivo provided an advantage over manual analysis as it allowed the coding categories to be readily accessible and easily altered as more understanding was developed during the analysis stage.

Using memos

Memos were kept throughout the data collection and analysis phase as a way to keep track of my insights (Bailey, 2007). Memos recorded information about my thoughts regarding data obtained while it was in the early analysis phase. Memos were used as a source of analysis and helped to develop the conceptualisation of themes and sub-themes from the data.

Questionnaire Analysis

Data analysis of the questionnaire used both quantitative and qualitative approaches where appropriate. Because the statistical effect of questionnaire version was not

significant, the responses were collapsed into one version and data analysis took place on the combination of both versions with no further accounting for them.

Analysis of open-ended questions

At the time of the questionnaire design, I intended to code responses to the open-ended responses and then analyse them quantitatively, thus making the questionnaire entirely quantitative. However, it became clear very early on that participants' responses were significantly different from each other and that the vast diversity in responses would therefore be difficult to code in a meaningful way. Therefore, I decided to analyse open-ended responses qualitatively in terms of the differences *between* time limited and unlimited conditions, thereby not needing to account for the vast eclecticism that was apparent in the responses to questions about treatment approach and conceptualisation¹². This means that qualitative data, like quantitative data, is compared *within* participants rather than *between*. Silverman (2006) suggests the following in regards to analysing texts.

There is one obvious trap in analyzing documents. Just as we may be tempted to treat interview responses as true or false depictions of inner 'experience', so we may scan texts in terms of their correspondence to 'reality'.....By contrast, the role of textual researchers is not to criticize or to assess particular texts in terms of apparently 'objective' standards. It is rather to analyse how they work to achieve particular effects – to identify the elements used and the functions these play. (p. 157)

A content analysis requires the establishment of categories and then a frequency count of how many responses fall into each of these categories (Silverman, 2006). However, as Silverman (2006) points out, "content analysis can involve a relatively arbitrary imposition of categories upon data. So always ensure that how you categorize fits the analytic model with which you are working" (p. 286). With this in mind, the following analysis will therefore take into account the 'analytic model' developed through the analysis of interviews.

¹² There are implications in this eclecticism to the extent to which psychologists are diverse in their treatment, and this will be discussed in further chapters.

The analysis of open-ended responses cannot account for the role of complexity in determining differences between time limited and time unlimited conditions. Qualitatively, it is not feasible to directly compare conditions across levels of complexity because of the different vignettes, and hence different types of responses dependent on particular aspects of the vignette. For example, in Version 1, the simple vignette refers to issues of depression, anxiety, and life satisfaction, whilst the complex vignette in Version 1 refers to previous trauma and current safety issues. Open-ended responses will therefore reflect these particular aspects of the vignette, and the role of complexity in determining differences in responses cannot be analysed. This means that the following qualitative analysis can only compare between time limited and unlimited, and can make limited interpretations besides frequency as to the effect of complexity on responses.

The present qualitative analysis aims to identify issues that are important to psychologists about time limits in an exploratory fashion. As such, failure to code a response into a particular theme does not necessarily represent its absence. For example, a response may strongly indicate a concept such as 'symptom alleviation' whilst not referring to a concept such as 'relapse prevention'. Because participants may not have written everything down, this cannot be interpreted to mean that a participant might not have considered differences in relapse prevention if they were specifically asked. Therefore, responses act as a flag to what participants think are the important issues, or important differences, rather than reporting a blanket representation of concepts surrounding the topic. Accordingly, responses were inductively analysed and placed into the code that represented the theme of participant's responses.

Quantitative Analysis

Quantitative data was analysed using SPSS version 16 (Chicago, USA) and Instat version 3.036 (United Kingdom). There were two types of quantitative data analysed; categorical and interval (Likert). Categorical data was derived from the first question, which asked about type of therapy used in each of the four conditions. In questions Five and Six, Likert scales were used to predict outcomes and rate satisfaction in each condition. Categorical data was analysed using Cochran Q tests, and where relevant were followed up with McNemar tests to ascertain the location of differences. Technically, a Bonferroni correction should be used in these cases to reduce the

likelihood of type I errors. However, because this research is exploratory the likelihood of Type II errors needed to be minimised in order to see any clinically important findings (Perneger, 1998). Therefore, Bonferroni corrections were not used. Interval level data were analysed using a repeated measures Analysis of Variance. The assumptions that come with this parametric test will be addressed in the next section. A two-way repeated measures ANOVA was used to measure the statistical significance of the differences between the four conditions on Likert scale questions. Using this type of ANOVA allows for the issue of differences *within* subjects to be analysed while removing the variability *between* participants' responses (Howell, 1999), thereby ascertaining the difference a time limit and complex client make to each participant. All main and interaction effects are reported as significant at $p < .01$. Effect sizes are reported using Partial Eta Squared.

Tests of Normality

The ANOVA used for Likert scale questions is a parametric test, which carries the assumption of a normal distribution of data. Therefore, before analysis began, data was tested to check whether the assumption of normality was violated. Critical values of skewness and kurtosis that were outside the range of -1.96 to +1.96 were taken as an indication that a variable was not normally distributed (Peat & Barton, 2005).

As shown in Table 3.3, Enhancement of Subjective Wellbeing (ESW) was the only variable normally distributed in all conditions, while Symptom Reduction (SR), Recovery of Life Functioning (RLF), and Satisfaction (SAT) had some conditions that were not normally distributed. Therefore, the latter three variables were transformed through ranking before further analyses were undertaken. ESW used the mean (M) to describe the data, whilst SR, RLF, and SAT used the median of the original data (not ranked).

Table 3.3. *Tests for the normality of interval variables (n=85)*

	Simple				Complex			
	Time limited		Time unlimited		Time limited		Time unlimited	
	Skewness/ SE	Kurtosis /SE	Skewness /SE	Kurtosis /SE	Skewness /SE	Kurtosis /SE	Skewness /SE	Kurtosis /SE
Enhancement of subjective wellbeing	-0.67	1.92	-1.51	-0.61	0.02	0.84	-1.03	0.09
Symptom reduction	-4.91*	6.33*	-13.11*	39.54*	-0.74	0.27	-0.36	-0.92
Recovery of life functioning	-0.43	-0.53	-2.81*	0.19	-3.71*	8.84*	-0.65	-1.23
Satisfaction	-5.20*	3.39*	-1.75	-0.45	-2.15*	-1.28	-4.5*	3.25*

*Values not falling between -1.96 and +1.96, and hence not normally distributed for these conditions in these variables

Transformation of data

Rank transformation was applied to variables with an interval level of measurement that were not normally distributed. Rank transformation can be described as procedures “in which the usual parametric procedure is applied to the ranks of the data instead of to the data themselves” (Conover & Iman, 1981, p. 124).

The variables shown above that do not meet criteria for a normal distribution (SR, RLF, and SAT) were transformed through ranking before the ANOVA was performed. One of the assumptions of ranking is that no variable has a response answered more than 70% of the time. This criterion was met so ranking took place and a stricter alpha level was used (0.01) in considering the significance of findings.

Before testing for interaction effects, ranked data was aligned to control Type I error rates (Beasley, 2002; Seaman, Walls, Wise, & Jaeger, 1994). The function of aligning ranked data is “to remove the nuisance effects (i.e., main effects) so that test statistics will be sensitive to the effect of interest (i.e., interaction)” (Beasley, 2002, p. 204).

Therefore, because main effects in the present study were significant, aligning took place before interaction effects were tested.

Treatment of missing data

After careful consideration, missing data on Likert scales was replaced with the average (de Vaus, 2002; Portney & Watkins, 2009). Also, five participants circled a range of adjacent numbers when responding to Likert scales rather than just circling the one number that was required. For example, these participants may have circled 6, 7, and 8 on the Likert scale, in which case their response would be entered as the average of these numbers (7). Lastly, some participants reported that they would 'refuse treatment' for the complex time limited condition; participants who reported this were allocated the average score so that the repeated measures ANOVA could still take place. A total of three participants indicated that they would refuse to treat clients in the complex time limited condition.

DATA REPRESENTATION

This section will describe how data from the interview and questionnaire will be represented in the findings chapters that follow. As indicated above, interview and questionnaire data was collected simultaneously, and the analysis of one did not inform the development of the other. In addition to the simultaneous administration of these two data collection techniques, the research questions for the interview and questionnaire are also the same. Interviews sought to find out about experiences and perceptions while questionnaires sought to find out about process and outcome. In reality, there was overlap between these two types of findings, and for this reason findings from both the interview and questionnaire will be presented together in the following findings chapters.

There will be two findings chapters in this dissertation. The first of these will report on findings that relate to the inputs of time limited therapy, and the second on the processes and perceived outcomes of time limited therapy. Over the course of data analysis it became apparent that this was a useful conceptual framework to both report and discuss findings from this research. It is common for psychotherapy literature to consider process and outcome (e.g., Orlinsky et al., 2004). The present research will also consider the 'inputs' to time limited therapy, relating to that which occurs before

the process of therapy begins and outcomes are achieved. For example, issues relating to the broad system of third party payers will be considered here. A similar framework has been used elsewhere (e.g., Reinert, Carver, Range, & Bobrycki, 2004), and has been described as a 'logic model' (McLaughlin & Jordan, 1999). The use of this conceptual framework in this thesis is not strictly based upon the formalities of a logic model, but was a useful framework through which to broadly consider the findings.

Representation of Interview Findings

Results will be reported via a discussion of interpretations and will be supported by quotes. There will be a balance between my interpretations of findings and the raw data shown through supporting quotes (Morrow, 2005). The use of identifiers after quotes allows for a more complete understanding of the experiential worlds of the participants (Hoyt & Bhati, 2007, p.206). For the purposes of the present research no identifier beyond the name of participants is relevant to report. For example, if years of experience was added, or gender, the implication might be that these factors would contribute to the interpretation of findings. Therefore, it is only appropriate to identify participants with a pseudonym so that a more complete picture of particular participant's responses can be tracked over the findings chapter. Sub-headings will be used to break up the analysis into sections. In this way, an interpretation has already been made once results are put into these sub-headings. This presentation of results aims to let "readers act as 'auditors' themselves" (Elliott et al., 1999, p. 222) insofar as narratives and their accompanying interpretations can be evaluated in the extent to which they logically connect. A summary of findings will also be presented to give an overall picture of the opinions of participants. There are clear implications for the analysis of data in the way that such summaries are presented (Miles & Huberman, 1994), because data and the interpretations made from data are not strictly separable in qualitative research (Kvale, 1996).

The presentation of interview findings will not be accompanied by a frequency count of how many participants' responses are coded into each theme. Calculating how many participants are represented by each theme can be considered postpositivist (Ponterotto, 2005), and hence against the epistemological assumptions of qualitative research. Additionally, as indicated above the interview questions developed over time, so

frequency counts might also give a distorted impression of what people were actually thinking as some participants may have thought but not enunciated certain issues.

Representation of Questionnaire Findings

Qualitative questionnaire findings will be represented through the use of quotes to support the findings being discussed. Tables with a summary of themes will be presented to show an overview of findings. Quantitative questionnaire findings will be represented through the presentation of descriptive statistics, interpretative statistics, tables, and figures.

QUALITY OF THE RESEARCH METHODS

This section will outline how research quality can be ascertained from the methodological design that has been taken. Specifically, it will focus on the reflexive approach taken, the generalisability of findings, and the use of triangulation.

Criteria for the rigorous collection and interpretation of qualitative findings have been put forward by various researchers throughout the years (e.g., Elliott et al., 1999). However, use of criteria may be problematic to the epistemological assumptions of qualitative research, and has been criticised (e.g., Reicher, 2000). As Hoyt and Bhati (2007) state, “[a]dherence to extrinsic criteria may become problematic, however, if it changes the character of qualitative work, creating a disjunction between the intrinsic principles that underlie naturalistic inquiry and the practice of qualitative researchers in the field” (p. 202). Morrow (2005) suggests moving towards “intrinsic standards of trustworthiness that have emerged more directly from the qualitative endeavor” (p. 252) and away from the notion of a parallel criteria that is extrinsic to qualitative research. The present research attempts to do this.

Reflexivity

This section will outline the steps taken to be reflexive throughout the research process. Reflexivity in research provides scope to understand how I, the researcher, may influence the research process (Patton, 2002). In this section I will consider my role as the researcher, some aspects of my background, the use of a reflective journal, and the use of participant checks as means to attaining reflexivity.

Researcher's education and experience

The role of the researcher in qualitative research is acknowledged to contribute to the type of data collected and the way it is interpreted. This section will therefore consider some aspects about my professional background that may influence my interpretation and analysis of data.

I am currently a registered psychologist in NSW, and began seeing clients for therapy in a community setting in metropolitan Sydney from July 2006 – August 2008. In the final year of my enrollment in the PhD program I commenced work in private practice where I was exposed to treating clients funded through such initiatives as Better Access and therefore provided therapy in time limits. In these last 11 months I therefore would have met criteria to participate in the present research. Being a member of the group under study is an advantage to minimise the cleft in interpreting findings (Miller & Glassner, 1997), and as such my registration as a psychologist and work as a practicing psychologist can be seen to be beneficial to the current research.

In hindsight, my personal experiences with and knowledge of the practice of psychotherapy were largely limited due to an initial lack of experience within the clinical setting. However, throughout the course of the research I became a registered psychologist and began to see clients in the settings described above. The community setting's mandate was to work in short timeframes with clients, however strict limitations on sessions were not enforced. This experience changed the focus of my research slightly as relevant issues became more apparent. The time of my registration as a psychologist coincided with the time I was editing the interview guide in preparation for my first interview. It was largely edited in light of my recent experiences treating clients. The editing did not so much constitute a significant conceptual change as it did a shift in the perspective of some questions to include a more realistic idea of therapeutic settings and guidelines.

My theoretical orientations largely derive from the postmodern therapies of Narrative and Solution Focussed. While I have received training in CBT and I borrow concepts from it such as thought monitoring and cognitive restructuring, the framework from which this is done is largely from the above mentioned modalities. Accordingly, it is possible that my interpretations of the results from this research are derived from these frameworks and therefore would be different if I came from a different theoretical

framework. My theoretical orientations and approach are also no doubt influenced by the supervisors I have worked with throughout my psychology internship and following my registration.

Reflective Journal

As previously mentioned, a reflective journal was kept during the process of data collection and analysis. The journal helped to adapt the interview guide and form initial coding schemes, as well as help with analysis. The reflective journal additionally served as a tool to bracket bias towards the research topic (Morrow, 2005). The reflexivity demonstrated in this approach helps to ensure rigour (Morrow, 2005).

Throughout the interview process (July 2006 – January 2007), the reflective journal was used to keep track of my thoughts regarding the interview process and data, and was a tool to help steer the ongoing development of the interview guide. Reflections were made about the interview process, participant's responses, and things that seemed to be working or not working throughout interviews. One of the key themes uncovered in the reflective journal was that participants were indicating a certain amount of defensiveness when answering questions about their practice. I found throughout the interview process that a conscious effort to develop rapport and asking questions more in-tune with participant's responses led to a decrease in this perceived defensiveness. This could of course be alternatively interpreted as improved interview technique over the data collection process.

Participant Checks

The checking of analysis by the participants of research has been put forward as a way to ensure the validity of qualitative findings and interpretation (Elliot et al., 1999). However, simply sending the transcripts back to participants some time after the interview to ascertain the accuracy of findings may be problematic if the interview itself acted as a catalyst for change (Morrow, 2005). The same author goes on to suggest that use of participant checks as a way of managing subjectivity may be better executed by the use of focus groups. In retrospect this may have been helpful to the present research, however it was beyond its scope. Reactions from participants in the present research indicated that the interview caused them to consider issues they had not previously thought of, so may have indeed acted as a catalyst for change. This is discussed further in the findings chapter following. For the present research, the most appropriate way to

consider the extent to which participants' voices were being clearly heard was through 'checking' interpretations throughout the process of interviews (Kvale, 1996). Therefore, while I was interviewing I checked with participants that my understanding was accurate, which also gave scope for more depth in participants responses.

Generalisability

There are limits in the extent to which the findings of the present research can be generalised. The interview had a small sample size (27) as is common in qualitative research, which renders it problematic to generalise from these findings. The interview, however, is in a unique position to capture a complexity of data that would not be possible using a research method that allowed for more complete generalisability. The questionnaire provides support for the generalisability of findings because of the larger sample (85 participants). The reliance on purposeful sampling is also a limitation in the extent to which present findings can be generalised.

The total of twenty-seven interview participants was deemed as sufficient for the purpose of this research because qualitative research does not aim for representativeness. As such, it is not possible to generalise these results to the same extent that results from a larger representative sample might be able to. However, triangulation of data from the interview with data from the questionnaire allows for both a degree of representation and a deep understanding. Patton (2002) suggests that reasonable extrapolations can be made from data that can take it beyond the confines of the data to a broader consideration. Consideration of contextual factors also aids in the trustworthiness of findings and interpretations (Morrow, 2005). Generalisability is also enhanced because the people, settings, places, and times investigated are similar to the context under investigation (Collingridge & Gantt, 2008).

Triangulation

Triangulation is an important aspect of research quality because it presents more than one perspective on the research phenomenon (Patton, 2002). There are two types of triangulation used in this thesis; data triangulation and methods triangulation (Denzin, 1989). Methods triangulation is used because of the different methods of qualitative and quantitative data collection. Data triangulation is used because the participants from

interview and questionnaire studies slightly overlap (18 of the interview participants also consented to the questionnaire).

Triangulation was inherent in this research design because of the use of mixed methodology with equal weight to qualitative and quantitative data collection techniques (Cresswell & Plano Clark, 2007). Using both the interview and questionnaire allows for further verification of the research phenomenon. Triangulation can be thought of as checking findings from quantitative and qualitative techniques “on the basis that they are likely to involve different sorts of threat[s] to validity” (Hammersley, 1996, p. 167).

Triangulation has been criticised by some, for example “the major problem with triangulation as a test of validity is that, by counterposing different contexts, it ignores the context-bound and skilful character of social interaction” (Silverman, 2006, p. 292). However, different contexts also allow for a richer understanding of the phenomenon of interest. The use of triangulation in the present study is not as a test of validity but to improve the interpretation of findings. As Miles and Huberman (1994) suggest, the “aim is to pick triangulation sources that have different biases, different strengths, so they can complement each other” (p. 267). Slife and Gantt (1999) suggest that the pluralism of mixed methods design allows for the use of ‘different measuring sticks’ to look at the same phenomenon;

If such differing philosophies and methods converge on a particular understanding – and some type of complementary results was found – then our confidence in the justification and validity or our understanding would be increased many fold. (p. 1461)

In the present study, interviews will give an understanding of the broad issues underlying time limited therapy, whereas the questionnaire will be able to answer specific hypotheses regarding this topic. Miles and Huberman (1994) suggest that “[i]n effect a new source forces the researcher to *replicate* the finding in a place where, if valid, it should re-occur” (p. 267). Therefore, analysis will take into account the degree to which findings from questionnaires and interviews are congruent.

CONCLUSION

The present methodology is a mixed methods approach to understanding the perceived impact of third party determined time limits on the practice of psychologists. It utilises a mixed methods design with both an interview and questionnaire, and operates within an interpretivist framework. Semi-structured interviews obtained entirely qualitative data while the questionnaire obtained a combination of qualitative and quantitative data. The following chapter will provide demographic information about the participants and consider the inputs and resources of time limited therapy.

CHAPTER 4: INPUTS AND RESOURCES IN TIME LIMITED THERAPY

INTRODUCTION

This chapter will report findings that relate to the inputs of time limited therapy. It will consider the organisational and contextual factors that act to influence the provision of therapy in third party determined time limits. There will be three sections in this chapter. The first section will present demographical information of the participants and their overall reaction to the research. The system that time limits operate within will then be discussed in relation to the present findings. The next sections will consider findings in light of the two different domains of 'inputs' that contribute to the system of time limited therapy; human resources and the resources of the system. The aim of this chapter is to provide the reader with an overview of psychologists participating in the research, and how they broadly perceive the system that time limits operate within.

PARTICIPANT DEMOGRAPHICS

This section will present the demographical information that relates to participants in the interview and the questionnaire study. Participants in both studies were registered psychologists in the states in which they practised.

Interview Participants

This section will provide some basic demographic and background information about interview participants and their practice of therapy, which was collected throughout the process of interviews. All participants were registered in NSW as psychologists, and 11 (41%) had membership of the Clinical College of the Australian Psychological Society. Twenty participants were female (74%), with a mean age of 47 (SD=10.5).

The mean length of time practicing therapy was 18 years (SD=10.9). The mean percentage of work through time limited third party payers was 49%, ranging between 25% and 80%.

Participants were asked which services they provided to clients through third party payers that used pre-set time limits. Twenty-one participants were registered with BOMHC, 20 were registered with Enhanced Primary Care, 15 were registered to provide EAP services, 12 were registered with Workers Compensation, eight were registered with Victims of Crime, seven were registered with the Better Access initiative¹³, two were registered with the Department of Veterans Affairs, one was registered with Transcultural Mental Health, and one with Multicultural Gambling Service (see Appendix I for a brief description of these programs).

All participants reported using CBT in their therapy, five participants exclusively. The remaining 22 participants identified as being eclectic in their approach. Nine participants reported using psychodynamic techniques, seven reported Solution Focussed Brief Therapy, three reported Interpersonal Therapy and Supportive Counselling, two participants reported using each of Gestalt Therapy, Narrative Therapy, Hypnotherapy, Psychoanalysis, Schema Therapy, Existential Therapy, and EMDR, while one participant reported using each of Acceptance and Commitment Therapy, Emotion Focussed Therapy, Self Psychology, Dialectical Behaviour Therapy, and Analytical Psychotherapy. Table 4.1 summarises this information.

Table 4.1. *Summary of interview participant information*

Participant pseudonym	Gender	Program Registration	No. years practicing therapy	% of work through 3 rd party payers	Tx Models	Registration
Nora	Female	EPC, VOC, BOMHC	30 years	60%	CBT, ITP	Clinical
Isabel	Female	BOMHC, BA, WC	5 years	40%	CBT	Clinical

¹³ The small number of participants registered with Better Access is due to the fact that Medicare only commenced this initiative after the first 20 interviews had been conducted.

David	Male	BOMHC, EPC, EAP, WC	20 years	25%	CBT, PD, PA, GT	Registered
Olivia	Female	EPC, WC, EAP, INS	10 years	50%	CBT	Clinical
Harriet	Female	BOMHC, EPC, WC	25 years	40%	EMDR, CBT	Clinical
Ken	Male	EAP, EPC, INS	12 years	70%	CBT	Clinical
Grahame	Male	BOMHC, EPC, EAP, WC	10 years	80%	CBT, ST	Clinical
Quibilah	Female	BOMHC, EPC, EAP	20 years	30%	SP, CBT, ITP, SFBT	Registered
Ella	Female	BOMHC, VOC, EPC, WC, EAP	8 years	40%	CBT	Registered
Monique	Female	BOMHC, EPC, EAP	5 years	50%	CBT, PD	Registered
Patrick	Male	BOMHC, EPC, EAP	7 years	40%	DBT, ACT, CBT	Registered
Richard	Male	BOMHC, WC, EPC, EAP	25 years	50%	CBT, SFBT, PD	Registered
Vera	Female	EPC, EAP	30 years	70%	CBT, EX	Clinical
Adam	Male	EPC, BOMHC, WC	5 years	50%	CBT, SC	Registered
Beatrice	Female	BOMHC, EPC, VOC	15 years	50%	CBT, HT, ITP, EMDR	Registered
Colin	Male	BOMHC, DVA, VOC, TMH, MGS, WC, EPC	3 years	70%	CBT, EFT, SFBT	Registered
Fiona	Female	EPC, VOC, EAP, WC	25 years	20%	PD, CBT, SFBT	Registered

Jessica	Female	BOMHC, EPC, EAP	10 years	60%	CBT	Registered
Lucy	Female	VOC, TMH, EPC	40 years	60%	SFBT, HT, CBT	Clinical
Sally	Female	BOMHC, DVA, EAP, EPC	15 years	60%	CBT, PD, SC	Registered
Tessa	Female	BOMHC, EPC, BA, WC	25 years	25%	CBT, SFBT	Registered
Ursula	Female	BOMHC, EPC	35 years	50%	CBT, SFBT, PD	Registered
Winona	Female	BOMHC, EAP, BA	35 years	35%	CBT, PD	Clinical
Xuan	Female	BA, VOC, BOMHC, WC	28 years	50%	CBT, PD, NT, EX	Registered
Yelena	Female	BOMHC, BA	30 years	35%	CBT, AP	Clinical
Zara	Female	BA, BOMHC, EAP	10 years	40%	PD, CBT, ST, PA, SFBT	Clinical
Amy	Female	VOC, BOMHC, BA, EPC, INS	15 years	60%	CBT, NT, GT, SC	Registered

Key to Table 4.1

Program Registration

EPC - Enhanced Primary Care
 BA - Better Access
 VOC - Victims of Crime
 EAP - Employee Assistance Programs
 WC - Workcover
 BOMHC - Better Outcomes in Mental Health Care
 TMH - Transcultural Mental Health
 DVA - Department of Veterans' Affairs
 MGS - Multicultural Gambling Service
 INS - Insurance Referrals

Theoretical Orientations

DBT – Dialectical Behavioural Therapy
 ACT – Acceptance & Commitment Therapy
 CBT – Cognitive Behavioural Therapy
 PD – Psychodynamic Therapy
 GT – Gestalt Therapy
 SFBT – Solution Focussed Brief Therapy
 SP - Self Psychology
 ITP - Interpersonal Therapy
 EX - Existential Therapy
 AP - Analytical Psychotherapy
 NT – Narrative Therapy
 ST – Schema Therapy
 SC – Supportive Counselling
 HT – Hypnotherapy
 EFT – Emotion Focussed Therapy
 EMDR – Eye Movement Desensitisation & Reprocessing

Questionnaire Participants

The questionnaire asked participants non-identifying information about their background and the psychological services which they provide in a time limit. This information is unfortunately limited because of a printing error that took place during the dissemination of questionnaires. A total of 85 psychologists participated in the questionnaire; however complete demographic information was only obtained from 63 (74%) of them. For the remaining 26% of participants, only information regarding third party program registration was attained. Tables 4.2 to 4.5 present the demographic information that was collected.

Table 4.2. *Distribution of age*

Age Group	Frequency (n=63)	Percentage
20-29	3	5%
30-39	14	23%
40-49	15	24%
50-59	23	37%
60+	8	13%

Table 4.3. *Proportion of male and female participants*

Gender	Frequency (n=63)	Percentage
Male	13	21%
Female	50	79%

Table 4.4. *Participants' years of experience providing psychotherapy*

Years of experience	Frequency (n=63)	Percentage
0-2	0	0%
2-5	4	6%
5-10	18	29%
10-20	26	42%
20+	15	24%

Table 4.5. *Registration with third party providers that utilise a time limit*

Program	Frequency (n=85)
Medicare (including EPC and BA)	79
Better Outcomes in Mental Health Care	55
Employee Assistance Programs	47
Workcover	47
Victims of Crime	22
Transport Accident Commission	16
Vietnam Veterans Counselling Service	14
Transcultural Mental Health	1
<i>(Other)</i>	
Insurance Referrals	4
Comcare	1
Carers Victoria	1
TOTAL	287

At the stage of designing this questionnaire Medicare funding for psychologists was only available through Enhanced Primary Care (EPC). During data collection Medicare benefits became available for psychologists through the Better Access to Mental Healthcare Initiative, which is substantially different to EPC (as described in Chapter Two). Unfortunately the questionnaire cannot distinguish between registration for these two programs.

The most common program to be providing time limited services through was Better Access or Enhanced Primary Care, followed by Better Outcomes in Mental Health Care (BOMHC), Employee Assistance Programs and Workcover. All participants (n=85) circled at least one option, demonstrating that they met selection criteria for the present study (i.e., all had exposure to time limited treatment).

Reaction to the research

I had the opportunity to meet with interview participants, and most of them indicated their motivation for participating in the research. A number of participants indicated that they consented to involvement with the study because they felt that the topic being discussed was of importance to their profession and that they wanted their voice to be heard. One participant returned her consent form with the following message; “This sounds like a fabulous (and long overdue) project!...Very happy to assist”. All of these participants who were enthusiastic about the research topic questioned (that is, were

critical of) the use of externally imposed time limits in psychotherapy. The other major subset of respondents indicated that they participated in the research because they wanted to support students doing psychological research and they appreciated how hard it was to find participants. These participants were varied in their opinion of time limits.

Throughout the interview process, a number of participants indicated that they appreciated the questions being asked of them, and that they had not necessarily thought of these issues before. As such, a number of responses were ambiguous and contradictory at times, which could be indicative of their preliminary thinking on the issues.

THE SYSTEM THAT TIME LIMITS OPERATE WITHIN

It became apparent fairly early on in the data collection process that participants were unable to isolate the time limit from the broader system that it was operating within. This was particularly apparent in the interview study. A number of participants indicated that they felt that therapy provided through a third party provider with a time limit constituted a different way of providing psychological services. Findings show that limits on session number cannot be separated from the whole system in which they occur.

...and when you impose a model, it's not just a time constraint...it's not the time constraint it's the model, the medical model, you diagnose, you pluck the right treatment and you apply it to the patient and if it doesn't work it's the patient's fault not yours. (Richard)

This section will further elucidate on findings relating to the perception of participants towards time limits and the broader context within which they operate. In order to explore how a time limited model of service delivery was experienced as 'different', the difference between providing therapy in this context and other contexts will first be considered.

The difference between externally imposed limits and self imposed limits

Findings show that for the most part it makes a difference to psychologists whether time limits are externally imposed or self imposed. Participants acknowledged that all

therapy was inherently time limited because of the limited resources that clients have to attend therapy.

I mean I suppose the other thing is when you think that through it's often about the cost for the person in terms of what, not everybody can afford to pay for what they need. So there'll be a lot of people with sort of unfinished business going away possibly even after twelve [sessions]. (Sally)

And [therapy is] also time limited by clients themselves coming in and stating they just want short-term work. (Quibilah)

The open-ended nature of therapy without third party time limitations meant that often participants did not know when therapy would end anyway. There is therefore less control over time in this context.

Even if the client is paying you don't know how long they're going to continue coming for and you just don't know that. (Zara)

Despite the acknowledgement that all therapy was limited anyway, having an external imposition of a time limit made a difference to participants. A number of participants indicated that they had a different attitude when treating clients in time limits, regardless of the amount of time they would consider 'usual' for treatment. I asked Amy how long on average her private paying clients would come to see her for.

When I look back over my stats I think usually it is around that amount of time [12 sessions] but I guess there's a perception that it doesn't have to be. (Amy)

For Amy this attitude difference could be attributed to both the time per se and the external accountability factors inherent in the time limited programs like Better Access.

You know usually [without time limits] there's like a three month burst of sessions really is what you're looking at. And that seems to be adequate for most people but there's not pressure involved in it which is a big difference. You don't feel that you're accountable or that you have to watch your p's and q's with various things. There is that feeling of, I don't know if I'd say big brother is watching, but you

know that kind of feeling of being accountable to a body rather than being accountable to yourself and I probably set fairly high standards for myself anyway so I prefer to be accountable to myself in some ways. (Amy)

Factors associated with the increased accountability of third parties appear to partially account for the different attitude towards time in therapy. Similarly to Amy, Xuan also indicated that her usual stretch of treatment would be similar in length to the Better Access allowance.

And a lot of my private clients are only really, if I look at my stats then they usually have six or the maximum of 12 sessions anyway. (Xuan)

Some participants reported that the main difference that comes with a time limit is one of external pressure, which subsequently affected therapeutic approach. Amy reflected that this was independent of time length in itself.

I would probably track a different way because it's, the client can be more expansive, we don't have that pressure on us and I probably would let the client drive the process a little bit more, which I find doesn't take a lot longer but it's basically a perceptual thing of having to cover a certain number of milestones in your progression that you have to do as part of this procedural delivery of a program rather than sort of think well we can go on if we need to. And not really needing to anyway probably in the long run with many with them. (Amy)

Having a time limit reportedly changed the pace that psychologists would work to during treatment.

...whereas when I know that they're going to come for a while and its open-ended then I can just kind of relax and let them do it at their own pace. (Xuan)

I trained in long-term psychodynamic psychotherapy in the 1980's in Boston, since then I have learnt to also do shorter term work – both

approaches work well. The difference is in pacing. (Questionnaire Participant 52)

Findings in relation to this attitude difference demonstrate that as control over time increases, attitudes towards time changes. The attitude of psychologists seems likely to change in relation to what can be achieved when time is limited, and shows that the attitude towards a time limitation is different to that of time length. The fact that time limits were imposed therefore made a difference to participants.

Opinions of third party funding of time limited psychotherapy

Participants expressed varied - and in some cases strong - opinions of the broader systems of third party payers that time limits operate within. Opinions are also shown to be varied based upon the different types of programs that referred clients through time limits, showing that it is not just the time limit but other factors to do with the referring body that contribute to perceptions of time limits.

