TIME AND CRISIS: A SURVEY OF 98 PLANNED SHORT-TERM TREATMENT PROGRAMS


Howard J. Parad
1967

D.S.W. converted to Ph.D. in 2011
Copyright by

HOWARD JOSEPH PARAD

1967
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. INTRODUCTION</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>II. THE CRISIS CONCEPT AND THE USE OF THE TIME DIMENSION; A REVIEW OF THE LITERATURE</strong></td>
<td>17</td>
</tr>
<tr>
<td><strong>III. STUDY DESIGN AND METHOD</strong></td>
<td>54</td>
</tr>
<tr>
<td><strong>IV. SAMPLE SELECTION AND CHARACTERISTICS</strong></td>
<td>77</td>
</tr>
<tr>
<td><strong>V. FINDINGS</strong></td>
<td>99</td>
</tr>
<tr>
<td>A. Intake Procedures</td>
<td>106</td>
</tr>
<tr>
<td>B. Time Factors</td>
<td>113</td>
</tr>
<tr>
<td>C. SST Case Criteria</td>
<td>125</td>
</tr>
<tr>
<td>D. Treatment Factors</td>
<td>135</td>
</tr>
<tr>
<td>E. Program Features</td>
<td>149</td>
</tr>
<tr>
<td><strong>VI. TOWARD A PROGRAM ASSESSMENT SCALE</strong></td>
<td>175</td>
</tr>
<tr>
<td><strong>VII. SUMMARY AND IMPLICATIONS</strong></td>
<td>191</td>
</tr>
</tbody>
</table>

## Appendix

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. QUESTIONNAIRES</td>
<td>222</td>
</tr>
<tr>
<td>B. CORRESPONDENCE FORMS</td>
<td>265</td>
</tr>
<tr>
<td>C. CODING INSTRUCTIONS</td>
<td>284</td>
</tr>
<tr>
<td>D. SELECTED TABLES</td>
<td>306</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>310</td>
</tr>
</tbody>
</table>
ACKNOWLEDGMENTS

Many persons and organizations have cooperated to make this study possible. My greatest debt of gratitude is to the hundreds of agency and clinic staff members who generously completed the questionnaires on which this report is based. Thanks are also due to Dr. Dorothy F. Beck, Clark W. Blackburn, Mildred Frank, William B. McCurdy, Joseph McDonald, and Mildred M. Wagle of the Family Service Association of America; Jacqueline L. Friend, Dr. Hyman S. Lippmann, and Dr. Meyer Seals of the American Association of Psychiatric Clinics for Children; Ann W. Shyne of the Community Service Society of New York; and the staff and consultants of the AAPCC-PSAA Planned Short-Term Treatment Study Project, including Rose Clifford, John Goda, Dr. George Levinger, Dr. James Horrissey, Dr. Henry Oppenheim, Libbie G. Parad, Dr. Donald E. Ralph, Jacqueline Van Vosis, and Judith Woodman.

In addition, I want to express my appreciation to the members of my dissertation committee, Dr. Viola W. Bernard and Dr. Alfred J. Kahn of Columbia University, for their warm interest and helpful advice.

I also wish to record my thanks to the National Institute of Mental Health for grant MH-02020 which partially supported the research described in this report.

R.J.F.
<table>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Toward a Paradigm for Classifying the Use of the Crisis Approach and the Time Dimension in Treatment Services</td>
<td>59</td>
</tr>
<tr>
<td>4.1</td>
<td>Regional Distribution of PSTT and Non-PSTT AAPCC Clinics</td>
<td>82</td>
</tr>
<tr>
<td>4.2</td>
<td>Regional Distribution of PSTT and Non-PSTT FSAA Agencies</td>
<td>83</td>
</tr>
<tr>
<td>4.3</td>
<td>Distribution of Size of Population Served by Number of AAPCC Clinics</td>
<td>84</td>
</tr>
<tr>
<td>4.4</td>
<td>Distribution of Size of Population Served by Number of FSAA Agencies</td>
<td>85</td>
</tr>
<tr>
<td>4.5</td>
<td>Distribution of Size of Staff</td>
<td>86</td>
</tr>
<tr>
<td>4.6</td>
<td>Distribution of Sample and Non-Sample FSAA Agencies by Size of Professional Staff</td>
<td>87</td>
</tr>
<tr>
<td>4.7</td>
<td>Number of PSTT and Non-PSTT AAPCC Clinics With and Without Waiting Lists</td>
<td>88</td>
</tr>
<tr>
<td>4.8</td>
<td>Number of PSTT and Non-PSTT FSAA Agencies With and Without Waiting Lists</td>
<td>89</td>
</tr>
<tr>
<td>4.9</td>
<td>Distribution of Agency Services Among Sample and Total FSAA Membership</td>
<td>92</td>
</tr>
<tr>
<td>4.10</td>
<td>Number of PSTT and Non-PSTT FSAA Agencies With and Without Group Treatment</td>
<td>94</td>
</tr>
<tr>
<td>4.11</td>
<td>Distribution of Opinions Within Sample and Non-Sample Groups About Professional Advisability of Offering PSTT Services</td>
<td>95</td>
</tr>
<tr>
<td>5.1</td>
<td>Distribution of Specialized Intake by Number of Respondents</td>
<td>106</td>
</tr>
<tr>
<td>5.2</td>
<td>Use of Application Form Before Intake by Number of Respondents</td>
<td>107</td>
</tr>
<tr>
<td>5.3</td>
<td>Distribution of Exploratory Intake for PSTT by Number of Respondents</td>
<td>108</td>
</tr>
<tr>
<td>Table</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>5.4</td>
<td>Distribution of Exploratory Intake for Non-PSTT by Number of Respondents</td>
<td>109</td>
</tr>
<tr>
<td>5.5</td>
<td>Number of Routine Exploratory Interviews Usually Held at Intake</td>
<td>110</td>
</tr>
<tr>
<td>5.6</td>
<td>Frequency of Reassignment for Non-PSTT Cases by Number of Respondents</td>
<td>111</td>
</tr>
<tr>
<td>5.7</td>
<td>Reassignment for PSTT and Non-PSTT Cases by Number of PSAA Respondents</td>
<td>112</td>
</tr>
<tr>
<td>5.8</td>
<td>Reassignment for PSTT and Non-PSTT Cases by Number of AAPCC Respondents</td>
<td>112</td>
</tr>
<tr>
<td>5.9</td>
<td>Number of Respondents With Waiting List</td>
<td>114</td>
</tr>
<tr>
<td>5.10</td>
<td>Median Number of Cases on Waiting Lists and Under Care</td>
<td>115</td>
</tr>
<tr>
<td>5.11</td>
<td>Number of Days Usually Elapsing Between Application and Initial Interview for PSTT Cases by Number of Respondents</td>
<td>116</td>
</tr>
<tr>
<td>5.12</td>
<td>Distribution of Number of Predetermined Interviews</td>
<td>118</td>
</tr>
<tr>
<td>5.13</td>
<td>Distribution of Use of Predetermined Number of Weeks</td>
<td>119</td>
</tr>
<tr>
<td>5.14</td>
<td>Method for Arriving at a Predetermined Number of Interviews</td>
<td>119</td>
</tr>
<tr>
<td>5.15</td>
<td>Distribution of the Upper Limit of the Range of Interviews and Weeks of Treatment for PSTT by Number of Respondents</td>
<td>121</td>
</tr>
<tr>
<td>5.16</td>
<td>Range for Number of Interviews and Weeks by Number of Respondents</td>
<td>122</td>
</tr>
<tr>
<td>5.17</td>
<td>Typical Practice if Service Needed Beyond PSTT Limits</td>
<td>124</td>
</tr>
<tr>
<td>5.18</td>
<td>Mean Ranks of Specific Criteria Used in the Selection of Cases for PSTT</td>
<td>126</td>
</tr>
</tbody>
</table>
LIST OF TABLES (Cont'd)

Table                                Page

5.19 Mean Ranks for Forced-Choice Criteria
   for Selecting Cases for PSTT          133

5.20 Distribution of Choices Regarding PSTT
   Goal Orientation by Number of
   Respondents                            136

5.21 Mean Ranks for Reasons Why PSTT is
   Effective                               138

5.22 Distribution of Opinions About Special
   Approaches to Lower Class Clients by
   Number of Respondents                   140

5.23 Distribution of Group Treatment Services
   by Number of Respondents                141

5.24 Distribution of Time-Limited Group Treat-
   ment Services by Number of Respondents   142

5.25 Number of Respondents Indicating Therapeu-
   tic Disadvantages to PSTT                143

5.26 Number of Respondents Selecting Specified
   Therapeutic Disadvantages of PSTT         144

5.27 Lack of Skill and Knowledge Compared With
   All Other PSTT Disadvantages by Number
   of Respondents                           147

5.28 PSTT Viewed as Treatment of Choice Versus
   Expediency by Number of Respondents      148

5.29 Mean Ranks for Reasons for Initiating
   PSTT                                      150

5.30 Crisis Versus Non-Crisis Rationales by
   Number of Respondents                    156

5.31 Crisis Configuration Scores by Number
   of Respondents                           161

5.32 Classification of PSTT Programs by Crisis
   Configuration and Early Accessibility
   Items                                     162
<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.33</td>
<td>Use of Planned Follow-Up by Number of Respondents</td>
<td>164</td>
</tr>
<tr>
<td>5.34</td>
<td>Changes in FSAA Staff Opinions of PSTT by Number of Respondents</td>
<td>169</td>
</tr>
<tr>
<td>5.35</td>
<td>Changes in AAPCC Social Workers' Opinions of PSTT by Number of Respondents</td>
<td>171</td>
</tr>
<tr>
<td>5.36</td>
<td>Changes in AAPCC Psychiatrists' Opinions of PSTT by Number of Respondents</td>
<td>172</td>
</tr>
<tr>
<td>5.37</td>
<td>Changes in AAPCC Psychologists' Opinions of PSTT by Number of Respondents</td>
<td>174</td>
</tr>
<tr>
<td>6.1</td>
<td>Program Assessment Scale Items</td>
<td>178</td>
</tr>
<tr>
<td>6.2</td>
<td>Distribution of PAS Scores for AAPCC and FSAA Samples</td>
<td>179</td>
</tr>
<tr>
<td>D.1</td>
<td>Sample Loss From 98 FSAA Agencies and 94 AAPCC Clinics by Original Designation as Formal or Informal Program and Reason for Non-Participation</td>
<td>306</td>
</tr>
<tr>
<td>D.2</td>
<td>Phi Correlation Coefficients Between 35 A Priori Program Assessment Items and Total Scores for AAPCC Sample</td>
<td>307</td>
</tr>
<tr>
<td>D.3</td>
<td>Phi Correlation Coefficients Between 35 A Priori Program Assessment Items and Total Scores for FSAA Sample</td>
<td>308</td>
</tr>
<tr>
<td>D.4</td>
<td>Interim PAS Items for FSAA and AAPCC</td>
<td>309</td>
</tr>
</tbody>
</table>
ABSTRACT

Time and Crisis: A Survey of 98 Planned Short-Term Treatment Programs

Howard J. Parad

This was an exploratory-descriptive survey of planned short-term crisis-oriented programs in 44 child psychiatric clinics and 54 family service agencies. The general study questions concerned the common and special characteristics of these programs, the extent to which formulations about the crisis approach and the structuring of the time dimension were utilized, and the feasibility of developing a scoring-instrument to profile certain important program features. Specific study questions dealt with theoretical formulations, practice processes, and administrative procedures.

Planned short-term treatment (PSTT) was defined to mean that certain cases were designated during the intake period, or shortly thereafter, to be seen for (a) a more or less limited number of in-person interviews and/or (b) a more or less limited period of time. The "crisis approach" included attention to the stress-crisis configuration (the precipitating event, the perception of and response to the event, and the resolution of the ensuing
problems) as well as emphasis on the prompt availability and accessibility of treatment.

Major findings were: The proportion of clinics with PSTT services was much greater than that of the agencies. PSTT was viewed as a treatment of choice rather than expediency. The goals of PSTT were generally focused on the client's "presenting" rather than his "underlying" problem. The primary reason for initiating PSTT was to meet the needs of clients in crisis situations. Treatment techniques were thought to require special adaptations in PSTT. The clinics—as compared to the agencies—were more likely to (1) have longer waiting lists; (2) use an application form as a screening device; (3) have centralized or specialized intake services; (4) have a longer time lapse between the application for help and the initial interview; and (5) use a larger number of exploratory interviews before the case was assigned to PSTT. In terms of these administrative factors, clinics seemed less accessible for early crisis intervention than agencies.

Only 21 clinics and agencies reported the use of a specific predetermined number of interviews or weeks of treatment for PSTT cases; the remaining 77 respondents used an approximate range of interviews or weeks as a way of flexibly structuring the time dimension. PSTT, as typically used by the respondents in this sample, encompassed up to 12 interviews which were offered over a period of up to three months.
Staff opinions about the professional advisability of PSTT were overwhelmingly positive, and when they changed--after PSTT services were initiated--they did so in a significantly positive direction.

A preliminary Program Assessment Scale (PAS) was developed to profile differences among respondents with a strong, moderate, or minimal investment in crisis-oriented PSTT. The PAS included 10 cross-validated items (for clinics and agencies) related to crisis formulations, time factors, intake procedures, staff training, and research. Further study will be needed to test this instrument.

The study suggests that continued careful experimentation with crisis-oriented PSTT programs in a variety of mental health services shows promise of (1) reducing the number of unplanned terminations by offering families under stress a meaningful and definitive type of brief service; and (2) serving--through the redeployment of available professional resources--an increasing number of individuals and families in stressful situations. Such programs might well be the treatment of choice for large numbers of families and thus deserve an important place in the spectrum of community mental health services.
"You know that we have never been proud of the fullness and finality of our knowledge; as at the beginning, we are ready now to admit the incompleteness of our understanding, to learn new things and to alter our methods in any way that yields better results."

Nature and Background of the Problem

Perhaps more than at any other time in the history of the family service and child guidance movements, today's professional climate fosters new theories, new modes of theory development, and new departures from traditional administrative arrangements and treatment techniques in clinical practice. This study is addressed to one such area of practice innovation, namely, time-limited crisis-oriented programs. The emphasis is on the use of planned short-term services in family service agencies and child psychiatric clinics that are accredited by the Family Service Association of America (FSAA) and the American Association of Psychiatric Clinics for Children (AAPCC) respectively.

---


2 Henceforth in this report the American Association of Psychiatric Clinics for Children will be abbreviated as AAPCC, and Family Service Association of America as FSAA.
Within the past few years, formulations of time-limited crisis intervention, preventive intervention, emergency and brief therapy—and their various interpretations and implementations in agency and clinic programs and in inter-agency community planning—have received growing attention in the literature of social work and social and community psychiatry. In fact, social work has even been defined in terms of its efforts at crisis management: "Generally speaking, social work can be visualized as centering on the management of cases with the objective of alleviating a crisis in the life of an individual, family or group."

In the light of the interest expressed in models of crisis intervention, it is surprising that there have been no comprehensive, systematic empirical studies of conceptualizations about and attitudes toward the utilization of brief crisis-oriented services by practitioners. The present study effort represents a descriptive approach to knowledge about current practice theory and technique in this area of mental health activity.

While structuring of the time-dimension, or time-limited


treatment, is not new, the use of crisis theory as a rationale for the structuring of time is recent; the postulates of crisis theory, to be presented in the survey of the literature in Chapter II, demand attention to the planful use of the time dimension.

In this investigation, the family agency and the child guidance clinic (now often referred to as the "child psychiatric clinic") are considered two basic and vital community mental health resources for the diagnosis and treatment of individuals and families who are experiencing problems in their psychological and social functioning. Although applicants to mental health clinics may more frequently phrase their requests in terms of physical or psychological symptoms than in terms of problems in social functioning, a number of investigators have pointed out that, in general, applicants to clinics and family agencies present quite similar problems. However, despite this fact, only recently has the family agency been "clearly and appropriately identified" as one of the core group of mental health activities.

1This study is based on the assumption that there are a number of common elements in the therapeutic processes of social casework, clinical psychology, and clinical psychiatry; casework and clinical psychology are viewed here as non-medical forms of psychotherapy.


3Schroeder, op. cit., 1.
Crystal has referred to the use of the family service agency as a "mental health first-aid" resource for help with "salamitous situations that can suddenly disrupt the balance of family life."¹ The slogan used by a number of family agencies, "Mental Health is Everyone's Business," indicates they regard themselves as mental health resources.²

Although there are, of course, organizational differences—for example, family service is a social agency and the clinic a medical facility³—their have been considered sufficiently unimportant so that a few communities have even developed merged family service and mental health programs.⁴ Such developments are partly due to the problem of scarce financial and personnel resources and partly to ideological convictions.


²See, for example, brochure published by the Family Service of New Haven, Inc., New Haven, Connecticut, Spring, 1965: "Not so long ago we thought of mental health as the concern of doctors, clinics, and hospitals. But the more we have learned about human beings, the clearer it has become that everyone who works with people can have an influence on mental health or lack of it."


⁴In 1965, twelve FSAA member agencies included mental health clinic programs. See "Family Service Statistics," Part III (June, 1966), 7. According to Mildred E. Wagle, FSAA Director of Mental Health Activities, there were 15 such family service-mental health programs as of January 30, 1967.
Relevance of This Study

The following factors contribute to the relevance of this study: (1) society's continued concern about the persistent and widespread problems of personal and family dysfunctioning; (2) the chronically plaguing personnel shortages that put a premium on the maximal utilization of scarce professional mental health resources of time and manpower; (3) the perennial concern about the waiting-list problem; and (4) the alarming number of treatment dropouts—that is, cases that are prematurely terminated as unplanned brief services. All these factors combine to create the current mood of professional soul-searching and the eager critical interest in program evaluation which are the preconditions for the discovery of new methods of offering effective mental health services to increasingly larger segments of the population.¹ Planned short-term crisis-oriented services have been suggested as one such method.²


Among those who have called for reappraisal in the field of child psychiatry are Mayer Sarnoff, "Implications for the Child Guidance Clinic of the Current Trends in Mental
The imbalance in the mental health field between available resources and the demand for these resources cannot be fully documented in this study. But two interrelated effects of the imbalance will be briefly discussed since they are central to this study—waiting lists and treatment dropouts. The scarcity of mental health resources, requiring the establishment of priorities for service, leads to the creation of the waiting list, which represents a decision, as of a given point in time, not to serve a particular individual or family in a stressful situation. Since such a large proportion of agency and clinic resources are devoted to intake and selection of clients, the high dropout rates in both family agencies and clinics have prompted critics to raise questions about the possible misuse of

---


scarce needed resources. As pointed out by Gordon in a recent article, the child guidance clinic sees only a small proportion—perhaps only five percent—of the children who need help; there are arbitrary elements in the selection of patients for treatment; and a large proportion of the "hand-picked patients" withdraw from treatment prematurely.\(^1\)

In addition to the humanistic concern with our failure to give help when it is needed, a practical source of interest in the waiting-list problem has been attributed to the stress created for the staff as well as for the agencies in the mental health professions. Hallowitz and Cutter have stated that the months of delay before the beginning of treatment "can be overwhelming, anxiety-producing, and discouraging for the clinic staff since they become concerned as to what may be happening in the cases that are not getting their attention, to say nothing of the potential harm to children and parents for whom service is being postponed."\(^2\) Caplan has referred to the frustration experienced by community agencies that cannot get quick service for the clients they want to refer as well as the frustration experienced by professional staff members in clinics: "This strain often leads to a vicious circle of rising pressure on the clinic to take patients, which is countered by the

---

1Sol Gordon, *op. cit.*

increasing erection of defenses by the clinic staff who be-
come fearful that they will be flooded and the quality of
their professional work will be eroded."

Among the theoretical sources of interest in the wait-
ing list problem are the writings of Caplan and Lindemann
who have stressed the importance of the availability of
therapy during the crisis, as near as possible to the period
of symptom formation. Closely related to their theoretical
proposition is the problem of waiting list attrition. In
Beck's study of 500 family service cases it was conclusively
shown that the longer a client waited for help, the greater
the likelihood that he would not accept help when it was
proffered. Of those kept waiting less than five weeks, 85
percent returned when recalled to help; the proportion,
however, declined to 50 percent for a waiting period of nine
weeks or more. She concluded, "If help cannot be offered
at the point of crisis, when need and motivation are both
maximum, it is often rejected later when it is made avail-
able."4

Thus, waiting lists remain a persistent problem in

1Caplan, "Beyond the Child Guidance Clinic," loc.

2Raquel Cohen, "Intake Procedures in a Community Mental
Health Clinic," Community Mental Health Journal. II (Fall,
1966), 252.

3Dorothy F. Beck, Patterns in Use of Family Agency
Service (New York: Family Service Association of America,
1961), 20.

4Ibid., 24.
both child guidance clinics and family service agencies. The dimensions of the problem are apparent from the family service statistics which indicate that 53 percent of the agencies belonging to FSAI had a total waiting list in 1964 of 8,220 families.\(^1\) No comparative statistics are available for the clinics (in part due to definitional difficulties in the collection of accurate data), although it is believed that the magnitude of the problem is at least as serious in the child guidance field.

The Problem of Treatment Dropouts

The alarming number of treatment dropouts—that is, cases that are prematurely terminated as unplanned brief services—is also pertinent to the present inquiry concerning planned short-term services. This problem has been a source of concern for many years in both child guidance and family service. In an important review article published almost ten years ago, Shyne summarized a number of studies with the observation that they evidenced "the greatest concern" about those who abort treatment—those individuals and families who need treatment but for one reason or another reject the offer of help.\(^2\) The tendency to project problems onto others in the environment, "low-motivation," and "resistance" were most frequently cited as reasons for


unplanned case terminations.\(^1\)

The statistics on unplanned terminations are pain-
fully impressive and have been documented in both the family
service and child guidance fields. For example, Beck's one-
day census study of family agencies revealed that 39 percent
of the total closings were unplanned terminations.\(^2\) Since
this statistic refers to a mixed adult and child population,
it is comparable to the finding of Woodward and his associates
in their study of 228 psychiatric clinics in the state of
New York which included services to children. They found
an overall withdrawal rate of 43 percent for treated patients
(that is, those who had gone beyond the diagnostic phase).\(^3\)

Termination rates varied, of course, with the age of the
patient, the number of interviews, the length of time in

treatment and other factors. There was a somewhat lower
dropout rate among child patients, which was attributed to
the fact that children, usually taken to the clinic by
their parents, are not free agents. One is forced to concur
with Gray's finding, based on a compilation of a number of
studies of child guidance clinic populations: "whether one
takes the generally conservative national figure of 25 per-
cent or some point within the range of the individual studies

---

\(^1\)Ibid., 230.

\(^2\)Beck, op. cit., 24.

\(^3\)Luther E. Woodward et al., "The Values of Statistical Reporting in the Planning and Revision of Community Mental Health Programs," American Journal of Orthopsychiatry, XXXI (April, 1961), 308.
(31 percent to 66 percent), it is obvious that a large proportion of the patient population terminates its contact before the staff feels it is appropriate.\footnote{1}

Closely related to premature withdrawal from treatment is the question of duration of treatment. Comparisons of statistics dealing with duration are difficult to make despite the efforts to promote uniform record keeping on a national basis by FSAA for family agencies and by the Public Health Service for clinics. Not only are different cut-off points likely to be used in each study, but many questions can be raised about the definition of a "case," as well as about the similarity of the client populations, especially as to degree of illness or severity of problem treated. Five interviews has frequently been used to represent a demarcation point between continuation and discontinuation or between brief and long-term service.\footnote{2}

In 1959, national statistics for out-patient psychiatric clinics indicated that 54 percent of the patients were found to have had less than four interviews.\footnote{3} In his study of clinics in New York state, Woodward found that 3.2 was


\footnote{2}{For example, this is the number used by Lillian Mipple in Motivation, Capacity, and Opportunity (University of Chicago, 1964), 3, and by Bernice Boehm, "Characteristics of Brief Service and Long Term Cases: A Comparative Study" (mimeographed, Family and Children's Service, Minneapolis, Minnesota, April, 1961).}

\footnote{3}{Gray, op. cit., 14.}
the median number of interviews for patients who terminated. He has made explicit the relationship between dropout and duration: "Forty-three percent of treated patients in the 232 outpatient clinics withdraw, most of them in the early period of their contact with the clinic, and 64 percent are seen only one to four times."\(^1\) Beck, in her study, *Patterns of Use of Family Agency Service*, found that 30 percent of the families were seen for not more than four interviews.\(^2\) More recent FSAA statistics have indicated that 74 percent of the family agency clients served in 1965 had five or fewer interviews; thus, on the average, only one out of five family agency clients has more than five interviews during a casework contact.\(^3\) Since family agencies serve a wider variety of functions and are not likely to be as selective in their intake procedures, as are certain clinics, this statistic does not compare unfavorably with Woodward's finding that: "In a goodly number of the clinics that stress treatment and select only patients believed to be well motivated for fairly intensive treatment, more than 50 percent of such patients do not get beyond the fifth interview." He concluded, "Treatment efforts are very likely being skewed in the direction of the staff's biases about therapy, rather than being based on a fully realistic assessment of patient needs, goals, and limitations."\(^4\)

---

\(^1\) Woodward, op. cit., 313.

\(^2\) Beck, op. cit., 36.

\(^3\) *Family Service Statistics,* Part V (March, 1966), 1.

\(^4\) Woodward, op. cit., 312-313.
Summary

In summary, then, the relevance of the present investigation of time-limited programs of crisis intervention derives from: awareness of the persistent problems of personal and family breakdown; the problem of personnel shortages which make it difficult for mental health agencies to meet the community's expectations for service; the waiting list dilemma; and concern about treatment efficacy—often manifested in preoccupation with the large number of cases that terminate prematurely as unplanned brief services.

Study Questions

The overall purpose of this investigation was to conduct an exploratory-descriptive survey of time-limited crisis intervention programs currently operating within the 155 AAPCC clinics and the 327 FSAA agencies. The general study questions were:

(1) How many planned short-term crisis-oriented programs are now in operation within the membership of the AAPCC and the FSAA?

(2) What are the common and special features of these programs?

(3) To what extent are formulations about the crisis approach and time-limited treatment being utilized by practitioners in these clinics and agencies?

(4) On the basis of the empirical findings related to the questions posed in this investigation, can a study instrument be developed to profile some of the important
features of time-limited crisis intervention programs, to be used as a conceptual and measurement tool in future studies of brief crisis-oriented services in mental health programs?

Specific study questions may be grouped under the following three broad categories: (1) theoretical formulations, (2) practice processes, and (3) administrative procedures and problems.

(1) What conceptualizations—from practice wisdom as well as the growing literature of social work and social and community psychiatry—concerning the crisis concept and the planned use of the time dimension, are actually being used by mental health practitioners in child guidance and family agency settings? In a modest sense, then, this investigation is concerned with the dissemination and use of a specific body of knowledge within a specific area of professional practice.

(2) What practice processes characterize the programs under study with respect to the structuring of the therapeutic process—for example, the amount of time elapsing between application and intake, the use of pre-planned time limits, criteria for case selection, and the use of group treatment and other techniques?

(3) What administrative procedures are involved in organizing and distributing time-limited crisis intervention services to the relevant target populations? Specific sub-questions here will deal with intake procedures, problems of case reassignment, case and program evaluation, and staff training.
Significance of This Study

It is hoped that this investigation will be of some significance to the mental health field by providing empirical data regarding the utilization of crisis formulations and time-limited approaches, by analyzing how experimental service patterns depart from traditional practice technologies, and by studying certain administrative procedures and problems that are related to these services.

Limitations

As with all social research, there are important limitations in this research effort. As an exploratory-descriptive study, this is an investigation in the general area of mental health programming and practice arrangements; it is not a detailed technical study of the clinical ingredients of the therapeutic process, nor does it deal with mental health consultation, which is an important form of "indirect" crisis intervention. Since this study will be limited to accredited members of the AAPCC and PSAA, such findings as may emerge may not be applicable to non-AAPCC mental health out-patient clinics or to social agencies in general, nor can they be regarded as applicable to hospital programs with in-patient populations. Finally, the twin problems of reliability and validity—inhomogeneous in all scientific research but especially pertinent in survey research involving open-ended narrative responses—will be discussed in Chapter III.

General Plan of Procedure

Following a selective review of the literature that pertains to the crisis approach and to the structured use of time, the design and method of this study—including definitions of important terms—will be explained in relation to the specific questionnaire items that were used. The extent to which the study sample—drawn from the AAFCC and the FSAA national memberships—corresponded, with respect to certain demographic variables, to the total constituencies of these organizations will be discussed in Chapter IV. Following a presentation of the main study findings, an effort will be made to develop a "program assessment" study instrument for classifying and measuring selected components of time-limited crisis-oriented mental health services.
CHAPTER II

THE CRISIS CONCEPT AND THE USE OF THE TIME DIMENSION:

A REVIEW OF THE LITERATURE

A comprehensive and systematic review of the mushrooming literature on the different and similar usages of "crisis" and "short-term treatment" would in itself require a separate study. The purpose of this chapter is to review briefly only those aspects of the crisis concept and the use of the time-dimension that seem pertinent to the present inquiry. Following a summary of the major assumptions of the crisis approach, a review of certain features of short-term therapy will be presented. Those features that are common to both crisis-oriented and short-term therapy will then be summarized.

Crisis Concept

Simply put, crisis refers to an upset in a steady state; it is a useful conceptual device for binding together certain types of "problem" and "need" that beset individuals and families under stress. But the investigator in the field of crisis studies is immediately confronted by the difficulty in differentiating "stress" from "strain"—that is, the specific event that may precipitate a crisis from the response to that event. Moreover, stress and crisis

17
it would seem that the profile of the mental health worker's intervention might well resemble the actual crisis profile; that is, as the crisis mounts to a peak, the worker's efforts might well be more frequent, whereas at the time of resolution, treatment sessions might be differently spaced.