Participants were almost unanimous in their assertion that working within limited numbers of sessions was not ideal for providing adequate therapy. In comparing their time limited work with work that did not have any external time limits, participants reported that a time limit hindered their ability to work in an ideal setting.

And maybe, to have everything finished in six sessions is not always the ideal. (Patrick)

Yeah I guess it's not really ideal. You know because you'd like to be able to work with the person for the length of time you determine they need to work with you. (Amy)

The type of client or severity of the presenting problem determined the extent to which time limits were deemed to be 'not ideal'.

...for majority of cases it's less than it should be I think. To do proper intervention for people with mild psychological difficulties that can work. People with moderate - sometimes that can work. However, people with severe psychological difficulties that's....if you have one session assessment, two sessions psycho-education, and then when

you start something cognitive behavioural you find it's not enough time to change. And some patients cannot afford to continue. (Adam)

In the quote above Adam is also referring to issues of access, which is addressed in more detail later in this chapter. Overall, participants perceived time limited therapy to be less than ideal, but despite this, participants generally felt that having third party referrals was better than the system it is replacing; fee for service therapy.

A significant proportion of participants indicated that even though the supply of funded sessions is limited, it is better than nothing to have a limited number of sessions to work with than nothing at all.

...the research doesn't seem to suggest that six sessions is enough but certainly it's better than nothing so um, that's fine. (Patrick)

I'm still able to do something; as psychologists we have to manage it. (Adam)

While not ideal, having some time for therapy was considered as better than having none, and Adam suggests that the onus of responsibility to therefore *manage* this limitation is on the psychologist. Participants mostly reported that although outcomes in this context may not be ideal, they represented steps forward for the treatment of clients.

But if they learn some of the core skills then that is at least a way ahead and not a way backwards anyway. (Patrick)

...you wonder whether you should even take them on but I guess we figure six sessions are better than none. (Richard)

Despite the limitations associated with time limits, there was a perceived benefit to having some time to do something, even if this was not an ideal amount of time for what was considered to be the right type of outcome.

Satisfaction with Predicted Outcomes of time limited therapy

Participants in both studies reported the impact of time limitation on themselves as psychologists. Overall, participants report feeling less satisfied with the treatment they can provide in time limited contexts. Questionnaire participants were asked to rate the

satisfaction they would feel with the outcome of their hypothetical treatment outcome of clients in the vignettes, based on time available and the complexity of the client's presentation¹⁴.

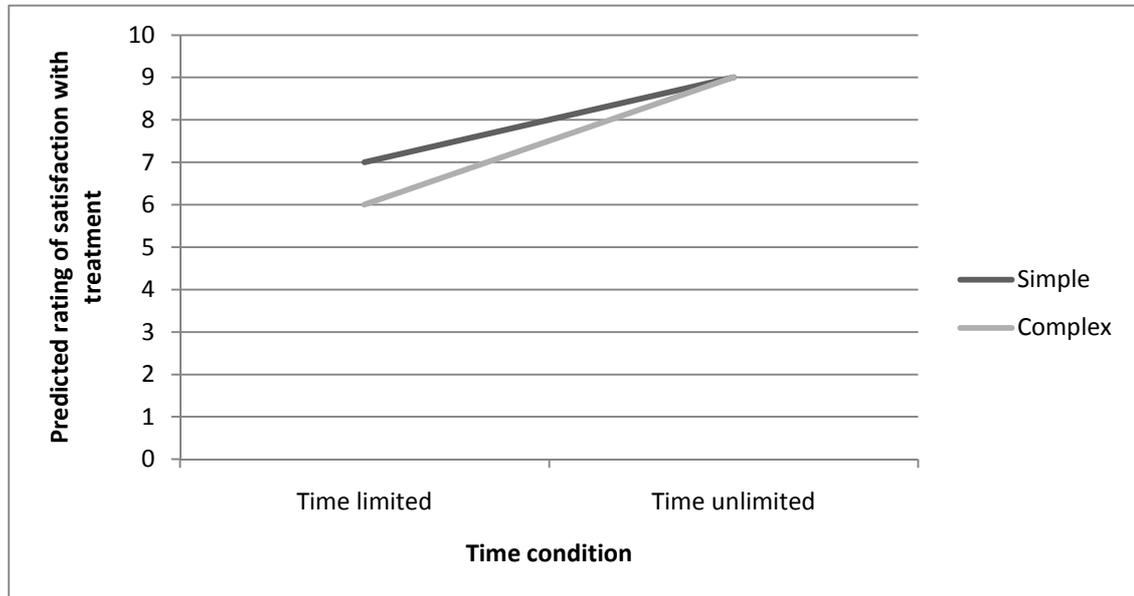


Figure 4.1. Ratings of satisfaction as a function of time condition and complexity level (medians)

There was a significant main effect of the amount of time on ratings of satisfaction, $F_{1,84}=75.785$, $p<.01$, $partial \eta^2 = .79$. There was also a significant main effect of the level of complexity on ratings of satisfaction, $F_{1,84}=316.599$, $p<.01$, $partial \eta^2 = .47$. Satisfaction was therefore significantly increased in time unlimited conditions as well as in simple conditions. There was also a significant interaction effect between time and complexity on ratings of Satisfaction, $F_{1,84}=42.472$, $p<.01$, $partial \eta^2 = .34$. This demonstrates that a complex case significantly contributes to the extent that time limits are seen as a detriment and hence result in lower satisfaction ratings. Satisfaction with outcome is therefore reduced by time limits, more so for complex cases.

Experiences of being managed

Although not the initial intention of this research, most participants expressed opinions regarding the experience of being managed through third parties. While I was asking participants about their experiences of working with time limits, participants were

¹⁴ As previously indicated, analysis of this variable was performed on ranked data.

letting me know about the *context* of providing therapy in time limits. One of the important aspects of this context was the experience of being managed, which was largely seen as an obstacle to providing effective therapy. When working within time limits participants reported that they had an added pressure from the need to provide reports and/or feedback to funding bodies. This external pressure meant that psychologists felt a need to produce tangible results as quickly as possible. The tangibility of results was reflected in the extent to which gains could be observed symptomatically, and hence measured in the outcome tests that are used for the vast majority of funded programs, for example The Depression Anxiety Stress Scale (DASS; Lovibond & Lovibond, 1995) as used in the Better Access initiative. There was thus a conflict between what participants perceived to be the outputs of the system and the extent of benefit in the outcomes of therapy. Because therapy was limited, in addition to the latter, this symptom reduction needed to occur as quickly as possible. The external pressure that participants reported feeling meant that they were more aware of the need to stay focussed on specific issues and ‘address’ these issues in an observable and measurable way.

I'm trying to focus a bit more on the particular issues that they've brought up, rather than look in a rather much more broadly...ah well I do a bit of that anyway. You know but I'm aware that I've got to do this, because they've been referred for a certain reason and I know I've got to write a report after six sessions and say how I've addressed that. (David)

I guess that's a pressure the fact that you know you're being watched now in some ways. And so you have to perform, clearly you do anyway... it's about being professional I suppose but there is this sense of someone else is involved in it. (Amy)

External management meant that psychologists were more aware of the need to be *seen* as effective.

...you have to say you did CBT and relaxation techniques in that session and you have to actually kind of go back over it and actually make sure that you've followed a particular treatment plan and it has

resulted in the outcome you've proposed it might have resulted in or it's come close to following that and so I guess that might vary a little bit more if you were not as bound by time and money. You might think oh no I actually won't do that this session because I can see they're going more in that direction but if you want to fit everything in six weeks, actually five weeks because the first one is usually getting to know you assessment session, so you're talking about five sessions generally speaking where you're actively therapeutic with them in terms of what you're providing. So the pressure is on, you've got to deliver these sorts of things, you've got to make sure you cover that, you cover that, because that's standard evidence-based practice for that particular type of condition and then you've got to look back and make sure you've done that. And then you've got to tell them you have. So I guess that's a little bit of an imposition in some ways.
(Amy)

Relationships with referring bodies were also mentioned as factors determining the extent to which external pressure was felt.

Now if there's a GP involved you're constantly accountable to them for outcomes. That can be a little bit of, it's a shared care kind of situation, you have to be very collaborative with it. But sometimes you think oh God I really would prefer to just be able to go on with this and not feel I had to perform, had to be seen to perform, you know?
(Amy)

According to some participants, being managed by third parties meant that clients also had different experiences in the therapeutic process.

And another difference which is quite important which is that there's the referrer, there's a relationship with the referrer as well, so there's a kind of, you know the whole sort of, the way that it, the relationship the patient has with the doctor that's referred them comes [inaudible]. My relationship with that doctor, there's more of a sort of sense of a sort of structure, more of a structure to it which is quite

different, I think very different for the patient coming in and people [who] got my name from a friend or they come in with a slightly different expectation. It's a slightly more medical model which is sort of diagnosis, treatment, and cure. Whereas I think other people will come in and they'll be more, often come in with a different agenda which is just to actually talk about something. (Xuan)

In regards to Workers Compensation work, the external pressure also has the potential to impact the way that client reports are framed, or what is focussed on.

...sometimes you have to write reports, and I'll generally write a report that just focuses on this very narrow well what's happened at work and how they are dealing with that and how they're going to get back to work or whatever. (David)

Participants generally indicated a greater feeling of accountability when working within a time limited program. While the feeling of accountability was because of and towards the funding body, it could not be separated from the pressure of the time limit.

Because of the need to, you're looking very often at a review after six sessions, um and it's a review by the GP so it's not just a review by me it's a review by somebody else to talk to this person and say well have you made progress? And to do another K-10 assessment and say well has that improved? So you definitely are more accountable and I, but I see that as a really good thing. (Tessa)

Participants indicated that their independence can be compromised when being 'managed' through programs that have time limits. Issues of independence and autonomy became important in this regard.

Well, I feel like it, in some way I lose a bit of my independence, and I like to feel independent. (David)

...largely it's a feeling of control over your own therapeutic direction, and being able to determine the time limit yourself based on what's presenting. And each client is different, each client is unique and I think every presentation has its own little nuances and you can't work

on some of those sometimes because you just have to stick to a sort of core emotional issues like mood elevation sort of issues or mood and depression issues and have to sort of focus specifically on that rather than adopt a very nuts and bolts approach to it rather than actually being able to see what's formulated that mood in the first place and it's not just purely genetic there's often school bullying or a parent that hit them every night or something; that you can't really focus on and you can't really begin to go above a relationship sort of more a psychodynamic relationship to assist in moving them on for example. In those kinds of scenarios so I mean that's one of the frustrations. (Amy)

Challenges to autonomy were seen as a source of frustration and further reflect the perception of being managed in systems of managed care.

'Working the system'

Some participants referred to the notion of manipulating 'the system' in order to make the most of the treatment they could offer to clients. Transferring clients between different types of funded programs was one way in which participants reported ensuring that clients had an adequate amount of therapy that was above the sessions offered through any one program.

I've had several other referrals under Medicare Plus [EPC], and the person has either, once they've presented, been more appropriately taken care of under Victims of Crime that I'm also registered with for example. Or maybe it turned out that it was actually a workers comp thing so then it became workers comp, or they just put it in under the private health insurance because they got more back. (Beatrice)

Another way to work the system was through determining diagnoses based on where participants wanted to obtain funding for their client from.

...for example I find in a trauma situation I might encourage them to apply for a Victims of Crime fund base of assistance. So you might start off with Medicare six weeks then 12 weeks, then you, say in the tenth week, say 'Look this really is related to early sexual abuse' in

those sort of contexts, and think a bit creatively and actually get them to apply for 22 sessions that way which you assess and approve and access. So you can usually, sometimes use various programs creatively across different departments and the same thing would apply with something like an insurance claim. If you start to get capped by the insurance company you can look at whether there's any other Government funding that you can use. So it's basically combining different funding approaches which helps to get around it at times. (Amy)

Because there are limited resources for third party funding of therapy available, some participants altered their diagnosis to focus on an issue that would warrant further funding.

Importance of Outcomes in Third Party Referrals

Participants reported that providing therapy in the context of third party time limited referrals brought an increased focus to the outcomes that could be achieved. This section will examine how time limits bring about this focus on treatment outcomes.

Probably the main thing is I'm really more outcome focussed, more aware of the third party, of the expectations. (Ursula)

[Time limits] make me just very focussed on specific techniques and what I can do to fix their presenting problems or [it] mightn't even be presenting problems – but what I can do to fix their problems as quickly as possible. (Harriet)

Having this increased focus on outcomes was sometimes seen as a source of efficiency.

I actually think they're [time limited referrals] really good and mainly because I think it makes you very aware of the need to keep a close eye on your outcomes and what you're doing. (Tessa)

However, others experienced the focus on outcomes as a source of pressure.

The problems are feeling the pressure to get outcomes, have positive outcomes within the time limits. (Monique)

Participants therefore largely reported that they were more aware of the need to produce tangible outcomes when working in time limited third party referrals. Many programs that fund therapy require some type of measurement of outcomes at the commencement and completion of therapy. Participants were sceptical about the utility of the outcome measures when used after short amounts of time.

...but in six sessions it's really difficult I think to provide reliable data about outcomes. (Ella)

Isabel was quite cynical about the use of the DASS to consider the outcomes of therapy in the BOMHC program.

But I hate to think that they were evaluating effectiveness, and maybe that's the only way they can, with the DASS, and I hate that because I think everybody's going to improve on the DASS score. Everyone! In fact it's stupid. (Isabel)

Some participants expressed concern that the outcome measures used may have some response bias.

And sometimes I wonder with these measures if we're not going to tap into the people-pleasing side of our clients and in fact maybe that's not always such a healthy thing if they're making the graph go up because they know that's how we all want it to be and how the doctor wants it to be... (Ursula)

I actually don't think they improve that much, I think they just like me. They want to go 'oh [Isabel's] great', but I don't know... (Isabel)

Some participants were therefore sceptical about the legitimacy or depth of information that could be attained from outcome measures used to report back to third party providers.

This section has shown that the broader system of third party providers was experienced as an important factor influencing participants' perceptions of time limits. The 'system' of time limited therapy is experienced as different from therapy outside of this system, and this is regardless of the amount of time that therapy would usually go for in some contexts. The *third party imposition* of time limits is therefore important to how time

limits were perceived. Overall, participants reflect gratitude for the funding from third parties but many also express frustration with the limitations it places on their ability to provide effective therapy for some clients.

HUMAN RESOURCES

Within the system of third party funding of therapy there are two human resources; the psychologist and the client. This section will present findings that relate to the influence of these human resources on the impact of time limited therapy.

The Psychologist

Psychologists who participated in the present study were diverse in a number of ways. Some key variables that appear to distinguish them in terms of how they view time limits were their therapeutic approach, and more broadly their treatment philosophy, perceptions of adequate length of therapy, and perceptions of what constitutes an adequate outcome.

Therapeutic Approach and Philosophy

The type of preferred therapeutic approach was shown to be an important factor in determining the impact that a time limit has on psychologists. Isabel provides a key example of the extent to which the preferred treatment modality can affect the interpretation, and subsequent effect, of a time limit in therapy. Isabel is a clinical psychologist, who indicated that she worked solely in CBT techniques. She was the only participant to indicate that time limits had a very limited effect on her work. This could be seen quite clearly in her conceptualisation of therapy.

...unless I can produce really good solid results very quickly with you I'm going to lose you or I'm not going to get where I want to. And I don't want you to depend on me so if I can get you out of here in 12 sessions, eight, I almost say ideally eight. I mean I know CBT talks about 12-16, but that's only when drugs kick in... but I don't want them to depend on me and I think in the longer term then that it gets into supportive counselling and I'm always terribly scared of that because it, it's a frame of therapy I don't work in at all because I don't ever, and as I say, I'm really upfront with my clients about this.

I say the longer you go to a therapist, the more you think you're crazy. And we've got to get you out and move you on and get you back into your life and I'm really very clear about what my work is. (Isabel)

Isabel's conceptualisation of time in therapy was so in line with time limited work that it is clear why she did not seem to be too impacted by having time limits imposed on her. When asked how often clients continue with her after the number of funded sessions has been reached, she indicated that she sees continuing as a failure in her ability to do therapy.

I try for not many. Because I see it as failure. You've failed! You didn't get, you know, you didn't get it done in six! But if I haven't made significant progress, or I tell you who I really access it for, and it used to be the same for Workcover. Where you see there's potential and it's taken them three sessions to even get motivated to make change. Or six sessions to even turn around, and drug and alcohol, a big one that, anxiety's really big on that. Depression to a certain degree. It's actually just those ones that you almost have to talk to a place where they're prepared to contemplate change. (Isabel)

Isabel appears in this research as a discrepant case and extreme in the opposite direction to other participants. Indeed, she went so far as to say that part of her motivation for participating in the research was to convey a point of view that she deemed to be substantially different to the other psychologists she has spoken with about time limited programs. This was distinct from the majority of participants who provide a substantially different view from Isabel regarding their conceptualisation of therapy and time limits. One such participant is Yelena, whose therapeutic approach was described as eclectic based on the type of presenting problem and client.

[I use] whatever seems to suit at the time really - whatever seems appropriate for the person – I use a variety of CBT, psychotherapy, more analytic psychotherapy. Just really anything that seems to be appropriate at the time. (Yelena)

Participants also reported different philosophies about the role of different types of therapies.

Well with people you start off using CBT and they are not really responding because you are just treating the symptoms – getting them to change the way they are thinking about today, and then they will mention something about, you know – on the second or third session they will mention something that has happened in the family from the past and you think “ah ha” that is the reason they are feeling this way so consequently then you have to go back and deal with that, and see that is almost six sessions taken up. (Winona)

The role of a psychologist in treating clients was also perceived as different between participants.

So see if you have six sessions with somebody like that...there's some people who need lots of sessions because they need support. And maybe Parish Priests provide that, or people in the community provide it as well, but for some people they haven't got that. (Nora)

It is clear that a participant like Nora considered support to have a role in providing psychotherapy. This is in contrast to Isabel, who spoke of support as though it was separate to the obligations of a psychologist.

BO [Better Outcomes in Mental Health] I think is really really good because it's focussed treatment, six sessions, it's not endless and it cannot be supportive counselling, you know in that process it can't be supportive counselling. (Isabel)

Theoretical orientation thus was a determinant towards treatment philosophy, which impacted on the perceived effect of a time limit. Participants in both the interview and questionnaire were diverse in their type and extent of eclecticism. This type of 'input' therefore influenced the topic of the following chapter; process and outcome.

Perceptions of how long therapy should be

Not only did participants differ in their treatment philosophy and approach, but also in their opinions about how long therapy should be. Participants additionally differed in

their notions of the flexibility of this length, and the degree to which it depended on the type of client. Perceptions of how long therapy should be therefore operated as an input because it determined the impact of a time limit. For example, at one end of the spectrum Yelena reported that therapy needs to last for approximately a year on average.

...however having the 12 session limitation is quite limiting because a lot of people need – people need to see you for about a year and they need to see you weekly – if someone is in an acute crisis they will often need twice a week for a while so 12 sessions go pretty quickly. (Yelena)

In contrast, David reported that 12 sessions would often be a reasonable amount of time in which to provide an adequate amount of treatment.

...twelve sessions you know you can do something, you know you're not gonna solve people's lives in that time but you can do something that may have an impact on their life. (David)

Colin, who had extensive experience working in a Medical Centre under short referrals reported that the EPC allowance (five sessions) was only enough to cover an elementary degree of psychological assistance.

Five sessions are only enough for a remediation, symptom alleviation, ah just education sometimes. (Colin)

In response to Question Four, one questionnaire participant indicated their average number of sessions, and that it would be common to see a client like Mary (see Questionnaire in Appendix G) and resolve this in 10-12 sessions: *'all symptoms alleviated; this is the case scenario of the large majority of my referrals and I would expect this to be resolved in 10-12 sessions'* (Participant 38). To other participants, this would not be feasible due to the complexity of the case. This finding shows the extent to which psychologists differ in their perceptions of the amount of time 'necessary' for treatment.

Some participants thought that having a time limit might even extend the length of therapy, leading to unintentional over-servicing.

Other people [not time limited] you can actually get a lot done in a few sessions. You can sometimes get a lot done in one or two sessions. (Vera)

One questionnaire participant spontaneously wrote about the length of therapy in terms of the dependence of clients.

I have spoken with clients who have previously been in long-term therapy, which has rendered them somewhat dependent and lacking resourcefulness. They fall apart when there is a 'glitch'. Short-term therapy if done well will give tools and directions that allow clients to forge their own road to recovery. Gestalt therapy can be powerful in this way so please don't underestimate the work that can be done in five sessions. (Questionnaire Participant 50)

To a large extent participants in this study did not report that the length of therapy need necessarily be long, but that there needed to be flexibility in this length. Differences between time limited therapy and therapy that was naturally short thus became apparent.

Participants' responses also indicated a certain degree to which psychologists themselves will *adjust* to the typical amounts of time in which they treat clients. The following quotes are from participants who had extensive experience working *only* in time limited programs and services for a significant proportion of their career.

And, it might be that I needed eight sessions or nine sessions. Sometimes, often it's not, the full 12, but it's actually really rather relaxed when it's 12. (Beatrice)

Sally had spent a number of years working for an EAP provider that provided a varied but generally small number of sessions. She had recently moved into her own private practice.

Or I might say if we had six sessions I would say something like "We've got six sessions that's quite luxurious so we've got plenty of time". It did start to feel very luxurious, believe me! After a while. It's like long-term psychotherapy!! [laughing] (Sally)

Notions of how long therapy needed to be varied significantly both between participants and within participants, based on client factors and perceptions of resources. Overall, the Better Access allowance of 12 sessions was not viewed as wholly inadequate by the majority of interview participants, but flexibility with this time was shown to be important to these participants for the most part.

Evidence-based determination of length

As discussed in the introductory chapter of this thesis, there is an evidence base for the implementation of pre-determined time limits in therapy. A number of participants commented on this evidence for time limits, and their opinion of EBP acted as an input to how they would work in a time limit. Cynicism regarding EBP and the possibility of working optimally in third party time limits was expressed by a number of participants.

But there is a ‘horses for courses’ thing here that is not considered by insurance companies. They just look at one set of data and judge everybody’s presentation and everybody’s therapy by those standards, and that’s very difficult to work within. I think that the variability that exists in private practice makes it very difficult for us to define what we do, who we do it with, how well we do it, and what results we achieve. Primarily because we don’t have the luxury of time to do all of that data collection, analysis, and presentation. (Beatrice)

Now they’re being very much more actively involved saying you can only have six sessions for a serious PTSD [post traumatic stress disorder] and someone is sprouting some nonsense about being able to cure it in that time. So you say “hang on you’re not a doctor you’re not a psychologist you’ve never seen the patient so what the hell are you talking about?” Well they say that’s what the literature says or whatever. So it really puts enormous constraints on our capacity to work with people. (Richard)

Having freedom to work for longer periods of time when necessary was a significant issue for the majority of participants. Justifications for time limits from third parties that were based on the ‘scientific evidence’ were a source of frustration for participants.

...it's about that balance between their timing and the artificial time that's been imposed on the process and sometimes it works fine because they're going to move quite quickly anyway because they're ready and they're ready to take what you say and they're ready to trust and it builds quite quickly. And other times it just doesn't. (Richard)

They've got some shiny studies from universities that will say six sessions of CBT is enough for PTSD. And expect that we can treat PTSD in the real world, when we can't control for comorbidity, we can't control for other lifestyle factors going on at the moment. Someone who has a PTSD from a car accident who still has to drive their car to and from work and still has near misses. Um, there I'm finding inappropriate pressure. Pressure that compromises the treatment. (Beatrice)

Overall, participants saw a difference between time limited therapy and therapy that ended up being short anyway, and felt that external restrictions on time were a move away from therapy based on the client's presentation. Factors associated with individual approaches to therapy impacted on how a time limit was perceived.

What counts as a suitable outcome

In considering how long therapy should be it is essential to consider the aims; that is, what constitutes a successful outcome. Participants differed markedly in their ideas about what psychotherapy should aim to achieve for clients. Differences were found between participants in relation to how much of an active role a psychologist should have in contributing to outcomes, how durable an outcome should be, how 'deep' an outcome should be, and whether outcomes relate to symptom removal alone or some type of personal development.

I guess that's what's different for me [when working in a time limit], is that I prefer to be very holistic, and not just deal with what's in front of me now but try to give people something that will build their resilience for future problems. (Beatrice)

He'd come from a lifetime of neglect and it came out of that neglect that he didn't really know how to look after himself so I needed to send him off to burnout retreats and...help him organise his time more effectively and do all of those sorts of things, I mean it was all intellectual. You know, he could do it, I mean he'd start putting some of those things into place. But he really needed more than 10 sessions to really understand, REALLY get what it meant to not neglect himself. (Quibilah)

...the ones [clients] that just want you to know how bad their life is. And that's probably where the beauty of the psychodynamic counsellor, the supportive counsellor, the psychotherapist and all those sorts of people because they operate perfectly for those people. Because they are after reassurance. But I don't, being a CBT therapist and a clinical psychologist, I don't think that's my role. I will do it to a certain degree so that they believe they're being heard. But I won't do it much and I'm not that type of person. (Isabel)

Some participants observed that their ideas about suitable outcomes changed through the process of working in time limited referrals.

...your expectations that you've got to work miracles in six sessions, um, you just sort of let that go a little bit and just do what you can at the time. (Patrick)

Perceptions of what constitutes a successful, or adequate, outcome were thus related to the treatment philosophy of participants. Some participants reported that a good outcome is just keeping clients going while others wanted more; what was seen as 'working' therefore depends on this perception of an acceptable outcome.

The Client

The other human resource brought to time limited therapy is the client. Participants' perceptions of different 'types' of clients made a difference to the perceived impact of a time limit. A client perceived as more complex for instance, may act to increase the impediment of a time limit, whereas a factor such as client motivation was seen as something that could be improved through a time limit. This section will discuss how

these types of client ‘inputs’ related to experiences with third party determined time limits for participants.

Some participants reflected that the ‘type’ of clients referred through third parties may be different.

I think you get a different type of client coming through the Better Outcomes because you're getting the people who can't afford the private work and.....so you're getting a different type of client and so I'm getting people who wouldn't otherwise have come along to pay privately. (Tessa)

Some participants saw the expectations of clients as fundamentally different when coming through a time limited program. This difference arose out of the time limit itself as well as the nature of referrals under funded programs in Australia, where clients do not necessarily initiate a referral to a psychologist.

... there's a difference because they think well, I'm just going to get something in six sessions, maybe 12 sessions, I'm going to get something that will work for me in that time. Whereas someone comes, just rings me up out of the blue, they will go with my assessment, to a degree. I'll put it "Well the two of us will need to assess it, but we will trust, between us we will trust that we're going, you know how far we need to go, or where we go or for how long". Whereas the program defines things, so really they've got a mindset of six sessions. (David)

Yeah, they come here they think I'm a doctor. So I have to explain, look I'm not a GP, my approach is not medical, ah you need to be more active. I will talk with you and you will also have a say to things. But they sense sometimes I think that because you are [a] health professional you know more than them. (Colin)

Client expectations may therefore be a further source of difference for psychologists when working in time limited referrals. The next section will consider the perceived role of client complexity in determining the impact of a time limit.

Client Complexity

Participants reported that the complexity of clients' presentations acted as a mediator to the constraint of a time limit. Firstly, participants highlighted the extent to which they needed to deal with situations that were complex.

Colin: Um, in reality, people who come to seek psychological help [do] not always bring psychological problem[s]. They also can bring a social problem, let's say dealing with Centrelink, and sometimes I need to prepare a report for Centrelink. And it takes me more time to prepare a, like, one or two page report just to explain the person. Um, people who are being affected from Department of Housing for example. So it's not only just psychological per se but sometimes also social and I need more...sometime[s] I need to do a visit to a person's house. So, yeah.

Tracey: Ok. So your role is stretched as a psychologist?

Colin: Yes

One client factor that was associated with complexity was personality disorders. For example, one questionnaire participant emphasised that it was essential to have longer term therapy with complex cases because '*short-term therapy can be detrimental to functioning of clients with personality disorders*' (Questionnaire Participant 11). The more complex a client's history or presentation, the less likely was the psychologist to feel as competent to treat the client as they would without a time limit.

There's been a lot of people who have come through with very long standing depressions for example for whom six session is hopeless.
(Beatrice)

...with more complex cases you're going to get to the end of the six sessions and sort of think "Hang on I really need more [sessions] but I haven't got them". (Tessa)

The severity of the disorder or the length of time that clients had their disorder for, thus acted to make participants feel more time was necessary.

The relationship between sexual abuse as a child and ending up in a violent relationship as an adult is, certainly in my treatment population, very high. There's a lot of work that needs to be done there. And it's the type of work that I can't do very fast. I don't know about other people, but I can't do it very fast. Twenty hours sounds like a lot of time, but the problems are so complex, there is complex PTSD, and PTSD, simple PTSD from a big problem, I don't mean a little PTSD from being in an armed hold up in a bottle shop kind of thing, that might be done in six to 12 sessions quite easily. (Beatrice)

It sometimes is a problem for – if cases are more complex or more chronic and it seems that the person could do more work, it's a problem in that it can some times take a few sessions to establish rapport with them and by the time you get there it is too late to start looking at any sort of underlying things – so I think that's a problem sometimes. (Jessica)

Client complexity was an issue which made psychologists reconsider how they should approach their therapy and what the goals of therapy should be when time was limited. The process changes as highlighted in the next chapter were particularly evident when the client presentation was of a complex nature.

Particularly people who've had abuse histories or something like that they want it to unravel at it's own pace sometimes. It's like [rushing] 'And then what happened then? And then? Now great, now what we need to work on is this.' And it's not that you're presenting it that way but you're feeling that way on the inside you know? (Amy)

Issues to do with *external limitation* as opposed to *number of sessions* became apparent here as psychologists felt it was most important to have freedom with these clients. Some participants gave examples of times they had treated a complex client without a time limit, but the length of therapy was actually as short as a typical limited program, or even shorter. There were other times reported when the timeframe set by a third party was inadequate.

...it depends on the client entirely. And there's many who have got to the end of the sixth session and it's been completely unresolved and not because we didn't make a connection, and there's been improvement, but the problems are so big, that, you know, clear issues of personality disorder, great dysfunction in relationships... (Richard)

The appropriateness of referral was an essential ingredient in the successful provision of treatment when working within time limits.

So all of the pressures which you've been talking about, no I don't feel them in the Better Outcomes because those presentations are relatively uncomplicated and I think that's because of the screening process from referral. They're not supposed to be complicated. The doctors are supposed to screen. And if I'm happy with what's coming through then I guess they're doing their job right. But the Victims of Crime thing doesn't screen for that. (Beatrice)

Complexity thus arose as an important determinant to the perceived impact of a time limit. For clients perceived as more complex, the time limit was experienced as a greater impediment. Complexity and its relation to perceived outcomes are discussed in the next chapter.

Client Motivation

A number of participants speculated upon the tendency for time limits to affect the motivation of clients. This was of particular note for clients who were perceived as difficult in some way.

[A time limit] helps if clients are a little bit difficult or ambivalent or unmotivated; it either focuses them or there is an endpoint, which personally helps me – I think you know it's another 3 sessions and they'll need to leave anyway. (Jessica)

The issue of who pays for therapy was perceived to affect motivation as well.

If someone else is paying generally the motivation is different from if they are paying....and I don't mean people who don't care about

treatment because they're not paying, but people care more about things that they pay for. Not all of the Victims of Crime work that I do, but the vast majority of Victims of Crime work I do, I see a very high level of motivation and a genuine gratitude that someone else is paying for it. So, the someone else is paying for it thing doesn't affect them. (Beatrice)

In general, participants seemed to feel that there was a difference in client motivation based on whether clients decided to attend therapy of their own volition or if a referral took place and clients would not have otherwise invested in therapy. External factors also impacted upon the motivation of clients according to some participants. Isabel felt that she could 'manipulate' the need to report back to GPs as a motivational influence on clients' homework completion.

...because also when they don't do their homework you can say things like I'm going to have to write in your report that you're not going to do your homework. And weird as it is, some people need a higher source. I know that's really stupid, but if they don't have the motivation themselves, then you have to use what you have to motivate them. (Isabel)

Client motivation was therefore perceived to be impacted through time limits and also the broader context of third party providers of psychological services. The issue of who pays for therapy was also considered to bring about different levels of motivation from the perspective of some participants.

Clients' Expectations

A number of participants referred to the idea that they thought clients were also acutely aware of time when working in time limits and might adapt their expectations of therapy to the amount of time available.

And it's funny how, I don't know that it was really, I mean I often found that people kind of really themselves understood that short-term nature and so although they might disclose about the child sexual assault, and I might have an opportunity to say some stuff about that to them. Standard stuff it's not your fault blah blah blah, but

sometimes that was... whether they just understood that that wasn't the place to do that work... (Sally)

Some psychologists expressed concern that the time limit might lead to clients automatically expecting to get better within the time prescribed. The concern was that clients would perceive the time limit to be an indicator of when they should be expected to get better by.