The worker relies heavily on the positive contagion of hope as a dynamic in promoting treatment efficacy. "He has reasons for expecting that crisis intervention will be effective; he has faith that prevention is possible."¹

Definition of Crisis Intervention

Thus, with its prompt and optimistic commitment to a specific and achievable treatment goal, crisis intervention means entering into the life situation of an individual, family or group to alleviate the impact of a crisis-inducing stress in order to help mobilize the resources of those directly affected, as well as those who are in the significant "social orbit". The crisis therapist has the dual objective of (1) reducing the impact of the stressful event and (2) utilizing the crisis situation to help those affected not only to solve present problems and work toward an adaptive resolution but also to become strengthened in mastering future vicissitudes by the use of more effective adaptive and coping mechanisms.

are often used interchangeably, thus robbing the term "crisis" of any precise meaning it may have. While all people face stress as part of the human condition, it should be emphasized that not all stressful experiences produce crisis situations.¹

Another source of confusion may be attributed to references to crisis as a "theory,"² a form of usage that is perhaps more honorific than scientific, since the constructs and techniques encompassed by what has been called the "crisis approach" lack the formal attributes of systematically validated theory.³ Still another difficulty confronting the student of crisis phenomena is the problem of objectively differentiating a crisis from a "noncrisis," that is, from ordinary day-to-day problem-solving behavior.⁴

¹For example, a research group at the Langley Porter Neuropsychiatric Institute has assumed that the application for help ipso facto involves the existence of a crisis situation; see M. Robert Harris et al., "Precipitating Stress: An Approach to Brief Therapy," American Journal of Psychotherapy, XVII (July, 1963), 466.


³However, it is reasonable to say that the crisis approach possesses the spirit of scientific inquiry, if one accepts Conant's definition of science as emerging "from the progressive activities of man to the extent that new concepts arise from experiments and observations, and the new concepts in turn lead to further experiments and observations." In this view, crisis is a fruitful "scientific" concept that has encouraged many investigators to test and observe. See James Conant, On Understanding Science (New Haven: Yale University Press, 1947), 24.

In the light of the complex field of forces that contribute to the stress-crisis sequence, crisis is viewed in the present study as a configuration involving (1) a specific and identifiable stressful event; (2) the perception of the event as meaningful and threatening; (3) the disorganization or disequilibrium response, resulting from the unsuccessful effort at coping with the burden imposed by the stressful event; and (4) the coping and interventive tasks that are involved in an adaptive or maladaptive resolution of the crisis situation. 1

In essence, then, crisis represents the perception of and response to an internal or external stress (or hazardous event) 2 that is defined as a threat to such vital goals as life, security, and affectional ties by the individual or individuals involved. Thus, the main affective components of the crisis experience are anxiety and tension. The following interrelated assumptions, commonly used to explain the phenomena of the ensuing crisis sequence, have been discussed in detail in the pioneering writings of the two main architects of the crisis approach, Erich Lindemann

---

1 The term "configuration" is used to convey the idea that the phases of the crisis sequence are interlocking; in practice, for example, "perception" of the stress as meaningful and threatening may almost imperceptibly shade off into a disequilibrium "response" phase. Yet, for purposes of analysis, it is necessary to attempt to separate the components of the configuration.

and Gerald Caplan.\(^1\)

(1) When a stressful event becomes a crisis, there is by definition, a period of disequilibrium during which the individual (or family) is both vulnerable to further breakdown and amenable to positive and corrective influence. Hence, the familiar observation that crisis means both danger and opportunity.\(^2\)

(2) The crisis is characterised by a significant "turning point," often described as "the point of no return" requiring the use of novel coping mechanisms.\(^3\)

(3) This turning point, accompanied by mounting anxiety and tension, often involves the mobilization of previously hidden resources.

(4) The tasks posed by the crisis situation are beyond the normal coping mechanisms of the individual whose resources (and perhaps those of the primary group network of which he is a part) are overtaxed.

(5) The duration of crisis is more or less limited.


depending on the total field of psychosocial forces—that is, the nature and perception of the threatening event, response patterns, and individual and group problem-solving resources. In this context, some observers have referred to the "self-limiting" or "normal crisis."¹

(6) A new equilibrium resulting from a complex of homeostatic mechanisms sets in, often within four to six weeks, leading to a level of mental health and social functioning that may be theoretically the same as, better than, or less satisfactory than that existing prior to the onset of crisis.²

(7) The crisis situation imposes a variety of tasks to be mastered. These vary from stress to stress and have been partially documented through empirical research. For example, mastery of the special tasks involved in coping

---
¹For example, Erik Erikson in "Identity and the Life Cycle," Psychological Issues, I (1959), 1-171, has referred to "normal" or "maturational" crises; they are considered normal because all human beings experience them in the process of growing up. They are generally viewed as periods of marked physical, psychological, and social change that are characterized by common "disturbances" in thought and feeling. At such times—for example, at puberty—a complex of biopsychosocial stimuli must be successfully mediated if the next maturational stage is to yield its full potential for further growth and development. For a critique of Erikson's use of "normal crisis," see Maurice Green, Discussion of "Eight Stages of Man," International Journal of Psychiatry, 71 (May, 1956) 392-394.

²Hence the familiar observation that some families emerge from crises as stronger and more effective units, while others become weaker and still others become dismembered. See Earl Koos, Families in Trouble (New York: King's Crown Press, 1946) and Neubis Hill, Families Under Stress (New York: Harper, 1949), which has differential examples of stress profiles.
with the birth of a premature baby is assumed to lead to a successful outcome, whereas unsuccessful coping results in a mentally unhealthy outcome. ¹

(8) With the overpowering of available coping and adaptive mechanisms, the stressful event typically reactivates old problems from the near or distant past, thus making possible the reworking of previously unresolved problems, which themselves may represent the sequellae of previous crisis situations that were unsuccessfully mastered. Thus, an opportunity—a second chance—is provided to deal with old problems that have erupted under the press of the crisis situation.

(9) During the crisis period, the individual is in a state of high anxiety. His ego patterns, therefore, are more likely to be open to influence and correction. As his defenses are lowered during this temporary period of disequilibrium, he is more accessible to therapeutic influence than he probably was prior to the crisis or than he will be following the establishment of a new equilibrium, with its accompanying consolidation of defensive patterns. During this period, a minimal preventive or therapeutic force may have a maximal effect.

(10) Typical clinical responses to crises may be

¹Gerald Caplan et al., "Four Studies of Crisis in Parents of Prematures," Community Mental Health Journal, I (Summer, 1965), 149-161.
roughly classified in terms of ego functioning. For example, events that threaten body integrity lead to anxiety states, loss of object relationships to depression, and 'growth' or 'maturational' crises—perceived as a challenge—to the opportunity for more effective mastery of future life situations.

The opportunities for ego growth through crisis resolution have attracted increased attention in the literature. For example, the Cummings have outlined three broad types of crisis situations: (a) those that are 'biologically tinged' and are therefore inevitable; these are comparable to Eriksen's concept of developmental or 'normative' crisis; (b) those that are 'environmentally tinged' (e.g., bereavement, retirement) and are somewhat less inevitable; and (c) those that are 'adventitious' (e.g., disasters, such as floods, fires, which are attributable to sheer chance factors). In other words, in this scheme, probability moves along a continuum from certainty to random chance. The Cummings have defined crisis as 'the impact of any event that challenges the assumptive state and forces the individual to change his view of, or readapt to, the world, or himself, or both.' The resolution of crisis results in 'new


3. Ibid., 54.
combinations of established (ego) sets." A problem, in contrast to a crisis, does not necessarily challenge the assumptive state and by definition implies that the available ego sets (and their related coping mechanisms and role repertoires) are serviceable, thus making it generally unnecessary to call into action novel methods of problem solving.

As pointed out by dramatists, novelists, and a number of behavioral scientists, crises can promote personal and social growth by enhancing the repertoire of ego sets. Successful resolution of crises makes it possible to master future vicissitudes with less anxiety and vulnerability. A lifetime of effective mastery of crisis situations ideally contributes to a mature and stable ego state which seems analogous to Erikson's concept of "generativity."¹

A number of stressful events which may be crisis-inducing or "potentially hazardous" have been studied. Typical of these are those investigated by Klein and Lindemann at the Wellesley Human Relations Service: (a) loss or threatened loss of a significant relationship; (b) the addition of one or more new individuals into a social orbit; and (c) transitions in social status and role sets as a consequence of such factors as entry into school or college, marriage, horizontal or vertical social mobility (e.g., job promotion).² All stressful events are obviously patterned

¹Erikson, op. cit.
²Klein and Lindemann, op. cit., 283-306.
by sociocultural arrangements as well as by psychodynamic perceptions.¹

From a sociological perspective, Hill has developed a highly useful classification scheme for analyzing "stressor events" in terms of their source, their perceptual meaning, and their organizational effects on the family.² He has also outlined the main elements of the stress-crisis sequence: (a) the stressful event, which interacts with (b) the family's crisis-coping resources and (c) the family's definition of the event, producing (d) the disequilibrium response.³

Many researchers have grappled with the complex conceptual and methodological problems related to the measurement of these variables in the crisis configuration. For example, Bloom has studied the rate of agreement of mental health experts in assessing the presence or absence of a crisis response in a number of fictional case analogues;⁴ Eyer has used independent judges to arrive at "crisis scores";⁵ Freeman and her co-workers at the Langley-Porter Neuropsychiatric Institute of San Francisco have developed


³Ibid., 143-147.

⁴Bloom, op. cit.

an instrument for studying the precipitating event and the behaviors related to it;\(^1\) and Caplan and his colleagues at Harvard have investigated the association between various types of crisis-coping behavior (during the disequilibrium phase) and the mental health outcome (during the resolution phase).\(^2\)

**Short-Term Therapy: An Historical Overview**

There seems to be a cyclical quality—a waxing and waning of enthusiasm—in the use of short-term therapy in both psychiatry and casework. In a review of short-term treatment in psychoanalysis and psychoanalytically oriented psychotherapy, Malan commented that "the early analysts seem to have possessed the secret of brief psychotherapy, and with increasing experience to have lost it."\(^3\) He attributed the progressive increase in the duration of analytic treatment to the preoccupation with recovery of ever-earlier childhood memories, the nature and resolution of the transference neurosis, a tendency to pursue each symptom to its many roots, therapeutic perfectionism, and the therapist's increasing passivity and failure to focus on specific goals.\(^4\) Freud himself experimented with the use of time limits, for

---


\(^2\) Caplan et al., "Four Studies of Crisis . . .". *loc. cit.*


example, in his work with the "Wolf Man" case. ¹

In general, attempts to limit the duration of therapy manifested themselves in a conscious opposition toward playing the passive role. For example, the work of Ferenczi, Franz Alexander, Felix Deutsch and other analysts had in common a reliance on focused interviews, active techniques of interpretation, and specific treatment goals. Forced to innovate in order to find some effective form of psychotherapy for large numbers of soldiers during World War II, American psychiatry devoted considerable attention to the use of short-term treatment, especially in traumatic neuroses. ² The Chicago Institute of Psychoanalysis, under the leadership of Franz Alexander, conducted a series of major meetings on brief psychotherapy. ³ In Boston, Felix Deutsch advocated brief "sector therapy" which was based on the technique of the "associative anamnesis." ⁴

The fluctuation of interest in short-term casework is almost as old as social casework itself. Over three

¹Ibid., 14.


decades ago Bertha Reynolds undertook a study of short-contact interviewing because of her conviction that short-term casework had an important but neglected place in the then existing network of social services. She concluded that "... short-contact interviewing is neither a truncated nor a telescoped experience but is of the same essential quality as the so-called intensive casework."¹

The functional school of casework, influenced largely by the work of Jessie Taft and guided by the theories of Otto Rank, elaborated an approach to casework that was based on the controlled use of time.² Taft referred to time limits as "one of the most valuable tools ever introduced into therapy."

In fact, she defined therapy in terms of time limits as a process in which the individual finally learns to utilize the allocated hour from beginning to end, without undue wear, resistance, resentment or greediness. When he can take it and also leave it without denying, trying to escape it completely or keep it forever because of this very value, in so far he has learned to live ... if he can live this hour, he has in his grasp the secret of all hours, he has conquered life and time, for the moment and in principle.³

Perhaps largely because of Taft's reliance on the teachings of Rank rather than of Freud, the use of short-term treatment—particularly the use of planned short-term treatment with more or less arbitrary time limits—evoked only


³Ibid., 17.
minimal interest from professional colleagues who, during the late thirties and forties, were embroiled in the controversy between the functional and diagnostic schools of thought.

Writing about the positive aspects of short-term treatment in 1948, Fern Lowry emphasized the demands which this form of treatment makes upon the skills of the worker, namely, development of a quick and positive relationship and immediate diagnostic assessment. In 1953, Gladys Townsend, outlining the basic principles which guided the Traveler's Aid Services in the use of short-term casework, commented, "Doubtless we have not shared as fully as we should have our conviction, based on an ever-growing body of experience, that meaningful services can be offered to, and made use of by, clients under time limited circumstances." She went on to agree with Reynolds that "it is not the length but rather the actual content and dynamic of the experience that is significant." During the fifties, there were also a few scattered experiments in the child guidance field which, despite their theoretical and practical significance, apparently attracted

1Fern Lowry, "Casework Principles for Guiding the Worker in Contacts of Short Duration," Social Service Review, XXII (June, 1948), 234-239.


3Ibid., 392.
only spasmodic interest.¹ That we are now experiencing a re-
surgence of interest in the many formulations and adaptations
of short-term treatment in psychiatry and social work is evi-
dent from even a small sampling of the current literature.²

The Problem of Values

One obvious reason for the cyclical variations in the
attitudes of psychiatry and social work toward the use of
short-term therapy is the hierarchy of values which has
located brief treatment at the bottom and long-term

¹See, for example, E. L. Phillips and E. S. Johnston,
"Theoretical and Clinical Aspects of Short-Term Parent-Child
Evelyn Alpert, "Short Clinical Services for Children in a
Child Guidance Clinic," American Journal of Orthopsychiatry,
XXVI (April, 1956), 314-323; and Elise Fell, "Short-Term
Treatment in a Child Guidance Clinic," Journal of Jewish
Communal Service, XXXVI (Winter, 1959), 144-149.

²See, for example, Anita Gilbert, "An Experiment in
91-97; Rachel A. Levine, "A Short Story on the Long Waiting
Murray and Walter S. Smuton, "Brief Treatment of Parents
in a Military Setting," *Social Work*, VIII (April, 1963),
57-64; Robert MacGregor et al., *Multiple Impact Therapy with
Families* (New York: McGraw Hill Book Co., 1964); C. P.
Jacobson et al., "The Scope and Practice of an Early Access
Brief Treatment Psychiatric Center," American Journal of
Psychiatry, CXXI (June, 1965), 1176-1182; and John A. MacLeod
and Louis W. Tinnin, "Special Service Project," *Archives of
General Psychiatry*, XV (August, 1966), 190-197.