...the other thing is, which is quite important is some people they think that ok, so because I've been allocated six and 12 sessions, I only need to go in for that long, and some people will actually think that they have done all the psychological work that they had to do on themselves because they were given those six referral sessions, so you know they might still be living with the consequences of not really sorted everything out properly. So it might give them a misperception that they have already addressed and treated a certain condition and their condition might still be there. (Zara)

The other thing that worries me is the expectations in the client for if they don't get better in six sessions. And that pushes that sort of idea that they've got to change. And if they don't change they fall back and it's even more exacerbated their sense of hopelessness etc. So that's the main thing I see um, that sort of pressure on the client in a sense. (Patrick)

Issues of closure became evident as participants referred to the need for clients to feel that (at least) something is finished when therapy takes place in an arbitrary time frame.

And the other thing, it's important that clients are able to reach some resolution in the number of sessions that have been given for it to be therapeutically helpful anyway. (Fiona)

Participants indicated that in response to the potential anxiety from expectations regarding time limits they would emphasise the arbitrary nature of the time limit.

Yeah, the idea that with six sessions that everything's going to be fine, it's not realistic and I ensure that the client knows in a sense. And the

pressure on them is not that. They might feel fine after six weeks or they may not, but you've got to be careful that that sort of ridge of six sessions is probably financial more than anything else. (Patrick)

In being aware of potential negative implications for clients' awareness of the time limit, participants indicated that they would act to account for these implications through informing the client about the arbitrariness of the time given.

This section has shown that factors regarding the individual characteristics of clients were therefore seen as determinants that impacted upon the experience of working in time limits. The type of clients who participants saw made a difference, and client motivation and expectations may be impacted by a time limit.

SYSTEM RESOURCES

The system of managed care in Australia has its own resources, and these resources differ depending on the source of third party referral. These resources were shown to be important to participants; the impact of the time limit could not in many ways be separated from them. This section will show how the ability to refer on to other resources or continue with therapy beyond the time limit was an important mediator to the perception of a time limit, and also how the flexibility of the referring agency made a difference. It will also consider the aims of third party provision of psychotherapy in terms of access and equity.

Ability to Refer On/Continue

For some participants the ability to refer on was a mediating factor to the pressure of a time limit. Participants reflected that they would assess which programs their clients might be eligible for and then refer them on to that after an initial block of funding. This referring might mean that they stay with the same psychologist or go to another psychologist for further treatment sessions.

...there is a small percentage of people that continue for a long time and a larger percentage that continue for a few more sessions. (Harriet)

...you know they've been a couple of cases that were really hard and really difficult, but they have actually been victims of crime cases and I've been able to move them over into that, so that's been alright. But if I didn't have access to that it would be much more frustrating for me. (Beatrice)

Finding a place or program to refer to also sometimes took up time within sessions (that were limited) and required the psychologist to think creatively about relevant services to refer to.

Yes it is a timely sort of...it's thinking and then making a few calls and finding appropriate services in the area where the person lives and so it's not always simple. Sometimes it's simpler than it sounds though. If you get lucky. (Amy)

Psychologists who referred on reported an attempt to access further free or subsidised sessions for their client in order to be able to continue with them. If it was necessary to refer on then at times psychologists would be reluctant to get involved with their client at all. A degree of frustration was acknowledged about this process, which was seemingly dependent on the seriousness or complexity of the client's presenting problem and the resources available to refer on to. Frustration also tied into psychologists' beliefs about the accessibility rights of clients to seek funded psychological treatment.

And I mean, there are times when I use six sessions to link people up with community services, so I don't treat them, I say I can't treat you because you need long-term work. But I've had, say I get a transsexual person who needs long-term assistance, who's had lots of abuse, they've come in here because they've been bashed by machos out there. So I would focus a lot on trying to link those people up rather than treat them. (Nora)

And so it meant there was only a couple I've seen who really what I've needed to do with the time is organise referrals to other services, rather than get them started in a therapeutic alliance with me. (Beatrice)

At times when referring on was not an option, participants reported they would become even more aware of the need for the client to feel ‘finished’ with therapy, and therefore try to give them a positive experience and encourage them to come back if the need arises.

I think the mistake, if you try and do too much when you’ve got a short time then the experience isn’t as active and not as productive for them and they may actually think “oh well I went to a psychologist but it didn’t help”. And then that link’s gone. Whereas I find sometimes with the short-term people I see they’ll come and they’ll have their six sessions and they’ll go away and then they might come back a few months later saying that was really helpful and now I’m ready for some more. (Xuan)

The type of program psychologists were working with also impacted upon the extent to which they could readily refer on or continue past the allocated funding.

[The] benefit of EAP work is that you can make ongoing referrals to either a psychiatrist or a psychologist or back to a medical practitioner or something like that. With the EPC you could do that too but it’s just a little bit more restricted. (Vera)

Referring on was thus seen as a way to get around the constraints of a time limit.

Flexibility of Third Party Funder

The extent to which the third party was seen as flexible was important in determining how constrained participants felt by time limits. Beatrice spoke about a time when the third party that was funding treatment extended the allocation of sessions based on her request.

So the limited nature of the therapy was doubled under those circumstances. And knowing that I had the freedom to work between six and 12 hours was actually really good. (Beatrice)

Psychologists reported on their opinions of specific funding programs in relation to the flexibility that they have over funded time for therapy.

...actually Victims of Crime are pretty good – they give you two hours to begin with including the writing of the report – so you have an hour and a half plus writing a report and then you send a report and you can recommend maybe eight hours or whatever you think – so their time is pretty good – I have even had as long as 16 sessions through Victims of Crime and other therapists have had longer I think because post traumatic stress is hard to cure. (Lucy)

Ah, it has its moments, it depends on, in certain cases, particularly with insurance there can be varying degrees of flexibility so sometimes you will get 10 sessions approved and will review the need for further sessions and they'll review the need for further sessions. So sometimes that's it - that's what you are getting, you've got to make the most of it. (Ken)

Richard spoke about a client who had completed 18 months of treatment with outcomes perceived to be good. Richard reflects that if this client had come through a funded program such as BOMHC and possibly just received six sessions the outcome would have been very different, and potentially harmful.

So in that sort of situation, eighteen months was not enough although we did very significant work. Six sessions he probably would have killed himself. So, depends on the patient and what's required and there should be a capacity to say look he finished in that time, it's all they need, or done this much work and these people need more and we need to be able to extend that, to get insurers and other people to see it that way. And to trust in our judgement. (Richard)

How flexible the third party provider was thus identified as an important factor in the experience of working in third party determined time limits.

Issues of Access and Equity

Despite the research intending to focus mainly on issues regarding the application of therapy in time limits, many participants referred to peripheral political issues. One of the main issues that arose in this domain was those relating to equity and access. Participants had different ideas about the construction of equity through third party

funded programs; some said that equity was enhanced while others were frustrated at the lack of equity. This section will reflect participants concern for issues of equity and the factors that influenced perceptions of whether time limits are accompanied by more or less equity.

Many participants reported that providing access to people through third parties resulted in a significant benefit to society because people who had previously been unable to access psychological services now had a degree of access.

The main thing that I like I guess is that it has made psychological services so much more accessible than they were before all of this happened. (Jessica)

The managed care model of service delivery that time limited programs can be seen to be operating under, have limitations in the extent to which certain client groups can be helped.

...someone who's got a personality disorder who's come to me through that, I'm thinking this person, they need extensive work. You know there's no framework within that kind of work to create a supportive environment, and some people need that. (David)

However, some participants said the short time frame of some time limited programs meant that they refused to provide services through them. These concerns were particularly apparent when talking about shorter time limited services such as EAP with a three session limit.

...they do offer a contract of like three sessions or something like that, and I've always thought that that was inadequate and unethical. I would only have ever got involved in something like that if it was clear from the start that that was an assessment and referral service only. I didn't even want to pretend that I could do therapy in three sessions because, quite frankly, if three sessions is enough you didn't need me in the first place. (Beatrice)

One psychologist who had a letter written to her requesting participation emailed me to say the following.

Thank you for your recent correspondence inviting me to participate in your research. I certainly feel that this is a very worthy subject! However, I am not seeing any clients under the schemes mentioned. Perhaps my explanation for this will be useful in the broader context of your research. I am registered via the Medicare Allied Health programme, but have not communicated this fact to my referrers. While I believe that the initiatives are steps in the right direction, I do not feel that I could work within the limitations set. I am also concerned about administrative requirements. For the very same reasons, and on the basis of prior experience, I am now also refusing to work with any clients involved in compensation cases. I wholeheartedly support broader public access to psychological services, but as a sole practitioner, I do not feel that I can operate effectively and efficiently within the confines of the schemes offered. I would assume that I am not the only psychologist in private practice making these choices. Best regards and best wishes for your research!

Uptake by psychologists of third party funded psychotherapy may therefore be impacted by the limitations involved. Nora had strong opinions about the limitations inherent in time limited therapy.

Well I think it's abusive. And generally inadequate. And of course what happens then is ethically, if you get somebody who, and most practitioners will tell you this I think, I'd be surprised if you don't get a number saying this, that when you do get somebody and you know that person needs more sessions, you give them more sessions at your expense. (Nora)

The idea of *pro bono* work was reflected in the responses of other participants as well. Three questionnaire participants reported that they would refuse to even begin treatment in complex scenarios if there was a time limit; *'I believe it would be unethical and abusive to begin this unless I was prepared to pro-bono follow up to completion'* (Questionnaire Participant 38). For those participants who did not indicate that they would refuse treatment in time limited conditions, a large subset expressed disappointment and frustration with the outcomes that could be achieved.

...her husband started getting abusive again so what did she do she went straight back to the poker machines and that was at the sixth session, and yeah frustration because she was not strong enough to be able to rise above it – so that is what I mean about the longer sessions of the – you know – even 12 sessions would have been better than just the six but there was a possibility through the General Practice division of having three more sessions but Liverpool ran out of funding – so the three sessions were not available for her and that is frustrating. (Winona)

Yelena: I actually would think if I were to work only with Medicare or Better Outcomes – for me as a therapist that would be very frustrating.

Tracey: Why?

Yelena: Because of the time limit – it is too frustrating to have to leave things undone, so I am happy with just a sprinkling.

The ability for clients to afford further treatment affected the extent to which this disappointment was felt.

But sometimes I feel very disappointed I can't complete what I started because of the limitation. Especially with the patient who can't afford to continue. (Adam)

David spoke about feeling pressure to act in such a way to ensure future funding of psychological services could be obtained.

David: ...well in terms of accountability, well I'm always accountable to the client. But with the program I'm kind of very keen for the program to be seen to be um, good. You know, because I want them to continue and be expanded and, so ah, I feel there's a third push forwards.

Tracey: So you're accountable not only to the client but also to the program?

David: Yeah that's right. To the success of the program. Not just that I've got to write all these reports, but I want it to work. (David)

Working in time limited programs created a difference in the scope of work for psychologists, and some participants indicated that this needs to be taken into account with factors such as supervision.

So it's high frequency for the psychologist and high intensity. And so because of that there's a much higher potential for burnout in psychologists in that line of work. So obviously supervision is a really important aspect of the professional management of that. (Sally)

In that regard, whilst access to psychological services had been increased through third party payers, concern was voiced over the types of services that could be provided through the time limits that came with this. In some cases, this could make psychologists reluctant to provide psychotherapy with certain types of third party providers.

CONCLUSION

This chapter has reported on findings that relate to the broader system that time limits operate within, and how certain factors act as inputs to determine the impact of a time limit. The system was shown to be important in determining how participants related their experiences of working in time limits, as the time limit was a factor of this system that could not in many ways be separated from it. The first section of this chapter showed that the third party imposition of a time limit was different to the use of a time limit for clinical reasons, or for therapy that might go for a short amount of time anyway. Overall, time limits were perceived as less than ideal for the therapeutic setting and while some participants expressed frustration with this, to have some therapy funded was better than having nothing. Participants also reflected on the experience of being managed by third parties and reported that they felt more accountable because of this. There was some attempt indicated by participants that different funding mechanisms could be 'worked' in order to provide more time in some contexts. The second section of this chapter considered the role of human resources in time limited therapy in determining the impact of a time limit. Participants were found to differ in

their therapeutic philosophy and their perceptions of how much time was necessary for treatment. Findings also show that perceptions of the client make a difference to time limited therapy; clients perceived as more complex were experienced as an impediment to effective time limited therapy, but a time limit could act to increase client motivation from the perspective of some participants. The third section of this chapter considered the resources of the broader 'system' in which time limits operate within and showed that experiences with this system determined in some ways how time limited therapy was perceived. Participants preferred to have the ability to refer on when needed and to have flexibility with the time available for treatment, although this would not necessarily extend therapy for most clients according to participants. While there was an acknowledged increase in access from third party provider systems, some participants expressed concern over the equity of this access for particular groups of clients. The next chapter will present findings that relate to changes in the process of therapy in order to adapt to the frame of the time limit and how outcomes are perceived in this context.

CHAPTER 5: PERCEPTIONS OF THERAPEUTIC PROCESSES AND OUTCOMES IN TIME LIMITED THERAPY

INTRODUCTION

This chapter will present findings that relate to the therapeutic process and perceived outcomes in time limited therapy. Findings in both the interview and questionnaire show that psychologists adapt to time limits by changing the process of therapy. There will be four sections in this chapter; the first section will consider changes in therapeutic approach and orientation, the second will consider changes in planning and structure, the third will consider changes in the conduct of therapy, and the last section will show perceptions of outcomes when working in third party determined time limits.

SECTION I: CHANGES IN THERAPEUTIC APPROACH AND ORIENTATION

Overall, findings in this section show that participants' approaches to therapy are perceived to be different when working in time limits. This section will show how the overall approach was viewed to change, and how theoretical orientation was flexible based on the time available and the complexity of clients' presentations. It will then go on to consider the use of psychoeducation in time limited therapy and how the therapeutic alliance was perceived to be impacted in this context.

General changes in approach

A number of participants indicated that they were likely to change their treatment approach when working within time limits to allow for appropriate gains to be made in the time specified.

...sometimes the um, the time limits make you work in um, different ways as well. (David)

After Amy described her theoretical approaches and stated that she tried to tailor her interventions to each client, I asked her if having a time limit would ever be an influencing factor to her therapeutic approach. She replied;

*I try not to let it do that but obviously sometimes it does [sighing].
(Amy)*

Participants reported that when working in time limits they were more inclined to use techniques that focussed upon the immediate issues at hand and enabled a recovery of symptoms. In order to do this, participants felt that they were working faster and with less depth.

*I guess I try to work a little bit faster, in case there isn't going to be an extra bunch of sessions at the end of it. Um, I think I'm probably less systematic, which, it sounds counter-intuitive, but, the things that I listed to use that I like to do, I reach into that bag and use what I think is necessary for this person and spend more time on this area with this person because that's what I think they need and so on.
(Beatrice)*

Depending on the type of preferred theoretical approach, psychologists reported feeling a need to change their preferred type of approach when working within time limits.

... [when time limited and] needing to do strong solution focussed work I'm not going to suddenly go off into Klienian psychotherapy or Freudian or Buddhism or something like that. Whereas I may draw on some of those things for someone who's really doing a lot of in-depth self development. So I won't go off into all those different branches while we have got a current situation that we need to focus on day to day. (Vera)

...each person's different but I guess you tend to use more cognitive and emotional based techniques with those briefer ones that you have no choice in. (Amy)

For psychologists who reported being psychodynamically oriented they felt that working within time limits made them more focussed on the here and now. This was viewed as a limitation in so far as therapy took on a 'superficial' focus with short-term gains and a questionable long-term outcome.

Whereas I won't focus too much, I'll use the countertransference but I won't be working as dynamically because with the shorter term clients I'll have an awareness, I'll be able to see it but I won't necessarily work with it because I can't open it up so big. (Quibilah)

Some participants discussed cases when time limits were extended or clients decided to continue therapy by paying for themselves for an indefinite number of sessions. The shift from time limited therapy to open-ended therapy brought about changes in approach.

So we got another lot of sessions and then she paid for herself. And initially it was very much focussed on CBT, and just recently I've become more psychodynamic and working with the functional adult and doing some hypnotherapy with her which I wouldn't have done with the pressure to use CBT and she said to me 'why didn't you give me this months ago?' She said 'wow this is fantastic!' So I think that's quite a good example. (Ursula)

This section has shown that participants broadly feel that their approach to therapy is different when working in time limits, separate to specific shifts in theoretical orientation. The next section will consider questionnaire findings relating to choice of orientation dependent on whether or not time is limited.

Choice of therapeutic orientation in different levels of time and complexity

This section will consider whether a time limit influences the choice of therapeutic orientation. Question One of the questionnaire asked participants what type or types of therapy they would use under the four conditions of the questionnaire. In addition to Cognitive Behavioural Therapy (CBT), Interpersonal Therapy (IPT), Solution-focussed Therapy (SFBT), Acceptance and Commitment Therapy (ACT), Psychodynamic approaches (PD), and Narrative Therapy (NAR), participants also had the option to

complete an option for 'other'. The frequencies for ACT and all responses put in 'other' were not high enough to include in the following analysis. Findings show that the choice of therapeutic orientation was related to both the time available and the level of complexity.

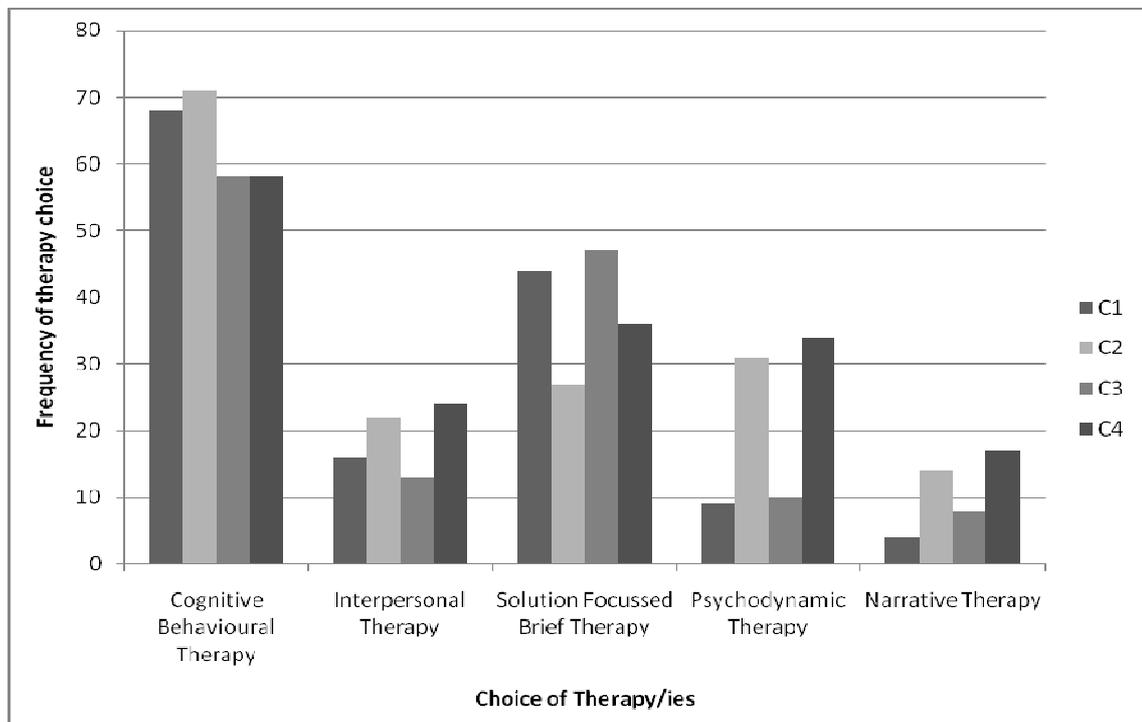


Figure 5.1. *Frequency of therapeutic techniques as a function of time condition and complexity level*¹⁵

Statistical analyses were done on CBT, IPT, SFBT, PD, and NAR to test for the significance of changes across conditions.

Table 5.1: *McNemar significance of differences in choice of theoretical orientation*

Conditions	Exact Significance (2-tailed)				
	CBT	IPT	SFBT	PD	NAR
STL & STUL	0.453	0.109	<0.001*	0.000*	0.002*
CTL & CTUL	1.000	0.013*	0.007*	0.000*	0.035*
STL & CTL	0.041	0.581	0.690	1.000	0.125
STUL & CTUL	0.002*	0.754	0.078	0.508	0.508
STL & CTUL	0.052	0.115	0.216	<0.001*	0.001*
STUL & CTL	0.004*	0.049*	0.001*	<0.001*	0.146

*Significant at the $p < .05$ level

¹⁵ STL – simple time limited
STUL – simple time unlimited
CTL – complex time limited
CTUL – complex time unlimited

Overall, the use of CBT significantly changed between the four conditions ($Q = 15.629$, $df=3$, $p<.05$). McNemar significance tests show that the use of CBT differed significantly between the “STUL & CTL” conditions, as well as the “STUL & CTUL” conditions. This means that CBT was significantly less preferred in both CTL and CTUL conditions compared with STUL, showing that CBT was less preferred when the situation was complex irrespective of whether time limits were applied or not.

The use of IPT changed significantly between the four conditions ($Q = 10.862$, $df=3$, $p<.05$). McNemar tests to follow up the location of these differences showed that use of this therapy significantly differed between “CTL & CTUL” conditions as well as between “STUL & CTL” conditions. IPT was therefore favoured in complex cases over simple ones, and this difference was more pronounced when working in a time limit.

The use of SFBT changed significantly between the four conditions ($Q = 19.808$, $df=3$, $p<.001$). McNemar tests showed that the use of SFBT differed significantly between “STL & STUL” conditions, “CTL & CTUL” conditions, and “STUL & CTL” conditions. This means that SFBT was significantly favoured in time limited conditions compared with time unlimited conditions.

The use of PD changed significantly between the four conditions ($Q = 57.214$, $df=3$, $p<.001$). The McNemar test showed that the use of Psychodynamic therapy differed significantly between the “STL & STUL” conditions, “CTL & CTUL” conditions, “STL & CTUL” conditions, and “STUL & CTL” conditions. This demonstrates that Psychodynamic therapy was significantly favoured in time unlimited conditions over time limited conditions.

The use of Narrative therapy changed significantly between the four conditions ($Q = 18.969$, $df=3$, $p<.001$). McNemar tests showed that the use of Narrative therapy differed significantly between the “STL & STUL”, the “CTL & CTUL”, and the “STL & CTUL” conditions. This shows that narrative therapy is preferred in time unlimited conditions compared with time limited, and is more utilised in complex presentations.

This section has shown some significant differences in choice of therapeutic orientation based on both the time available and the level of complexity. Cognitive behavioural therapy appears to be favoured in simple presentations compared with complex, whilst solution focussed therapy and Psychodynamic therapy vary based on the time available.

Whilst solution focussed therapy is a favoured choice in time limited conditions, Psychodynamic therapy is favoured in time unlimited conditions. Findings in this section have shown that a time limit contributes to the choice of therapeutic orientation. It has also shown how participants respond to client factors (complexity) in adapting their therapeutic approach.

Psychoeducation

All the interview participants except one (Isabel) reported that psychoeducation and the use of self directed learning play a bigger part in their therapeutic approach when time is limited. The very focus of therapy is more likely to turn to the alleviation of symptoms and therefore psychoeducation provides the most readily adaptable tool to provide treatment gains in short and/or limited amounts of time. Psychologists interviewed felt a responsibility to give clients the tools to improve their condition and this was accomplished through placing a firmer focus on psychoeducation when working within time limits. Self directed learning became a tool to compensate for the lack of time psychologists were able to spend with their clients insofar as it was an attempt to continue therapy beyond the limited amount of sessions available.

And I've always used a lot of handouts and things like that so I think that really supports and improves your efficiency in a time limited framework. In fact I don't see how you could do it without it, without handouts to be honest. (Sally)

I'm just probably more aware of it when there's only six sessions so you might dish out a lot more stuff [handouts] in a sense. (Patrick)

...how they can control their problem by their own thinking way and their own thoughts. So patients have to think this way in any sort of treatment. Especially because of the limitation. So I would want to emphasise to psycho-educate my client. Because I know I'm not with them a long time. I know they can't get access to me any time. So I put a lot of emphasis on psychoeducation. (Adam)

The increase in psychoeducation was seen by some participants as a different type of mindset to therapy without this focus.

And if I think about how I compare my mindset when I'm doing that to when I'm doing the short-term stuff it's more sort of educative I suppose in the short-term one. That's probably a bit more in my mind; it's a little bit more business-like and a little bit less psychoanalytic. So it's a bit more psychoeducation, more towards that. So if I was to have to kind of conceptualise, it'd be psychotherapy versus psychoeducation...almost. (Sally)

The focus on psychoeducation was reportedly used in an attempt to give clients skills so that the outcomes of therapy can be achieved despite the limited access to psychologists.

And so if I'm working short-term I'll work much more cognitively and I'll work psycho-educationally, so I'll try, what I'll try to do is I'll be training people in the skills in order to help themselves. (Xuan)

In order to make the most of available time, a number of participants indicated that they would use adjunct treatments. Using these treatments therefore limited the extent to which the time limit was seen as a constraint.

[I'm thinking] can we provide additional resources, self-help groups, exercise programs, you know whatever. That sort of stuff. I hone in pretty quickly on doing those things and I do send people off to...I'm a great believer in 12 step groups and other self help groups. So I'll always get people if they want to go along in addition to whatever work we do. (Vera)

...like I'll often use particular self-help books in concert with the six sessions and that works really well. (Grahame)

The type and complexity of the presenting problem also indicated the extent to which adjunct treatments could be successfully used in order to limit the constraint of a time limit.

I've had quite a few people come through that program who've presented with panic disorder or a GAD [generalised anxiety disorder] and I've done the initial assessment and then straight away

I've sent them away with the panic surfing manual which they can work through over six sessions. And that's a five session program and it works beautifully so I'm often doing that. I find that the programs limited when, I mean it's definitely limited for people with personality disorders. It's not very helpful for that but I have used schema therapy approaches using some of the stuff published by Jeffrey Young, who's the schema therapy guru if you like. And what I often find is that I can recommend that people go and buy his book, work through it, space out the sessions, and then also have a little bit of email contact as well. And that allows me to really utilise those sessions well.
(Grahame)

For clients without complex presentations adjunct treatments were perceived to be helpful in ensuring appropriate gains in limited amounts of time.

The shift towards psychoeducation and self directed learning in time limited therapy is important because it demonstrates firstly that psychologists change their approach, and secondly that this approach to change still attempts to leave clients with an improved outcome.

The therapeutic alliance

The therapeutic alliance has been shown to be a key ingredient to successful psychotherapy, as discussed in Chapter Two, and some participants reflected on the perceived effect of time limits on the therapeutic alliance. Having a time limit was sometimes seen as an obstacle to the development of an appropriate therapeutic alliance.

...because you can't push the therapeutic alliance and issues of vulnerability and trust. (Richard)

It is a huge challenge because if someone is long-term and you know it is going to be long-term, there are very very few psychiatrists who you can refer to for long-term work - those who do psychotherapy as a psychiatric practice are usually full up if they're good and there will be quite a long waiting list and a lot of psychiatrists just don't do it - so what to do - that needs to be discussed at the beginning of the

sessions and so immediately it is putting a limit on the relationship if you like - it is saying this is not going to be the secure platform that you need. (Iris)

Therapeutic process is therefore impacted by the broader system of time limits, in that the therapeutic alliance was affected by the limited scope a time limited referral might provide. Some participants reported an increased awareness of the need to develop a therapeutic alliance when time was limited.

If I know I've got a short time frame, then it's probably even more important the therapeutic alliance be built easier and earlier. (Ella)

...it puts more pressure on getting it right in the first session, perhaps, I suppose that could be advantageous if you look at it that way. You know you have to engage them in the first session and I think I tend to do that anyway but there is a lot more pressure on the fact that if you want this person to come back for six sessions you've got to hook them in the first one and then you've got to make sure that they feel they want to be involved. So I suppose one of the things it does is make you more aware of that relationship building aspect in the first session. (Amy)

Some participants indicated that the therapeutic relationship was essential to enter into 'deeper' parts of therapy. In this way, the time limit acted as an indirect influence over the therapeutic relationship as depth was prohibited through a time limit.

I think I tend to work much more cognitively, much more actively like a psychologist, and a lot of the other psychotherapists¹⁶ learnt to do this as well. But once the relationship is really established and they're actually more, they're comfortable with the setting and the therapist and everything, then they'll, you can take them a bit deeper, and you can take them a bit deeper into the murky bits of their minds, because they've got that relationship established. (Xuan)

¹⁶ Xuan had practiced in the United Kingdom for several years as a psychotherapist before relocating to Australia and working as a psychologist.

The major problem that I see it creates is interfering with the therapeutic relationship and limiting the kind of therapy that can be done, having to do this sort of band aid work rather than [inaudible] so to speak. (Yelena)

In reporting the perceived importance of the therapeutic alliance, Nora reflected that losing the ability to respond to clients on an individual level compromised the alliance.

So it really is very individual, and I think that's what's been lost in this, it's pushing us into a formula, and people are not formulas. They are individuals and that's what this, you know, it's so contradictory, we talk about the rapport with the therapist, that being the most important, 46% effective or whatever they say, I mean it's a long time since I read about it but if you talk about that that's about being sensitive and supportive of the person, and being in the moment with that person, listening to them and understanding it so they understand that you understood, and they get a sense that you're going to support them. And yet then we turn around and say we'll do it all in six sessions! (Nora)

External factors were also indicated as having an influence on the therapeutic alliance. The medical model was seen by Xuan as a determinant to the type of relationship that could be developed.

...you've probably, I probably work more, what happens then is you unconsciously pick up more of the kind of the doctory, the expert role in the relationship so I think it changes the relationship that you have with your client. (Xuan)

Findings in this section indicate that a time limit can act to influence the development of the therapeutic alliance. While participants indicated that they took on pressure to develop the alliance quicker, there was some scepticism about the extent to which this could be effectively done in limited timeframes.

SECTION II: CHANGES IN PLANNING AND STRUCTURE

Overall, findings show that participants report changes to the way that they plan and structure therapy when working in an externally determined timeframe. This section will consider what forms the focus of time limited therapy from the perspective of participants, and how this focus differs from their work without a time limit. It will then go on to look at findings that relate to the reported experience of rushing through therapy when working in time limits, and how this may influence the efficiency of therapy. Lastly this section will consider the structure of therapy when working in a time limit.

Choice of Presenting Problem and Predicted Treatment Plan

This section will present findings from open-ended responses to Questions Two and Three of the questionnaire. Question Two asked participants to consider “which presenting problem/s would you focus on?” Overall, 79% of participants in simple scenarios and 84% of participants in complex scenarios indicated a difference in their response to this question between time limited and time unlimited conditions. Question Three asked participants to consider “What would be your treatment plan for this client?” Overall, 87% of participants in simple scenarios and 92% of participants in complex scenarios indicated a difference in their responses to this question between time limited and time unlimited treatment. Therefore, for the most part, participants’ responses indicate that a time limit requires a different approach. Although these two questions intended to ask about separate domains (choice of presenting problem and treatment plan), analysis of these responses showed that themes largely overlapped. Findings from these two questions will therefore be presented together, as they relate broadly to issues of how participants hypothesised they would approach therapy.

Nine codes emerged from the thematic content analysis of Question Two and Three, falling into two major themes. Their names and frequencies are reported in Table 5.2. Coding identified that there were two broad types of differences between responses in time limited and time unlimited conditions. These two themes related to ‘doing more’ in unlimited conditions and ‘doing differently’ in unlimited conditions. The number of participants in Table 5.2 refers to how many participants had different responses

between time limited and time unlimited conditions. The following section will describe each theme and provide examples of responses that represent it.

Table 5.2. *Differences between predicted therapeutic approach in time limited and time unlimited conditions*

Themes	Categories	Frequency in simple scenarios		Frequency in complex scenarios	
		Question 2 (n=67)	Question 3 (n=74)	Question 2 (n=71)	Question 3 (n=78)
'Doing more' in unlimited conditions	Addressing more content	35 (52%)	0 (0%)	30 (42%)	0 (0%)
	More depth in unlimited	2 (3%)	28 (38%)	1 (1%)	25 (32%)
	More scope for historical factors	12 (18%)	12 (16%)	13 (18%)	17 (22%)
	More thorough assessment	0 (0%)	2(3%)	0 (0%)	2 (3%)
	Addition of a different approach in unlimited	0 (0%)	30 (41%)	0 (0%)	36 (46%)
'Doing differently' between limited and unlimited conditions	More symptom focussed in limited conditions	8 (12%)	0 (0%)	8 (11%)	0 (0%)
	More problem focussed in limited conditions	0 (0%)	6 (8%)	0 (0%)	18 (23%)
	More client-centred in unlimited conditions	1 (1%)	3 (4%)	2 (2%)	0 (0%)
	Referring on in limited conditions	0 (0%)	3 (4%)	3 (4%)	11 (14%)

'Doing more' in unlimited conditions

This theme relates to participants' responses indicating that they would do more when they have an open-ended timeframe for treatment. There were several ways in which participants indicated that they would do more in unlimited conditions; through addressing more content, working on a 'deeper' level, taking historical factors into account more, doing a more thorough assessment, and including a different approach.

Firstly, participants showed a considerable inclination to 'address more content' when unlimited with time. Responses coded in this category were rather straightforward in

the extent to which participants were clearly just putting additional steps, that is, their list of issues to address was growing. For example, in the simple limited condition Participant 1 wrote *'University, relationship with boyfriend'* and added *'relationship with mother'* in the simple unlimited condition. Similarly, while *'stress'* was written in the complex limited condition, *'marital separation; drugs and alcohol; emotional problems'* was added in the complex unlimited condition (Participant 8).

Secondly, participants' responses indicate that they would do more through 'working on a deeper level' without time limits compared with time limited treatment. 'More depth' was taken to mean either an explicit comment indicating depth or reference to the notion of looking further into issues through such things as questions of meaning and gaining a more complete picture. Participant 84 wrote in the complex unlimited condition *'as for brief but in more depth'*. More depth may also be indicated by the treatment plan beginning in the same way in both conditions, but adding scope for further consideration of issues in the unlimited condition. For example, in the simple unlimited condition Participant 14 wrote *'as before [time limited] but more emphasis on insight into repetitive patterns, more in-depth application of skills; broaden range of issues addressed and more opportunity for practice'*. More depth was also indicated through looking at the same issues but with more depth shown through time spent. For example, in the simple unlimited condition Participant 31 wrote *'ditto, but longer, more repeated sessions to better support rehabilitation (longer coaching/support phase particularly improvement)'*.

Thirdly, participants responses showed an inclination to have more consideration of historical factors in time unlimited conditions. Historical factors were taken to be those which are located in the patient's history and are not a current concern (although their impact may still be current). While focussing on current issues of safety in the complex limited condition, Participant 9 provided scope for historical factors in the complex unlimited condition; *'i) deal with most pressing problems first; ii) help her to understand and deal with issues from the past; iii) look at her sense of self; iv) help her to grow up emotionally'*. While participants' responses in time limited conditions reflected more of a tendency to focus on present issues, responses in time unlimited conditions included an account for the historical factors of a client's presentation.

Fourthly, some participants referred to doing a more thorough assessment in unlimited conditions. While in the time limited condition there was scope for ‘assessment’, in the time unlimited there was time for *‘assessment (thorough)’ (Participant 8)*.

Lastly, findings show that some participants used an additional approach, separate to theoretical orientation, in time unlimited conditions compared with time limited conditions. For example, in the simple limited condition one participant wrote *‘Mood and thought mapping; relaxation strategies; cognitive restructuring/rehearsal/values/decision making’* but added *‘Establish personal narrative on schema’* in the unlimited condition (Participant 5). Similarly, Participant 13 wrote in the simple unlimited condition *‘as for 5 sessions, but more extended use of narrative therapy to establish a more flexible approach to life; more exploration of the presenting relationship issues/trauma issues, if found’*.

Overall, responses in this section demonstrate that there is ‘more’ that participants would do in time unlimited treatment compared with time limited treatment. ‘Doing more’ in unlimited conditions related to addressing more content, working on a deeper level, taking more historical factors into account, utilising more assessment, and using additional approaches. The next section will consider differences in responses that relate to changing the approach taken rather than doing more.

‘Doing differently’ between limited and unlimited conditions

The second major theme to emerge from the open-ended responses to the questionnaire was that of ‘doing differently’. Participants differed in the extent to which their responses were different between time limited and time unlimited. Responses show that some participants hypothesised they would have a partly different treatment focus on presenting problems between time limited and unlimited conditions. For example, in a limited condition Participant 7 wrote *‘feelings of helplessness; time pressures’* but adjusted the response to *‘Feelings of helplessness; relationship with boyfriend and mother’* in the unlimited condition. While in the complex limited condition Participant 21 wrote *‘personal safety; grief and loss; short-term strategies and options for self and family; psychoeducation; cognitive restructuring’* he adjusted the response to *‘trauma and grief/loss; patterns of emotional dysregulation; family of origin; identity formation; self-harming syndrome; psychoeducation; negative self-image’* in the complex unlimited condition. Some participants’ responses indicate that the extent of this

difference would result in a focus for treatment that would be completely different between time limited and unlimited conditions. While in the simple limited condition one participant wrote *'stress/time management; depressive symptoms'*, in the unlimited condition they wrote *'separation/attachment issues re: moving out'* (Participant 85).

There were several ways in which differences in approach were shown in the data. Firstly, some participants demonstrated that their focus would be more on alleviating symptoms when working in a time limit: *'immediate symptoms (reduction of); interpersonal factors with her boyfriend (possible brief couples counselling); problem-solving re: uni work'* (Participant 33).

Secondly, some participants indicated that their focus would shift to problem-solving and other practical issues in limited conditions. Particularly in complex presentations, there was a preference to focus on problem-solving in time limited conditions that was not evident in time unlimited conditions. Participant 32, for example, indicated that, in the time limited condition he would focus on solving immediate problems (by using psychoeducation and helping the client to develop coping strategies), whereas, if he were working without a time limit he might focus instead on relationships and cognitive therapy for the client's perfectionism and anxiety.

Thirdly, the ability to be guided by clients was shown to be compromised through a reduction in client-centredness. Participant 60 suggested that she would be guided by the client's goals in the time unlimited condition, but did not mention this as important in the time limited condition. The participant considered that it would also be important to maintain a focus on stress management but would shift to a focus on the client's goals (*'hopefully explore on stress management initially but be guided more by what Luke brings to the sessions'*). Increases in client-centredness in unlimited conditions was indicated through responses that were less 'technique driven' and more 'client driven' in unlimited conditions. For example, in the simple limited condition Participant 9 wrote *'i) help him identify thought patterns that contribute to his anxiety and depression; ii) challenge and change those thoughts; iii) look at behavioural ways to ease his anxiety and depression: caffeine use, exercise, increase pleasant events'* but included scope for more client-centred work in the unlimited condition *'i) thoughtful and thorough exploration of issues; ii) identify areas he wants to work on and in which*

order; iii) use CBT and psychodynamic techniques; iv) support and guide client to make long-lasting changes’.

Lastly, different approaches were shown by a greater reporting of referring on to other sources in time limited conditions. For example, in the complex limited condition Participant 43 wrote *‘assessment of anxiety, depression, and suicidality; assessment of coping skills and support systems; referral to GP/SARC, mental health (whatever available)’* but did not indicate any referral to outside sources in their response to the complex unlimited condition. Referring on includes the use of self-help books and other things that require the patient to actively ‘work’ outside of therapy, however this code only applies when the ‘referring on’ happens in the limited condition only.

In summary, questionnaire responses regarding treatment approach demonstrate that differences between responses in limited and unlimited conditions fall broadly into the categories of addressing more issues in unlimited therapy and addressing different types of issues in unlimited therapy. While responses regarding choice of therapeutic orientation indicate that there are significant differences between the predicted types of approaches taken in the four conditions, open-ended responses of the questionnaire allow for some explanation of how treatment may differ regardless of theoretical orientation. The next section will consider how time limits may ‘speed up’ the process of therapy.

Rushing through therapy

The experience of time pressure was a key theme that arose out of the data. All interview participants reported feeling that they were under some degree of ‘pressure’ when working within treatment time limits, and that this pressure was absent when working privately or otherwise without time limits. Time pressure was also reflected in questionnaire responses. In some cases time pressure was mediated by the type of presenting problem, therapeutic approach, and the client. This pressure was seen as both a positive and negative force at times, and brought about changes to the process of therapy.

When working through time limited programs, psychologists were more likely to feel pressure to cover things in shorter than ideal amounts of time. Most participants

experienced this as a challenge and as something which pushed their pace of therapy to become faster.

...the challenge I guess is not to try to push too much in a sense. Obviously you don't have much time but that doesn't mean that you've got to double up and give them two sessions worth of information in one session. (Patrick)

Or sometimes the time limit can get me very panicky when I know that I've got a lot more work to do just to get that client OK, especially if they're a trauma victim, and I'm thinking Jesus, we've only got one more, ooooooh, we need more time! (Xuan)

Rushing through therapy appears in the data as an attitudinal factor separate to how much time might have been utilised without the time limit. When comparing the feeling of working in time limits with working without time limits, a number of participants referred to it as a feeling of being more relaxed with less pressure.

Well longer term people, then I use more psychotherapy, so we do more in-depth work. The content of the sessions is often quite different. So it's not as immediate, and there'll be more talking, more narrative type dialogue, a lot less rushed. So when we know we've got an open-ended timeframe it's not so rushed so it's a much more relaxed way of working. (Fiona)

Rushing through therapy was also related to pressure to avoid mistakes and make sure that the core of the clients' problems was addressed as soon as possible.

So it's hard for me because I'm thinking how fast have I got to get this done, where do I start, and there's no forgiveness of not starting with what's perhaps the most crucial thing. Or, it's not at all unusual to get to session number three and the most crucial thing emerges because it wasn't disclosed or it wasn't asked about. (Beatrice)

Pressure from the time limit was seen by some participants as a serious compromise to both the process and outcome of psychological interventions.

I think the pressure to push people along...that on occasion, I have found myself, where I'm pushing for a person along a bit more rapidly than is good for them. (Nora)

...you're only able to apply a sort of cosmetic quick fix type of brief therapy approach, whereas you might want to do something a little bit more in-depth. (Amy)

The presence of this time pressure meant for some participants that something was lost from the process of therapy. David refers to this loss as a decrease in the understanding of the significance of clients' stories when working differently because of the time limit.

I'm thinking well I want to get all the information I can very quickly, and therefore I might not understand the significance of some of that information. (David)

Knowing that the time limit was there also created pressure to do things that some participants felt was beyond their reach. Time pressure meant that psychologists became more aware of the disparity between the progress they had made and the progress that still needed to be made to achieve suitable outcomes.

And sometimes you realise that they're not moving and it's all going to take time and sessions are running out. And you know that if you try and push people then it's just going to destroy the trust. (Richard)

Like Richard above, a number of participants referred to the time pressure as a type of dilemma between 'staying with' the client and 'moving forward' because of the pressure of time. This section has shown that pressure is experienced by psychologists when the natural time course of therapy is perceived at odds with a restricted number of sessions.

Increased efficiency

While rushing through therapy was seen as a compromise to some important facets as indicated above, the need to rush was also experienced as a source of efficiency. This efficiency was brought about because rushing reportedly encouraged participants to maintain their focus, work to their optimum ability, and be very engaged in the

outcomes of treatment. A number of participants reported this to be a significant benefit of working within time limited treatment programs. It seems that awareness of the time limit could act as a source of motivation in a sense to make sure that certain outcomes were achieved in the time provided.

So it's quite nice to have that six week period to work towards, sorry that six session program to work towards, and then extend it if necessary. So I don't mind it, I think it actually gives clients a sense that you're on track. I wouldn't say that I'm the most structured therapist but it kind of gives me a bit of a structure to work towards. So yeah it's good. (Grahame)

Participants who reported this positive aspect to time pressure seemed to indicate that it was the increased *control* of time that was favourable. The time limit put firm boundaries around what could be discussed, the depth to which these issues could be discussed, and the time over which these issues could be discussed. The element of control thus introduced is not readily available without external time limits.

So on the one hand there's positive aspects to that, that um, you know, maybe I work quicker with that, and more, you know and I'm thinking more strategically if I work with a program¹⁷ [time limit]. (David)

David was able to identify the time limit as constituting a change in both his and his clients' sense of time and focus; however while acknowledging the benefits he also acknowledged detriments.

People have a sense that there's an end to it and, that in some ways sets both their own and my mind towards um, you know, "well we better get something done in that time". Whereas, sometimes you know if you don't have that, it can you know, meander, and I don't think that's bad necessarily as long as you can afford it, that's quite useful. (David)

¹⁷ The language that developed over the course of my interview with David meant that he used the term 'program' to refer to third party referrals that came with time limits.

Some participants' accounts indicate that the imposition of a time limit allows practitioners to have more control and hence influence over their management of time in therapy.

And [without time limits] you work in a slightly more sort of airy fairy type of way. That's not a very technical word, but I think you know what I mean. So yes although I always intend to keep it to a limited sessions, I mean I've certainly got some people who I've got in the past, I've worked with and then after a number of sessions I sort of think "hang on, where am I actually going with this? Am I just letting it extend too long?" Whereas with this [Better Access] you can't do that because you know that after six sessions you've got to have a review. And with some of them six sessions is it. (Tessa)

Amy felt the time pressure could make her so focussed on moving in a timely manner throughout therapy that it was beneficial to the energy that she put into therapy.

...but generally I think that can put some pressure on that building side of things and possibly bring out the best in you maybe. (Amy)

Some participants indicated that time limits were beneficial in also getting clients to adhere to the need to rush through therapy.

...it can be almost manipulated to do that for example if you've got someone who's perhaps not really immediately very good at explaining the situation or they're ventilating perhaps in, as much as I'd like to let them go on in what becomes an unproductive way then I can bring them back to task and say look we need to look at how we're going to divvy this up. We've got five sessions so I want to send you away today with something very specific to work with. So I suppose from that point of view it does whereas if a person is just coming along privately and paying a full fee and then I wouldn't, I would still bring them back to task because that's my job but I possibly wouldn't do it quite the same way. (Vera)

Time pressure could also act to increase client commitment, or at least have an 'out' to dealing with uncommitted clients, according to some participants.

It helps if clients are a little bit difficult or ambivalent or unmotivated, it either focuses them or there is an endpoint, which personally helps me – I think you know it's another three sessions and they'll need to leave anyway. (Jessica)

It can be seen that while rushing through therapy may be experienced as negative in some contexts by participants, there are also positive aspects that can propel therapy and allow for increased focus. Time pressure may provide a focus and a boundary in which specific, targeted treatment can be used to good effect. However, it might also “hurry up” treatment leading to the failure to deal with important issues, or reduce the effectiveness of the intervention. Time pressure may provide some motivation for psychologists but may also be reflected in anxiety and a sense of almost panic in other psychologists. Overall, this section has demonstrated that time limits bring an increased awareness of and pressure from time which participants feel simultaneously puts unrealistic pressure on them and acts to propel therapy through increased efficiency.

Structuring therapy

In addition to rushing through therapy, findings show that structure was perceived to increase when time is limited. Many participants reported this as a positive impact of time limits.

It certainly helps with the structure and the, you know “let's be goal focussed because we have only got six sessions together so we can't waste time, so we can't spend time doing things that are less relevant” – so it definitely helps with structure. (Jessica)

...you know when the boundaries are held better sometimes you can work better. (Xuan)

Yeah I think I spend a bit more time on the planning and just being more focussed on the particular things that I'm going to do instead of letting it become a sort of general you know, interpersonal type counselling. Which obviously you always spend some time on but I'm trying to be more structured than that for most people. (Tessa)

Therapy that was referred through a third party was reported to be more structured in comparison to therapy provided privately. The control over time that exists in time limited programs is absent from open-ended therapy and as such there is less need to keep to a firm plan.

So you know, sometimes [without a third party referral] you may only be getting one session with them, it's very difficult to gauge whether this client's now going to be a long-term client or a one-off from that one. Whereas the medical model I think has that structure that you know you've got to write a report on and you know you have to get something done. (Xuan)

But there's a sense I think that for people paying for themselves [not time limited], that they don't know when they're going to be finishing up. And I think they feel a little bit out of control because of that. Like they don't feel like, I don't think they feel like anyone in particular is directing how far things go on, how long things go on for. (Grahame)

The increased structure in time limited therapy also helped to facilitate containment and limited the scope of therapy, which was seen as advantageous in approaching time limited therapy.

...you can keep them very focussed on their goals, there's something nice about being able to say "we can only work on this". You know when they go "I want to do this, this and this", you can say "well look in our time frame we can really only work on this". And in some ways the endless stretch of the private client that comes in to see you, and that you have no limits on, it's actually harder to kick their butt as much as you can in a time limited thing. (Isabel)

Increased structure was seen to be of benefit to *both* psychologists and clients by some participants.

So it does give you a focus if you know how many sessions you've got, what you can realistically do with people so I guess it makes you more focussed in your intervention and you're upfront with patients from the beginning about what the limitations on the service are and what

you know. I think it helps them to really focus on what's important in the here and now for them. (Ella)

Increasing structure was a reported adaptation to a time limit, and was generally perceived as beneficial to the therapeutic process.

Assessment

Interview participants were asked to reflect on their assessment procedure when treating clients through time limited programs. For those who felt that they assessed differently, they reported an increased focus on immediate symptoms and as a consequence the assessment was likely to have less breadth. Participants were not unanimous in their comments on assessment. Some participants reported that their assessment stayed the same while others felt that it changed anywhere from slightly to substantially.

No, I don't do anything differently there at all. I need to find out why the person's here, I need to find out why somebody sent them, but I also need to find out why they're here. What's happening in their lives currently and a little bit of that history that will pinpoint what's led them to the present situation. (Vera)

Other participants felt that their assessment approach did indeed change as a result of time limits.

You're not allowing yourself to branch off into various assessments, thinking "I wonder if...?" you're just thinking "well I don't have time to wonder about that. We'll see how this goes". You can't be as creative with your assessment I suppose in that sort of context either. You might think I wonder if we're dealing with a sort of personality trait or you might look at occupational assessments [to] see whether they're suited to their job or something like that. You just think "well no they're not in that sort of situation. They're saying they're not so they're not". You can't really explore things as much through assessment. So that's probably a bit of difference to it. (Amy)

I assess more specifically at the beginning – if I have got – because if I know that it's an open-ended number of sessions I figure that I only need to work out what their primary concern is and then other things

will just come out as we go along if they need to whereas if it is limited number of sessions then we need to get really clear about what we are going to be working on. (Jessica)

It seems that the extent to which participant's approach to assessing changed depended on the formality of the assessment approach usually taken. For those who took assessments in a more formal manner, their assessment changed and reduced its depth, whereas for those who were more client-centred in their assessing their approach did not change due to time limits. Questionnaire participants were not specifically asked about assessment, but two participants spontaneously responded that they would use more in-depth assessment in unlimited conditions, as shown in the previous section.

The funding body also brought with it particular assessment requirements, which a number of participants commented on. The structure of therapy therefore needed to change to account for this. Referring to the use of the DASS in Better Access, Amy said the following;

But that's a kind of pressure on you because you're thinking oh I'll do this really quite mediocre basic measurement I'm using with them that for some reason Medicare has decided is the assessment of choice. (Amy) [referring to the DASS]

The implications of a limited assessment, for those participants who acknowledged it, were felt to be restrictive in the depth of understanding that could be attained.

Treatment Planning

Participants were also asked if they did anything different with their treatment planning when treating clients through time limited programs. For those who said that they did do something different, they indicated that they were more likely to make plans for sessions that covered the symptom reduction they felt was necessary to finish by the time the sessions ran out.

...with the longer open-ended stuff I might just wait until a nice little moment comes up where that's another, again an issue; like it's surfaced again. And then I might introduce that body of information, those kind of skills, that kind of education process and stuff. So I

guess that would be the difference whereas with the short-term stuff I'd almost be throwing it at them, whether they raised it or not. (Sally)

There was reportedly less scope for flexibility in treatment plans when working in time limits.

...when I'm focusing on very much a short-term model then I'll focus much more on the kind of things that, like things that I need to do so I'll have more of a treatment plan in my mind if not on paper. I think that's what it is. Whereas I'll, I think if I'm not thinking short-term then I will allow, I'll still start with a treatment plan but I'll allow that treatment plan to be more flexible. I think that's the difference. (Xuan)

Tessa spoke about the kinds of things that she would consider in her treatment plan. The quote below demonstrates the extent to which she is focussing on outcomes and keeping check of her progress.

...what have we done in this session what have I achieved, where do I need to go next, what are the strategies that I need to be looking at next time, do I need to be doing relaxation? Do I need to be doing sort of CBT on this particular aspect or you know, which handouts do I think I'll use? And so on. (Tessa)

External factors also made participants more inclined to rely on firmer treatment plans when working in time limits. For many time limited programs it is a requirement to write a report and this was also useful in increasing psychologists' focus on treatment planning.

That nice thing is you have to write a report, you have to keep yourself in check. Oh my God, did I do cognitive challenging? I'd better do cognitive challenging. I often thought I should get a thing to tick yep I've done cognitive challenging, I've done... you know because sometimes when you've got many clients, and you're like what will I do today, you know it'd be nice to say yeah you've done that. But you usually kind of know what you've done. (Isabel)

There was thus more urgency and less flexibility to the treatment plans when working in time limits due to the time pressure and the need to ensure treatment gains in the timeframe provided for.

SECTION III: CHANGES IN THE CONDUCT OF THERAPY

This section will show how a time limit can change the therapeutic process in more general ways than the above sections have discussed. It will consider participants' reports of becoming more directive, increasing their containment of issues, having an increased focus on symptoms, and providing less scope for historical considerations.

Increased 'Directiveness'

Most participants reported working more prescriptively, or with increased 'directiveness' when under time constraints. Prescriptive approaches to psychotherapy require the psychologist to be active in their suggestions to clients.

So maybe I'm pressing people to make these sorts of changes by suggesting and setting some homework rather than allowing it to develop which I would in a normal therapy relationship. (Richard)

And I would tend to take a less - probably tend to take a more psychoeducational, a more prescriptive approach in some cases if there is a limited number of sessions because there is not the time to allow people to come up with these ideas themselves. You know if it is open-ended and they are coming back it is really lovely that there is lots of time for them to work things out themselves whereas once again, limited number of sessions, that is not always going to happen – and sometimes you have just got to tell them – this is what it is – this is what we need to be doing. (Jessica)

This process change indicates an increase in a 'doing to' approach in therapy, whereby the psychologist uses more control in the development of the content of therapeutic sessions. Therapy becomes focussed more on what the therapist thinks is important rather than what the client thinks is important.

So then [when time limited] I'll use more brief interventions like solution-focussed approaches that are more problem-solving, goal setting, teaching strategies like relaxation, stress management. So more acute skills based teaching, so that people can go on and put those into practice. (Fiona)

So you become more of an expert maybe and probably become more, give slightly more guidance. I mean with me I know it's not guidance, because I tend not to tell people what to do, although they often think I have, but I'm more educational, you know I'll talk to them more about anxiety and about how anxiety works and mindfulness and get them to be more into their thoughts and do their thought records and stuff like that. (Xuan)

In being more directive, participants reflected that they were more likely to push a specific agenda in their therapy compared with times when they were not working under time constraints.

I'm probably a bit more prone to um, give, ah to be very concrete with suggestions, and I'm probably less, I do that less...if they just come to me without a program. (David)

I sometimes feel that I'm being a little bit too directive, instead of staying with the client in their own time. (Ursula)

This increased directiveness seems to eventuate as a result of the time constraint in an attempt to 'achieve' certain things within the allotted time.

...whereas with a program I'll feel like I'll make a really quick, almost hasty decision. Not unhappily you know, you just do it. So I'll make a very quick decision and I'll give them suggestions about things to do in between sessions even though if I was doing other work I probably wouldn't do that. (David)

The more directive approach also seems to arise out of the need to make quicker interpretations and assumptions when time is limited.

And, I'll make presumptions about...for example, someone says they feel anxious, I tell them in the first session, you know, you should do some breathing, take some slow breaths, for an hour or whatever and all that stuff. And I often don't do that if I see people without a program. Because I'm thinking "well let's understand what you mean by anxiety. Let's understand you know, the history of it, what does it feel like, positive and negative, and what's it a warning of, and what's the history of this, and where do you think this came from". I'll want to pursue those things, and at some point in that, you know it might be earlier or it might not be so early. I might say "well let's do some breathing while we work on trying to understand why you suddenly feel like that". Or I'll have a presumption that if someone is, suddenly has a panic attack, I'll...if I'm with a program I'll suggest they do some breathing and relaxation, you know probably in the first session. If they're not coming through some program I'll probably be more inclined to think, "well what other problems do you have in your life?" So you know it changes the work very clearly. (David)

The above indicates that being directive as a psychologist may mean making interpretations and assumptions that would not otherwise be made. Time pressure reportedly increases the need for psychologists to be directive in their work.

So maybe I'm pressing people to make these sorts of changes by suggesting and setting some homework rather than allowing it to develop which I would in a normal therapy relationship. (Richard)

Directiveness from a psychologist seems to increase the extent to which therapy is prescribed, and this 'doing to' approach is, for some participants at least, the only possible option when time is limited.

You know different clients have different views on what therapy is and some clients really just want to talk you know – they don't want techniques done to them and so I find that a bit difficult because I am wanting to impose my techniques on them and they're just wanting supportive counselling really – and supportive counselling is a very valid thing, some people get a lot of benefit out of talking and being

supported. So blocking that is not always good although it might be therapeutically helpful to block it with some people because some people, if they just talk about their problems and there are not any interventions to shift things – their problems just get reinforced which you don't want to do – but I guess if you have got a never ending quantity of time and someone else is paying for sessions you are never in a great hurry to fix them anyway because they just like to come and talk so you let them do that whereas with this that is never an option. (Harriet)

Ursula spoke about this increased directiveness in relation to what her therapy is like when time is not limited. She expresses concern over the different level of empowerment in the client when control is taken away from the determination of length of therapy.

So with the private [time unlimited] clients I feel I'm able to hand the power over to them, because that's really what I'm trying to do with them is help them to come into their own power and so being able to take it at their own pace and to focus on what they want to focus on is very empowering for them. So the pressure is I feel a little bit disempowering for the client. (Ursula)

The disempowerment of clients referred to above means that therapists are *increasing* their control over therapy.

I think when I've got a limited number of sessions then I'll be more controlling of what goes on in those sessions. Because I'll have more of an agenda about what I want to get done, whereas if I know it's open-ended then I'll just relax a bit and let the same thing happen, maybe but at the client's pace which means that I'll let them bring it up and deal with it when it comes up rather than kind of pre-empting it. May not be a good thing but I think that's just me trying to kind of give them some tools. (Xuan)

Harriet speaks of her therapy becoming ‘imposing’ on the client. The increased focus on ‘doing to’ clients is clear from her explanation of the different philosophy under which she operates when working in time limits.

I guess there is more of an emphasis on techniques rather than just a free flowing, let the client lead more; I guess I have to be a bit more in control of where the session goes and what happens in the session. So it is about maintaining control and imposing control. (Harriet)

Being directive was sometimes seen as advantageous when client motivation was an issue.

It can be good from the perspective that it really forces you to be fairly goal directive and for some insurance [time limited] clients that can be a very good thing to have a very clear idea in mind of what can be done in that time frame and what sort of commitment they have to make. (Ken)

This quote indicates that the increased directiveness in time limits allows for a quicker treatment response and treatment engagement from clients who might otherwise be slow. However, directiveness was also seen as disadvantageous because of the limited understanding that was able to be attained by therapists.

I suppose that is one of the advantages in a way that it forces you to put...although it's problematic too because on the one hand it forces to put in front of the client all the options, but on the other hand the problematic side of that is that you're doing it before you really understand this person well, before you've got enough information, you're taking a bit of a punt at times I think. You're sort of treating the person as though we deal with all of these things in a very logical and theoretical sort of way. (Nora)

Nora's last sentence also indicates that the process of therapy is substantially changed from a client-centred conceptualisation to a prescriptive one that allows for limited understanding.

A number of participants referred to the medical model as something that was being espoused in third party systems of psychotherapy delivery. It was also the influence of the medical model that brought about increased directiveness from the perspective of some participants.

In private work I'll go into detail to the background for information. I'll ask [the] patient to collaboratively working towards an assumption of what is their main issues, goal setting; treatment planning will be conducted collaboratively with the patient. While here, people think that yeah prescriptive approach because they just saw the doctor, they think I'm not a doctor, tell me what to do. Um, so they tend to wait until I tell them something. (Colin)

Increased directiveness was seen as an important step away from 'treatment as usual', and was brought about through the need to complete therapy in a given timeframe. Similarly to the increased use of psychoeducation techniques, directiveness also constitutes an increased emphasis on a 'doing to' approach to the client, rather than a 'being with' approach. The former emphasises techniques of change, the latter the therapeutic alliance.

Prioritisation

Participants reported that they were more likely to prioritise their clients' concerns into ones needing more immediate attention and focus when they had a limited amount of time to work within. Priority turns to practical issues that can be focussed on in the time prescribed and away from attempts to obtain a 'deep' understanding of clients.

And if I can see quite clearly that this is really where they need to be focussing but they're focusing somewhere else I'll be very directive. But if I ask a question and somebody says "I don't know", I might say "well look it seems to me this is really where we need to be focusing because I think that is going to make the biggest difference in the shortest time", rather than taking the time of getting them to work it through. (Ursula)

...maybe one advantage of it in some ways is that it pushes you to really 'cut to the chase' and prioritise what's most important. (Patrick)

Prioritising was seen as detrimental to the therapeutic process at times; however a necessary evil to allow for therapeutic change in limited amounts of time.

And if I'm time limited I'm thinking, oh, really got to make sure I get to that, then I'll pull it out of sequence. And it never works as well as when I can do it in the sequence. (Beatrice)

So if it does seem like what they are raising at that time is something that would be a priority goal then [I] immediately start to go to the process of renegotiating the goal but if it does seem like it is a peripheral issue, which is tough, because you know I guess it is at odds at times with the way I would ideally like to be able to conduct treatment with a lot of clients but [you] just know in the back of your mind that you run the risk of getting to the end of the 10 sessions and having to sort of covered all these tangential issues but made little progress in relation to the specific goals detailed in the beginning and in my experience of doing that you sort of learn to say that is okay, well if I work in that context, even though I might feel harsh at the time; and you do as much as possible to keep the momentum on those specific goals. (Ken)

The increase in time awareness and time pressure appears to suggest that at the outset of therapy psychologists prioritise by placing limitations on the number of issues to be addressed.

Within 12 sessions we would only do – rush to get things done – I just don't think you can do that – I think you just have to decide what you can do at the outset and what you cannot and stay away from what you cannot do. And if it is something that is ongoing, or that I think is going to take more than 12 sessions I would certainly say so at the beginning and talk about what we can and cannot do – what we can or cannot work with during that time. (Yelena)

Because clients referred from third parties are generally referred for a particular reason, this was another incentive to prioritise client issues. It seems that it is a combination of this reality with the pressure of time that caused the general increase in prioritisation.

I'm a much more concrete thinker when I work through a time limited program. I'm trying to focus a bit more on the particular issues that they've brought up rather than look in a rather much more broadly...ah well I do a bit of that anyway. You know but I'm aware that I've got to do this, because they've been referred for a certain reason and I know I've got to write a report after six sessions and say how I've addressed that. Whereas if I work without a program they'll say "I've got this particular thing", and I'll say "well tell me about everything and we'll see what relates to this and what doesn't". And so, in that way, um, the work is on the one hand, once again, it's less focussed and yet it's broader. (David)

In order to engage in this type of prioritisation psychologists need to compromise the breadth that they would ordinarily work with when treating clients. This raises interesting issues in terms of what else becomes limited when time is limited, as for some participants this constituted a distinct difference compared with the work that they would do without a time limit.

So on the one hand there's positive aspects to that, that maybe I work quicker with that, and more, you know and I'm thinking more strategically if I work with a program. And then the other side of it is that I don't feel...I feel constrained by it. And I think that the people who come to see me through the program are constrained by it. Because for them to take some detour, you know they're not sure where they're going, think 'oh no I've got to pull back', or they might feel like 'I've only got a few sessions so I can't do that'. And sometimes the detour is more...it ends up quite fruitful. So um, on the one hand it makes the work more focussed but on the other hand it lacks the breadth compared with work I don't do through that program. (David)

Participants engaging in prioritisation of issues did so in order to get the most out of the time available in the time limit, and in this way it was described as advantageous. Nora talks about this as being advantageous to the process of therapy *when it is limited*, however not advantageous when compared to therapy that is not time limited.

“These are the things that are on offer and possibilities; let’s work out which way we’re going to use them best for you”. Um, and that’s problematic because on the one hand it’s useful because it’s the only way you can do it with them, but on the other hand it leaves me very frustrated because I think I could be working more effectively with this person if I had a longer term process with them. (Nora)

One way that participants reported prioritising was through the increased use of goal setting.

[I’m] very goal directed in a shorter number of sessions and just trying to pick up a few important aspects and I guess you tend to work from a point of view that it is better than nothing – for a lot of people. (Ken)

I guess I would tend to be, as I said just more specific, more goal focussed and there would need to be a limited number of goals if we only have a certain number of sessions we may not be able to look at everything that they wanted to look at. (Jessica)

Psychologists indicated that their increased awareness of time resulted in them being more conscious of the specific goals of therapy.

Whereas with the shorter timeframe I’m very clear with people, so if we’ve got say four sessions, ok we’ve got four sessions, need to be clear about what we want to achieve at the end of the four sessions. And then at each session we need to be clear about what we want to achieve at those sessions that’s working toward the end goal. (Fiona)

While goal setting was reportedly more important when working in time limits, some participants indicated that they would be less thought-out compared with when there were no time constraints.

If I know that I have got unlimited sessions with a client I will tend to for example take a little bit more time with the process of goal setting than otherwise I would do with the client if I was under a time limit.
(Ken)

Goal setting was thus another tool to compensate for the impact of a time limit and allow for prioritisation in time limited therapy.