Although this review has been focused on time-limited
treatment of individuals and families, the growing interest
in time-limited group therapy should also be mentioned. See,
for example, Helen Beck, *The Closed Short-Term Group*, U.S.
Department of Health, Education, and Welfare: Children's
Bureau, 1965; Frederick H. Stoller, "Accelerated Interactions:
A Time-Limited Approach Based on the Brief, Intensive Group,"
(Missed epoch report, State of California, Department of
Mental Hygiene, Bureau of Research, March, 1966); and R.
Ashley Weeks, *Youthful Offenders at Highfields: An Evaluation
of the Effects of the Short-Term Treatment of Delinquent Boys*
"intensive" service at the top, rather than regarding these services as part of a time continuum, each important in its own right. This belief in the higher value of long-term treatment is strongly held despite some empirical data to the contrary. The evaluation of the outcome of psychotherapy involves complex methodological problems which are the subject of much debate but are beyond the scope of this study. In his recent review of research in the family service field, Briar has challenged the social work profession's tendency to equate long treatment with "deep" and "better" treatment. He has criticized a central assumption of the

---

1 Relevant to this debate are (1) Hans J. Eysenck, The Effects of Psychotherapy (New York: International Science Press, 1966), which has critiques of Eysenck's behavioral approach by a number of leading psychoanalysts and researchers, including Cleaver, Kubie, Strupp, and Zetzel; (2) George Levinger, "Continuation in Casework and Other Helping Relationships: A Review of Current Literature," Social Work, V (July, 1960), 40-41, which asserts that the length of treatment per se cannot be considered a reliable indicator of successful outcome; (3) Jerome Frank, Persuasion and Healing (New York: Schocken Books, 1965), 15, which states that "there is no evidence that a larger proportion of patients in long-term treatment improve or that improvement resulting from long-term treatment is more enduring than that produced by briefer treatment"; (4) J. N. Shlien, "Cross-Theoretical Criteria in Time-Limited Therapy" in Proceedings of the Sixth International Congress of Psychotherapy, London, 1964, Part IV (Basel/New York: S. Karger, 1965), 121, which reports a study of effectiveness using three experimental groups, from which it is concluded that "time-limited therapy is effective, and twice as efficient as unlimited therapy; and (5) Lillian Rippet, Motivation, Capacity, and Opportunity (Chicago: University of Chicago, 1964), 188, which indicates that in a sub-sample of 71 cases, 40 per cent of the clients with less than 25 interviews had a "favorable" outcome; in sharp contrast, 80 per cent of those who had 25 interviews or more had a favorable outcome.
continuation studies—that continuance is synonymous with effectiveness:

Not only is the validity of this assumption in doubt . . . . but it also diverts attention from one of the most well-documented facts about family agency services—their predominantly short-term character. The continuance studies imply that the task is to find out how short-term cases can be helped to become long-term ones. Another approach, and one that may be more consistent with service realities, is to ask what can be done to increase the effectiveness of short-term casework.¹

Another recurrent value-laden issue facing mental health workers with respect to the use of the time dimension is whether short-term therapy is based on expediency or choice—whether it is dictated by the exigencies of manpower shortages and long waiting lists, or whether it is the preferred form of treatment for certain types of people. In an address delivered before the Fifth International Psychoanalytical Congress in Budapest in 1918, Freud anticipated that there would be certain adaptations in analytic technique in order to provide some form of suitable "psychotherapy for the people": "It is very probable, too, that the application of our therapy to numbers will compel us to alloy the pure gold of analysis plentifully with the copper of direct suggestion."² In the same speech, Freud made specific reference to society's responsibility to


provide mental health services to the poor: "One may reasonably expect that at some time or another the conscience of the community will awaken and admonish it that the poor man has just as much right to help for his mind as he now has to the surgeon's means of saving life."¹

More than fifty years later, Small, almost echoing Freud's words, emphasized that "the single most important public service for a psychotherapeutic profession is to evolve brief psychotherapeutic procedures aimed . . . at the amelioration of symptomatic behavior or of crisis situations" for the masses of citizenry. He estimated that approximately 17 million people were potential recipients of this type of help.² Clearly underlying Small's position were considerations of expediency—that is, the supply of available mental health manpower is not adequate to meet the demand for service.

Some writers have emphasized the use of time-limited therapy as a treatment of choice on the basis of a philosophical rationale. Shlien, for example, has stated his position unambiguously:

We have not been interested in brevity simply because of economy, though supply and demand factors do matter. . . . We are not interested in mass production, 'instant therapy,' or mechanical salvation for incompetent therapists. We are interested in the fact that therapy is never truly interminable, and

¹Ibid., 401.

that since time limits exist, they may be used to some advantage. In essence, this means that time may be infinite, but life is not.1

According to Shlien, emphasis should be placed on the "quality of experience not on the quantity";2 by "quality" he means an energetic investment—by both therapist and patient—in the therapeutic encounter.3

How Short is Short-Term Treatment?

The problem of differentiating short-term treatment from long-term treatment has always been a puzzling one. When asked how long his "brief therapy" would take, Alexander replied that he used the term brief therapy in a "realistic sense"—that is, to refer to a period of time that was shorter than orthodox psychoanalysis.4 When challenged that brief therapy might then mean as many as 65 sessions, Alexander changed the term "brief"—a source of great contention among his analytic colleagues—to the term "flexible" in order to explain the structuring of the time dimension: "Our emphasis is not on briefness but on flexibility and economy achieved by concentration on the therapeutically

1Shlien, op. cit., 118.

2Ibid.


4Alexander and French, op. cit., 145.
pertinent factors. Thus, in Alexander's view, the time dimension was structured not so much in terms of the number of interviews or the duration of treatment but rather in terms of planfully manipulating the frequency of therapy sessions.

In his survey, Malan found little systematic evidence concerning the actual dimensions of short-term treatment, either in terms of number of interviews or length of therapeutic contact. Indeed, Malan himself defined brief therapy in terms of a range of 10 to 40 interviews; Bellak and Small have defined emergency and brief psychotherapy in terms of one through six sessions, each session lasting from 45 to 50 minutes; Wolberg has generally regarded short-term therapy as lasting for no more than 20 interviews, over a period of up to five months; and Sifneos, in a report of seven years experience with short-term psychotherapy, used a wide range, from two to 12 months, to encompass short-term treatment. Arguing not for longer therapy but for more "equitable and efficient use of therapeutic time", Bernard

---

2 Malan, *op. cit.* 34.
5 Wolberg, *Short-Term Psychotherapy*, 140.
has emphasized the importance of the flexible patterning of
the time dimension, to fit the needs of the individual
patient.\textsuperscript{1}

Both the number of interviews and the duration of
treatment considered as falling within the limits of short-
term treatment seem generally shorter in casework than they
are in psychiatry. Garcea and Irwin, for example, have
described a form of "limited contract" service as a type
of short-term therapy, lasting for four to six interviews.\textsuperscript{2}
Gilbert reported an experiment in brief treatment of parents
at Johns Hopkins involving a series of five interviews,
spaced over an 11 week period.\textsuperscript{3} The Community Service Society
has defined planned short-term treatment as lasting up to
eight interviews, following intake, over a period of three
months.\textsuperscript{4} Similarly, the Jewish Board of Guardians has
utilized a period of three months for its planned short-term
treatment program, but, unlike the Community Service Society,
has considered 12 interviews as the cut-off point.\textsuperscript{5}

\textsuperscript{1}Viola W. Bernard, "Dynamic Psychiatry in Relation to
Poverty," \textit{American Journal of Psychiatry}, CXXII (September,
1965), 260-263.

\textsuperscript{2}Ralph A. Garcea and Olive Irwin, "A Family Agency
Deals with the Problem of Dropouts," \textit{Social Casework}, XLIII
(February, 1962), 71-75.

\textsuperscript{3}Anita Gilbert, \textit{op. cit.}, 91.

\textsuperscript{4}Ann W. Shyne, "An Experimental Study of Casework

\textsuperscript{5}Robert Shaw \textit{et al.}, "A Short-Term Treatment Program
and its Relevance to Community Mental Health" (Unpublished
paper read at the annual meeting of the American Ortho-
Thus, there seem to be almost as many interpretations of short-term treatment as there are of the time dimension itself.

Goals of Treatment

Throughout the various usages of short-term therapy, there has been a continuing debate as to whether brief therapy should be equated with "superficial" or "minor" therapy. As previously indicated, there has been a general tendency to equate length of therapy with the efficacy of the therapy. At the 1942 meeting of the Brief Psychotherapy Council in Chicago during World War II, a number of objections were raised against the use of such terms as "major and minor," "superficial and deep" as descriptions of brief psychotherapy. Alexander commented that "treatment is never considered minor by the patient."¹

Frank has differentiated between "symptom relief" (which he equated with distress reduction) and "attitude change." The former is related to what has been referred to as the "placebo effect," induced by the therapist's stimulation of a hopeful expectation regarding help; the latter is more related to the power and prestige of the therapist and his "specific influencing techniques."²

Sellak and Small have defined the goal of emergency psychotherapy and brief psychotherapy as the "quickest

---

¹Proceedings of the Second Brief Psychotherapy Council. 69.
²Frank, op. cit., 208.
possible relief" of symptoms and maladaptations "because of their crippling or endangering nature." Their formulation of emergency therapy has had as its goal the achievement of "homeostasis where equilibrium has been disturbed."\(^1\)

Although they have emphasized a "symptom-directed orientation" to enable the patient to carry his everyday social roles and allow nature's self-recuperative powers to take over, this does not negate the importance of insight.

Because of the shortness of the treatment period, Bellak has commented, the therapist "does not have time to wait for insight to develop; he must foster insight."\(^2\)

Wolberg, too, has stressed utilization of insight as a "corrective force," in order "to relate symptoms to inner conflict," and "to recognize self-defeating defensive mechanisms."\(^3\) Far from accepting the notion that brief therapy is a form of superficial treatment, he has taken the position that "we may ultimately influence the total personality in depth, including the unconscious through short-term therapy." He has also argued that differentiation between "superficial versus deep therapy" is indeed a false dichotomy: "Psychotherapy is no mining operation that depends for its yield exclusively on excavated psychic ore."\(^4\)

---

\(^1\)Bellak and Small, op. cit., 9. 
\(^2\)Ibid., 6. 
\(^3\)Wolberg, op. cit., 143. 
\(^4\)Ibid., 137.
Since this type of work requires considerable experience, Wolberg is in agreement with Bellak that it is not for the novice.

Criteria

Examination of the literature on short-term therapy reveals little agreement on the criteria for selection of cases and much debate on the criteria for measuring improvement. In fact, it may be said, that any case can be long-term or short-term, depending upon a variety of chance factors. Wolberg has frankly taken the position that "the best strategy . . . is to assume that every patient, irrespective of diagnosis, will respond to short-term treatment unless he proves himself refractory to it." However, he has set forth a number of general criteria which fulfill one or more of the following aims: (1) to restore quick re-equilibrium in an "acute neurotic disorder"; or (2) to deal with an acute upset in a "chronic personality disorder"; or, (3) to provide help in a residual category of cases that are unsuited for or are unable to take advantage of long-term treatment, for example, for reasons of finances or availability of time. Included in the latter group are individuals with overly strong dependency drives or ego defects which make the use of the uncovering techniques of long-term treatment inadvisable.

On the basis of intensive study of brief therapy,

\[1\] Wolberg, op. cit., 141-142.
albeit with a small group of cases, Malan has summarized his views regarding criteria as follows: (1) There is no evidence to confirm the view that brief therapy is suitable only for relatively "mild" problems of recent duration, a position taken by Sifneos and other writers; good results, based both on clinical and statistical data, have been obtained in helping patients with "relatively severe" neuroses of long duration; and, (2) contrary to much of the writing in this field, the use of interpretation in dealing with transference is not contraindicated but is indeed an important aid in promoting a positive treatment outcome.¹

Thus, it appears that virtually any case can be considered suitable for short-term treatment, irrespective of diagnostic category, nature of the presenting problem, or other clinical considerations.

Treatment Techniques

In general, the treatment techniques used in short-term therapy have been considered substantially the same as those used in long-term therapy but with certain modifications and adaptations. A primary change in technique is the more active role of the therapist. "Anathema to short-term therapy is passivity in the therapist. Where time is of no object, the therapist can settle back comfortably and let the patient pick his way through the lush jungles of his

¹Malan, op. cit., 274.
Closely related to the importance of constructive activity is the emphasis on the use of focused interviewing. The acceptance of limited but clear-cut goals is another related principle, more emphasized in short-term than in long-term, open-ended treatment. Techniques of "role rehearsal" or "anticipatory guidance" are often used to prepare for stressful situations which the patient is likely to encounter between interviews or after therapy has been terminated. Also important is the proper utilization of community resources to relieve environmental pressures, especially during a crisis period.

The utilization of "adventitious influences" which enhance the therapeutic process—among them the placebo effect which will be considered later as a variant of the self-fulfilling prophecy—has been urged. The therapist in short-term treatment must keep constantly in mind the fact that "people incessantly strive to heal themselves psychologically" and these self-healing efforts are often efficacious. The need for the therapist who does short-term treatment to borrow from other disciplines and schools

1 Wolberg, op. cit., 135.


3 Ibid.


5 Ibid., 133.
of thought has also been pointed out. Since attention is concentrated on the client's present problem in functioning rather than on less relevant childhood antecedents, history-taking is generally used selectively in short-term approaches. Taft strongly criticized the passive therapist whose main function is to listen while the client empties himself of his past.

Short-term therapy places a burden on the worker to make each contact meaningful, a point of view expressed by Taft as well as Reynolds who spoke of the discipline of not being able to put off to other contacts the resolution of foggy portions of an interview. Some writers have commented on the hazards or demands created by the time pressures; on the grounds that the time limit has often induced anxiety which in turn has influenced the therapist toward a kind of overdirective interviewing or excessively narrow focusing of the treatment process. However, Lowry has taken the position that "Just as time may be limited without being limiting, so in short contact casework, the limits of time need not limit our services." Perhaps because of the above mentioned anxiety, the lack produced in the "brevity of the session" satisfaction.

1Ibid., 136.

2Taft, The Dynamics of Therapy . . ., 10.


5Ibid., 56.
situations as real, they are real in their consequences.\textsuperscript{1} Thus, the attention of the investigator should be drawn, not only to the objective features of a social situation, but to equally meaningful subjective factors.\textsuperscript{2} With respect to short-term treatment, the attitudes of the client and the mental health worker toward the therapeutic situation as well as toward each other can often have a crucial impact not only on the therapeutic engagement but also on its continuance and outcome. Equally cogent for the purposes of this brief review is Merton's observation that "a single success proves it can be done."\textsuperscript{3} Thus, if the therapist has experienced success—perhaps in just one short-term case—this experience may well contribute to a mind-set of therapeutic optimism. When communicated in the form of hopeful expectancy to the patient or client, this feeling of optimism may, in turn, influence the course of therapy itself.

In discussing the self-fulfilling prophecy, Frank has stressed that an important source of efficacy for all types of psychotherapy has been the "shared belief" of the patient and therapist that the methods being utilized will actually work.\textsuperscript{4} In more specific terms, Frank has pointed out that one of the elements accounting at least in part for the successful outcome of all types of psychotherapy

\textsuperscript{1}Quoted in Robert K. Merton, \textit{Social Theory and Social Structure} (Glenco, Illinois: Free Press, 1949), 179.

\textsuperscript{2}Ibid.

\textsuperscript{3}Ibid., 195.