Containment

Participants reported that they would actively contain what it was that they were focussing on when they worked within time limits. Because they were more aware of time in addition to being more focussed on symptoms, they felt a need to limit, or contain, both the number of issues discussed, and the depth at which these issues were discussed. While the increased need for prioritisation forced participants to consider ‘what problem to manage’, containment refers more broadly to ‘problem management’ (that is, once the problem has been agreed upon).

Yes it's more - very just identifying a problem and working with that problem. And one problem. (Quibilah)

[I] tell them “look, this is the problem, we will not have the time to work on the whole problem here, but we can manage this maybe aspect of it because it's more immediate”. So I help them manage that. (Zara)

So the short-term therapy needs to be more contained, it needs to have a boundary around what can actually, what's therapeutically helpful and what's also going to result that the client can finish the end of those five sessions still in a highly functioning state without opening something that can't be [inaudible]. (Fiona)

Containment became particularly evident and important when participants referred to clients whose needs were more complex.

...because we have got the limit for example I am not willing to get into exposure to the memories of her trauma because it would just open things up and then she would have nowhere to go so that has

been a problem a couple of times in that you just think that “I could really help you but I just need to prepare you to be referred on to someone else”. That is the major problem I think, is that sometimes when you need more you can’t – you just can’t have it – it is not available. (Jessica)

...where you have got someone with perhaps a more complex presentation if it’s trauma related for example and getting the flexibility saying these are the sessions that’s it. And you’ve got to make the call is it worth offering the sessions to potentially get to the point of opening up a can of worms with the client and not necessarily being able to have them deal with that so – I guess you have got to be very mindful of where you are going to go with the client right from the outset if you have got that time limited period and be very frank about what you can and cannot accomplish in that time frame, which can be very difficult at times. (Ken)

A number of participants expressed concern over the idea of ‘opening a can of worms’ when working in time limits, and then not being able to address the issues that arise from this.

I would be trying not to go too deeply into their – whatever the problem is because it is just in my view unethical to open up a can of worms and not being able to work the whole way through it. (Yelena)

Also knowing I’ve only got a limited number of sessions I’m not going to do anything that’s going to open that up because I know that we’re going to have to stop long before any of that can be addressed appropriately and that in my way would be making a client very vulnerable and then leaving them vulnerable. Which therapeutically wouldn’t be in their best interest. (Fiona)

Ethical issues were of concern for psychologists who felt that some things simply could not be addressed when time was limited. The ethical dilemma became whether to address the more complex issues superficially or to leave them aside altogether. Both these options involve containing.

I had someone who had been sexually abused in childhood, in early childhood, they really need to work that through; you cannot do that in 12 sessions so you would work through probably the, managing the physical reactions in certain situations but not go very deeply into the emotions and feelings that they had back then because you just cannot do that. (Yelena)

Some participants felt that experienced therapists working in time limits developed specific types of skills suitable to the work, which included the ability to contain.

...in a way if you've got someone like that short-term I mean you almost have to be skilled enough to do virtually nothing. And everything goes back to front and I think someone who's unskilled in short-term therapy with those clients tends to do too much. (Xuan)

Well I guess you really have to be I think part of the skill as I said before is being able to really hone in on what are the important issues and what you realistically can provide, and not really raising too many issues that you're going to be opening up things for patients that you're not going to be able to deal with. (Ella)

Containing issues was problematic for some participants because it brought with it an inadequate understanding of the issues discussed.

...you might sort of get insights into the presenting problem when you're looking at other areas and you can see more when you are looking at the whole complete picture – you know family history, relationship history, work history, social contacts, drug and alcohol issues – not to say that I exclude all of those, but you just develop a bigger picture and more insight into the presenting problem and sometimes, you know, obviously the presenting problem is what you work on but it leads to dealing with other issues as well that perhaps [are] probably more of a causative factor. (Monique)

A number of participants also felt that clients also took responsibility for actively containing the scope of therapy.

...they might not be prepared to work so well at certain things, just because it's like opening up a wound and if they know it can't be continued they just get a little bit anxious about doing it. (Zara)

They'll be more circumspect about how they describe something. So you know for example, instead of getting the whole gory details about the selling of the house, it'll just be the house got sold last Sunday or last Monday or whatever. It'll just be a briefer interaction. (Sally)

Over time, clients then become more comfortable in whether to disclose more in their life, more things that have been troubling them for a long time. Whereas in a short, when you know you've only got a limited number of sessions, there would be no way a client would open themselves up to that anyway because then they're exposed, they've exposed an old wound and then we can't address it. And I think with the long-term treatment people have a lot more time to develop that trust in the relationship. Where they feel a lot more comfortable and safer to go to some areas that they wouldn't do if they know they've only got five sessions for example. (Fiona)

In order to contain 'successfully' when time was limited, some participants indicated that it was important to adapt expectations to suit the timeframe.

So managing expectations is a really important thing. Managing the expectations of the patient and also managing my own expectations in terms of you know, there might be a number of issues that need to be addressed but then just focusing in on what's the most realistic and important at that given time. (Ella)

While the above indicates that clients are also aware of the need to contain the scope of therapy in limited numbers of sessions, some participants indicated that it was problematic when they had clients undo the containment towards the end of therapy.

No, it scares me. As I said before when they bring up some problem and you think - "oh my goodness I have only got two sessions left to deal with this serious problem" - because people will not bring it out in the beginning because they are not too sure - it makes them

vulnerable - so they hold it back - and then when they start to relax a bit and start to feel a little better then they will bring it out and then by that time it scares me because I think – “how am I going to deal with this in two sessions?” - because if you bring it up it is going to cause a lot of distress for them and then you cannot diffuse it because you don't have the time, so that is when that is difficult. (Winona)

It may benefit, I'm just wondering if the client might feel from their perspective there is some containment. Like I only need to go for this number of sessions – at the same time that is double-edged I think – they could have unrealistic expectations that the issue could be resolved completely in that time frame. But it might give some sense of security or containment to people. (Monique)

Containment can be seen as a double-edged sword from the perspective of both clients and psychologists. On the one hand it allows for a specific scope in therapy, and the subsequent control that comes with this, while on the other hand these limitations may be troublesome for the types of outcomes that can be achieved from therapy.

Symptom Focus

The consequences of being directive, prioritising, and containing clients when working in time limits reportedly leads to the possibility that depth is prohibited and there is a limit to how much can be focussed on. In order to accommodate these limitations, a number of participants said that they would therefore focus on symptoms.

You focus more on symptoms and trying to manage symptoms; that is a bandaid solution. (Yelena)

This notion of a 'bandaid solution' to therapy when working in time limits was common for participants who felt strongly that time limits significantly limited the way in which they worked. When client presentations were complex, participants indicated that they were particularly likely to focus on manageable symptoms and not address other issues that might be addressed without a time limit.

...you know these were chronic issues but at that time she was also going through a very big court case. And was having acute anxiety symptoms so rather than really looking at the history and going back

over time, really looking at helping her develop positive coping strategies to manage her symptoms and problem solve for that issue that she was going through at that time. And in six sessions, that was plenty, dealing with the acute symptoms of anxiety, what to do about certain aspects of the court case, like problem-solving with her and also talking to her about what sort of support she needs, self care strategies, self calming strategies, so it was very much about keeping the background in mind, having, being aware of that background information that this patient was but not really going into it too much because realistically I wasn't going to change much in six sessions.
(Ella)

Despite most psychologists expressing the importance of focusing on symptoms to give clients at least some therapeutic movement, some indicated that it was difficult to remain symptomatically focussed for the whole duration of therapy.

I should do, perhaps I feel, in the short sessions that I should limit it to symptoms. But I know as soon as I start to sit down with someone and we start to work, and if it's working well then the issues are going to come up. There's nothing I can do about that. (Patrick)

In addition to symptoms being the easiest thing to focus on in limited amounts of time, participants felt that there was also external pressure to focus on symptoms.

...in these programs there is pressure to do that and to focus on symptoms when in fact other techniques can be equally effective.
(Ursula)

Pressure to focus on symptoms therefore arose out of the external demands of third parties as well as participants' perceptions that focusing on symptoms was a way 'around' the time limit.

Historical Considerations

Many participants indicated that in prioritising and being directive when working within time limits, they therefore increased their focus on present issues over issues relating to the past. When working within time constraints psychologists almost unanimously reported a tendency to focus on issues of the here and now that could help

to reduce psychological symptoms as opposed to issues that they might otherwise be working on to create more depth within the sessions.

I guess that's what's different for me [when time limited], is that I prefer to be very holistic, and not just deal with what's in front of me now but try to give people something that will build their resilience for future problems. (Beatrice)

For some participants this was experienced as a source of efficiency.

I guess it helps me in just being more focussed on treatment rather than, because you know you can spend time talking about history. (Harriet)

Yeah, focussed on the present. What are the things that are affecting this person here and now. (Ella)

Focus on the here and now meant not only that past issues were not addressed, but that participants felt they could not address how past experiences may play a role in present behaviour. Ella spoke about a time when she had limited sessions and her client was in a crisis involving an upcoming court case. Ella reports focussing on immediate symptoms and problem-solving but feeling unable to address factors of the client's presentation that may have contributed to the current crisis.

If I had an unlimited amount of sessions I'd probably do a lot of that same sort of stuff, that symptom management but I'd probably be exploring past history stuff, you know eventually. Once the crisis had sort of settled and she had managed, you know because it wasn't the time to explore past issues then and there because she was in the middle of a crisis, but once having settled probably exploring past patterns of behaviour, past relationships, core beliefs about relationships, core beliefs about herself, so really unravelling I guess some of the beliefs she has about herself and how those beliefs may be perpetuating the sort of situation she was in. So over time that might be something I would do. (Ella)

For some participants, this focus on the here and now was due to the change in therapeutic modality when working in time limits.

Well there's just different in that with the solution focussed you're looking more at the immediate situation and the short-term future more. Whereas if you're working in a psychotherapeutic way, and more psychodynamic, then you're getting more to the underlying issues of personality, family of origin history, maybe exploring some early childhood traumas etcetera. (Fiona)

Grahame talked about the *choice* that he presented to clients in focussing on the here and now or a broader perspective, however this choice was only available when time could be extended.

And so he's a kind of classic example and in his case what we actually did was I suggested to him that we have a choice. We could either work on some of the long-term stuff or we could work on the panic symptoms. And what I've done actually with a few people has been that sort of thing. We work on the symptom stuff or we work on the longer term stuff. And sometimes we do that in a way...he was one that I said was going to need more, he was going to need 12 sessions and possibly continue with booster sessions afterwards. (Grahame)

The increased focus on the here and now was seen as necessary in order to account for the impact of a time limit. This section has shown that a time limit brings about changes in the conduct of therapy from the perspective of psychologists. While participants reported the need to be more directive in time limited therapy, they also reported prioritising the content of therapy by containing issues, focussing on symptoms, and limiting the scope for historical considerations. The next section will describe how therapeutic outcomes are perceived in time limited therapy.

SECTION IV: OUTCOMES FOR CLIENTS

In addition to perceived changes in the therapeutic process as a result of third party imposed time limits, participants also reported that the outcomes that could be achieved were limited overall. Participants generally perceived the outcomes of time limited

therapy to be different in two types of ways; the type of outcome that could be achieved and the extent of change that could be made.

Participants in the questionnaire study were asked to predict the outcomes of therapy depending on the four levels of time and complexity. Question Four asked participants to consider “How would you expect the client’s symptoms to react to this treatment?” Responses to this question serve as a useful indicator to the types of perceived differences that having a time limit and a complex case might make to therapeutic outcomes. Overall, 75 (88%) of participants in simple scenarios and 79 (93%) of participants in complex scenarios indicated differences in their responses to this question between time limited and time unlimited conditions, showing that for the most part a time limit is seen to influence the type of outcome that can be achieved. Responses to this question related to either the type of outcome or the extent of change that could be achieved, as shown in Table 5.3.

Table 5.3. *Differences between predicted outcomes in time limited and time unlimited conditions*

Themes	Categories	Frequency in simple scenario (n=75)	Frequency in complex scenario (n=79)
Type of Outcome	Same but with an additional domain of outcome in unlimited therapy	14 (19%)	1 (1%)
	Relational issues dealt with in unlimited but not limited therapy	7 (9%)	11 (14%)
	Only problem-solving achieved in time limited therapy	2 (3%)	2 (3%)
Extent of Change	No/minimal improvement in time limited therapy	7 (9%)	26 (33%)
	More complete symptom alleviation in time unlimited therapy	22 (29%)	19 (24%)
	Deeper level of change in time unlimited therapy	10 (13%)	6 (8%)
	More permanent change in time unlimited therapy	28 (37%)	16 (20%)
	Future resilience in unlimited but not limited therapy	8 (11%)	16 (20%)

Table 5.3 identifies the themes that arose from questionnaire findings in relation to predicted outcomes. Interview participants also spoke about similar issues, so there is no logical necessity to separate interview and questionnaire findings, with these themes addressed on a combined basis in the next section.

Type of Outcome in Time Limited Therapy

This section will address findings that relate to the nature of what can be achieved in time limited therapy. Some participants (19% in simple scenarios and 1% in complex scenarios) show that the type, or domain, of outcome is seen as different in time limited therapy. For example, one questionnaire participant wrote *'resolve'* in a time limited condition, but *'resolve symptoms and gain an increased sense of self efficacy'* in an unlimited condition, showing that although there was resolution in the limited condition, there would be an additional 'type' of outcome in the unlimited condition, which in this case was an outcome related to agency. Types of outcomes were seen to be in some cases completely different between time limited and time unlimited conditions. For example another questionnaire participant wrote in the simple limited condition that the outcome would be *'reorganise time commitments; more assertive; communicating with boyfriend about needs'*, while in unlimited *'working relationship beginning; feeling better about verbalising anxieties with therapist; independent confident sense of self'*. In these cases there was therefore no overlap between the outcomes in time limited conditions compared with time unlimited. The types of outcomes that could be achieved in time limited therapy were therefore perceived to be largely different from those that could be achieved in therapy without a time limit. The rest of this section will consider the specific ways in which this was the case.

Some participants (9% in simple scenarios and 14% in complex scenarios) predicted that a difference in outcome would relate to an improvement in interpersonal relating in unlimited conditions but not in time limited conditions. For example, while the complex limited condition might allow the client to *'improve anxiety symptoms'*, in the complex unlimited condition an outcome of therapy would be *'more meaningful relationships'* (Participant 7). Similarly, Participant 5 wrote in the complex limited condition *'relationship difficulties to be ongoing'* but in the complex unlimited condition that there would be *'improved confidence in decision making re: relationships and*

parenting; clearer goals for future'. For some participants, an open timeframe therefore meant that outcomes could result in improved relating to other people.

Some participants (3% in simple and 3% in complex scenarios) indicated that time limited therapy would only allow for a problem-solving outcome when compared with time unlimited therapy. This was demonstrated through there being only an attempt to solve the practical problems of the client rather than improve their psychological symptoms in time limited conditions: *'I would expect it could help her come up with a plan to deal with the situation but would not expect improvement in mood'* (Participant 72). Similarly, Participant 6 wrote in the complex limited condition *'some relief from solutions to immediate crises'* but *'hopefully deeper change, better life choices, positive changes'* in the complex unlimited condition. Concern was voiced over the functioning of participants in complex conditions treated in five sessions: *'I would be very concerned about ST [short-term] and LT [long-term] safety issues'* (Participant 4). Overall, there was an increased focus on problem-solving in time limited conditions; however doubt remained for some participants about the ability of time limited treatment to ensure safety in complex presentations.

Extent of Change in Time Limited Therapy

Many participants reflected that the extent of outcome was necessarily limited in time limited therapy. This section will discuss participants perceptions of 'how much' could be achieved in outcomes when working time limits.

The time limited thing in some ways is slightly more challenging and you have to be more prepared to let it go if the person's problems, and the person, and not be too, just think you can, you know, remind yourself that this is all you can achieve in the time...that you've got to be satisfied with that because it's better than nothing. (Sally)

Sally above indicates that she is aware of the different extent of outcome that can be achieved in time limited programs so she intentionally gears her expectations towards this.

In the questionnaire, some participants (9% in simple scenarios and 33% in complex scenarios) indicated scepticism about the outcome in the time limited condition by suggesting that there will be no or minimal improvement: *'very little headway as I*

would envisage client being distressed throughout the five sessions' (Participant 45); 'Very moderately. I would expect that, given her history, she would be slow to trust and to integrate any therapy benefits' (Participant 2).

Without a time limit, some participants (29% in simple scenarios and 24% in complex scenarios) reported that symptom alleviation would be more complete: 'symptoms would hopefully clear up or at least become manageable' (Participant 37); 'significant reduction of depression and anxiety' (Participant 56). By comparison, in a time limited condition symptom improvement would be weaker: 'change is initiated but unstable. There would be reduction in depression and anxiety, but these changes can easily be overwhelmed by the everyday problems that continue to challenge the client' (Participant 21); 'show some improvement but not disappear at end of 5 sessions' (Participant 77).

The depth to which therapy could be conducted was an issue that arose out of the data and some participants (13% in simple scenarios and 8% in complex scenarios) suggested that this was a loss to the quality of their therapy. Change that was described as 'deeper' meant for some participants that change would have effects encompassing more than the immediate problem: 'hopefully deeper change, better life choices, positive changes' (Participant 6). Some participants indicated that whilst there may be improvement in time limited conditions, unlimited conditions would allow for a 'resolution' of the presenting problem. For example, in the complex limited condition Participant 2 wrote that change would be 'Very moderately. I would expect that, given her history, she would be slow to trust and to integrate any therapy benefits', while in the complex unlimited condition 'Over time, with therapy, I would expect that her symptoms would abate to a large extent'. Therefore, in limited conditions the outcome may be perceived as nonexistent, minimal, or leaves significant material to be addressed in some way.

Participants varied in how much 'resolution' was perceived to be important to therapeutic outcomes. For example, Fiona reported it to be essential to any type of benefit.

And the other thing, it's important that clients are able to reach some resolution in the number of sessions that have been given for it to be therapeutically helpful anyway. (Fiona)

Depth of outcome was not an issue for clients whose problems were more discreet.

It just depends on how deep the problem is and how long it has existed. But I suppose if it is just an anxiety reaction to having a bad boss or something and there is no – there is nothing in the background that would indicate that it's stirred up old material then it would be alright, but normally to get really therapeutic benefit you need to work with your emotions and CBT is great but it is not sufficient by any means. (Yelena)

Jessica talks about being in a situation where she initially thought that she would have a client for a limit of 12 sessions, only to find that she obtained funding for a further 12 immediately after they finished the initial set.

This is a woman who once again has a lot of difficult background issues and all of that and I thought that I was working with her for 12 sessions and so was very careful to keep the boundaries very strict because I think she could become quite dependent just because of lack of attachment in the past. And she has actually now been re-referred since the project has changed hands so she is coming to me for another 12 sessions. And it is sort of an interesting thing because if I had known that it was going to be 24 sessions I would have approached it quite differently – I feel that we skimmed over a lot of things – and now do we go back and work through those things in more detail?... which is probably what I would have done had I known the limit that we actually had so I guess she is another example of that. (Jessica)

In this example, the difference between what was done in a time limit compared with what would have been done without a time limit related to the amount of detail. Furthermore, some participants felt that client empowerment became limited when

limiting depth in time limits. Amy spoke about the need to either get quickly to the core issue or avoid going to this deep level if the case was complex.

And I think sometimes you want the patient to drive the process a little bit more, for their own needs and that's just not really possible under that sort of system. I mean if you're client focussed and you're wanting the client to, like an unravelling, like the layers of the onion coming off you have to basically get in there and rip three off at a time with this sort of an approach. And that doesn't feel comfortable for some people but there's not much choice if you want to get into the core issue and you want to try to move them on sometimes, or sometimes you can't touch that issue because you know it's too sensitive and you just have to leave it alone, which is another difficult thing. (Amy)

Many participants indicated that working through time limits meant their work was not complete, and that they needed to accommodate for this in other ways.

I sort of think strongly about what things I think the client needs to learn in a kind of 'patch up' way. Or at least point them in the right direction. So for example with the assertion skills, I might not think they're going to learn that from a handout but I'll certainly give them a handout so they can start their journey. So that journey might not continue with me, but they go "oh yeah I see how if I change what I do with my assertion then that could change how I am in the world and how that effects me emotionally" and things like that. (Sally)

Well I do what I can. It's a bit like working in a MASH tent or something isn't it. You sort of just apply a dressing and hope for the best. (Amy)

Furthermore, some participant's responses (37% in simple scenarios and 20% in complex scenarios) indicated that change would be more permanent in therapy without a time limit: 'more likely to maintain gains made in therapy' (Participant 22). In the simple limited condition Participant 19 wrote 'positive changes but can't guarantee the long-term nature of the change', compared with 'a long-term change in a positive

direction' in the simple unlimited condition. How durable gains were related to the notion that symptoms might relapse in a short amount of time: *'I would expect a relapse of symptoms within the next year'*. Predicted gains were therefore temporary rather than long lasting.

Future resilience was also alluded to by some participants (11% in simple scenarios and 20% in complex scenarios) in time unlimited conditions: *'I would expect to see a growth in sense of personal power and belief in her ability to cope on her own'* (Participant 46); *'given time and commitment, client may develop strategies to deal with the stressors in her life'* (Participant 44).

Some participants indicated that the outcome was more likely to be a 'bandaid' solution as opposed to a genuine treatment of the issue at hand. Because of this, psychologists felt that gains were unlikely to be as durable compared with if they had an unlimited amount of time to work with what the client presented with. This was mediated by the type of client and their presenting problem.

I routinely see people go from severe to normal or severe to moderate scores [on the DASS]. But, I don't know if that's enough to know that the service is really helping long-term. (Beatrice)

I would prefer to have them completely fixed up because like - actually I got a call this morning from a young girl that I saw maybe six months ago and you know I saw her for maybe six sessions and she was doing fine and I got a call from her this morning - things have blown up again and she is so distressed again so I am seeing her again this week - so with the longer time they tend to integrate more and can - so that if something blows up in the future they are able to deal with it. (Winona)

However, Olivia thought that some clients also had the potential to act independently to broaden the gains made in therapy.

...and the clients that have really gotten it - so who have really understood what you are teaching them will understand that relevance even if you don't - they will say " I can really see how that

will be useful at work or at home” or whatever – even if you do not talk about how they can apply it. (Olivia)

Xuan spoke about how gains can come and go, and the end result of cyclical change may in fact take longer to become apparent.

So sometimes the short time, they're highly motivated, they know what they want to change. But they fail because a lot of it is really hard and a lot of change is a cycle and you know that whole Prochaska and Declementi cycle is so appropriate. You know that you fail and then you come back, and you fail again and you think about it again and you go through the cycle and you fail again and you come back to therapy again. And then suddenly you've got it and it's a goer. Where you just don't have that luxury, so it can be a bit restraining especially when you're working with something like social anxiety which is very deeply engrained, and it's slow to change. (Xuan)

While there was concern voiced about the durability of gains made in limited timeframes, it also seems that perceptions of the aims of therapy interact with the extent to which this was seen as a problem.

Predictions of outcomes based on the phase model

Questionnaire participants were asked to predict outcomes across the three domains of the phase model on a 10-point Likert scale for each of the four conditions. Table 5.4 shows the means and medians that were derived from this. Overall, participants predicted that outcomes in all domains are rated higher without a time limit.

Table 5.4. Ratings given by psychologists to indicate predicted success of treatment as a function of the hypothetical treatment conditions on a scale of -5 to +5 (n=85)

	Simple		Complex	
	Time limited	Time unlimited	Time limited	Time unlimited
Enhancement of Subjective Wellbeing (means)	2.57	4.13	1.38	3.61
Symptom Reduction (medians)	3	4	1.5	4
Recovery of life functioning (medians)	2	4	1	4

*Enhancement of Subjective Wellbeing*¹⁸

There was a significant main effect of the amount of time on ratings of ESW, $F_{1,84} = 382.411$, $p < .01$, *partial* $\eta^2 = .82$. There was also a significant main effect of the level of complexity on ratings of ESW, $F_{1,84} = 70.614$, $p < .01$, *partial* $\eta^2 = .46$. Predictions of ESW were therefore significantly lower in time limited conditions compared with time unlimited, as well as significantly lower in complex presentations compared with simple.

There was a significant interaction effect between the level of complexity and the amount of time, $F_{1,84} = 22.530$, $p < .01$, *partial* $\eta^2 = .21$. This indicates that the difference between time limited and time unlimited was not the same whether cases were complex or simple. Looking at the interaction graph (Figure 5.2), this effect reflects that a time limit (compared with time unlimited therapy) lowers estimations of ESW significantly more in complex cases than it does in simple cases.

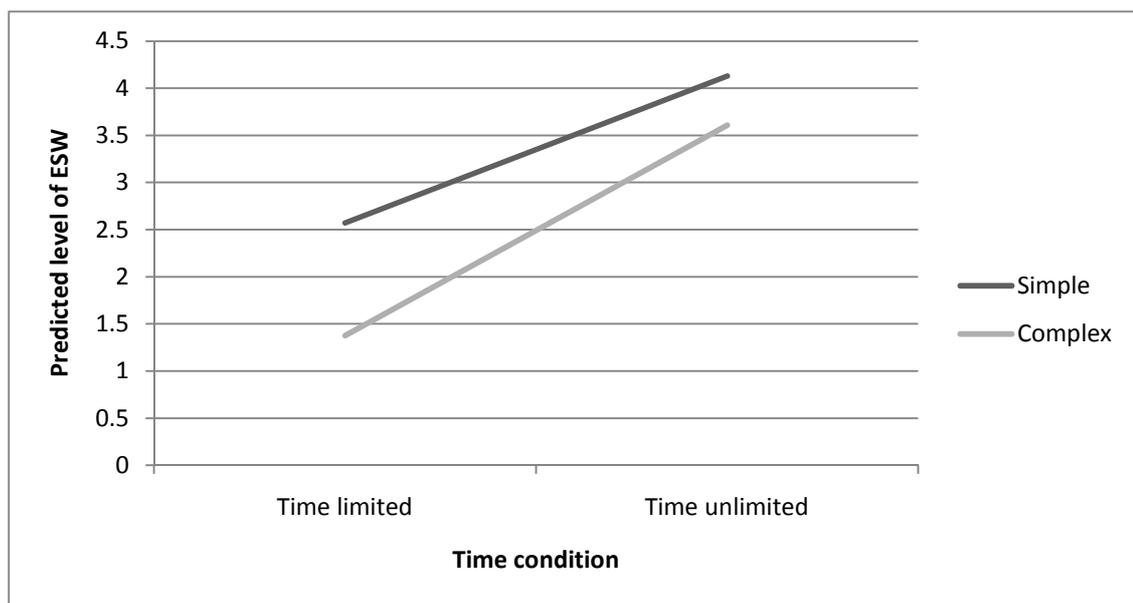


Figure 5.2. Ratings of ESW as a function of time condition and complexity level (means)

*Symptom Reduction*¹⁹

There was a significant main effect of the amount of time on ratings of symptom reduction, $F_{1,84} = 384.063$, $p < .01$, *partial* $\eta^2 = .48$. There was also a significant main effect of the level of complexity on ratings of symptom reduction, $F_{1,84} = 75.979$, $p < .01$,

¹⁸ As previously indicated, ESW was normally distributed, so analysis was performed on raw (unranked) data.

¹⁹ As previously indicated, some conditions in the symptom reduction (SR) variable were not normally distributed, so all tests in this variable were performed on ranked data.

partial $\eta^2 = .82$. Having a time limit therefore significantly lowered expectations of SR, as did having a more complex presentation.

There was a significant interaction effect between the level of complexity and the amount of time for the symptom reduction variable, $F_{1,84}=22.236$, $p<.01$, *partial* $\eta^2 = .21$. Figure 5.3 shows that time limited treatment (compared with time unlimited treatment) lowered scores of SR significantly more in the complex scenario than it did in the simple one.

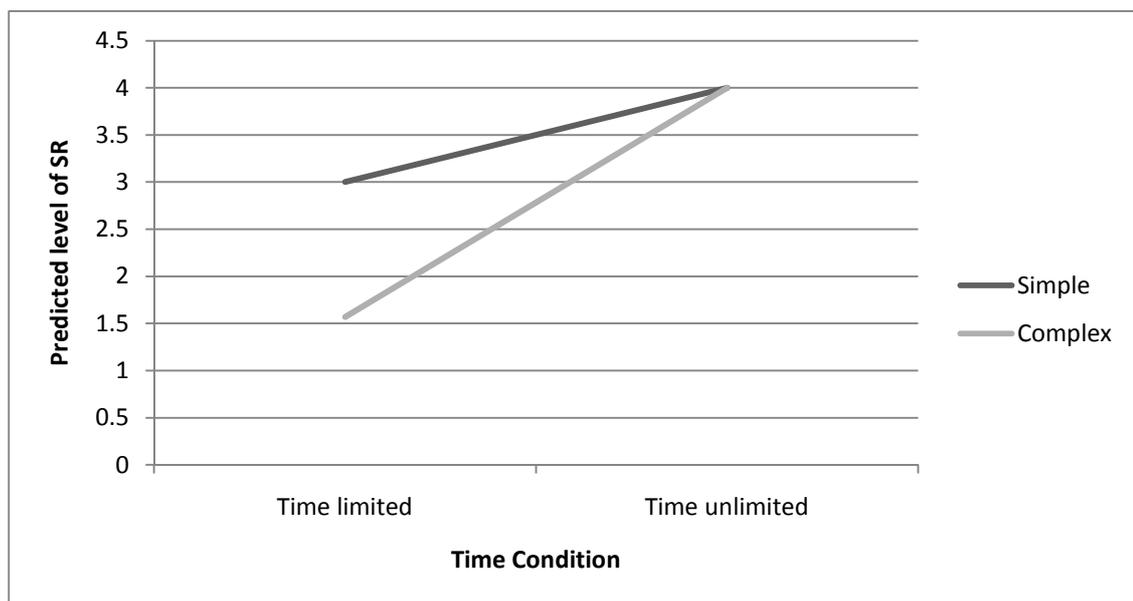


Figure 5.3. Ratings of SR as a function of time condition and complexity level (unranked medians)

*Recovery of Life Functioning*²⁰

There was a significant main effect of the amount of time on ratings of RLF, $F_{1,84}=457.633$, $p<.01$, *partial* $\eta^2 = .85$. There was also a significant main effect of the level of complexity on ratings of RLF, $F_{1,84}=61.516$, $p<.01$, *partial* $\eta^2 = .42$. RLF was therefore significantly lower in time limited conditions and complex conditions.

The interaction effect was significant, $F_{1,84}=11.404$, $p<.01$, *partial* $\eta^2 = .21$, showing that a time limit lowers estimations of RLF significantly more in complex cases compared with simple cases.

²⁰ As previously indicated, some conditions in the Recovery of Life Functioning (RLF) variable were not normally distributed, so analyses took place on ranked data.

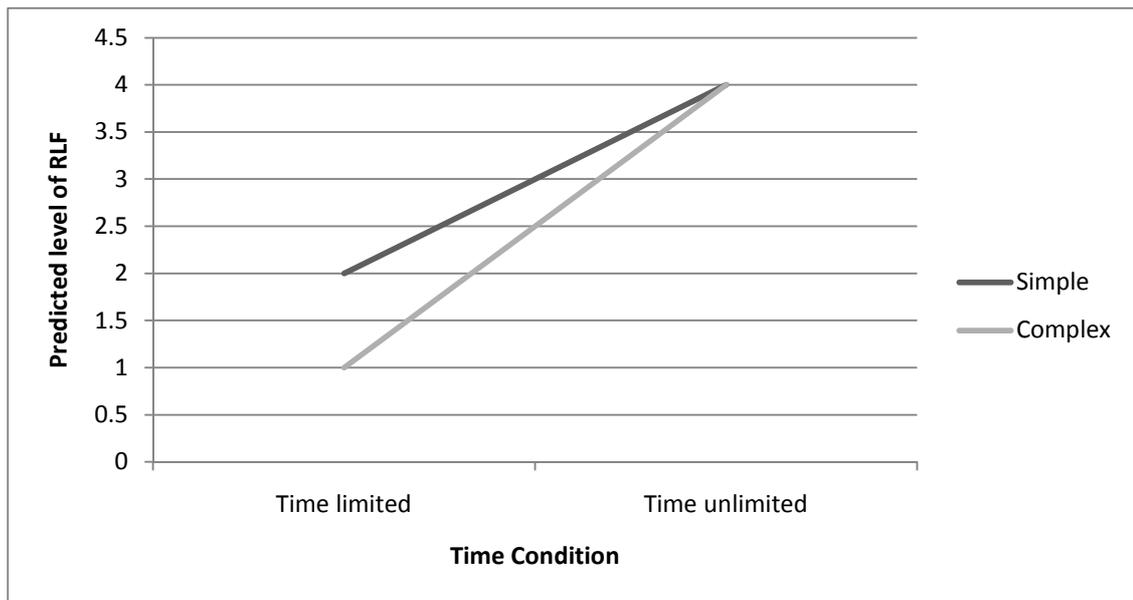


Figure 5.4. Ratings of RLF as a function of time condition and complexity level (medians)

All effects are therefore significant on a comparison of predicted outcomes across the four conditions of the study. Participants consistently predict that outcomes will be rated higher without a time limit, and that the level of complexity interacts with this effect to make outcomes even lower when a complex case is accompanied with a time limit.

Overall, this section has demonstrated firstly that there are perceived differences in the extent of change between time limited and time unlimited conditions, and that these differences relate to symptom alleviation, depth of change, issues of resolution, whether change is permanent, and whether there is 'adequate' change. Outcomes in time limited therapy are perceived as weaker than what can be achieved without a time limit.

CONCLUSION

This chapter has presented findings that demonstrate how participants reported changes in their process of therapy due to time limits, and how they perceive the outcomes that can be achieved in this context. The first section of this chapter showed that participants report changing their approach to therapy in ways that have theoretical implications for the outcomes that can be achieved. Choice of theoretical orientation was found to differ based upon both the amount of time available and the complexity of client presentation, indicating that orientation is flexible at least for this sample of psychologists. There were also more general ways in which therapy was hypothesised to be approached in

time limited contexts, for example with a change in the development and outcome of the therapeutic alliance. Questionnaire findings showed that most participants reported changes in their approach when working in time limits; however there were vast differences between the types of approaches that individual participants indicated. The second section of this chapter showed that the structure and planning of time limited therapy may be different to therapy without a time limit. Participants reflected that there was 'more' to be done in therapy without a time limit, and there was pressure to ensure the efficiency of therapy when working in a time limit. There was also a reported increase in structure in time limited therapy; with this structure came some, although few overall, changes in assessment and treatment planning. The third section of this chapter demonstrated the extent to which there were changes in how therapy was conducted. In limited conditions, participants reported the need to 'rush' through therapy, which could be achieved by being more directive and prioritising issues more and which acted to diminish the extent to which therapy could be 'deep' for many participants. There was a reported need to contain the content of therapy to account for the timeframe and increase the focus upon symptoms. The last section of this chapter showed that the outcomes of time limited therapy are consistently predicted to be weaker than what can be achieved without a time limit. This chapter has given an indication of the ways in which the process of therapy is different because of a time limit, and the outcomes that result from this. The next chapter will discuss all findings from the present research project and will draw together the three different considerations that have formed the structure of findings in this thesis; the inputs and resources of time limited therapy, the processes involved, and the outcomes perceived to be achieved.

CHAPTER 6: DISCUSSION

INTRODUCTION

This study aimed to explore, from the perspective of Australian psychologists, the perceptions of third party determined time limitations in psychotherapy. The specific questions addressed through this study have been: *What are psychologists' perceptions of providing time limited psychotherapy in the context of third party payer referrals? What are the perceived impacts on therapeutic processes? What are the perceived impacts on therapeutic outcome?* Psychologists working in private practice in Australia participated in this research and provided their views on third party restrictions on time, as well as information about how they adapt their therapy and their perceptions of outcomes.

The present research questions were answered through a mixed methods design that used a semi-structured interview and a questionnaire to ask about psychologists' perceptions of providing psychotherapy within time limits set by third party providers. This research design allowed for the capturing of broad and contextual information in qualitative sections, as well as an appreciation of the significance of these findings in quantitative sections. The interview captured rich information regarding participants' experiences and opinions of time limits, while the questionnaire was able to confirm that time available was a strong, persistent indicator of change in therapeutic conceptualisation, technique and predicted outcome. The findings of the interview and the questionnaire studies were congruent and offered overlapping information, with no contradiction.

Use of a mixed methods design allowed data analysis to account for the complexity that has been ascertained in the present study. The type of information sought during this study relates not to individual client's outcomes but perspectives by psychologists on the broad context of time limitation; therefore excluding the appropriateness of

outcomes research, clinical trial designs, and even naturalistic designs of psychotherapy in practice as relevant means to address the present aims. The present research is therefore well placed to contribute to the type of knowledge that is missing in the literature regarding how the use of third party determined time limits impact upon perceived practice and outcome. The use of a mixed methods design allowed for an appreciation of the extent to which findings could be generalised (Slife & Gantt, 1999); because findings from both the interview and questionnaire agreed there is support for the generalisability of this study. The interview and the questionnaire studies occurred contemporaneously, which did not allow one data collection technique to inform the development of the other. Rather, the contemporaneous nature provided for a wide ranging inquiry at a fixed point in time into the phenomenon under study and sets the ground for work in hypothesis testing studies in the future. Further, the use of mixed methods allowed for the collection of findings that overcame the limitations of each data collection technique on its own (Hammersley, 1996; Miles & Huberman, 1994).

The present research has shown that time limited therapy is perceived as different to that without a time limit. While this perceived difference is not necessarily surprising, it does underpin the issue that time limited treatments as commonly found in various third party payer systems do have impacts upon how psychologists deliver services as well as the psychologist's perception of outcome. The present findings are partly supported by the existing evidence; however this research allows scope for a deeper practical understanding of how psychotherapy is impacted by time limits.

Time limits were found to be associated with three different domains; the inputs of psychotherapy, the processes involved, and the outcomes that can be achieved. Interviews had been intended to find out about experiences and perceptions while questionnaires aimed to understand process and outcome. In reality, there was overlap between these two data collection methods, and it was for this reason that findings of the different data collection techniques were presented together. While questionnaires were able to show significant differences between time limited and time unlimited work in a number of ways, the depth of information obtained through interviews suggests that it is the external imposition of a time limit that was important to participants. The time limit was accompanied by other factors such as accountability and pressure to achieve suitable outcomes in the prescribed time. Chapter Four of this thesis considered the inputs of time limited psychotherapy, and showed that the time limit could not be

separated from the context in which it occurred. The inputs and resources of time limited psychotherapy were shown to impact on how participants perceived and experienced a time limit. Chapter Five considered the processes involved in time limited psychotherapy, and showed that therapeutic processes are largely perceived to be different when working in the context of a time limited third party referral. The perceived outcomes of time limited psychotherapy were also presented and it was demonstrated that outcomes in time limited therapy are perceived as weaker compared with the outcomes of therapy without a time limit. Furthermore, participants were significantly varied in their perceptions of what constituted a successful outcome, which influenced their perceptions of a good time limited outcome.

The aim of this chapter is to consider the implications of these findings for the provision of psychological services in time limited frameworks. This chapter will consider the effects of systems of third party time limited referrals, and elaborate on the connection between the inputs, processes, and outcomes of this system. Some of the implications from this research for the practice of psychology will be outlined and discussed in light of relevant policy and practice issues. This chapter will also consider the limitations of the research and make some suggestions for future research. Firstly, this chapter will consider the broad system of time limited therapy determined by third parties and how it is experienced by psychologists.

How the third-party payer system is experienced by psychologists

The time limited world of psychotherapy is diverse. In Australia, some sources of time limitation provide a limited number of sessions on a yearly basis while other sources provide only a one-off funding block of sessions. The number of sessions funded also varies between different funding bodies; some such as EAP providers may provide as little as one session while others such as Victims of Crime fund up to 20 sessions. Third party referrers are varied not only in the number of sessions they will provide funding for but also in their aims for funding psychotherapy and this was an important determinant to the experience of a time limit. There is thus a broad range of settings within which a psychologist in Australia may provide time limited psychotherapy under the auspice of a third party provider.

The fact that time limits were externally imposed by third parties made a difference to participants' perceptions of a time limit, compared with when participants worked in a

client determined timeframe. The question that arises from this finding is how and why an externally imposed time limit is different from self-imposed, or from psychotherapy that would go for the same time anyway. One of the reasons that emerged from the findings surrounds the fact that along with the externally imposed time limit came other factors, and these factors affect the process of psychotherapy. For example, participants reported feeling more accountable, and the locus of control over the completion of psychotherapy shifts to include a third party. The system of time limited psychotherapy contributes to the push for accountability, requires a relationship with a third party, and is accompanied with a certain type of pressure. The interview study was in a position to identify that the imposition of a time limit made a difference to psychologists, and was largely seen as a shift away from practices considered 'ideal'. Findings clearly showed that psychologists feel compelled to 'manage' the time limit and that this is often perceived as a shift away from ideal practice.

The participants of this study largely indicated that they would like to be in command of how long treatment can go for and therefore have therapeutic length tailored to each client. It remains unclear how this desire for control over time may relate to therapeutic outcomes, although participants mostly indicated that adequate outcomes could be more readily assured without time limits. Certainly there are findings in the present study to suggest that therapeutic efficiency and awareness of therapeutic movement is enhanced by time limits. However, the desire for control over time relates to the decreased satisfaction in time limited conditions and participants' perceptions of ineffective processes and inadequate outcomes that were sometimes accompanied by a time limit. Clinical impressions suggest that clients can also be trusted to determine when they have received enough benefit from psychotherapy (Given, 2002), which was confirmed in a preliminary study (Carey, 2005) and a further study (Carey & Mullan, 2007).

The negative emotional responses to third party time limits indicated in Chapter Four show that some psychologists experience stress and frustration as a result of providing services in the context of time limited referrals. Previous research has also demonstrated the frustration of being burdened with paperwork not intrinsically connected to the provision of psychotherapy when working in managed care type settings (Rupert & Baird, 2004). Some participants identified burnout issues when working with high caseloads of time limited clients, which Rupert and Baird identified in their survey of American psychologists working with high managed care workloads.

Participants in the present study indicated that they feel impelled to take shortcuts in psychotherapy, and their treatment can feel like a shift away from ideal ethical treatment. This has implications for the uptake of these programs by psychologists, which was also reported by some participants who indicated that they either have or are considering refusing to provide treatment through third party determined time limited contexts. There were also a handful of potential participants who advised me that they did not consent to participate on the basis that they refused to provide therapy in the context I was investigating. However, if psychologists refuse to provide psychotherapy through third party systems this may create a system where access is inhibited for those who cannot afford to pay for therapy privately (Cantor & Fuentes, 2008).

SECTION I: THE INPUTS, PROCESSES, AND OUTCOMES OF TIME LIMITED PSYCHOTHERAPY

Previous research has already shown that the number of sessions available makes a difference, even before third party influences (Barkham et al., 1996; Reynolds et al., 1996; Shapiro et al., 2003), but this research shows that a time limit cannot be separated from the system under which the number of sessions is imposed because once a time limit is imposed, it has implications throughout the whole process. For example, third party time limited referrals affect the types of clients available for treatment, the choice of treatment, assessment and diagnosis, and how psychotherapy is conducted. It also affects how therapists conceive of, report, and achieve outcomes. This section will discuss the implications for psychotherapy delivered in this context by considering the inputs, processes and outcomes of time limited therapy.

The Inputs of Time Limited Psychotherapy

There were several important inputs of time limited psychotherapy identified in the present research that acted to determine the impact of a time limit. These inputs included the broad system that time limited therapy operates within, the human resources of clients and therapists, and the resources available in the system. The inputs of time limited therapy show that providing therapy in this context is about more than an external limitation on session number per se; the context of third party providers acts to make psychologists feel more accountable and aware of being managed. The human resources involved in time limited therapy were also found to be inputs to the system.

Psychologists providing time limited psychotherapy act as inputs because with participants' responses came a diverse range of opinions on the very role of psychotherapy, its length, aims, and notions of the place of funded therapy. From the perspective of participants, clients were also considered to be diverse, and the complexity of their presentation arose as an important determinant to the constraint of a time limit. This section will discuss the role of the time limit, psychologist factors, and client factors in their capacity as inputs to time limited psychotherapy.

The time limit

The first important input to consider in time limited psychotherapy is the time limit itself. A time limit can act to accelerate therapy (Barkham et al., 1996; Eckert, 1993; Reynolds et al., 1996) and the present research allows for a further understanding of why this may be the case. Participants reported taking on pressure from a time limit that resulted in an increased pace and perceived efficiency of therapy. Although a distinct subgroup of participants was frustrated with the imposition of time limits, they were still able to report an increased efficiency. Further, participants reflected that even if their therapy would typically proceed for around 12 sessions, having an external imposition of 12 sessions was still experienced as different to them. A time limit has thus been shown to be about more than just the length of treatment, as the limitation had an effect over and above the number of sessions provided.

Something of a paradox is presented when considering the present findings in light of previous research that has consistently shown an average of a small number of sessions that clients attend treatment for. It is well established that actual uptake of sessions by clients is low across a variety of settings (e.g., Barr & Pegg, 2006; Carey, 2006; FHSA, 1994, cited in Scott, 2004), and this includes uptake from the Better Access initiative (Giese et al., 2008). The paradox is that participants expressed a preference for flexible time rather than third party restrictions, yet acknowledged that psychotherapy would not necessarily be longer anyway. This paradox can partially be explained by considering the role of the third party in imposing a time limit. The imposition is contrasted with clinically determined time limits as well as treatment that might end up being short anyway. The time limit is therefore functionally superfluous to some extent, as shown in previous research on time limitation (e.g., Amabile et al., 1976). That is, a time limit may not always impact upon the length of therapy. However, the paradox may also be explained by considering that the average number of sessions is just that; the sum of

utilised sessions divided by the number of clients receiving these sessions. The ‘utilisation paradox’ (Shapiro et al., 2003) referred to by participants was further reason for the desire for flexible timeframes. Participants reported that they want flexibility with the amount of time they have for psychotherapy rather than a set limit that was for the most part experienced as arbitrary.

The length of psychotherapy is also an ethical consideration. The ethical standard of informed consent states amongst other things that consent is informed through “clarifying the frequency, expected duration, financial and administrative basis of any psychological services that will be provided” (Standard A.3.3. of the Code of Ethics; APS, 2007). It could be argued that working in time limited models allows for a clearer conceptualisation of time in therapy and hence a closer abiding with this standard. However, it could also be argued that a time limit hinders the ability to talk about the ‘expected duration’ that a course of treatment would naturally follow because the timeframe is pre-determined. So while the client may be specifically aware of how much time they have left in psychotherapy, this might not necessarily be in line with the expected duration of a ‘complete’ treatment.

While the focus of this research has been on the implications of the temporal boundary provided through time limits, there was some limited evidence from two interview participants that in some situations psychotherapy may in fact be extended when externally limited. That is, a psychologist may work to the time limit and not to the problem; for example if they are allocated 12 sessions they may make therapy last 12 sessions even though in other circumstances treatment might end earlier. The result is therefore unintentional over-servicing, which Carey et al. (2009) suggested as a potential effect of the time limit operating in two to three blocks of six sessions as it does in the Better Access initiative. This unintentional over-servicing may compromise Standard B.3 of the Code of Ethics (APS, 2007), which states that psychological services should only be provided for the time necessary.

Psychologist Factors

The second input to emerge as an important determinant to the experience of a time limit was the variations between psychologists. Chapter Four showed that there are marked individual differences between psychologists: they differ in their philosophy of psychotherapy, the way in which they practice psychotherapy (including their

theoretical orientation), their views on the necessary time for psychotherapy (and how flexible this need be) and what they believe to be the overall aim of psychotherapy. This finding was equally robust in both types of data collection techniques, and has been acknowledged elsewhere (e.g., Larsson, Kaldø, & Broberg, 2009; Ogunfowora & Drapeau, 2008). These variations therefore resulted in different types of processes and outcomes in order to adapt to the time limit.

Participants in this study expressed different opinions about time limits. To some participants, time limits were experienced as rigid while to others they were perceived as flexible. Flexibility was shown, for example, through reports of obtaining funding from other sources at the end of the initial source of funding or through extending therapy pro bono. Previous research has identified that most psychologists believe it to be their responsibility to continue with treatment if a third party limits the time available but there is more work to do (Murphy et al., 1998), and this was also evident in the findings of the present study. Regardless of perceptions of flexibility, participants also differed in their opinion of time limits. While overall the time limit was seen as a barrier to effective treatment, to some participants it was a source of efficiency and appropriate. There were two factors that corresponded with a positive opinion of third party determined time limits. Preference for CBT was one of these factors, as well as the extent of working experience providing treatment in short time limited programs, for example through EAPs. Some participants indicated that they have 'nothing to offer' in only limited sessions, while others did not see a difference between how they provided services in time limits as opposed to without time limits; most participants were somewhere in-between. These differences in perceptions of the appropriateness of time limited psychotherapy may relate to the differences between participants on how much time was perceived as necessary for psychotherapy, which for interview participants ranged from between a few sessions to a year. This diversity in opinion on how much time is necessary has been found elsewhere (e.g., Pirkis et al., 2006), but opinion on appropriate length was not a predictor of the experience of a time limit, thus showing that flexibility with time was considered important even if estimations of necessary treatment length were low.

The effect of a time limit appears to be mediated by the type of therapeutic brand (and therapeutic philosophy) that psychologists use. The more participants worked *solely* in CBT approaches the less of an impediment, or difference, they perceived a time limit to

be. The pattern that participants who were more in tune with a CBT treatment philosophy were more adapted to the use of time limits appears logical when considering what it is about CBT that makes it a distinct type of psychotherapy. For example, the use of homework and therapist direction of session activity are two features specific to CBT (Blagys & Hilsenroth, 2002), and these two features were also reflected in the present findings that relate to adapted therapeutic process due to time limits. For those psychologists already utilising these techniques, a time limit therefore had less of an impact upon them. CBT is also a goal setting approach, and the very nature of goals renders them adjustable to temporal requirements.

Client Factors

The complexity of a client's presentation was found to be an important input determining the extent to which a time limit was reported as a constraint, influenced process, and limited perceived outcomes. Many participants found complex client presentations a significant impediment to successful time limited psychotherapy. There is theoretical evidence to consider client complexity as an important input to any type of psychotherapy, and therapy should be tailored in order to account for the degree of complexity (Groth-Marnat et al., 2001). The present research builds on this to show empirically that the complexity of a client's presenting problem influences treatment approach as well as perceived outcomes in time limited psychotherapy. The questionnaire used both a simple and complex vignette to ask about predicted treatment approach and outcome based on time, and found consistently that a complex presentation resulted in weaker perceived outcomes and use of different approaches to psychotherapy. A complex presentation was also shown to be associated with a reluctance to engage in-depth with problems, which could be reflected in the weaker perceived outcomes of complex presentations in time limited therapy. Although statistically substantiated in the questionnaire that there are significant differences in perceived approach, outcome, and satisfaction based upon the complexity of a client, there were still some participants in both studies for whom complexity did not contribute towards a perception of difference between time limited and time unlimited treatment. However, overall the findings of this research indicate a preference from psychologists for longer term therapy for complex client presentations, and in particular there is a need to consider the nature of the therapeutic relationship in complex presentations (Briere & Scott, 2006). The therapeutic alliance was considered to be

more important with a complex presentation, but there was less scope to develop it when working in a limited number of sessions. Many participants were challenged by complex presentations in time limited conditions, and adapted their therapy to suit this timeframe but felt less satisfied with the outcome.

The present study has shown a concern from participants that a pre-set timeframe will impact on the expectations of clients in that they may automatically expect to 'get better' in the time prescribed. A limit of six sessions, for example, could thus make a client automatically expect to be improved at the end of these six sessions from the outset of psychotherapy. This is important given previous research which has identified that the biggest predictor of treatment duration is clients' expectation for how long treatment will take (Mueller & Pekarik, 2000). Further, previous research tells us that clients have an awareness of time pressure when time is limited in the health services they receive, and that they in fact actively ration their discussions in an attempt to manage the limited time (Pollock & Grime, 2002). This was also voiced as a concern from the participants of the present study; if clients ration their discussions some important material may be missed or brought up at a later date with little scope to attend to it, thus rendering therapy less effective.

Therapeutic Processes

Most participants perceived a time limit to affect their process of therapy, and for a subset of participants this difference was experienced as a barrier to effective treatment. Change in therapeutic process was a robust finding from both the interview and questionnaire. Although there were marked differences in the process of therapy between participants, it was almost unanimous that whatever this process was it would be adapted when working in a time limit. The ways in which processes were reported to change include theoretical orientation and approach, planning and structure, and the conduct of psychotherapy. Understanding exactly what is meant in relation to the results on process changes is difficult in light of the ambiguity over exactly what makes psychotherapy helpful (Dallos & Vetere, 2005). This section will consider the efficiency of time limited psychotherapy, changes to therapeutic approach based upon a time limit, including the therapeutic alliance and assessment, and problem definition in time limited psychotherapy.

Therapeutic efficiency

The time limit was perceived to introduce an urgency that changed the nature of treatment. There is a certain mode of practice that happens when working in time limits, and participants largely demonstrated that they had worked out a 'system' to adapt to the effect of a time limit. Efficiency was achieved by containing the issues that could be addressed as well as containing the 'depth' of treatment, achieved by engaging in more symptom-oriented treatments, and by utilising a more structured therapeutic approach. Research in the area of ageing has shown that when time is limited goals change (Carstensen et al., 1999; Lang & Carstensen, 2002), and the present research indicates that imposing a time limit may change the goals of therapy for some psychologists. Participants in both interviews and questionnaires indicated strong differences in what they would aim to achieve in time limited psychotherapy, and therefore strong differences arose in how they would go about doing this - the therapeutic process. Time limits may decrease intrinsic motivation (e.g., Amabile et al., 1976), and the present research supports this in its application to time in therapy. Time limits appear to make psychologists more aware of time, which in turn changes the way they do therapy to maximise the efficiency of their therapy in the time they have. In terms of motivation, findings were unexpectedly diverse; while some participants reported less motivation others reported more. Generally, for those participants with a client-centred approach, motivation appeared to be decreased while for those with a more structured CBT approach, motivation was increased. It therefore seems that for psychologists with a commitment to insight, an emphasis on time will possibly de-motivate them, whilst those oriented to instrumental goals may have their motivation enhanced by time limits.

For the most part, time was used differently in time limited psychotherapy compared with therapy without a third party determined time limit. Evidence for this can be seen through participants' greater awareness of the need to refer on, increased symptom focus, and a less client-centred approach. When working in time limits, participants had a different attitude towards and use of time, and hence took a different approach to psychotherapy than they believed they might otherwise take. Results from the present research confirm that time limited psychotherapy requires the therapist to develop a "time-sensitive attitude" (Bor et al., 2004, p. 8), insofar as participants indicated that they were for the most part acutely aware of the time limit and sought to accelerate treatment progression within the prescribed timeframe. Regardless of participants'

opinions of time limits, the perception that a time limit could act to increase efficiency was almost unanimous.

It has been previously indicated that short-term psychotherapy may constitute more of a consultation than psychotherapy (e.g., Kreilkamp, 1989). In order to make psychotherapy brief, psychotherapy can be condensed, or the same amount can be covered but with less therapist contact (Key & Craske, 2002). Many participants in this study referred to the increased use of adjunct treatments such as bibliotherapy, which has been demonstrated to be efficacious in its own right (e.g., Gregory et al., 2004) and equally efficacious to cognitive psychotherapy in depressed patients (Den Boer et al., 2004). Adjunct treatments were thus used as an adaptation to therapy when working in limited timeframes, in an attempt to maximise efficiency.

Theoretical orientation and approach

Time limitations and degree of complexity contribute to the choice of therapeutic orientation according to the findings of the present study. Theoretical orientation is thus shown to be flexible and will be influenced by external factors – that is, a time limit and client complexity – separate to training or theoretical preference. Participants varied in the extent to which their orientation was flexible and there was a small percentage of participants in both studies who used only one theoretical orientation and did not vary based on time or complexity. The orientation of all these participants was CBT. These findings therefore support those of Malik et al. (2003) to show that therapy conducted in different therapeutic orientations is variable, but this variation is less for psychologists with a preference for cognitive therapies. The present research has demonstrated that conceptualising psychotherapy in terms of a science of inputs and outputs misses a large degree of what actually happens when therapy is delivered. Although theoretical orientation was related to some findings, it did not account for a significant proportion of the differences found between participants; theoretical orientation in itself was flexible anyway. This is because participants were not only largely eclectic, but varied in the type of eclecticism engaged in. Some participants were technically eclectic (Lazarus & Beutler, 1993) and others reported significant theoretical and ideological eclecticism as well as technical eclecticism. Eclecticism was thus reported as a tool to adapt to a time limit.

Having a time limit may change the way psychotherapy is delivered in several meaningful ways. Being non-directive is one of the fundamental core skills taught in counselling and psychology (e.g., Egan, 2007), however different therapeutic orientations vary significantly in the degree to which they discourage directiveness. Directiveness also varies across the course of the treatment, with therapists becoming more directive over sessions as time progresses (Keijsers, Schaap, Hoogduin, & Lammers, 1995). The present study suggests that a time limit is another factor that determines the level of directiveness: under a time limit, psychologists are more directive *throughout the treatment*. Congruent with suggestions from Hazlett-Stevens and Craske (2002) findings show that time limited work requires the psychologist to keep focussed on particular goals and be directive in maintaining this focus. Systems of managed care may necessarily change the role of the psychologist to become more directive and result in a step away from being client-centred (Cantor & Fuentes, 2008). From the present study, increased directiveness was utilised as a tool to ensure adequate gains could be made. However directiveness was also seen as a shift away from client-centred psychotherapy, which was problematic to the treatment philosophies of a significant proportion of participants.

The important question in regards to process revolves around the extent to which these differences constitute a different type of psychotherapy, as Bor et al. (2004) suggest a time limited model requires. The present research has affirmed the possibility that in addition to a difference between therapeutic approaches in long-term and short-term being apparent, a difference between time limited and time unlimited approaches is also apparent. Third party referrals have been shown in this research to be about more than just a time limit. For example, the Better Access initiative constrains not only time but also the types of treatments to be utilised through its focus on CBT (DoHA, 2007). For psychologists more inclined towards client-centred or other insight based treatments, the imposition here is also a constraint.

Therapeutic alliance

Another facet of the therapeutic process reportedly adjusted when working in time limits was the formation of the therapeutic alliance, which is an important determinant of effective psychotherapy (e.g., Baldwin et al., 2007; Horvarth, 2001). Psychologists reacted to time limits by increasing their 'doing to' behaviour and decreasing their

'being with' behavior. This is in contrast to the notion of the therapeutic alliance being a reciprocal process or influence, as opposed to something the psychologist 'does' to a client (Andrews, 2001). Establishing a therapeutic alliance quickly is essential in brief psychotherapy as the limited time means that it is not possible to focus solely on establishing this relationship for long (Key & Craske, 2002). This idea was also reflected by participants in the present study, who felt pressure to focus on therapeutic change earlier in the treatment, thereby altering the formation of the therapeutic alliance. The lack of time available in time limited therapy to explore the therapeutic relationship may mean that therapy is "reduced to an unchallenged power relation" (Cushman & Gilford, 2000, p. 991). Furthermore, therapist flexibility positively contributes to the formation of a therapeutic alliance (Ackerman & Hilsenroth, 2003), however participants in this study reflected that a time limit rendered them in a position with less ability to be client-centred, so this may have contributed to reports of a time limit acting as a barrier to the therapeutic alliance. The nature of the therapeutic relationship may also be altered given reports that psychologists would discuss with clients ways to acquire further funding and about how to manage the time limit. The issue appears to be that the third party payer hinders both the client and psychologist from forming the most effective therapy relationship and utilising theory and technique for the benefit of the client.

Assessment

Prior to this research commencing, it was anticipated that psychologists would conduct their assessments differently based on the available time for therapy, and interviews specifically addressed this question. Findings do not show that assessment is considerably different for the majority of participants, so despite the opportunity for further assessment when not time limited, few participants reported this. As discussed in Chapter Two, assessment may be a casualty of time limited treatment (Beutler, 1999), but formal assessment for the most part was not a casualty in the present findings. This may be in part because few respondents reported a formal assessment component to their treatment approach. However, participants did largely indicate that they had a reduced *understanding* of their clients in time limited contexts, which was experienced as a limitation. History taking has thus been shown to be a casualty of time limited therapy, which was experienced as a limitation to understanding clients. Psychotherapy funded through the Better Access initiative in Australia is intended to

have limited assessment that is “generally ...not expected to extend beyond the initial consultation” (Littlefield & Giese, 2008, p. 44), so a more detailed assessment may not be an aim of funded psychotherapy. However, reduced understanding of the history of clients was experienced by many participants as a barrier to effective treatment. Understanding the impact of further assessment and how much assessment is necessary in time limited treatment are important questions (Carey et al., 2009).

Problem definition in time limited psychotherapy

The way in which treatment targets were defined was reported to shift when working in a time limit. Treatment planning was shown to be approached differently by participants who felt particularly pressured by the constraint of a time limit. The questionnaire in particular showed that psychologists may drive the choice of ‘presenting problem’ depending on the time available. Psychological problems in time limited treatment were more likely to be perceived in terms of symptoms than in treatment without a time limit. Defining problems in this way meant that the process of treatment shifted to include a greater focus on psychoeducation and adjunct treatments. Psychoeducation is recommended in the policy documents of both Better Access (DoHA, 2007) and BOMHC (Pirkis & Blashki, 2003), so forms part of an endorsed approach to time limited treatment. Regardless of time limits, psychoeducation is recommended as part of a standard treatment approach in CBT (Corey, 2005), but present findings show an increased pressure to educate the client and thereby teach them to manage their problem.

Providing therapy in time limits can lead psychologists to ‘compress’ their treatment and target symptoms more in their approach. In line with the present results, Bor et al. (2004) state that time limited psychotherapy is “containing for both the therapist and the client. It provides a real, rather than imagined, boundary. This contributes to a sense of emotional safety and containment” (p. 23). Containing therefore changes the way in which therapy is addressed; the focus of therapy shifts to account for keeping the client safe by not exposing them to distressing material that cannot be adequately addressed. The definition of the target problem is thus again altered to account for a limited timeframe.

Changes to the process of psychotherapy are an important finding because they indicate the degree to which psychotherapy is not systematic in practice. There are pushes for

psychotherapy to be systematic and accountable, but in practice it seems to vary both between and within psychologists. Third party provider programs that are predicated on the use of systematic treatments may therefore be missing the reality of treatment. Overall, participants largely indicated that they want flexibility, and that the lack of this was contrary to their theory, training and their experiences of providing effective psychotherapy. Participants were ambivalent about the distinction between their theoretical position and the restraints of the service. Overall the structure, focus, and boundaries of time limited treatments was experienced as beneficial, but they also reported restrictions that at times limit their ability to do effective psychotherapy.

Therapeutic Outcomes

Improvement in a valued direction is of course the desired outcome of psychotherapy, so understanding whether a time limit may influence this outcome is a critical factor to consider given the prevalence of psychotherapy provided in the context of third party determined time limits. Overall, therapeutic outcomes are perceived to be different when working in a time limit. The outcomes considered in this section are psychologists' evaluation of success, the type of success, length of symptom-free period before relapse, and inoculation against further relapse. This section will also discuss the complexity of considering outcomes in light of the broader issue of how and whether time limited treatment can be considered effective depends on what are considered appropriate outcomes. Before specific outcomes are considered, this section will briefly discuss the lack of agreement shown in the present research about what an appropriate therapeutic outcome is.

Notions of a successful therapeutic outcome

In this study, psychotherapy has been shown to be diverse in a number of ways. Notions of the aims of psychotherapy, appropriate therapeutic processes, and how a time limit impacts upon psychotherapy were diverse across participants. Psychologists in this study are using a broad range of approaches, however it remains unclear how such vastly different approaches to therapy relate to client outcomes. The varied aims of psychotherapy shown by participants in this study indicate, for example, that there needs to be a clearer distinction between psychological treatment and psychological first aid. Three sessions may be a different type of treatment to 12 sessions, or may not

be treatment at all but rather a source of education and support. Either way, the definition and boundaries of acceptable practice need to be clearer.

A clear example of the lack of clarity over what constitutes an acceptable outcome was shown through the questionnaire. When I asked questionnaire participants about 'symptom alleviation' in Question Four, many of the responses seemed to be about personal growth. This reveals an important 'muddying of thinking' in the profession of psychology. Do we alleviate symptoms of mental distress or assist with personal growth? It seems that many participants were not sure. Many participants seemed to doubt that symptom alleviation was enough and reported that therapy is not finished until something 'deeper' is achieved. But when considering issues of funding, it should be clear whether tax payers and insurance companies should fund what may be considered as personal growth. Either way, this research has highlighted the lack of distinction between the two and the diverse range of personal opinions on the matter. Carl Rogers has pointed out that the field of therapy is "completely chaotic and divided". He observes that therapists are "not in agreement as to their goals or aims [nor in] what constitutes a successful outcome of their work. They cannot agree as to what constitutes a failure" (Comer, 2001, p. 6). The literature in EBP would suggest that outcomes can be measured through improvements on assessment measures; however these assessment measures do not appear to be routine practice based upon the current research.

The present research appears to indicate that notions of an adequate outcome will be adapted to the context in which therapy is provided. Outcomes are not fixed but are context dependent; so what 'counts' as a successful outcome can vary according to the therapist, the client, and the context that therapy is provided in. Positive outcomes from the perspective of psychologists, clients, researchers, and third party funding may involve "diverse and incommensurate concerns" (Cushman & Gilford, 2000, p. 992). The present research shows that the perspective of an adequate outcome was adaptable to the context of limited therapy funded by a third party.