\textsuperscript{4}Jerome Frank, \textit{op. cit.}, 3.
in the therapist's ability to arouse the patient's hopeful attitude toward help.\(^1\) Kogan also has referred to the need to improve practice techniques to enhance the client's motivation for constructive problem-solving as well as his "sense of the potential helpfulness of the agency."\(^2\) Within the general framework of the self-fulfilling prophecy, a number of investigators have pointed out that, as part of the shared optimistic belief, the patient tends to formulate his problem in terms of the therapist's frame of reference.\(^3\)

Short-term treatment has often been mentioned as the treatment of choice for "potential discontinuers."\(^4\) Garces and Irwin have attributed the marked lowering of the rate of attrition in cases handled by "limited contract" interviewing (as compared with those handled through open-ended treatment approaches) to the changed attitude of the staff in providing reassurance and hope to potential discontinuers.\(^5\) That is, the worker's wish to engage the client in

\(^{1}\)Ibid., 74.


\(^{3}\)Luther E. Woodward et al., "The Value of Statistical Reporting," loc. cit., 313.


\(^{5}\)Garces and Irwin, op. cit., 73-74.
treatment was probably more effectively communicated be-
cause of the worker's enthusiasm and optimism.

Similarly, Ripple has reported that the most crucial
single service variable in the University of Chicago study
of motivation, capacity, and opportunity was not the
worker's casework skill, "but rather the amount of encourage-
ment given during the first interview." ¹ Ripple's study
also showed that discouragement almost invariably led to
discontinuance of treatment. Only eight out of 178 clients
for whom "service was considered discouraging," continued
to the fifth interview.²

Social Class and Short-Term Treatment

In recent years there has been a great deal of in-
terest in the relationship between a patient's social class
position and the type and amount of psychotherapy which
he is likely to receive.³ Some writers have asserted that
their present time orientation, as well as other aspects
of their life-style, predispose lower and working class
persons toward short-term therapy as the treatment of

¹ Ripple, Motivation, Capacity and Opportunity, 199.
² Ibid., 203.
³ One of the pioneering works in this field is A. B.
Bollingshead and F. C. Redlich, Social Class and Mental
Illness (New York: John Wiley, 1958). For a critique, see
S. N. Miller and E. G. Mishler, "Social Class, Mental
Illness, and American Psychiatry: An Expository Review,"
Milbank Memorial Fund Quarterly, XXXVII (April, 1959),
174-199.
choice.  

In this connection, Bernard has advocated an egalitarian mental health ethic regarding the "equitable" use of therapeutic time. She has warned against the danger of committing unintentional discrimination: "I am currently concerned—as a long-time advocate, myself, of more diversified forms of psychotherapy, including so-called brief psychotherapy—about some implications of a discernible trend toward arbitrarily limiting the kinds of psychotherapy to be provided for 'the poor' to these short-term measures." However, Bernard has conceded that limited-goal, brief-treatment may well be the treatment of choice for certain working and lower class patients who are "exclusively interested in rapid symptomatic relief."

The findings of Coleman and his colleagues, in their comparative study of a psychiatric clinic and a family agency, in general supported the hypothesis that the type

---


3 Ibid., 261.

4 Ibid.
of treatment received by a client in a family agency or a patient in a psychiatric clinic is highly influenced by his social class position.\(^1\) After reviewing a number of studies, Frank has concluded (a) that the higher a person's social class position the more likely he is to be treated over a longer period of time; and (b) that treatment drop-out rates are disproportionately represented by the lower socio-economic group.\(^2\) Differences between client and worker in social class and the lack of congruence in certain values and beliefs have been discussed by Rosenfeld and Shyne as factors in the non-use of or abortive disengagement from treatment.\(^3\) Frank has also observed that it is often harder for many lower-class clients and patients to sustain treatment because of the lack of availability of baby-sitters, difficulty in obtaining time off from work for appointments, and other practical factors.\(^4\)

In addition to the controversy in the literature concerning the extent to which the therapeutic disciplines of psychiatry, social work, and psychology, do or do not serve members of the lower class, there has been question

---


\(^2\) Frank, op. cit., 119.


\(^4\) Frank, op. cit., 247.
about whether the techniques of psychotherapy are different for members of the lower class. Hollis, among others, has argued against stereotyping the poor.\footnote{Florence Hollis, "Casework and Social Class," \textit{Social Casework}, XLVI (October, 1965), 463-471. See also Carol H. Meyer, "Individualizing the Multiproblem Family," \textit{Social Casework}, XLIV (May, 1963), 267-272.} She has stated that the "difference between casework with the average low-income, poorly educated client and casework with the average middle-income, well-educated client . . . are differences in specific techniques and emphases rather than in basic casework method."\footnote{Ibid., 470.} Hollis has agreed that certain changes and innovations in technique are needed and that crucial to any work with the poor is the worker's faith in the client's capability and motivation for change.\footnote{Ibid.} She has also mentioned the concern about providing service at the point of crisis as well as the provision of opportunity for continuing with the same worker who sees the client at point of intake.\footnote{Ibid.}

Summary

On the basis of a review of the literature, crisis, as used in the present investigation, has been conceptualized as a configuration involving the identification of a specific precipitating event; understanding of the person

\begin{enumerate}
\item Ibid., 470.
\item Ibid.
\item Ibid., 468.
\end{enumerate}
affected by that event; consideration of how the person views and feels about the event—whether as a threat or not; analysis of his response to the event in terms of signs of disequilibrium; and, finally, an awareness of the coping efforts of the individual for grappling with the crisis as well as the interventive efforts of the worker.

It is clear from the literature that the length of short-term therapy is an ordinal rather than an interval type of concept; indeed, the literature is often vague in defining the number of interviews or weeks typically used in short-term treatment. Within the context of short-term therapy, time may be viewed as a philosophic concept, a treatment of choice regardless of the problem of scarce resources; or as an expedient measure to enable mental health services to provide more and faster services to a larger number of people; or as a combination of expedient factors and therapeutic desiderata. Some writers regard the use of arbitrary time limits as a device for enhancing client or worker motivation; others have emphasized the capacity of certain clients to tolerate only a limited period of contact, because of psychic disturbances or because of deficiencies in the resources available in their social environment. Actively focused interviewing, emphasis on specific treatment goals, selective history-taking, and follow-up interviews have been presented as typical features of short-term therapy.

The question regarding criteria for the selection
of cases that are suitable for short-term intervention has also been found to be a very thorny one. Clinicians have recognized the difficulty of specifying precisely applicable diagnostic criteria for short-term therapy, since so many variables—problem perception, client capacity and motivation, agency function, and worker's skill—are intertwined. Moreover, at intake virtually any case may be theoretically regarded as short-term or long-term; treatment arrangements for any given case may as often be influenced by expediency as by design. As indicated by Malan's review, in the last analysis the response of the client or the patient to the mental health worker's early supportive and interpretive efforts seem to offer the best practical clinical clue as to which cases will respond to short-term therapy. While stressing the paucity of empirical research on the question of criteria, this brief review has, of course, not pretended to cover the extensive psychotherapy literature, including clinical case study research, concerning the diagnostic basis for the use of various treatment modalities.

Crisis and Time

The importance of proper timing with respect to the prompt availability of help and early intervention at a time of crisis cannot be overemphasized. By definition, crisis intervention means offering help during the period
of disequilibrium when the patient's anxiety and suggestibility are high, when a minimal therapeutic force can have a maximal effect. Other reasons for early intervention include: (1) the actual facts concerning the impact and perception of stress are less likely to be distorted; (2) the more active the patient's conflict, the more amenable he is to treatment; and (3) before a new equilibrium has been set, secondary gain gratification can be avoided, thus intensifying the patient's motivation for help. In terms of the administrative arrangements necessary for the crisis approach, the time elapsing between the application for help and the beginning of treatment should be minimal.¹

Since many crises have been found to be self-limiting, the therapist's intervention should take place during the crisis experience or it may not be effective at all. And because the acute phases of a crisis situation usually extend for only a few weeks, treatment can often be limited to this more or less definable brief period.² Moreover, during this crisis period, treatment goals must be directly and dynamically linked to the key issues with which the individual and his family are struggling.

With respect to the spacing of interventive efforts,


CHAPTER III
STUDY DESIGN AND METHOD

Study Design

This is a descriptive-exploratory investigation.1 The main study instruments were two mailed questionnaires. The first was designed to locate the study sample and the second to furnish detailed program information regarding planned short-term crisis-oriented services in family agencies and child guidance clinics.2 As indicated by the review of the literature in the previous chapter, the state of knowledge regarding both the crisis concept and the use of planned short-term treatment is rudimentary.3 Thus, the writer believed that a base-line empirical study, with documentation concerning certain aspects of the

1The study sample included 54 FSAA agencies and 44 AAPCC clinics; details concerning sample selection will be given in the next chapter.

2This study is part of a national three-stage study of planned short-term treatment services, jointly sponsored by AAPCC and FSAA. Stage I consisted of a "locator questionnaire" to obtain the study sample; Stage II, "a general program questionnaire" to provide detailed information concerning the agencies and clinics under study; Stage III, case schedules concerning PSTT cases opened and closed during a designated period. Stage III, now in process, is beyond the scope of the present inquiry.

3Henceforth planned short-term treatment will be abbreviated as PSTT.
crisis approach and the use of time-limited treatment, was indicated.¹

This study is descriptive in the sense that selected characteristics of two phenomena—the use of the crisis concept and the structured use of the time dimension—were studied within two specified samples—child guidance clinics that belong to AAPCC and family agencies that belong to FSAA. A descriptive approach also facilitated study of similarities and differences between the AAPCC and FSAA sample groups.

The dilemma facing the present researcher was that of avoiding an operational definition of PSTT which was either too tight or too loose—too restricting or too all encompassing. And, as pointed out in the review of the literature, since the problem under study—the use of time-limited crisis-oriented services—did not involve easily measured unitary phenomena, the matter of definition in itself became an extremely complex and elusive one.²

Since there was no logical way of differentiating short-term from long-term treatment through an acceptable definition of the length of time involved, the phenomenon


²Hyman has discussed both the importance and the difficulties involved in conceptualization of the phenomenon to be studied in survey research. See Herbert Hyman, Survey Design and Analysis (Glencoe, Illinois: The Free Press, 1955), 63-74.
"planned short-term treatment" was operationalized as a variable to be studied in this investigation. In other words, it was impossible to study short-term therapy without some reference to the specific ways in which time was structured as a meaningful dimension of human experience. Thus, it became necessary to operationalize planned short-term treatment in terms that would make it clear that the mental health worker (psychiatrist, psychologist, or social worker) had the intention of limiting treatment—through a specific or approximate number of interviews or weeks. The operative words were "intention" and "limiting", used here to differentiate "planned" short-term cases (short-term by design) from "unplanned" short-term cases—that is, treatment drop-outs (short-term by default).

With these considerations in mind, the following definition of "planned short-term treatment" (PSTT) was adopted:

**Planned short-term treatment** means that certain cases are designated at the point of application, referral, intake, or shortly thereafter to receive a more or less limited number of in-person interviews and/or to be seen over a more or less limited period of time. It does not refer to case situations where the agency (clinic) contact is ended on an "unplanned" basis against the advice of the case-worker (therapist) nor to those where an early closing is mutually agreed upon by family and worker (therapist) at the point of termination.  

---

1In arriving at this operational definition, the writer was influenced by the formulation of the PSTT program now in operation in the Community Service Society in New York. Here PSTT is regarded as service which is given "within not more than eight in-person client interviews and not more than three months after the completion of intake." See Ann W. Shyne, "An Experimental Study of Casework Methods." *loc. cit.* 536.
The above definition represented a compromise between an excessively tight definition—which would have arbitrarily specified a given number of interviews or period of time—and an excessively loose definition—which would have included cases that were not short-term by design. Thus, this definition of PSTP made it clear that the time dimension had to be structured in advance, shortly after the case was accepted for treatment. While the exact point at which this treatment decision was made of course varied from one program to another, cases that became short-term during the middle or later phases of treatment were not considered PSTP. It should also be emphasized that the word "treatment" was specified in the definition in order to rule out purely diagnostic or informational types of brief service.

Definition of Crisis

As indicated in the previous chapter, the following elements were included in the stress-crisis configuration for the purpose of this study: A specific and identifiable stressful event; the perception of the event as meaningful and threatening; the response to the event as manifested in the period of disorganization or disequilibrium; and the coping tasks and interventive efforts that are involved in the adaptive or maladaptive resolution of the crisis situation.

The link between the operational definition of the
planned use of the time definition and the formulation of
the crisis as a configuration consisted largely in the
rationale for intervention during the period of disorganiza-
tion or disequilibrium. This rationale was based on:
(a) immediate availability of PSTT service, as close as
possible to the perception of crisis impact; and (b) maximum
accessibility during the response and resolution phases of
the crisis.

These operational definitions have been conceptualized
in a preliminary paradigm (See Table 3. 1). As indicated
in this table, there are four logical service categories
with respect to the dimensions of crisis and time as
operationalized for the purposes of this study. These
are: (1) PSTT crisis-oriented services; (2) non-PSTT
crisis-oriented services; (3) PSTT non-crisis-oriented
services; and (4) services that are neither PSTT nor
crisis-oriented. The present study is concerned with the
crisis-oriented PSTT (+ +) and non-crisis oriented PSTT
(- +) cells, with emphasis on the former. Obviously, the
non-PSTT cells (+ -) and (- -) are by definition beyond the
scope of this survey. The table also clarifies that (a)
not all brief service programs are oriented to a crisis
framework, and (b) not all crisis-oriented programs are
grounded exclusively to brief service approaches.
<table>
<thead>
<tr>
<th>Crises-Oriented</th>
<th>(++)</th>
<th>Non-Crises-Oriented</th>
<th>(-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) early accessibility at time of crisis perception and response; no waiting period</td>
<td>(1) early accessibility at time of crisis perception and response; may be short waiting period</td>
<td>(2) open-ended orientation toward time dimension</td>
<td>(2) use of PSTT limits (specific number or approximate range of interviews or weeks) during crisis response and resolution phases</td>
</tr>
<tr>
<td>(1) may be short or long waiting period</td>
<td>(1) may be short or long waiting period</td>
<td>(2) open-ended orientation toward time dimension; no use of PSTT limits</td>
<td>(2) use of PSTT limits (specific number or approximate range of interviews or weeks)</td>
</tr>
<tr>
<td>(3) no special attention to crisis configuration</td>
<td>(3) no special attention to crisis configuration</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*This preliminary paradigm is presented here to diagram the rationale for the present study's focus on time and crisis factors. The components in the two PSTT cells (+ +) and (- +) will be discussed in detail in Chapters V and VI of this report.*
Questionnaire Instruments

Two basic study instruments were used in this investigation: The Stage I locator questionnaire and the Stage II general program questionnaire. The former was designed to obtain the study sample, the latter to provide detailed information about program rationales and processes as well as staff attitudes about the program.

When authorization for conducting the study was received from the two sponsors, AAFCC and FSAAA, informal estimates were obtained from professional personnel in the headquarters offices of these two national organizations regarding the number of agencies and clinics that would probably (a) fit the PSTT operational definition and (b) complete the instruments required for participation in the study. These informal estimates ranged between ten and fifteen for each of the sample groups; thus, it was thought that there would be 20-30 programs that would meet the criteria for inclusion.

The only feasible method of obtaining a sample was through the use of the Stage I locator questionnaire.¹

The following key questions were included:

(1) Does your agency now have in operation a planned "short-term treatment program"? (PSTT study definition, previously referred to, was given here.) If Yes, please check the items below that apply to your agency:

(a) Certain cases are designated at intake or shortly thereafter to receive an approximate number of interviews or to be seen over an approximate period of time.

¹See Appendix A. 1.
(b) Certain cases are designated at intake or shortly thereafter to receive a specific predetermined number of interviews or to be seen over a specific, predetermined period of time.

(3) If your answer to question 1(a) is No, do you have an informal program of short-term service which you do not think meets the study definition of PSTT?

(a) If you have an informal program, please describe your program.

In addition, the locator questionnaire elicited the following material: (1) the date on which PSTT had been established; (2) the number of cases open during the month of January, 1965; (3) whether there were special services for emergency situations; (4) whether there was a waiting list, and if so, the number of cases on the waiting list; and (5) whether, if not now in operation, PSTT was contemplated for the future (this was asked in order to include those programs about to begin PSTT). In addition, respondents were asked to check the one item that most nearly described their agency's thinking about the professional advisability of offering PSTT; the choices ranged from "strongly disapprove" to "strongly approve" and included a "no opinion" option.

The answers to these questions were extremely helpful in developing the major content areas in the Stage II questionnaire.

On the basis of experience with the Stage I locator questionnaire, it seemed advisable to utilize a combination of structured, unstructured, and semi-structured
questions in order to (a) obtain comparable data for certain questions; (b) give respondents maximum freedom in presenting factual and attitudinal material that seemed important to them; and (c) provide opportunities to check the internal consistency of the respondents with respect to certain key items. The questionnaire was designed to provide space for respondents to add comments on important questions; respondents were urged to append extra statements and to use extra paper for additional formulations whenever they deemed such a step necessary. In each major content area of the questionnaire, a combination of questions and a variety of approaches—structured, unstructured, and semi-structured—were used to provide for maximum participation and information from the respondents.

The Stage II general program questionnaire was divided into the following sections:

1. identifying information to characterize the study sample and to be used subsequently to compare the study samples with the AAPCC and PSSA membership universes;
2. intake data concerning application and waiting list procedures;
3. time factors, which elicited information concerning the use of a predetermined or approximate number of interviews or weeks for treatment, and related information;
4. case criteria concerned with the selection of cases for PSET;
5. treatment factors which dealt with the goals and techniques of treatment, as well as certain ideological sentiments; and,
6. program

---

\(^{1}\text{See Appendix A. 5.}\)
factors which sought information concerning theoretical formulations, case evaluation procedures, research activity, and staff attitudes.

Since it would be inappropriate to give a detailed presentation concerning the researcher's rationale for including each of the items in this questionnaire, a brief review of three key areas, pertinent to the six categories mentioned above, will be presented. These are: (1) theoretical formulations, (2) practice processes, and (3) administrative procedures.

Theoretical Formulations

Recognizing that "crisis intervention" was in a fair way of becoming a bandwagon movement, the present writer did not wish to ask direct questions concerning the crisis approach early in the questionnaire because he thought that such questions would probably contaminate subsequent responses.1 Thus, at the very outset, the tactical decision was made not to introduce the term "crisis" until the latter part of the Stage II general program questionnaire (in the section titled "Program Factors.")

The crisis-related query was deliberately located last in a series of five possible rank order choices; respondents were requested, in the light of their agency's experience, to rank order a series of items (pressures of

---

1The word "crisis" was not mentioned in the instructions for the Stage II program questionnaire. During this phase of the inquiry, the title of the investigation was "F3AA-AAFCC Planned Short-Term Study Project," thus emphasizing the time factor rather than the crisis approach.
long waiting list, scarce professional personnel, handling purely informational requests, offering a training experience for students, meeting the needs of clients in crisis situations) which had been often referred to as reasons for initiating PSTT. By locating the crisis question in the number five position, an effort was made to avoid influencing respondents to select this item unless it was actually related to the rationale for their PSTT services.

If respondents elected "meeting the needs of clients in crisis situations" as a reason for initiating PSTT, they were asked to give a narrative explanation of their agency's definition or formulation of "crisis."

Another question concerning theoretical formulations did not refer at all to crisis: "Briefly, what is the theoretical rationale that underlies your planned short-term treatment services?" Here, again, it was assumed that only certain respondents would actually formulate their PSTT theoretical rationales in crisis terms.

Practice Processes

Also included in the questionnaire was a group of items eliciting information concerning the practice processes associated with PSTT in such areas as the use of a predetermined number or range of interviews or weeks of treatment; the upper limit for the time range used in PSTT; the rationale for using a particular number or range of interviews or weeks; agency or clinic practice regarding
case assignment after the expiration of the time limit; reasons why PSTT was considered effective; and the utilization of special PSTT treatment techniques.

Administrative Procedures

Finally, a number of questions were designed to tap both factual and attitudinal information concerning a variety of administrative procedures that were thought to be relevant to a crisis approach or a time-limited approach, or both. These included questions about waiting lists and application forms; whether there was a routine exploratory period for PSTT cases as compared with non-PSTT cases; whether PSTT cases, in contrast to non-PSTT cases, were reassigned after the intake period; whether PSTT was offered in a special or integrated administrative unit within the agency or clinic; whether provisions were made for immediate service following application for help; and, whether there were planned follow-up, research, and training procedures for PSTT services.

Rationale for Questionnaire Items: Summary

The writer intended to examine the data concerning "crisis" formulations to test the extent to which certain components of the crisis configuration (event, perception, response, resolution) were or were not present. It was thought that respondents who were crisis-oriented would, in more or less specific terms, think of (a) a precipitating event which (b) led to a state of disequilibrium or
disorganization in individual or family functioning which required (c) certain coping efforts on the part of the individual and family and prompt but time-limited intervention on the part of the worker or therapist.

With respect to the structured use of the time dimension, it was assumed that the pertinent questions in the study instrument would elicit factual data as to precisely how the time-limits were structured, as well as whether program conceptions of PSTT did in fact meet the requirements of the study definition (that is, an indication of intent to limit treatment to a specific number or approximate range of interviews over a specific or approximate period of time shortly after intake).

A number of assumptions were also operative regarding the presence or absence of selected administrative procedures which were thought to facilitate the crisis approach, or a time-limited approach, or both. The main assumptions tested here were (1) whether respondents claiming to utilize the crisis approach required applicants for help to wait for a long period of time before they were actually seen for treatment interviews; (2) whether help was made available during a crisis period; (3) whether cases were reassigned to another worker after the intake procedure; and (4) whether there were administrative provisions for follow-up of cases toward the end of or after the crisis sequence.
Protests

Both the Stage I locator questionnaire and the Stage II program questionnaire were pretested. Prior to the construction of the locator questionnaire, the researcher met with a group of 16 workers from psychiatric clinics and social agencies who were attending graduate seminars at the Smith College School for Social Work in July, 1964. This group reviewed and criticized the items used in a preliminary locator questionnaire which they filled out. On the basis of this experience, a new questionnaire was developed and pretested in four AAPCC clinics and five FSAA agencies. The Stage I locator questionnaire was mailed on February 1, 1965.

The general program questionnaire was pretested among a small group of clinics and agencies, including three AAPCC clinics and four FSAA agencies, to make sure that the questionnaire items were unambiguous and meaningful. Pretest respondents were asked to comment on the time spent in completing the questionnaire and to offer any relevant criticisms. A few minor revisions in wording were made on the basis of the pretest. The general program questionnaire was mailed on October 7, 1965.

Sponsorship

In the light of the writer's interest in studying time-limited crisis-oriented services in two types of basic mental health programs, family agencies and child guidance clinics were considered appropriate for this purpose, since
they are usually designated as mental health resources.\textsuperscript{1} In addition, it was important for the implementation of the study to have sponsorship from the parent accrediting organizations in order to encourage their membership affiliates to participate in the research. Both AAPCC and FSAA provided joint sponsorship for the study, thus fulfilling an important organizational precondition for undertaking the research. Because of the accrediting requirements in AAPCC and FSAA, it could be assumed that the membership group within each sample met certain criteria with respect to staff qualifications and program. In addition, it was considered advantageous to have two study samples which dealt with patients and clients with similar problems (in the area of parent-child and family relationships) but which were known to have some organizational differences. It was also assumed that the child guidance clinics and family agencies, with their interest in therapeutic and program experimentation, would be well-motivated for participation in the study.

\textbf{Staff Involvement in Completing Questionnaires}\textsuperscript{2}

To a gratifying extent, the schedule instructions for completion of the Stage II general program questionnaire were followed by both clinics and agencies. The FSAA

\textsuperscript{1}\textit{Supra.} 3.

\textsuperscript{2}There were 54 FSAA and 44 AAPCC questionnaires which met study requirements.
questionnaire was to be filled out by the director of casework (or the person in charge of the casework program) after consultation with the executive director, agency supervisors, and other knowledgeable staff members. The questionnaire was completed by the director of casework in 30 agencies, by the executive director or associate director in 14 agencies, and by the supervisor of casework in seven. One questionnaire was filled out by each of the following: a senior caseworker, a director of a short-term treatment project, and a research coordinator. The executive director was consulted in 32 of the 40 agencies in which the director or the associate director did not take direct responsibility for filling out the questionnaire.

The AAPCC instructions requested that the questionnaire be filled out by the chief psychiatric social worker (or the staff member in charge of the casework program) after consultation with the chief psychiatrist, chief psychologist, clinic supervisors, and other staff members who were knowledgeable about the clinic's program. Forty-one of the questionnaires were filled out by the chief psychiatric social worker, two were completed by the chief psychiatrist, and one by the chief psychologist. In two of the three clinics where the chief psychiatrist was not consulted, the coordinator of children's psychiatric services served as the consultant, and in the third the associate chief served as consultant. The chief psychologist was consulted in 33 of the 44 clinics.
The actual details of staff participation in filling out the questionnaires are difficult to assess. It was hoped that the questionnaire would be discussed with colleagues either informally or in staff conferences. The questionnaire section entitled "Identifying Data" (see Appendix A: 5) asked only for the names and titles of staff who were consulted. The average number of persons involved in filling out the questionnaire was three for both FSCA and AAPCC. However, four persons were involved in 23 agencies and clinics, and five or more in an additional 23 agencies and clinics.

The numbers involved are more meaningful in relation to the size of the agency or clinic. For example, in the smaller agencies and clinics (with under five workers) there was total participation of staff on the part of almost all respondents. Through their supplementary comments, some of the medium-sized agencies indicated greater involvement of their staffs than was apparent in the mere listing of names on the questionnaire face sheet. For example, the following note, appended to the completed questionnaire, was received from an agency with a staff of 16: "We consulted the executive director and staff having intake responsibility in branch offices and the central office, as well as workers having special case loads, that is, those dealing with the aging and unmarried mothers." Similarly, a clinic that listed only three names on the questionnaire face sheet consulted "the psychiatric
director, chief clinical psychologist, and, in group con-
ferences, all six social work staff members."

It is interesting that the questionnaire responses
for four of the largest family agencies were among the
lowest in numbers of persons consulted. In two large
agencies, the directors of casework did not list the names
of other staff members; in a third agency, one staff member
was consulted; and in a fourth, three were consulted.
However, on the basis of materials appended to the ques-
tionnaires, it could definitely be established that these
questionnaires represented not the thinking of one person—
or even of a small group within a large functionally
specialized organization—but rather the distillation of
agency policy which had evolved through a complex system
of supervisory, staff discussion, seminar, and committee
meetings. Furthermore, these agencies were more likely
to append formal policy statements concerning PSTT (includ-
ing carefully worded criteria for PSTT case selection).
Moreover, correspondence made it clear (in both the Stage
I locator and Stage II general program questionnaires)
that many agencies and clinics utilized the study instru-
ments as a springboard for staff discussion. This was
especially true of those agencies and clinics that were
just beginning to grapple with the problems of initiating
PSTT programs.

Of primary interest in the multidiscipline child
guidance clinics was the extent of involvement of the
three disciplines. All three disciplines participated in the filling out of the questionnaires in 33 clinics and two disciplines in ten clinics. The one clinic in which the questionnaire was filled out by a social worker only was one of the largest in the country where—as with the larger family agencies—a great deal of interdisciplinary staff discussion had taken place. This clinic had also contributed a number of professional publications concerning the material covered in the questionnaire.

Thus, it may be reasonably concluded that the instructions for having key staff members participate in completing the questionnaires were followed by virtually all respondents.

Coding Procedures and Inter-Coder Reliability

Detailed code instruction sheets for the Stage II questionnaires (the focus of the present study) are included in Appendix C. Since the questionnaires were pre-coded, there was no reliability problem except in connection with semi-structured and unstructured narrative responses. The following open-ended items required inter-coder reliability checks: (1) specific criteria used for the selection of P
def cases; (2) group treatment services; (3) procedures for case evaluation at the end of a specified treatment period; (4) the theoretical rationales underlying P
def; and (5) special staff development or training programs that were established in preparation for or as part of P
def.
The following procedures were used to check inter-coder reliability in classifying the responses to these narrative questions:

The study samples of 54 agencies and 44 clinics were divided into sub-samples, which were selected randomly (every other one) after they were all placed in alphabetical order by states. Thus, there were 22 in each AAPCC sub-sample, and 27 in each FSAA sub-sample. One sub-sample was used to develop coding instructions; the other was set aside to be used for the subsequent reliability check.

When the code instructions were completed, the narrative items in the samples that had been set aside were independently coded by a professional worker (a clinical psychologist who had not had any experience in a family agency or a child guidance clinic) and the present writer. After disagreements were noted on inter-coder reliability forms, they were reconciled by consensus. The independent coding procedure, followed by consensual discussion, was utilized in both the AAPCC and the FSAA samples. All other narrative items were then scored by only one of the two raters.

The overall reliability rate was 84.5 percent for all narrative items, which was considered quite satisfactory for this study. The highest rate of agreement, 45 agreements out of 48 judgments to be made (or 93.8 percent) was in relation to a highly important question, PSTT theoretical rationale. The lowest rate of agreement, 79 agreements in judging 101 responses (or 78.2 percent) was in
relation to the criteria used for the selection of PBT cases. This was a difficult item which involved classifying responses within a range of 11 possible choices.

Since the crisis concept is central to this study, it is worthwhile to illustrate some of the "crisis" criteria listed by respondents concerning the selection of cases for PBT. One coding category included narrative responses which mentioned "stress" or "crisis" situations using one or more of the following: "strong ego, strong motivation for help, recency of onset, specific etiology, or naturalational stress." Examples from respondents included the following: "Persons with relatively healthy egos in stress situations"; "families under stress because of naturalational hump"; "adequate, well-integrated client-functioning impaired by crisis"; "client--ordinarily self-sufficient--with situational or developmental crisis"; and "child in a developmental crisis where brief help to the parents and/or child may set the course in a better direction."

In addition, it may be helpful to give examples of another "crisis situation" coding category. This category was defined as follows: "Crisis situation or stress, using one or more of the following: weak ego (pathological or borderline personality problems), weak peer motivation for help, multiple problems ('multi-problem' or 'hard-core' individual or family situations) recurrent crisis in re-opened case, or acute eruption of chronic crisis." Examples
of PSTT criteria responses that were coded within this
category included: "Client with long-standing chronic
problem has short-term experience of treatment with follow-
up during crisis period"; "poorly defended but functioning
until stress occurred"; "limited goal treatment--crisis and
chronic stress"; "chronic problems, family seeking relief
from stressful situations"; and "acute crisis in families
with chronic psychosocial and economic problems."