Considering perceptions of outcome in time limited therapy also depends on what is taken to be a suitable outcome of psychotherapy, whether limited or not. This is a contentious question and there were significant differences between participants regarding what a suitable outcome is. It is clear that for the most part psychology is

headed towards a symptom management approach to treatment and away from facilitative approaches to elicit change and provide support (Prochaska & Norcross, 2003), but participants in this study differed significantly in what they viewed as a successful therapeutic outcome. To some participants symptom alleviation was enough while to others symptom alleviation was just the beginning. This may be partially accounted for by the broad range of therapeutic approaches taken by participants of this study; however therapeutic change has some common elements despite the delivery of psychotherapy through different orientations and by different psychotherapists (Carey et al., 2007).

It is also important to consider how outcomes are defined by the third party funder of psychotherapy. Systems of third party providers of psychotherapy have brought about shifts in the idea of what constitutes a successful outcome (Cantor & Fuentes, 2008). Third party systems may need to acknowledge explicitly that expected outcomes are different from and more limited than other contexts. The Better Access initiative does not have clearly defined aims of therapeutic outcome (DoHA, 2007). The policy documents suggest that the immediate output of psychotherapy should include information on “assessments carried out on the patient; treatment provided; and recommendations on future management of the patient’s disorder” (DoHA, p. 38). As Cushman and Gilford (2000) suggest, “[m]anaged care treatment philosophy implies that therapy is most efficient when the therapist’s personal idiosyncrasies and theoretical preferences are bracketed off or at least made secondary to standardized goals and objectives” (p. 989). Findings from this research also suggest that as an adjustment to a time limit psychologists can set aside their theoretical preferences in the aim of achieving quick and efficient, but symptomatic, change. For participants whose philosophy was already represented by this ethos, a time limit brought about fewer changes in conceptualisation, approach, and perceived outcomes. However, as Cantor and Fuentes ask, “should the economic system alone determine what is best for patients, or should psychologists make that determination?” (p. 642).

The major source of time limited psychotherapy in Australia is presently through the Better Access initiative. The limitation of 12 sessions²¹ in this initiative is based on the calendar year, so clients are in fact eligible for a further 12 sessions in the next calendar

²¹ In ‘exceptional circumstances’ 18 sessions may be granted.

year. The ability for psychotherapy to be utilised in a problem focussed way through this design may mean that each potential block of psychotherapy can focus on the specific presenting problem (Mander, 2003). However complex client presentations were found to interfere with the perceived appropriateness of these limitations. Despite a significant subset of participants expressing dissatisfaction with the system of time limitation, the system thus created was perceived as adequate in addressing symptomatic problems but lacking in its ability to address relapse and complicated needs. Based on the present findings, psychotherapy in Australia can thus be defined as symptomatic, psycho-educational, brief, and potentially recurrent.

Predictions of outcome in time limited therapy

Overall, participants predicted the outcomes of time limited therapy to be weaker compared with the outcomes of time unlimited therapy. However, some participants had symptom oriented views on outcomes while other participant's views were more complex and included issues such as durability of gains, inoculation against future relapse, quality of life, and overall functioning. There was thus a diverse range of opinions on an appropriate psychotherapeutic outcome shown in the findings of the present research.

Findings regarding the process of psychotherapy showed that depth was perceived to be limited in time limited psychotherapy, and this lack of depth was also reported as an outcome of time limited therapy. Outcomes were predicted to be significantly lower when time limited. The questionnaire asked participants to predict therapeutic outcomes based on the four different conditions of time and complexity; that is, a simple and a complex client presentation in a time limited and a time unlimited condition. The Phase Model (Howard et al., 1993) was used as a theoretical model through which to ask participants about outcomes, although the model was not explained to participants. Findings show that outcomes are predicted to be significantly lower in all domains of the phase model when working in a time limit, and complexity interacts with the time limit to make outcomes lower again.²² There is therefore an overwhelming response that outcomes are perceived as weaker when working in a time limit. Findings indicate

²² Separate to the aims of the present research, the predictions of the Phase Model would suggest that findings should have demonstrated progressively less improvement in each domain; however there was no statistically significant difference between predicted outcome in each domain of remoralisation, remediation, and rehabilitation (see Appendix J).

this weaker perception of outcomes is related to the lack of control the psychologists feel they have when working in a time limit. The finding also supports meta-analytical evidence of the positive relationship between treatment length and therapeutic outcome (Orlinsky, Grawe, & Parks, 1994), although treatment length did not account for all changes in perceived outcomes.

The reported increased focus on symptom reduction by psychologists in time limited therapy was seen as problematic to many participants as they saw this as a move away from substantive therapeutic gains and towards a 'bandaid' approach to therapy. However, the effectiveness of therapy in this context once again depends on the criteria for a successful outcome. Previous research has demonstrated the need to consider quality of life in addition to symptom reduction, and that symptom reduction does not necessarily predict improvements in quality of life functioning (Norberg et al., 2008). Participants in the present study largely expressed views in concurrence with this, as they were sceptical about the long-term gains that could be made when focusing on symptoms in limited amounts of time. Symptom identification and removal became more important in time limited work, and for participants who reported being client-centred in their approach, they felt more inclined to work within the medical model of diagnosis and targeted treatment, thereby changing their perceptions of outcomes. Different ideas about psychotherapy aims could therefore act to determine perceptions of outcome success.

Regardless of views on adequacy, for the most part outcomes were viewed as different to what could be achieved in open-ended psychotherapy. For example, the goal of time limited CBT is not automatically the same as time unlimited CBT (Key & Craske, 2002), and this was reflected in the findings of the present research regardless of theoretical orientation used. It is therefore logical that for those participants who reported a preference for brief CBT, they not only made limited changes to their therapeutic process but also reported outcomes to be of a similar nature to therapy without an external time limit. As the previous section discussed, psychologists indicated that they adapt their process to suit the time available. In the process of adapting, outcomes were perceived as adequate at times and at other times as inadequate. Some things about this adapted process therefore led to substandard outcomes, for example the inability to look at issues of trauma as shown through findings on containment. The increase in efficiency as identified in changes to

therapeutic process is therefore a trade-off for a level of effectiveness considered adequate. Controversy over adequate outcomes can also be found in the literature. For example, Hansen et al. (2002) suggest an appropriate outcome will be clinically significant change while Given (2002), in response to the latter, suggests that brief psychotherapy may be adequate for some on the basis that psychotherapy need not aim to see everyone through to full functioning.

Participants reported feeling more accountable in third party contexts of time limitation, which was accompanied by a demand for outcomes over process. Instead of leading to long-term outcomes, time limited treatments lead to outputs, such as measurement on the DASS (Lovibond & Lovibond, 1995). From the perspective of many participants the system of third party funding does not appear to be genuinely focussed on achieving long-term outcomes, and is not facilitating of them. Whilst sometimes outcomes were perceived as adequate, some things about the processes of time limited psychotherapy were perceived to lead to inadequate outcomes, for example the need to contain and the subsequent inability to look at complex trauma.

The durability of gains was questioned in time limited therapy, and a number of participants expressed concern that relapse is more likely after time limited therapy that does not allow for 'completion'. There was something about the process of time limited psychotherapy that was perceived to relate to the inability to inoculate clients against relapse. In questioning the durability of gains that could be made when timeframes are too short, there are implications for the long-term cost of providing psychotherapy to clients, which will be discussed in the following section.

SECTION II: IMPLICATIONS AND CONCLUSIONS

This section will consider some implications for practice and policy arising from the present research, describe the strengths and limitations, identify some future directions for research, and finish with some concluding remarks on the contributions of this study to the field of psychology.

Implications for Practice and Policy

This research took place at a time when Australian psychologists were becoming increasingly exposed to work referred from third party providers in a time limited

format, making time limits a contemporary issue to discuss. Increased funding in the form of the Better Access initiative was introduced during the time that data collection took place in November 2006, and being one of the significant sources of time limited psychotherapy, this made the present research a relevant issue for participants to engage with.

The intention of the present research was to find out about the impact of time limits, but the findings include a much broader spectrum of considerations. This included broader implications surrounding, amongst other things, that a time limit in third party determined time limits operate differently from time limits which are therapeutically or clinically motivated. Therefore, it cannot be assumed that what is effective in the latter can be transferred to the former. Third party funding of psychotherapy has widespread effects on psychotherapy (for individuals, as a population, and on psychologists), which have been shown to relate to the inputs, processes, and outcomes of the system of time limited therapy. This section will discuss the implications of this research for practice and policy. It will begin by considering the aims of third party systems that fund time limited therapy. Implications for the training of psychologists will be discussed as well as the implications for policy involving third party determined time limits.

How successful the system is at addressing its aims

This section will consider how successful the third party provider system is at addressing its implicit aims in terms of improving access, improving mental health, containing costs, and providing evidence-based practices. Although the third party providers referred to throughout this thesis have been diverse, there has been a focus on the Better Access and BOMHC initiatives. This section aims to consider the broader aims of third party providers in the provision of mental health services.

Improving access

Increased access to psychological services is an important factor in the provision of mental health services. For example, in a large-scale survey of clients receiving treatment from the Better Access initiative, 96% reported that without Medicare funding they would be unable to see a psychologist (Giese et al., 2008). While disillusioned with some aspects of treating clients in time limits, participants also largely expressed that this limited accessibility to treatment is better for clients than having nothing.

Findings have demonstrated that while psychologists are happy with the increased access to psychotherapy for some clients, individual access can be impeded by time limits if more time is required. This was particularly apparent for those clients considered as having more complex and chronic needs, which has been acknowledged elsewhere (Sanchez & Turner, 2003). In addition, some participants expressed skepticism about the beneficial effects and sustainability of the outcomes of treatment when bounded by time limits. Findings have highlighted particular ethical concerns for psychotherapy when time is limited. Principle A from the Code of Ethics of The Australian Psychological Society states that psychologists should “ensure that all people have reasonable and fair access to psychological services and share in the benefits that the practice of psychology can offer” (APS, 2007). Working in a time limit was sometimes perceived as a barrier to upholding this ethical code.

Improving mental health

Mental health is recognised as an important factor in the nation’s health, as shown through the National Action Plan on Mental Health 2006-2011 (COAG, 2006). It is the recognition of the importance of mental health and its relation to physical health (Arnetz, 1996; Chiles & Lambert, 1999; Lambert & Ogles, 2004; Lyons & Chamberlain, 2006) that guides third party funding of psychological services, and there has been a significant uptake of mental health services since Medicare began subsidising them through the Better Access initiative (DoHA, 2009a). At a population level, it may therefore be important to consider assessing on a large scale the utility of third party systems of mental health funding. In regards to Medicare, an evaluation of the Better Access initiative is currently underway and will be completed in 2010 (DoHA). Understanding the extent to which initiatives such as Better Access can improve mental health can be gained by examining the outcome measures associated with it (Whiteford et al., 2008), and data can also help to provide information regarding the use of EBP by psychologists (Carey et al., 2009), which the Better Access initiative is predicated on.

Cost containment

Third party systems of providing mental health services may involve rationing the services that are provided (Miller, 1996), which includes amongst other things the use of a time limit to control costs. However, the present research indicates that it may be

necessary to think differently about funding that involves time constraints in the policy. It has already been shown that on average clients only attend for a small number of sessions in both time limited *and* time unlimited contexts, and this has been shown in a wide range of settings (e.g., Carey, 2006; Hansen et al., 2002; FHSA, 1994, cited in Scott, 2004). However the present study demonstrates that psychologists feel that psychotherapy cannot be done properly, or it is at least different, when they have a time limit. In that regard, if a time limit does not make therapy shorter on average, and possibly even longer (given reports of potential over-servicing) then it does not act to actually reduce the amount of time paid for on average. This questions the applicability of session limits as a means to managing mental health expenditure.

When considering the allocation of funding for mental health, Tustin (2009) suggests that some resources should be targeted towards the least severe category of mental illness but that the system needs to be balanced to allow funding for more severe and debilitating conditions. The boundaries of what constitutes a severe enough psychological disorder to receive funding should perhaps be clearer. In order to be funded by the Better Access initiative, patients need to meet criteria for a psychological disorder based on the ICD-10 (WHO, 1992), but there is evidence that non-DSM based criteria may be a better predictor of therapeutic outcome (Clarkin & Levy, 2004). Impairment based assessment may be more useful in this way, for example the Global Assessment of Functioning (GAF).

Providing evidence-based treatments

The system of managing psychotherapy by third parties is predicated on the use of EBP (Carey et al., 2009). From the perspective of such programs as Better Access and BOMHC, EBP and CBT are roughly synonymous (with some exceptions such as IPT). Evidence-based practice has offered promise to the ability of psychology to be accountable (APA Presidential Task Force on Evidence-based Practice, 2006), although there is acknowledgement that the individuality of therapists will influence the application of psychotherapy in practice (e.g., Gaskovski, 1999). One might expect that psychologists would be more inclined to use empirically supported treatments (ESTs) when working in time limits because they have been empirically validated in a time limited context, but only one interview participant reported this. So there appears to be either a low awareness of ESTs, or a low uptake for other reasons demonstrated in the

present research. Previous research has found that there are more perceived barriers than facilitators to the implementation of EBP (Pagoto et al., 2007). Also of note, no participants commented that a time limit interfered with their ability to utilise EBP, despite the overwhelming response that a time limit could compromise treatment process and outcome. A certain amount of scepticism about the findings from efficacy studies was expressed by a subset of interview participants who saw the timeframes shown to be efficacious in research studies as unrealistic for the clients they came across in their practice.

Although generalisability is limited, the present findings seriously challenge the prevailing orthodoxy that CBT and EBP are the current treatments of choice. There was a wide range of therapeutic approaches and differing degrees of flexibility shown in the participants of this study. If CBT and EBP are not as utilised as orthodoxy would have us believe, this further challenges the applicability of what CBT and EBP tell us about time in the real life practice of psychotherapy. The scientist-practitioner model and its emphasis on evidence-based approaches was scarcely mentioned, as participants largely seemed to use their 'clinical wisdom' in adapting to time limits. However, the use of clinical wisdom may be appropriate for psychologists in practice if it is combined with information from empirical research (Leahey, 2000), particularly given the limitations of understanding and applying a scientific process to psychotherapy that have been acknowledged elsewhere (Dallos & Vetere, 2005; Gaskovski, 1999; Jones, 2003).

Implications for the training of psychologists

The present research also highlights several implications for the training of psychologists providing therapy through third party time limited referrals. Although not the original intention, the present research has demonstrated a vast difference between the treatment approaches taken by practising psychologists. The participants in this research, although not necessarily representative of psychologists in private practice in Australia, show the extent to which eclectic approaches are used in psychotherapy, supporting the findings from previous research (e.g., Levenson & Davidovitz, 2000). Most psychologists have been found to have some degree of disconnect between the formal theory they have been trained in and their real-life practice (Hoshmand & Polkinghorne, 1992), rendering the practice of therapy diverse.

Although training for brief psychotherapy was not asked about in the present study, the open-ended nature provided scope for participants to bring this issue up, which no participants did. Previous research in the US has identified that only half of psychologists practicing brief psychotherapy had received specific training for it (Levenson & Davidovitz, 2000). Standard B.1.2. of the Code of Ethics (APS, 2007) states “[p]sychologists only provide psychological services within the boundaries of their professional competence” (p. 18). In hindsight it is unfortunate that information regarding training for time limited and brief psychotherapy was not specifically asked about during the data collection process. However, no participants responded with comments relating to their training for time limited and/or brief psychotherapy as opposed to psychotherapy that was not brief. This research may therefore raise the question of whether psychologists are adequately trained to deliver treatment in the context of third party determined time limits. The Better Access initiative has taken some steps towards ensuring the quality of psychological services with the introduction of mandatory professional development for registered psychologists (DoHA, 2009a).

While there are treatment guidelines provided with Better Access (DoHA, 2007) and BOMHC (Pirkis & Blashki, 2003), the Australian Psychological Society does not have specific ethical guidelines relating to the provision of psychological services in time limited and/or managed care type settings. A document of this type might prove useful in addressing the above ethical issues. Similarly, education of psychologists may do well to consider a module on how to manage funded psychotherapy. Hansen et al. (2002) suggest an emphasis should be made in treatment guidelines on the time needed for clinically significant change.

The present findings are highly supportive of the suggested treatments in the Better Access initiative, which require both generalist and clinical psychologists to focus on CBT and psycho-education (DoHA, 2007). Even where participants indicated reluctance to do so, process changes highlight the shift towards CBT processes in time limited treatments. A potential recommendation from the present research is therefore an increased focus on training in CBT for psychologists working in time limited third party funded schemes. Regarding the Better Access initiative, findings from this research might indicate the necessity for psychologists to be adequately trained in CBT. The changes to therapeutic process identified in this research highlight the intuitive shift towards symptom-based, psychoeducational, and goal setting techniques. These

techniques fall neatly under the umbrella of CBT. Therefore, the overwhelming acknowledgement that these techniques are more readily suited to time limited treatments may mean that the training of psychologists to work in a CBT model should be ensured for psychologists providing services through such initiatives as Better Access. However, while the shift towards CBT approaches was acknowledged by participants, it was also perceived as a limitation at times, and therefore questionable if relied on as a sole therapeutic technique. Further, a potential problem with such a focus in training upon short-term treatment may mean that few psychologists will be left to know the difference between different treatment modalities (Cantor & Fuentes, 2008).

Implications for policy involving third party determined time limits

Cushman and Gilford (2000) refer to the ability of managed care systems to act to influence the very way in which mental health care is defined. If externally determined time limits become the norm, then ideas about the length of psychotherapy will change over time to accommodate this influence.

It is very much in the interest of health policy-makers to allocate funding based on appropriate evidence, and literature suggests that this is the intention of policy (e.g., DoHA, 2007; Pirkis & Blashki, 2003). Policy regarding psychotherapy is based upon the available evidence; however there is no convincing rationale for considering a particular timeframe in psychotherapy (Carey, 2005). The present research has contributed further information for consideration of the use of time limits in psychotherapy through demonstrating that it brings about changes in the way that psychologists approach their therapy and conceive of outcomes.

A number of participants in this study have expressed concerns for the ethics of treatment that is provided in time limited contexts, particularly with complex clients. Previous research has also identified pressure to compromise ethical principles to be positively associated with higher levels of workload in managed care type settings (Rothbaum et al., 1998), and identification of ethical difficulties is not related to theoretical orientation (Murphy et al., 1998).

Furthermore, the present research indicates the need to be clearer about what a successful therapeutic outcome is, and whether and how it can be successfully measured. Participants had different ideas about what constitutes a meaningful therapeutic outcome. Policies of third party providers should have a precise view that

accurately represents current understandings of the complexity of outcomes and what it knows about the relation of mental health to physical health, functional output, and other factors that contribute to quality of life. Including cost-effectiveness in addition to effectiveness research in policy decisions may mean that the scope of adequate outcomes is broadened (Halpern, 1999).

Findings have shown that there may be some 'hidden costs' involved in the delivery of psychological services through third party determined time limits. Participants' indications that they would 'work the system' show not only that there are times when more psychotherapy is perceived to be necessary, but that psychologists can actively seek alternative funding through different sources. Also, while time limited psychotherapy allows for control over expenditure, outcomes for clients may be less than ideal and the true financial benefit diminished in the longer term by the need for recurring psychotherapy funding.

Writing from the viewpoint of the managed care system in North America, Herron et al. (1994) argued that mental health is being funded at the level of 'necessity' which accounts for a narrow conception of mental health, and may not be cost effective in the long-term despite its short-term appeal. Some participants in this study referred to notions of an adequate outcome that included not just immediate symptom relief but also return to functioning. This 'deeper' type of outcome alluded to is possibly similar to what Herron et al. (1994) describe as 'improvement', which involves in addition to 'necessity', scope for characterological improvement. Measuring a 'characterological' type of outcome may be more problematic (Herron et al., 1994) because of the difficulty in conceptualising and operationalising it. These different types of outcomes parallel those described in the Phase Model (Howard et al., 1993), for which there is available outcome measures (e.g., COMPASS Treatment Assessment System; Lueger et al., 2001). This assessment provides outcomes for current well being, current symptoms, and current life functioning (Lueger et al., 2001), thereby giving a description of therapeutic outcomes that account for more than immediate symptom relief.

When looking at the therapeutic literature, there appears to be two very contradictory sets of information and viewpoints. The first set of literature refers to EBP and is systematic but has trouble relating to the 'real world'. The other set is less developed,

less clear, but has information collected from the 'real world'. This distinction roughly parallels the differences between efficacy and effectiveness research (Seligman, 1995). The present study relates to this latter group; however policy for the third party funded delivery of psychotherapy is predicated upon the former type. Policy would do well to take into account the findings from the latter type of research (Bohart et al., 1998), because it allows for an understanding of the gap between the aims of policy and the practice of psychotherapy.

The overwhelming response from participants of this study has been that flexibility is needed with time rather than a predetermined number of sessions. A vast number of research trials have shown treatment to be effective in a set time frame (e.g., Bower et al., 2000); however research has also shown that clients in the real world typically attend for a small number of sessions. Further, impressions of outcomes by psychologists in the real world provide support for the flexibility of treatment length based on client characteristics (e.g., Given, 2002). Dose response studies have shown that eight sessions of psychotherapy are needed for a 50% improvement rate (Howard et al., 1986), however a naturalistic study showed that 15-19 sessions were in fact necessary for the same level of improvement (Hansen & Lambert, 2003). Together with the present findings, there is therefore support for the use of flexible timeframes in third party systems of psychotherapy provision. Overall, one of the most important implications for policy is the extent to which the present research has identified a gap between what participants believe to be ideal practice and the compromises they have to make to this in order to practice in the reality of third party provider systems. Together with previous research regarding perceptions of necessary time and actual uptake, findings indicate that psychotherapy without time limits would not necessarily become materially longer on average.

Strengths and Limitations

It has been a significant strength of this study to gain both an in-depth understanding of issues surrounding time limited psychotherapy in interviews, while also gaining an appreciation of the extent to which these issues were expressed in a larger sample through the questionnaires. This study had the ability to capture information from the perspective of psychologists on an issue of reported importance to them. The research has also been able to understand how psychologists view time limits in a broad sense,

rather than specifically for any one client. Interviews have provided an in-depth understanding of how time constraints are viewed and accounted for by psychologists; however they are limited in their ability to claim representativeness and any systematic 'effect'. Questionnaires showed findings to be in agreement, and supported in a larger sample, significant statistical effects for the role of time limits and complexity in determining predicted approach and perceived outcome.

While it is methodologically sound to observe how participants behave in the setting being studied (Hoyt & Bhati, 2007), there was no scope for this in the present study. Future research on the present topic may include some type of observation or analysis of psychotherapy transcripts in order to hear first-hand how psychologists adapt to time limits. Rather than this, the present research has captured the thought process regarding time limits in a general way and is suitably placed methodologically given the current state of research in the area.

Despite the significance of findings, caution needs to be exercised about the extent to which these findings can be generalised and said to represent the view of all psychologists providing time limited services in Australia. The consistency of findings across both data collection techniques offers support for the external validity of the findings. However, there may still be some limitations in the reliance on psychologists' interest in the research to participate. Both interview and questionnaire participants could have been eager to participate because of a personal inclination towards expressing their views on the topic. Psychologists who did not consent to participate may have expressed different views. Further, it is unclear how these findings may generalise to systems of third party determined time limits outside of the Australian context. With these cautions in mind, the present findings provide a distinctive insight into the experiences of psychologists working within time limited contexts in Australia.

The questionnaire was informed by a repeated measures design, so was thus able to capture information about the effect of manipulating, in the same hypothetical client, the effect of time and complexity on predicted approach and outcome. The effects of the time limit and level of complexity were thus able to be isolated. A potential weakness of the questionnaire was its hypothetical nature, so participants' actual behaviour may have been different, although there is evidence to suggest that the intentions of health professionals do correspond to their actual behaviour (Eccles et al.,

2006). A further limitation to this interpretation is the use of five sessions as the limitation in the questionnaire, which is one session less than the minimum referral number through Better Access. Using six sessions as the hypothetical session limit in the questionnaire would have been more appropriate in hindsight, although at the time the questionnaire was developed the Better Access initiative had not yet been announced. To that extent the research was limited by the rapidly changing financial and professional context of providing mental health services in Australia.

More systematic information regarding the training of participants in the questionnaire study may have helped to answer the question posed by Carey et al. (2009) regarding the unclear justification for the differential Medicare funding between clinical and non-clinical psychologists. Perhaps training may have accounted for the type or extent of difference between approaches taken and outcomes achieved in the different time conditions, or perhaps not. In retrospect, this would have been a useful question to ask.

As with all research analysis, and despite attempts to avoid this, my interpretation of results may have been reflective of a preconceived idea of what respondents might say regarding the research questions. Despite the strategies used to ensure research quality as outlined in Chapter Three, bias cannot claim to have been avoided. Notions of what constitutes change will affect interpretations of process, and hence any research that looks at process in psychotherapy will be oriented towards a particular theoretical position on psychotherapy (Dallos & Vetere, 2005). Similarly, the way in which questions were asked in the interviews may have been reflective of my bias, and subsequently may have influenced participants to respond in particular ways.

Findings provide information regarding how practising psychologists perceive their psychotherapy in a general sense in light of time limits; however this does not enable the ability to capture how time limits may be perceived in light of a specific client. Similarly, the focus of this research has been on the perception of psychologists and it is likely that clients' perceptions would have contributed additional information to the interpretation of findings. Previous research has identified discrepancies between the expectations for psychotherapy by therapists and clients (e.g., Pekarik & Wierzbicki, 1986), so research involving clients may be in a position to shed light on different aspects of the present research topic. Relying on self-reports also has inherent

limitations because of the dependence on the ability of participants to effectively communicate relevant parts of their experience through language (Polkinghorne, 2005).

The design of the questionnaire may have rendered it open to response bias. One interview participant (who also acknowledged in the interview that she was a questionnaire participant) commented that the questionnaire was very much set up to assume that participants would mark a difference between the two columns of time limited and time unlimited. This inherent assumption may have impacted the way in which participants then responded.

The findings of the present research provide information relating to the perceptions of time limits in third party systems. However, it should be noted that there were participants in both the interview and questionnaire study who would disagree with the major findings of the present research. Isabel, an interview participant, was adamant that she was not affected by time limits because she tried to work in a similar timeframe to that provided by Better Access and BOMHC anyway. There were three questionnaire participants who marked comments along the lines of 'same' in unlimited conditions, and subsequently showed no differences between their work in time limited and time unlimited conditions. Fortunately, information from Isabel's interview can provide some insight as to why this might be the case, and indeed these questionnaire participants reported that they only used CBT, which is in line with findings from the interview, that practitioners predominantly engaged with CBT as a sole technique were less impacted by time limits.

Future Directions

The present research has highlighted a number of gaps in knowledge regarding the practice of psychology in third party provider systems. How do the variables of psychotherapy length and psychotherapy limitation differ and what does length account for in the present study? Although the findings clearly demonstrate that time limits are about more than treatment length, length may have been a confounding factor for the present results. Future research could aim to separate these two variables through the use of a study that allows for more control of these variables than was possible using the present interpretivist methodological framework.

There are also implications for the evaluation of psychotherapy. Findings have shown the extent to which clients were experienced as diverse, as well as the extent to which psychologists will be flexible in their approach based on clients. Clients in the real world therefore differ from perceptions of clients gained from efficacy studies, and research would do well to account for the complexity of the multiple interactions in psychotherapy (Krause & Lutz, 2009; Stiles, 2009).

Future research may act to determine what guidelines can be given to psychologists in light of the present findings, in particular to account for the perceived challenges that are associated with third party payer systems generally and time limits specifically. In particular, the combination of time limits with preferred treatment styles (mostly CBT) advocated through many third party providers raises important issues about the assumption of a superiority or dominance of a specific technique in psychotherapy that appears to put practitioners and their science at loggerheads.

It is beyond the scope of this research to look at the impact that psychologists' changes in therapeutic process brought about by time limits might have on the clients themselves; future research in this area would be valuable to provide an insight to the impact of time limits from the perspective of clients. For example, from the perspective of psychologists, clients were believed to contain and constrict the content brought up during psychotherapy. Future research may aim to determine the validity of this finding based upon the perspective of clients in time limited contexts.

This research provides some consistent evidence that the outcomes that are achieved in time limited contexts are perceived to be weaker than those that can be achieved without a time limit. Future research may consider the evidence for this finding in actual practice, for example, through an experimental design that compared the outcomes of time limited psychotherapy with the outcomes of time unlimited psychotherapy followed up over a suitable length of time. It raises the issue also that time limited psychotherapy providers might see the same client return for treatment across the years, and a long follow-up time would be necessary to capture this serial treatment user. Further, future research may act to systematise the methods used, for example through considering verbal exchange structures (Stiles & Shapiro, 1995) in time limited psychotherapy compared with time unlimited psychotherapy. It could be

useful in future research to compare transcripts of sessions to identify how the themes elucidated in the current study map onto actual therapist-client interactions.

This research also provides scope for future research to consider issues of depth in psychotherapy, which efficacy studies have failed to capture. Many participants reported that their 'depth' of psychotherapy was compromised when working in a time limit, and that the outcomes that could be achieved were weaker and also with less 'depth'. The notion of depth in psychotherapy may make intuitive sense but remains lacking in a clear conceptualisation. Future research may consider this notion further and perhaps also look at how different levels of 'depth' relate to immediate and long-term outcomes.

Conclusion

This study has attempted to understand how third party determined time limits are viewed and experienced by psychologists in private practice in Australia. It has been shown that psychologists appear largely eclectic in their approaches and client-centred in the treatment decisions that they make, and that a time limit interferes with this process. The critical issue to emerge for private practitioners in third party systems is what they can do in the time that's available to them. It has been shown that there are important inputs that determine the context of time limited therapy, and that therapeutic processes are adapted resulting in outcomes perceived to be different, and in many cases weaker.

Methodologically, the present study has contributed to an understanding of how interpretative studies can contribute a significant understanding of how psychotherapy is practiced in real life as opposed to in a research setting. The findings in the present study have been distinct in their ability to understand psychotherapy from the perspective of psychologists and without imposing a theoretical framework upon the participants. Because of this openness, an understanding of the diversity of experience and expectation that is operating in the 'real world' has been attained, contributing a significant understanding to the practice of psychology away from treatment and outcome studies. It is the ability of qualitatively-oriented research to 'build from the bottom up' that has contributed to this understanding, and it has demonstrated the promising possibility for research to take a step away from positivist notions of

psychotherapy, therapists, and clients. At the very least, it demonstrates that a *different* kind of understanding can be attained from interpretative inquiry into psychotherapy.

Psychotherapy is a relatively young profession (O’Gorman, 2007) and is subject to change and further development. The consensus is that the future of psychotherapy will involve more directiveness, problem-focussed and psychoeducational approaches, and briefer time frames (Norcross et al., 2002). This research has therefore been suitably placed to contribute information relating to this evolving context of psychotherapy service provision.

In conclusion, third party determined time limits have been found to have an impact upon psychologists that has implications beyond the length of psychotherapy. The broader system of third party referrals has implications for the delivery of psychological services in Australia, which clinical understandings of time limitation have not accounted for. Previous research has shown that the number of sessions available makes a difference, but the present research shows that a time limit cannot be separated from the system under which it is imposed, because once it is imposed, it has implications throughout the whole process. A time limit has thus been shown to be an important influence on the inputs, processes, and outcomes of therapy provided in the context of third party determined time limits.

This study has contributed an understanding of the impact of time limits as psychotherapy is delivered by practitioners in the real world. Moves towards the management of mental health services by professionals outside of the client-practitioner interaction have important implications for the way that psychotherapy is delivered. Time limits instituted by third parties have the potential to define how psychotherapy should be conducted, and as such are a powerful influence on the future delivery of mental health services.

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APPENDIX A



The University of Sydney

School of Behavioural & Community Health Sciences

Dear _____,

My name is Tracey Wright, and I am a PhD candidate at the University of Sydney, under the supervision of Dr Chris Lennings. My research is titled "An Investigation of Time in Therapy: Psychologists' Reactions to Working within Treatment Time Limits" and it aims to explore issues to do with the session limits for psychologists that are used in such programs as Better Outcomes in Mental Health Care ("BOMHC") and the Medicare Plus program for psychologists. This research is not affiliated with either the Medicare Plus or BOMHC program.

You have been contacted because you are a psychologist treating clients through the Medicare Plus and/or BOMHC program, and as such you will be familiar with the use of session limits while treating clients. For this research, 'session limits' refer to programs of psychological intervention that place a restriction on the amount of sessions available for client treatment. The purpose of my research is to explore the impact these session limits have on psychologists, their views towards treatment, and their treatment planning.

Your participation in this project would be highly valued because of the expertise you have gained in the practice of psychology and your exposure to the above programs. It will be very helpful to gain an insight to your opinions on the relevant issues, and gather feedback about this aspect of treating clients within a session limited framework.

Attached to this letter are two participant information sheets (for interview and/or questionnaire) and a consent form. Please return the consent form in the enclosed envelope should you wish to participate in this research. Should you require any further information about the project, please do not hesitate to contact me on (02) 9351 9979 or via email on T.Wright@student.usyd.edu.au.