The Problem of Validity

Face validity only can be claimed for the present
study. As previously indicated, the instructions for com-
pleting both the Stage I locator and the Stage II general
program questionnaires were easily followed by the respond-
ents. The questions seemed logical and reasonable to
virtually all respondents; this was demonstrated by the
fact that there was no difficulty in answering questions,
either during the protest phases or during the actual com-
pletion of the questionnaires. Moreover, an independent
professional judge (who coded narrative items) and the
present writer both believed that the questionnaire items
actually elicited an appropriate range, quantity, and
quality of factual and attitudinal data. Also contribut-
ing to the face validity of this inquiry was the fact that
all questions were relevant to the study issues and seemed
to accord with customary professional usage. Of the 98
respondents who agreed to complete all the required study
instruments, only two complained about the design of the questionnaire, and these complaints were minor ones. On the other hand, a number of respondents wrote unsolicited testimonials to indicate that they and their fellow staff members had found the opportunity of participating in this study helpful and stimulating because of their shared interest in crisis-oriented brief services. Finally, there was an acceptable level of staff participation in replying to the questionnaires, as was pointed out earlier in this report.

Methods of Data Analysis

As indicated in the previous discussion of inter-coder reliability, content analysis was used in relation to all narrative items, which were coded in preparation for IBM data-processing. Methods of statistical analysis were used whenever feasible. This study produced mostly nominal data, a fair amount of ordinal data on certain rank order questions, and occasional interval data. Thus, in general, non-parametric tests of significance were used.¹

¹A "program assessment" scoring device, based on an analysis of questionnaire responses, will be discussed in Chapter VI both with respect to theoretical rationale and statistical analysis.
CHAPTER IV
SAMPLE SELECTION AND CHARACTERISTICS

Selection of Sample

A total of 54 FSAA agencies and 44 AAPCC clinics met the following criteria for inclusion in the study:

(1) The agency or clinic reported in the Stage I locator questionnaire that it offered P3TT\(^1\) services which met the study definition of planned short-term treatment; or

The agency or clinic reported in the Stage I locator questionnaire that it offered an informal program of short-term service which, in the opinion of two independent raters, met the study definition of P3TT.

(2) The agency or clinic confirmed that an ongoing P3TT program was actually in operation at the time of the present investigation by completion of all of the study instruments, including the Stage II program questionnaire and the Stage III schedules on individual cases assigned to P3TT during a designated period (November 1, 1965 to January 28, 1966).\(^2\)

---

\(^1\)P3TT has been defined in Chapter III.

\(^2\)As previously indicated, while the present investigation is a part of the total FSAA-AAPCC Planned Short-Term
The preliminary stage of this study was concerned with locating those FSAA agencies and AAPCC clinics which offered PSTT services. A locator questionnaire was sent to all FSAA agencies (N=327) and AAPCC clinics (N=155) which were affiliated as of February 15, 1965. Of these, 314 FSAA agencies (96 percent) and 143 AAPCC clinics (92.3 percent) responded to the questionnaire.

Fifty-six of the FSAA agencies (17.8 percent) replied that they had PSTT programs that seemed to meet the study's definition of PSTT. An additional 135 agencies (43 percent) reported that they had "informal" programs of short-term treatment which they did not think met the study's definition of PSTT. Of the 143 clinics responding to the locator questionnaire, 64 (44.8 percent) had PSTT programs which apparently met the study's definition and 57 (39.9 percent) had "informal" programs. One hundred and twenty-three agencies and 22 clinics replied that they had no current PSTT program; these were automatically excluded.

The 56 FSAA agencies and 64 AAPCC clinics, self-designated as offering PSTT services, were asked to participate in the major phase of the total FSAA-AAPCC study (involving

---

Treatment Study Project, it is not concerned with the analysis of Stage III case schedule material. The present study is focused on the Stage II program questionnaire.

1Agencies and clinics reporting PSTT programs were requested to provide confirming material in questions asking for (a) the specific predetermined number or approximate range of interviews or weeks used in PSTT; (b) the date their program started; and (c) the number of families served in PSTT through in-person interviews from January 1, 1965 to January 31, 1965.
completion of a detailed program questionnaire and PSTT case schedules).

The narrative responses of the agency and clinic programs described as "informal" \(^1\) were read independently by two raters \(^2\) to check whether they met the PSTT study criteria for selection. It was decided to exclude from the study those family agencies which clearly stated that informal short-term treatment was restricted entirely to the following types of concrete services: (1) cases requesting homemaker service; (2) cases requiring financial aid; (3) routine legal aid referrals for "social evaluation"; and (4) requests for services for the aged involving placement in homes or institutions for the aged.

Finally, certain clinics and agencies were excluded if it seemed clear that the time limitation was utilized only as an intake or diagnostic study period to determine whether long-term treatment was indicated. Put more positively, a criterion for inclusion in the study was that a limited number of interviews or weeks of treatment (whether a specific pre-determined number or an approximate range) was viewed by the respondent as constituting a meaningful unit of treatment.

\(^1\)Agencies and clinics with an "informal" program of short-term service which they thought did not meet the study definition of PSTT were asked to describe their "informal" program. Many respondents appended detailed supplementary statements. For the actual wording of these items, please see Appendix A. 1.

\(^2\)In addition to the present writer, a professionally trained social worker served as a rater for this phase of the study.
Examples of the types of responses excluded were:

(1) those agencies which stated they had an informal program, but the short-term period was "not planned, but rather a part of the casework process"; (2) those which vaguely referred to short-term treatment as "a result of the mutual definition of goals based on the client's need and the worker's assessment of it"; or (3) those which clearly disavowed the use of a pre-planned time limit: "We recognize at intake those cases which might be short-term in the same way that we give recognition to those cases which may be long term. All are individually evaluated at intake, but certainly with no specific time limit or number of interviews."

With respect to the 192 agencies and clinics reporting informal programs, there was agreement between the raters concerning inclusion or exclusion from the sample on 186 cases (97 percent agreement). The few disagreements were resolved by discussion between the raters.

Of the 135 PSAA agencies having informal programs, 42 were asked to participate in the major part of the study and 30 of the 57 AAPCC clinics were asked to participate further. The intention was to encourage participation in the study by all agencies and clinics which seemed to have a PSTT program, although they had elected in the locator questionnaire to indicate that theirs was an informal rather than a structured program.

Of the 192 agencies and clinics asked to participate, 54 agencies and 44 clinics agreed to complete all study
instruments including the submission of PSTT case schedules.\(^1\) Thus, 94 agencies and clinics did not participate in the study. Of these, 32 stated they did not actually offer PSTT services; the remaining 62 declined to participate.\(^2\) Of these non-participants, 23 gave "lack of time or staff" as their reason for not participating, 15 cited "change of staff," and 24 offered no reason, despite the writer's use of two follow-up letters to encourage maximum participation. There are no data available to permit any meaningful comparison with respect to PSTT program operation or rationale between the participant and the non-participant groups. Thus, it must be emphasized that any findings or conclusions drawn from this study apply only to the 98 participating agencies and clinics. A special follow-up study of the non-participants would be necessary to determine the extent to which such PSTT services as are offered by them are similar to those within the study sample. However, such a study is beyond the scope of the present investigation.

The remainder of this chapter will present the major differences and similarities between the AAFCC and FSAA sample groups and the total memberships of their respective accrediting organizations.

---

1Detailed information concerning sample loss is in Appendix Table D. 1.

2There were no significant differences between these 62 non-participants (29 AAFCC and 33 FSAA) and the sample respondents regarding regional distribution, size of population served, or the presence of a waiting list. However, there were proportionately fewer FSAA agencies with small staffs (less than 7 staff members) in the study sample \(\{x^2=11.68, df=5, p<.05\}\). Size of staff data were not available for AAFCC non-participants.
Regional Distribution

Table 4.1 presents data concerning the regional distribution of the sample and non-sample AAPCC clinics.

**TABLE 4.1**

REGIONAL DISTRIBUTION OF PSTT AND NON-PSTT AAPCC CLINICS (N=143)

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Clinics&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PSTT</td>
</tr>
<tr>
<td>North Atlantic</td>
<td>14</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>9</td>
</tr>
<tr>
<td>Southeastern</td>
<td>4</td>
</tr>
<tr>
<td>Midwestern</td>
<td>8</td>
</tr>
<tr>
<td>Southwestern</td>
<td>6</td>
</tr>
<tr>
<td>Western</td>
<td>3</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>44</strong></td>
</tr>
</tbody>
</table>

<sup>a</sup>Source: Stage I locator questionnaire

With respect to regional distribution, there is no significant difference between the AAPCC sample and the non-PSTT group in the total AAPCC membership. Table 4.2 presents similar data for the F5AA agencies.

<sup>1</sup>n.s. = non-significant statistically.
TABLE 4.2
REGIONAL DISTRIBUTION OF PSTT AND NON-PSTT PSAA AGENCIES\(^a\)
\((N=322)\)

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PSTT</td>
</tr>
<tr>
<td>North Atlantic</td>
<td>11</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>6</td>
</tr>
<tr>
<td>Southeastern</td>
<td>8</td>
</tr>
<tr>
<td>Midwestern</td>
<td>18</td>
</tr>
<tr>
<td>Southwestern</td>
<td>3</td>
</tr>
<tr>
<td>Western</td>
<td>8</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>54</strong></td>
</tr>
</tbody>
</table>


As with the child guidance group, there is no significant difference between the PSTT and non-PSTT groups.\(^1\)

Thus, the regions with the largest number of clinics and agencies also had the largest number of PSTT respondents. The largest number of family agency respondents (18) were in the Midwest; in contrast the largest number of AAPCC sample participants (14) was located in the North Atlantic region.

\(^1\)Findings are considered "significant" when differences are sufficiently great so that \(p<.05\).
Size of Population Served

There was a significant difference between the size of population served by AAPCC sample clinics as compared with clinics within the total AAPCC membership. The difference in distribution is presented in Table 4.3.

**TABLE 4.3**

<table>
<thead>
<tr>
<th>Population</th>
<th>PSTT (N=44)</th>
<th>Non-PSTT (N=99)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 100,000</td>
<td>2</td>
<td>35</td>
</tr>
<tr>
<td>100,000 - 199,999</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>200,000 - 499,999</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>500,000 or more</td>
<td>23</td>
<td>24</td>
</tr>
</tbody>
</table>

(x²=16.00, df=3, p<0.01)

*Source: Stage I locator questionnaire*

Whereas 35 out of the 99 non-sample AAPCC clinics were located in communities with a population under 100,000, only 2 of the 44 sample group were located in communities of this size. Thus, the smaller communities were definitely under-represented in the sample. Consequently, there were proportionately more PSTT services in larger communities than in smaller communities; as indicated in Table 4.3, 35 of the sample clinics were located in communities that serve 200,000 or more. The largest
number of sample clinics served communities with a population of 500,000 or more. One may speculate that the reason for the proportionately larger number of PSTT services in the larger population areas is that these clinics have experienced greater community pressure for service and have found PSTT a way of using scarce staff resources to help more people. Whatever the reason, it is clear that 79.5 percent of the AAPCC sample were located in communities of 200,000 or over in contrast to only 49.5 percent of the 99 non-PSTT clinic group.

Table 4.4 presents similar data for the size of population served by the FSSAA sample group.

<table>
<thead>
<tr>
<th>Population</th>
<th>PSTT (N=54)</th>
<th>Non-PSTT (N=268)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 100,000</td>
<td>7</td>
<td>43</td>
</tr>
<tr>
<td>100,000 - 199,999</td>
<td>10</td>
<td>65</td>
</tr>
<tr>
<td>200,000 - 499,999</td>
<td>19</td>
<td>86</td>
</tr>
<tr>
<td>500,000 or more</td>
<td>18</td>
<td>74</td>
</tr>
</tbody>
</table>

\(x^2=1.57, \text{ df}=3, \text{ n.s.})


In contrast to the clinics, there was no significant difference between the size of population served by the
FSAA sample as compared with the non-sample group. Only a slightly larger proportion (statistically non-significant) of FSSTT agencies were located in the larger communities (37 out of 54, or 68.5 percent) as compared with the non-FSSTT family agency group (160 of 263 in communities serving 200,000 or more, or 57.9 percent). Of the 98 AAPCC and FSAA programs in the study 72 (73.5 percent) were located in the larger communities.

Size of Staff

Table 4.5 provides information concerning distribution by size of staff within the AAPCC and FSAA study groups.

<table>
<thead>
<tr>
<th>Size of Professional Staff</th>
<th>AAPCC (N=44)</th>
<th>FSAA (N=54)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Percent</td>
</tr>
<tr>
<td>Under 5</td>
<td>3</td>
<td>6.8</td>
</tr>
<tr>
<td>5 - 6.5</td>
<td>6</td>
<td>13.6</td>
</tr>
<tr>
<td>7 - 10.5</td>
<td>14</td>
<td>31.8</td>
</tr>
<tr>
<td>11 - 19.5</td>
<td>12</td>
<td>27.3</td>
</tr>
<tr>
<td>20 - 49.5</td>
<td>9</td>
<td>20.5</td>
</tr>
<tr>
<td>50 and over</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>No response</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Totals</td>
<td>44</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Weighted totals are used: two part-time staff members equal one full-time staff member. This is in accordance with standard FSAA statistical procedure.*
While, by inspection, it would seem that the proportion of family agencies with small staffs (five or under) was greater than the equivalent group within the AAPCC sample (22.2 percent as compared with 6.8 percent), differences between FSAA and AAPCC with respect to staff sizes were not statistically significant ($x^2=9.05, df=5$).

Unfortunately, since there are no uniform data available concerning the size of staff for the total AAPCC membership, Table 4.6 below presents data concerning the distribution of sample and non-sample FSAA agencies only.

**Table 4.6**

**Distribution of Sample and Non-Sample FSAA Agencies by Size of Professional Staff**

<table>
<thead>
<tr>
<th>Size of Professional Staff</th>
<th>Sample (N=54) No.</th>
<th>Sample (N=54) Percent</th>
<th>All Agencies (N=314) No.</th>
<th>All Agencies (N=314) Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5</td>
<td>12</td>
<td>22.2</td>
<td>110</td>
<td>35.0</td>
</tr>
<tr>
<td>5 - 10.5</td>
<td>7</td>
<td>13.0</td>
<td>56</td>
<td>17.8</td>
</tr>
<tr>
<td>7 - 10.5</td>
<td>12</td>
<td>22.2</td>
<td>52</td>
<td>16.6</td>
</tr>
<tr>
<td>11 - 19.5</td>
<td>11</td>
<td>20.4</td>
<td>48</td>
<td>15.3</td>
</tr>
<tr>
<td>20 - 49.5</td>
<td>7</td>
<td>13.0</td>
<td>33</td>
<td>10.5</td>
</tr>
<tr>
<td>50 and over</td>
<td>4</td>
<td>7.4</td>
<td>15</td>
<td>4.8</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>1.8</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>54</strong></td>
<td><strong>100.0</strong></td>
<td><strong>314</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*a* Weighted totals are used; two part-time staff members equal one full-time staff member.