Yours sincerely,

Tracey Wright
PhD Candidate

APPENDIX B



The University of Sydney

School of Behavioural & Community Health Sciences

PARTICIPANT INFORMATION SHEET

Research Project

INTERVIEW

“An Investigation of Time in Therapy: Psychologists’ Reactions to Working within Treatment Time Limits”

This study is about the use of session limits in psychological treatment. It aims to explore psychologists’ reactions to working within time-limited treatment programs such as Medicare Plus (5 session per annum limit for allied health workers) and Better Outcomes in Mental Health Care (6 session limit for psychologists).

The study is being conducted by Tracey Wright, PhD Candidate, and will form the basis for the degree of Doctor of Philosophy at The University of Sydney under the supervision of Dr Christopher Lennings, Senior Lecturer.

Your involvement in this research requires you to participate in an interview, which will ask various questions in order to ascertain your view on particular aspects of session limited practice. You will not be identifiable in any way through participation in this research to anyone but the researchers. This project is independent of the Medicare Plus and BOMHC programs, and could have equally been applicable to other forums of psychological practice that engage in the use of session limits.

It is estimated that the interview will take approximately one hour of your time. With your permission, the interview will be tape-recorded so that a transcript of the interview can be kept on file for data analysis.

Participation in this study is completely voluntary - you are not under any obligation to consent. Should you consent to participate, you may withdraw your participation at any time without stating your reason and without penalty or prejudice.

The information I wish to gather from you is purely for my research and higher degree and will not be used for any other purposes. All aspects of the study, including results, will be strictly confidential and only the researchers will have access to information on participants.

You will not be identified in any way in the publication of results. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report. All participants will receive a copy of a summary report at the end of the research.

This study aims to develop further understanding in this very relevant area of treatment practice in Australia, and your participation is very much appreciated.

There is no restriction on you discussing the study with other people. If you would like to know more at any stage, please feel free to contact one of the following people.

Tracey Wright

PhD Candidate

Ph: 9351 9979

Dr Christopher Lennings

Senior Lecturer

Ph: 9351 9587

Any person with concerns or complaints about the conduct of a research study can contact the Manager, Ethics Administration, University of Sydney on (02) 9351 4811

APPENDIX C



The University of Sydney

School of Behavioural & Community Health Sciences

PARTICIPANT INFORMATION SHEET

Research Project

QUESTIONNAIRE

“An Investigation of Time in Therapy: Psychologists’ Reactions to Working within Treatment Time Limits”

This study is about the use of session limits in psychological treatment. It aims to explore psychologists’ reactions to working within time-limited treatment programs such as Medicare Plus (5 session per annum limit for allied health workers) and Better Outcomes in Mental Health Care (6 session limit for psychologists).

The study is being conducted by Tracey Wright, PhD Candidate, and will form the basis for the degree of Doctor of Philosophy at The University of Sydney under the supervision of Dr Christopher Lennings, Senior Lecturer.

Your involvement in this research requires you to read over two case scenarios, and then answer some questions in relation to these scenarios. This project is independent of the Medicare Plus and BOMHC programs, and could have equally been applicable to other forums of psychological practice that engage in the use of session limits.

It is estimated that the case scenarios will take approximately ten to fifteen minutes of your time. A postage paid envelope will be included with your case scenarios for postage back to the researcher.

Participation in this study is completely voluntary - you are not under any obligation to consent. Should you consent to participate, you may withdraw your participation at any time without stating your reason and without penalty or prejudice.

The information I wish to gather from you is purely for my research and higher degree and will not be used for any other purposes. All aspects of the study, including results, will be strictly confidential and only the researchers will have access to information on participants. You will not be identified in any way in the publication of results. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report. All participants will receive a copy of a summary report at the end of the research.

This study aims to develop further understanding in this very relevant area of treatment practice in Australia, and your participation is very much appreciated.

There is no restriction on you discussing the study with other people. If you would like to know more at any stage, please feel free to contact one of the following people.

Tracey Wright

Dr Christopher Lennings

PhD Candidate

Senior Lecturer

Ph: 9351 9979

Ph: 9351 9587

Any person with concerns or complaints about the conduct of a research study can contact the Manager, Ethics Administration, University of Sydney on (02) 9351 4811

This information sheet is for you to keep

APPENDIX D

PARTICIPANT CONSENT FORM

“An Investigation of Time in Therapy: Psychologists Reactions to Working within Treatment Time Limits”

I,, give consent to my participation in the research project
Name (please print)

TITLE:

Questionnaire only

Interview only

Questionnaire and Interview

In giving my consent I acknowledge that:

1. The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.
2. I have read the Participant Information Sheet and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.
3. I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher(s) now or in the future.
4. I understand that my involvement is strictly confidential and no information about me will be used in any way that reveals my identity.

Signed:

Name:

Date:

APPENDIX E



The University of Sydney

School of Behavioural & Community Health Sciences

Dear _____,

My name is Tracey Wright, and I am a PhD candidate at the University of Sydney, under the supervision of Dr Chris Lennings. My research is titled “An Investigation of Time in Therapy: Psychologists’ Reactions to Working within Treatment Time Limits” and it aims to explore issues to do with the session limits for psychologists that are used in such programs as Better Outcomes in Mental Health Care (“BOMHC”) and Medicare for psychologists. This research is not affiliated with either the Medicare or BOMHC program.

You have been contacted because you are a psychologist treating clients through the Medicare and/or BOMHC program, and as such you will be familiar with the use of session limits while treating clients. For this research, ‘session limits’ refer to programs of psychological intervention that place a restriction on the amount of sessions available for client treatment. The purpose of my research is to explore the impact these session limits have on psychologists, their views towards treatment, and their treatment planning.

Your participation in this project would be highly valued because of the expertise you have gained in the practice of psychology and your exposure to the above programs. It will be very helpful to gain an insight to your opinions on the relevant issues, and gather feedback about this aspect of treating clients within a session limited framework.

Attached to this letter are a participant information sheet and a questionnaire. Should you wish to participate in this research please complete and return the questionnaire in the reply paid envelope. If you require any further information about the project, please do not hesitate to contact me on (02) 9351 9955 or via email on T.Wright@usyd.edu.au.

Yours sincerely,

Tracey Wright
PhD Candidate

APPENDIX F

Interview Guide

Before we begin, I'll just briefly remind you what this research is about. I'm looking at psychologists opinions in regards to session-limited treatment programs, such as Medicare plus and BOMHC. When I say session-limited therapy, I mean therapy that has had a time limit put on it, for example, the 6 sessions that are funded for psychological treatment through BOMHC. My research is not trying to find out things specifically for BOMHC or Medicare plus, but I am using these as examples of programs that use session limits.

1. Demographic questions
 - a. What time limited treatment programs are you registered for? How long for?
 - b. How much of your work with clients is taken up by these time limited treatment programs? What percentage?
2. What do you think of providing psychological services through projects such as Medicare Plus/BOMHC?
3. What do you think about the use of a time limit in
4. Is there any aspect of therapy that you think the time limit facilitates?
5. Is there any aspect of therapy that you think the time limit creates a problem for?
6. What type of challenges have you encountered as a result of treating patients within these time limits?
7. How do you approach therapy differently when treating through time-limited therapy, compared with therapy where a time limit isn't used?
 - a. Any examples?
 - b. Do these time limits affect your treatment planning in any way?
8. Do you think that your motivation to treat clients is impacted in any way through the use of a time limit?
9. Do you think that client's motivation is impacted through the use of a time limit?
10. Anything else?

APPENDIX G

Questionnaire (Version One)

“An Investigation of Time in Therapy: Psychologists’ Reactions to Working within Treatment Time Limits”

Thank you for agreeing to participate in this research project. In this section, scenarios of a client’s presenting problem will be given and followed with questions about how you would approach their treatment. Your participation is expected to take about 10 or 15 minutes of your time. Scenarios are hypothetical - it may be helpful for you to consider thinking about previous clients who are similar to the ones presented below, and what you have done with them.

Please find enclosed a reply-paid envelope for your return to the researcher. If you have any queries please feel free to contact the project researchers;-

Tracey Wright
PhD Candidate
University of Sydney
9351 9979

Dr Chris Lennings
Senior Lecturer
University of Sydney
9351 9587

Note:- You will not be identified by the information that you provide, which will be used solely for research purposes.

How old are you? 20-30 30-40 40-50 50-60 60+

Which gender are you? Male Female

How many years of experience have you had treating clients?

0-2 2-5 5-10 10-20 20+

Are you registered for the provision of psychological services through any of the following programs and organisations that require you to work within a specific amount of sessions? Please tick all that apply.

EAP Programs Medicare Transcultural Mental Health

WorkCover Victims of Crime Transport Accident Commission

Vietnam Veterans Counselling Service Better Outcomes in Mental Health Care

Other _____.

Scenario 1

Lucy is a 25-year old student who has recently been to see her GP with complaints of feeling depressed, tense, and unable to concentrate on her studies. These symptoms have been bothering her on and off for the last year, and have escalated to a more serious level in the last 3 months.

Lucy was brought up by her mother as a single parent and moved out of the family home 6 months ago to live with her boyfriend of 9 months. She reports this as being a difficult experience and one that has left her feeling unsupported during periods of intense stress.

Lucy has been feeling increasingly overwhelmed by the scope of work she needs to complete for her course, and reports a feeling of helplessness in getting everything completed on time in addition to working 3 days a week to support her new lifestyle.

The following questions require you to think about what would be different in your treatment given a choice of a “limited 5 session therapy” or “unlimited session therapy” approach, given the above scenario.

	Limited 5 Sessions	Unlimited Sessions
<p>1) Is there a particular treatment model/s you would use?</p> <p>(Please circle)</p>	<p>CBT IPT Solution-focussed ACT</p> <p>Psychodynamic Narrative</p> <p>Other_____.</p>	<p>CBT IPT Solution-focussed ACT</p> <p>Psychodynamic Narrative</p> <p>Other_____.</p>
<p>2)Which presenting problem/s would you focus on?</p>		
<p>3)What would be your treatment plan for this client?</p>		

	Limited 5 Sessions	Unlimited Sessions
4)How would you expect the client's symptoms to react to this treatment?		
5) Which of the following would you expect to see in your client? (Please circle relevant number)	<p>Enhancement of subjective well-being -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Symptom Reduction -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Recovery of Life Functioning -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Other (please explain)</p>	<p>Enhancement of subjective well-being -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Symptom Reduction -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Recovery of Life Functioning -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Other (please explain)</p>
6)How satisfied would you feel with these changes as a psychologist?	<p>1....2....3....4....5....6....7....8....9....10 Not at all satisfied – Neutral – Very satisfied</p> <p><i>Please give reasons</i></p>	<p>1....2....3....4....5....6....7....8....9....10 Not at all satisfied – Neutral – Very satisfied</p> <p><i>Please give reasons</i></p>

Scenario 2

Luke is a 48-year-old finance executive who works with a large bank known for its high staff turnover in high-pressure positions. Luke says he has been feeling increasingly burnt out by the pressure at work, and has been taking both his own and his wife's doses of sleeping tablets every night, in an attempt to get some rest. Last week he broke down after hearing about a significant mistake he made that is likely to cost the company dearly. He was found crying on the bathroom floor at work and appeared intoxicated. He begged his colleague not to tell anyone, and promised it would not happen again.

Luke's wife recently initiated a separation from him, assuming custody of their two sons, aged 11 and 14. At the same time that this happened, Luke's long-term girlfriend at work ended their relationship, saying that she was tired of Luke's moodiness.

Despite Luke's considerable income he is in debt, and under threat from his wife that she will push for the family home in their divorce proceedings. Luke has been receiving numerous phone calls from creditors chasing him up, and is considering filing for bankruptcy.

Luke approaches you saying he is feeling a currently unbearable amount of stress.

The following questions require you to think about what would be different in your treatment given a choice of a "limited 5 session therapy" or "unlimited session therapy" approach, given the above scenario.

	Limited 5 Sessions	Unlimited Sessions
1) Is there a particular treatment model/s you would use? (Please circle)	CBT IPT Solution-focussed ACT Psychodynamic Narrative Other_____	CBT IPT Solution-focussed ACT Psychodynamic Narrative Other_____
2) Which presenting problem/s would you focus on?		
3) What would be your treatment plan for this client?		

	Limited 5 Sessions	Unlimited Sessions
4)How would you expect the client's symptoms to react to this treatment?		
5) Which of the following would you expect to see in your client? (Please circle relevant number)	<p>Enhancement of subjective well-being -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Symptom Reduction -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Recovery of Life Functioning -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Other (please explain)</p>	<p>Enhancement of subjective well-being -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Symptom Reduction -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Recovery of Life Functioning -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Other (please explain)</p>
6)How satisfied would you feel with these changes as a psychologist?	<p>1....2....3....4....5....6....7....8....9....10 Not at all satisfied – Neutral – Very satisfied</p> <p><i>Please give reasons</i></p>	<p>1....2....3....4....5....6....7....8....9....10 Not at all satisfied – Neutral – Very satisfied</p> <p><i>Please give reasons</i></p>

APPENDIX H

Questionnaire (Version Two)

“An Investigation of Time in Therapy: Psychologists’ Reactions to Working within Treatment Time Limits”

Thank you for agreeing to participate in this research project. In this section, scenarios of a client’s presenting problem will be given and followed with questions about how you would approach their treatment. Your participation is expected to take about 10 or 15 minutes of your time. Scenarios are hypothetical - it may be helpful for you to consider thinking about previous clients who are similar to the ones presented below, and what you have done with them.

Please find enclosed a reply-paid envelope for your return to the researcher. If you have any queries please feel free to contact the project researchers;-

Tracey Wright
PhD Candidate
University of Sydney
9351 9979

Dr Chris Lennings
Senior Lecturer
University of Sydney
9351 9587

Note:- You will not be identified by the information that you provide, which will be used solely for research purposes.

How old are you? 20-30 30-40 40-50 50-60 60+

Which gender are you? Male Female

How many years of experience have you had treating clients?

0-2 2-5 5-10 10-20 20+

Are you registered for the provision of psychological services through any of the following programs and organisations that require you to work within a specific amount of sessions? Please tick all that apply.

EAP Programs Medicare Transcultural Mental Health

WorkCover Victims of Crime Transport Accident Commission

Vietnam Veterans Counselling Service Better Outcomes in Mental Health Care

Other _____.

Scenario 1

Phillip is a 32-year-old maths teacher at his local high school, who has recently been to see his GP with complaints of feeling anxious and depressed. Over the last 2 years he has noted a marked decline in the amount of satisfaction that he feels as a result of his job, and has recently been considering a career change.

Upon finishing school, Phillip immediately commenced studies in an advanced mathematics degree. He found this to be an intensely stressful time of his life, and consistently felt like he was behind his peers and needed to devote more time to studying. This led him to complete his degree with a lower qualification than he initially planned and pursue a graduate diploma in education to become a teacher. He felt some anxiety at this time over whether he was taking the easy way out.

While Phillip is friendly with a number of colleagues at school, he reports a feeling of isolation and wishes he could work somewhere that offered more social stimulation, and possibly the chance to meet other women. He reports anxiety at never lasting more than one year in a relationship with a woman, and is hoping to settle down and start a family within the next few years.

Phillip came from a strongly religious family that emphasised the value of hard work and integrity over the pursuit of short-term gains. He reports feeling some guilt over his thoughts to change his career, and also feels some ambiguity over his own beliefs in relation to the church he was brought up in.

The following questions require you to think about what would be different in your treatment given a choice of a “limited 5 session therapy” or “unlimited session therapy” approach, given the above scenario.

	Limited 5 Sessions	Unlimited Sessions
1) Is there a particular treatment model/s you would use? (Please circle)	CBT IPT Solution-focussed ACT Psychodynamic Narrative Other_____	CBT IPT Solution-focussed ACT Psychodynamic Narrative Other_____
2) Which presenting problem/s would you focus on?		
3) What would be your treatment plan for this client?		

	Limited 5 Sessions	Unlimited Sessions
4)How would you expect the client's symptoms to react to this treatment?		
5) Which of the following would you expect to see in your client? (Please circle relevant number)	<p>Enhancement of subjective well-being -5...-4...-3...-2...-1...0...1...2...3...4...5 Deterioration – No change – Positive change</p> <p>Symptom Reduction -5...-4...-3...-2...-1...0...1...2...3...4...5 Deterioration – No change – Positive change</p> <p>Recovery of Life Functioning -5...-4...-3...-2...-1...0...1...2...3...4...5 Deterioration – No change – Positive change</p> <p>Other (please explain)</p>	<p>Enhancement of subjective well-being -5...-4...-3...-2...-1...0...1...2...3...4...5 Deterioration – No change – Positive change</p> <p>Symptom Reduction -5...-4...-3...-2...-1...0...1...2...3...4...5 Deterioration – No change – Positive change</p> <p>Recovery of Life Functioning -5...-4...-3...-2...-1...0...1...2...3...4...5 Deterioration – No change – Positive change</p> <p>Other (please explain)</p>
6)How satisfied would you feel with these changes as a psychologist?	<p>1...2...3...4...5...6...7...8...9...10 Not at all satisfied – Neutral – Very satisfied</p> <p><i>Please give reasons</i></p>	<p>1...2...3...4...5...6...7...8...9...10 Not at all satisfied – Neutral – Very satisfied</p> <p><i>Please give reasons</i></p>

Scenario 2

Mary is a 35-year-old mother of 5 children, aged 3, 5, 6, 9, and 11. Mary has had various partners throughout her life, and only two of her children have the same father. Mary currently has an AVO out against both of her last two partners, and reports feeling consistently under threat both personally and for her children. Another partner, who she reports to be the most violent, is currently serving time in gaol and is due to be released next month. Mary reports considerable anxiety about this situation.

Mary reports her upbringing to be periodically marked by violence. She was sexually abused by an uncle between the ages of 8 and 11, but was not believed by her mother. She describes her mother as swinging between violent outbursts and overbearing protectiveness. Mary reports having one aunty who was something of a role model to her, and who made her feel genuinely cared about. Her aunty died last year, and since this time she has felt numb and unable to find energy to do the things that she used to be able to do. She is currently not working.

In the past, Mary has reported feelings of suicide to a counsellor at the local domestic violence outreach centre, but claims that she is currently feeling too 'empty' to act on any thoughts of killing herself.

The following questions require you to think about what would be different in your treatment given a choice of a "limited 5 session therapy" or "unlimited session therapy" approach, given the above scenario.

	Limited 5 Sessions	Unlimited Sessions
1) Is there a particular treatment model/s you would use? (Please circle)	CBT IPT Solution-focussed ACT Psychodynamic Narrative Other _____	CBT IPT Solution-focussed ACT Psychodynamic Narrative Other _____
2) Which presenting problem/s would you focus on?		
3) What would be your treatment plan for this client?		

	Limited 5 Sessions	Unlimited Sessions
4)How would you expect the client's symptoms to react to this treatment?		
5) Which of the following would you expect to see in your client? (Please circle relevant number)	<p>Enhancement of subjective well-being -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Symptom Reduction -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Recovery of Life Functioning -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Other (please explain)</p>	<p>Enhancement of subjective well-being -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Symptom Reduction -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Recovery of Life Functioning -5....-4....-3....-2....-1....0....1....2....3....4....5 Deterioration – No change – Positive change</p> <p>Other (please explain)</p>
6)How satisfied would you feel with these changes as a psychologist?	<p>1....2....3....4....5....6....7....8....9....10 Not at all satisfied – Neutral – Very satisfied</p> <p><i>Please give reasons</i></p>	<p>1....2....3....4....5....6....7....8....9....10 Not at all satisfied – Neutral – Very satisfied</p> <p><i>Please give reasons</i></p>

APPENDIX I

Medicare Australia

Medicare Australia is a government agency which provides a federal framework for the delivery of Australia's publically funded universal health insurance program. Medicare is funded through progressive income tax and an income tax-related Medicare levy, to provide affordable and accessible healthcare to Australian residents (Medicare, 2009a).

Enhanced Primary Care (EPC)

In September 2004, Medicare began funding psychological services under the EPC program, which provided patients being managed by their General Practitioner (GP) under an EPC plan access to Medicare rebates for allied health services (Medicare, 2009b). EPC funding allowed for up to five 25 minute sessions with an eligible allied health professional per year, including registered psychologists (Medicare, 2007).

Better Access

Following EPC, the Better Access initiative was introduced in November 2006, to provide Medicare funding as part of the Australian Government's \$1.9b reform of Australia's mental health system (COAG, 2006). The aim of the initiative has been to increase community access and create new referral pathways to mental health care, by funding on referral from the GP an initial set of six sessions, then following review by the GP a further six sessions per calendar year. In exceptional circumstances, an additional six sessions may also be funded.

Better Outcomes in Mental Health Care (BOMHC)

BOMHC was introduced by the Australian Federal Government in July 2001, to improve community access to quality mental health care, by funding access to psychological services through GPs. The Access to Allied Psychological Services component of the program allows GPs to refer eligible clients for specific, time-limited evidence-based psychological interventions, aimed to provide assistance for short-term intervention. Under BOMHC, patients are eligible for a maximum of 12 sessions per calendar year – six time-limited sessions with an option for a further six sessions

following a mental health review by the referring GP (DoHA, 2009b). BOMHC is administered by the network of local Divisions of General Practice across Australia, which receives Government funding to purchase allied psychological services in each local Division (APS, 2009).

Victims of Crime

Each of the Australian states and territories have in place programs which offer compensatory short-term face to face counselling to victims of violent crimes that have occurred in their respective jurisdictions. Whilst the structure and approach to the provision and funding of services for victims varies within each state's Victim Support Agency, with the exception of Queensland and South Australia, each agency has in place short-term funded referral services to psychologists. Victims and their families are referred by the respective agencies to psychologists in private practice for appropriate counselling to assist victims recover from the effects of violent crime.

Example: New South Wales

The Approved Counselling Scheme provides funded counselling to victims of violent crimes that have occurred in New South Wales. The scheme provides an initial 2 hours of counselling by an approved psychologist, to assess whether the victim will benefit from further counselling. The Counsellor is then required to submit a recommendation for further counselling funding up to 20 hours, setting out a brief history of the act of violence and the assistance that counselling will provide. Applications may also be made to fund counselling for family members of a homicide victim for up to 20 hours of counselling (Lawlink, 2009).

Workcover (Work Health Authority in Northern Territory)

Workcover is the state government body and statutory authority to achieve safe workplaces, effective return to work and security for injured workers, including those requiring the services of a psychologist. Workcover, or an insurance organisation operating as approved Agents to the scheme, are responsible for determining the approval of a claim for referral to a psychologist, and fund the cost of consultations for the specified period of time. This may include psychological services provided in relation to primary injuries arising from work related psychological trauma, or secondary injuries arising as a consequence of work related physical injury.

Example: New South Wales

There are currently seven insurers acting as agents in the NSW Workcover Scheme with no universal framework currently in place for the assessment of psychological treatment services, such as a common understanding of the 'reasonably necessary treatment' requirement. Approved scheme agents are responsible for determining treatment session requirements and funding approval under a claim, utilising varying treatment plan templates and information surrounding aims, objectives, outcomes and treatment timeframes provided by the claimant and treating psychologist. This is currently the subject of a proposed Psychological and Counselling services regulatory framework currently being developed (Workcover, 2009).

Example: Comcare

Comcare is an Australian Government agency which administers workplace injuries and disease in the Commonwealth jurisdiction, including rehabilitation and compensation under the Safety, Rehabilitation and Compensation Act. Funding for psychological services is provided subject to the development of a treatment plan which outlines the type of treatment needed, frequency of treatment and for how long. This treatment plan is then required to be sent to Comcare for approval of the specified funding sessions, who are responsible for assessing the reasonableness of the treatment and relationship of treatment to the work related injury or illness (Comcare, 2009).

Motor/Traffic Accidents

Statutory bodies which administer and regulate Motor/Traffic Accidents schemes in each Australian state and the Northern Territory have been established to assist victims injured in a road accident who require the services of medical practitioners and allied health professionals as part of their treatment, rehabilitation and recovery. These government insurance agencies are responsible for funding the cost of rehabilitation services, including approval for claims relating to psychologist treatment. This funding and subsequent referral to psychologists in private practice is usually for a specified period of treatment and not ongoing in nature (MAA, 2002). Various types of road users are protected under the respective schemes, including pedestrians, drivers,

passengers and cyclists, with scheme funding typically being generated through motor vehicle owners by compulsory contributions paid when registering vehicles.

Example: Transport Accident Commission (TAC)

The TAC funds the reasonable cost of short-term psychology services following injuries sustained in a transport accident, where there is a proper clinical justification and following the provision of a written referral from a GP (TAC, 2008). To facilitate the initial funding of treatment, the TAC requires treating psychologists to clearly document goals, measures and outcome measures. A Mental Health Treatment Plan (MHTP) is required for all new clients where treatment is requested beyond an initial 5 sessions of care. Treating psychologists are required to contact the TAC towards the completion of the MHTP to discuss the client's progress and request approval for further sessions if required. In some circumstances, a Mental Health Treatment Review (MHTR) may be requested. The TAC also provides funding for treatment of immediate family members where the victim dies or has severe injuries.

Transcultural Mental Health (TMH)

The TMH service provides access to clinical consultation and assessment and other mental health services for people of cultural and linguistically diverse (CALD) backgrounds (TMH, 2009). TMH works in partnership with mental health services, GPs and culturally diverse communities across Commonwealth and State levels, to recognise and respond to cultural, linguistic and religious diversity in the community. This includes short-term direct services and intervention provided through the TMHC Clinical Services consultation model and outreach clinics which provide specific support to patients, including the development of culturally appropriate treatment plans. The provision of these clinical services, including short-term therapy for patients under referral, is free of charge.

Multicultural Problem Gambling Services (MPGS)

The MPGS works with the TMHC to provide services to problem gamblers from culturally and linguistically diverse communities and their families, by providing quality and accessible counselling, treatment and support services. Financial assistance for this project was provided by the NSW Government from the Responsible Gambling

Fund, to provide assistance including counselling in a preferred language and the funding of referral to psychologists in private practice.

Department of Veterans' Affairs

The Commonwealth Department of Veterans Affairs (DVA) delivers government programs for war veterans, members of the Australian Defence Force, the Australian Federal Police and their dependants. The DVA will fund veterans' consultations upon referral and for the treatment of a specific condition, with a DVA registered psychologist provider (DVA, 2009). After an initial assessment, the treating psychologist prepares a written care plan which determines the type, number and frequency of services required based on the client's clinical needs. This then needs to be approved by DVA for the payment of the approved funding sessions.

Vietnam Veterans Counselling Service (VVCS)

The VVCS is a counselling service funded by the DVA specifically for Vietnam War veterans and their families, requiring assistance with mental health issues surrounding their war experiences and re-adjustment difficulties. The counselling service includes the provision for funded referrals to other specialised psychological services if necessary and the referral of country veterans to local counselling.

Carer's Victoria (Carer's)

Carer's is the peak body for carers in Victoria, whose mission is to ensure recognition of the contribution, experiences and needs of carers and families, including the introduction of the Mental Health Carer Support Fund. The fund is made available by the Victorian Department of Human Services and is administered by Carer's, for services including short-term counselling for the carer beyond that usually provided by the public mental health system. This includes the funding of treatment sessions for carers and family members to deal with the emotional and relationship impacts of caring (Carer's, 2009). As funds available under this program are limited, approval of session funding considers the assistance provided to the carer, the immediacy of the need and/or potential crisis aversion.

Employee Assistance Programs (EAPs)

Employee Assistance Programs typically provide short-term counselling, support, assessment, therapy and referral services to assist employees and their families to deal

with personal problems and issues that may impact their work, well being and health. The use of EAP services have increasingly become widespread in the workplace, however the level and scope of services provided are often diverse between providers. The number of sessions offered through EAPs varies according to the employer and in some cases because of the nature of the employment (e.g., members of the police force are offered considerably more sessions than the average employee in Australia).

Other Insurance

Other insurance referred to in the thesis relates to alternative insurance funding for psychological services, including private health insurance, income protection insurance and disability insurance. Most private health insurers offer coverage or rebates on psychological services, the extent being dependant on the respective level of cover. Income protection and disability insurance provide financial support in the event the policyholder is (often temporarily) unable to work due to illness or injury, including funding assistance for treatment to assist in the return to work process.

APPENDIX J

Test for support of the phase model's predictions

The Phase Model predicts that movement through Enhancement of Subjective Wellbeing (ESW), Symptom Reduction (SR), and Recovery of Life Functioning (RLF) should be dependent on having completed the prior stage (Howard et al., 1993). In order to understand the extent to which this prediction held true in the present study, Spearman's correlation for non-normal data was used. This test is able to show the extent of correlation between answers in the three stages, separately for each condition of time and complexity.

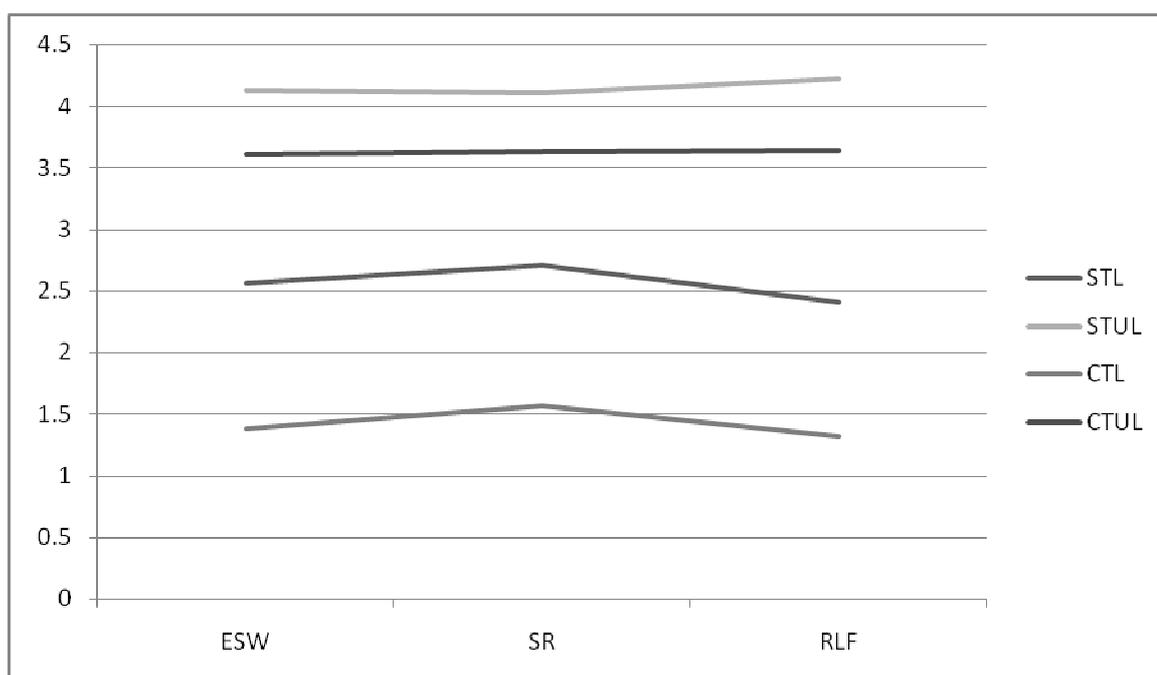


Figure A.1. *Estimation of the phase model based on time condition and complexity (means)*

For the simple time limited condition, ESW was significantly correlated with SR, $r_s(83)=.630$, SR was significantly correlated with RLF, $r_s(83)=.502$, and ESW was significantly correlated with RLF, $r_s(83)=.591$ (all $ps < 0.01$).

For the simple time unlimited condition, ESW was significantly correlated with SR, $r_s(83)=.666$, SR was significantly correlated with RLF, $r_s(83)=.622$, and ESW was significantly correlated with RLF, $r_s(83)=.676$ (all $ps < 0.01$).

For the complex time limited condition, ESW was significantly correlated with SR, $r_s(83)=.732$, SR was significantly correlated with RLF, $r_s(83)=.667$, and ESW was significantly correlated with RLF, $r_s(83)=.682$ (all $ps < 0.01$).

For the complex time unlimited condition, ESW was significantly correlated with SR, $r_s(83)=.736$, SR was significantly correlated with RLF, $r_s(83)=.721$, and ESW was significantly correlated with RLF, $r_s(83)=.639$ (all $ps < 0.01$).

All differences were thus nonsignificant. There are three possible explanations for the nonsignificant differences found between the stages of the Phase Model. Firstly, it is possible that the present study has not shown support for the phase model, secondly that it has not adequately described each stage of the phase model, or thirdly that it has not assessed the Phase Model in a suitable way. For the phase model to be supported in the present study, ratings should have decreased between ESW and SR, and decreased again between SR and RLF. There is a slight increase in SR for time limited conditions that is not present in time unlimited conditions, however this increase is not significant. The implications for the present study are not momentous, as it seems likely that participants took on their own meanings for each of the Phase Model stages, and didn't see that they were significantly different from each other, and in particular didn't seem to recognise the accumulative prediction of the three stages. Nonetheless, the findings do not support the cumulative phases of outcome that the Phase Model predicts.