*b* These data, applicable to February 1, 1965 (when the Stage I locater questionnaire was mailed), were provided by FSAA; they do not include "administrative" staff.
Although 35 percent of the FSAA membership consisted of agencies with a staff of under five, only 12 out of 34 (22.2 percent) of the sample group fell within this interval. The differences, however, between the sample and total agency group were not statistically significant ($x^2 = 3.42$, df = 5).

Waiting Lists

As indicated by Table 4.7, an overwhelming majority of AAPCC clinics had waiting lists as of the time of data-collection in February, 1965.

| TABLE 4.7 |
| NUMBER OF PSTT AND NON-PSTT AAPCC CLINICS WITH AND WITHOUT WAITING LISTS$^a$ |
| PSTT (N=44) | Non-PSTT (N=37) | Total (N=131)$^b$ |
| Have Waiting List | 35 | 78 | 113 |
| No Waiting List | 9 | 9 | 18 |

($x^2 = 2.52$, df = 1, n.s.)

$^a$Source: Stage I locator questionnaire.

$^b$There were 12 non-respondents to this question.

$^1$While FSAA provides regular bulletins ("Family Service Statistics") with service statistics, AAPCC does not have a comparable reporting system. Hence, it was not possible to obtain uniform information concerning size of staff for the AAPCC membership. There is, therefore, no way of determining whether the AAPCC sample over-represented or under-represented the total AAPCC constituency with respect to the size of staff.
Thus, of the total number of clinics for which waiting list data were available, 113 out of 131 (86.3 percent) had waiting lists, whereas only 18 (13.7 percent) did not.

The above table shows there was a slight but non-significant trend in the direction of proportionately more waiting lists among clinics that did not have PSTT; 79.6 percent of the PSTT sample had waiting lists at the time of the study as compared with 89.7 percent of the non-PSTT sample within the AAPCC membership.

A different picture emerges upon examination of comparable data within the FSAA sample as shown in Table 4.8.

**Table 4.8**

<table>
<thead>
<tr>
<th>Have Waiting List</th>
<th>PSTT (N=54)</th>
<th>Non-PSTT (N=268)</th>
<th>Total (N=322)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have Waiting List</td>
<td>33</td>
<td>118</td>
<td>151</td>
</tr>
<tr>
<td>No Waiting List</td>
<td>21</td>
<td>150</td>
<td>171</td>
</tr>
</tbody>
</table>

\(X^2=5.27, \text{df}=1, p<.05\)


In sharp contrast to the large number of clinics with waiting lists (86.3 percent of all AAPCC clinics, sample and non-sample), slightly less than half of all family agencies had waiting lists (46.9 percent). This means that the waiting list problem was relatively more
serious for the AAPCC clinics than for the family service agencies, in terms of the numbers in each group that had to cope with this problem in the community.

Table 4.8 also shows that agencies with PSTT were significantly more likely to have waiting lists than agencies in the non-sample group of the FSAA constituency. Whereas only 44 percent of the non-PSTT family agencies had waiting lists as of the time of the study in 1965, 61.1 percent of the PSTT agencies had waiting lists. While it may be speculated that the establishment of a PSTT program would seem to militate against waiting lists—by reducing if not virtually eliminating them—it is clear from Table 4.8 that this was not the case for the group under study.

The waiting list problem is a complicated one; it is possible that the PSTT agencies were more accessible and visible in the community and therefore attracted more people. Thus, while PSTT services may have been instituted to reduce or eliminate waiting lists by seeing more people for fewer interviews, paradoxically, the fact that services were brief and available to a wider segment of the community may have created or contributed to the waiting list pressure.

It may be more cogently argued that because of the presence of the waiting list, the groups within the PSTT study sample have elected to develop time-limited services in order to deal with this pressure. Lending support to
this interpretation is the fact that since the FSAA sample agencies were more likely to be located in larger communities, they were more likely to experience a greater demand for service—which in turn made the presence of a waiting list all the more likely.

Number of Cases Open

The fact that the FSAA sample agencies were more likely to experience a proportionately greater demand for service than the non-PSTT group is further supported by an examination of the statistical data concerning the number of cases\(^1\) that were open (January 1 to 31, 1965) in PSTT as compared with the non-PSTT group. The median number of open cases for all FSAA agencies was 210; of 49 PSTT agencies reporting on this item, 36 (73.5 percent) were above the median. Of 227 non-PSTT agencies reporting, 102 (44.9 percent) were above the median \((x^2=13.14, df=1, p<.001)\). Thus, it is clear that agencies with PSTT programs had a significantly greater number of open cases than those without PSTT.

The differences between the AAPCC sample and non-sample, with respect to the number of cases open during the same period (January 1 to 31, 1965), were in the same direction but did not reach as high a level of significance. Of 41 AAPCC sample agencies which reported on this item,\(^1\)

---

\(^1\)Cases were uniformly defined as family units for both FSAA and AAPCC.
25 (61 percent) were above the AAPCC median of 150 cases; in comparison, only 39 out of 88 non-PSTT clinics (44.3 percent) were above the median caseload ($X^2=3.17$, df=1, .05<p<.10).

Agency Services

As social agencies, family service programs frequently offered ancillary social and other services in addition to the basic family counselling program. Table 4.9 presents the relevant data:

**TABLE 4.9**

**DISTRIBUTION OF AGENCY SERVICES AMONG SAMPLE AND TOTAL FSAA MEMBERSHIP**

<table>
<thead>
<tr>
<th>Service Offered</th>
<th>Sample (N=54)$^b$</th>
<th>Total FSAA (N=322)$^b$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Percent</td>
</tr>
<tr>
<td>Adoption</td>
<td>10</td>
<td>18.5</td>
</tr>
<tr>
<td>Homemaker</td>
<td>23</td>
<td>42.6</td>
</tr>
<tr>
<td>Foster Placement</td>
<td>14</td>
<td>25.9</td>
</tr>
<tr>
<td>Traveler's Aid</td>
<td>15</td>
<td>27.8</td>
</tr>
</tbody>
</table>


$^b$Statistics do not equal N because some agencies offer more than one service.

Since crisis-oriented services often require the use of ancillary resources, it is noteworthy that the sample group had a somewhat higher proportion of homemaker resources
than other family agencies and a much higher proportion of traveler's aid services — by definition usually crisis-oriented. Examination of Table 4.9 shows that the FSAA sample group offered proportionately fewer adoption and foster placement services than the non-sample group within the FSAA membership. It is likely that the adoption and foster placement services were under-represented in the sample because these in loco parentis services are, by definition, difficult to offer on a time-limited basis that is more or less arbitrary.

Group Treatment in FSAA Programs

Table 4.10 demonstrates that the family agencies with PSTT were significantly more likely to have group treatment services. Thirty-two of the 54 sample group (59.3 percent) had group treatment services, as compared with only 105 of 265 of the non-PSTT family agencies group (39.6 percent). Additional information concerning the nature of the group treatment services will be presented in Chapter V as part of the findings for this study.

---

1 The AAPCC sample and non-sample groups cannot be compared with respect to this item because non-sample statistics are not available from AAPCC.
TABLE 4.10

NUMBER OF PSTT AND NON-PSTT PSAA AGENCIES
WITH AND WITHOUT GROUP TREATMENTa

<table>
<thead>
<tr>
<th></th>
<th>PSTT (N=54)</th>
<th>Non-PSTT (N=265)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have Group Treatment</td>
<td>32</td>
<td>105</td>
</tr>
<tr>
<td>No Group Treatment</td>
<td>22</td>
<td>160</td>
</tr>
</tbody>
</table>

\( \chi^2 = 7.06, \text{ df}=1, p<.01 \)


Staff Opinions About PSTT

Of importance for understanding the differences and similarities between the sample groups and the universes from which they were drawn is a question about staff opinions concerning the professional advisability of offering PSTT services. Data concerning these attitudes are outlined in Table 4.11. This table indicates that (excluding the no response categories), 34 (87.2 percent) of the AAPCC sample held positive opinions ("approve" or "strongly approve") about the professional advisability of offering PSTT at the time of the Stage I locator questionnaire in February, 1965. In marked contrast, only 64.7 percent of the non-sample AAPCC group held a positive opinion about the advisability of offering PSTT services.1

1Yet it is noteworthy that the overwhelming majority of non-PSTT respondents held positive opinions about PSTT even though they did not offer such services.
<table>
<thead>
<tr>
<th>Opinion</th>
<th>AAPCC(^b) All Respondents (N=143)</th>
<th>AAPCC(^b) Study Sample (N=44)</th>
<th>PSAA(^c) All Respondents (N=514)</th>
<th>PSAA(^c) Study Sample (N=54)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disapprove</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Disapprove</td>
<td>9</td>
<td>0</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>Mixed opinion</td>
<td>36</td>
<td>5</td>
<td>88</td>
<td>7</td>
</tr>
<tr>
<td>Approve</td>
<td>46</td>
<td>15</td>
<td>114</td>
<td>20</td>
</tr>
<tr>
<td>Strongly approve</td>
<td>40</td>
<td>19</td>
<td>56</td>
<td>25</td>
</tr>
<tr>
<td>No opinion</td>
<td>5</td>
<td>1</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>No response</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

\(^a\) Data were compiled from Stage I locator questionnaire in reply to question: "Please check the one item that most nearly describes your agency's (clinic's) thinking about the professional advisability of offering PSTT services." Six choices (from "strongly disapprove" to "strongly approve" were offered, as well as a "no opinion" option.)

\(^b\)(\(x^2=12.24, df=1, p<.001\)), based on dichotomizing "approve" and "strongly approve" vs. other opinion categories.

\(^c\)(\(x^2=19.35, df=1, p<.001\)), based on dichotomizing "approve" and "strongly approve" vs. other opinion categories.

Table 4.11 reveals an equally impressive difference between the PSAA sample group, 86.5 percent of whom had a positive opinion regarding PSTT, and the non-PSTT group, only 59.4 percent of whom held a positive opinion of PSTT. Again, the difference between the sample group and the universe from which it was drawn was significant at the
.001 level.

Thus, as expected, both the AAPCC and FSAA samples showed significantly more positive attitudes toward the professional advisability of offering PSTT than those agencies and clinics which did not participate in the study.

Summary

(1) There was no statistically significant difference concerning the regional distribution of sample agencies and clinics as compared with the national membership groups from which the samples were drawn.

(2) While there was no statistically significant difference within the FSAA group regarding the size of the population served, there was a significant difference for the AAPCC group, which indicated clearly that the sample over-represented communities with a population of 200,000 or more. It was pointed out that 79.5 percent of the AAPCC sample were located in communities serving 200,000 or more in contrast to only 49.5 percent of the non-sample group. Seventy-two of the 98 agencies and clinics in the study (73.5 percent) served communities of 200,000 or more.

(3) Although there were relatively few small AAPCC clinics (with staffs of 5 or less) compared with the FSAA sample group, this difference was not statistically significant. There were four family agencies with staffs of
50 or more in the FSAA sample group. Although there were proportionately fewer small FSAA agencies and proportionately more medium size agencies in the sample than in the total FSAA membership, the differences showed only a minor trend in the direction of significance.

(4) On the question of waiting lists, FSAA sample agencies were significantly more likely to have waiting lists than those not included in the sample; there was no significant difference in this respect among clinics. It was speculated that the presence of a waiting list was an important factor in prompting family agencies and clinics to experiment with the initiation of time-limited crisis-oriented services. Whether or not PSTT was present, the overwhelming proportion of AAPCC clinics had waiting lists (113 out of 131, or 86.3 percent of those clinics for which information was available). In contrast, less than half (46.9 percent) of all family agencies had waiting lists. Thus, the waiting list problem was proportionately greater for AAPCC clinics than for the FSAA membership group.

(5) With respect to ancillary services, the FSAA sample group was less likely to offer foster placement and adoption and more likely to have homemaker and traveler's aid services. The homemaker services were viewed as especially important within the context of time-limited crisis intervention since they provide a resource that is often needed to help families in emergency situations.
(6) There was no information concerning group treat-
ment for the total AAPCC membership group; but such data
were available for FSAA; thus, a comparison could be made
between the FSAA sample and the universe from which it was
drawn. It was found that family agencies with PSTT were
significantly more likely to have group treatment services.

(7) There was a highly significant difference
between the FSAA and AAPCC PSTT samples and their respec-
tive total memberships with respect to the proportion of
staff members holding positive opinions regarding the pro-
fessional advisability of offering PSTT services. The
association between positive sentiments and PSTT services
will be explored in Chapter V.
CHAPTER V
FINDINGS

It will be recalled that one of the overall purposes of this investigation was to conduct an exploratory-descriptive survey of the differences and similarities among time-limited crisis-oriented services operating in the 54 FSAA agencies and 44 clinics that met the study definition of PSTT. In general, study questions were concerned with three broad areas: theoretical formulations, practice processes, and administrative procedures. Following a summarized listing of the main study findings related to these questions, the data on which these findings were based will be presented and discussed.\(^1\) For purposes of this presentation, data will be arranged according to the following content areas which were used in the Stage II questionnaire: intake procedures, time factors, PSTT case criteria, treatment factors, and program features.

A. Intake Procedures

(1) Generally, clinics had more specialized or centralized intake procedures than agencies.

\(^1\)All findings reported as "significant" were based on differences within and between samples which were at least at the .05 level. Detailed statistical information will be included in the presentation of data.
(2) As compared with agencies, clinics were significantly more likely to use an application form before intake.

(3) There was no significant difference between clinics and agencies regarding the use of routine exploratory interviews for PSTT and non-PSTT cases during the intake period.

(4) But when routine exploratory interviews were held for PSTT, they were significantly greater in number within the AAPCC sample than within the PSAA group.

(5) Clinics showed a trend toward a slightly longer exploratory period than agencies for non-PSTT as well as for PSTT cases.

(6) In most clinics and agencies, PSTT was offered through an integrated part of the on-going clinic or agency program, not through a special or separate administrative unit. Only three clinic and six agency respondents indicated the use of a special unit for PSTT.

(7) Generally, in both clinics and agencies PSTT cases were not reassigned after intake. There was a significant difference, within both the PSAA and AAPCC samples, concerning case reassignment for PSTT as compared with non-PSTT cases, which were much more likely to be reassigned after intake. However, there was no significant difference between the two samples concerning the reassignment of non-PSTT cases.
B. Time Factors

(1) The proportion of clinics with a waiting list was significantly greater than that of the agencies.

(2) For those reporting a waiting list, there was a strong trend in the direction of a shorter waiting list for FSAA.

(3) The median proportion of waiting list cases in relation to the median number of cases under care in clinics was 22.6 percent; for agencies the median proportion was 3.9 percent. Thus, the proportion was more than five times greater in clinics than in agencies.

(4) The agencies had a significantly shorter elapsed time between the application for help and the initial interview.

(5) Fourteen clinics and seven agencies reported the use of a specific predetermined number of interviews or weeks of treatment for PSTT cases; the difference between the samples was significant.

(6) In those PSTT clinics and agencies in which a predetermined number of interviews or weeks was used, the modal method for arriving at such a predetermined number was informal staff discussion rather than systematic research.

(7) For those respondents using a range rather than a specific predetermined number of interviews or weeks, the median upper interview limit, for both samples combined, was 10; the median upper limit for the number of weeks
of treatment was 12. There was no significant difference between the two samples with respect to these upper limits.

(3) All respondents indicated that there was provision for extension of service, transfer, referral or reassignment if the client or patient needed service beyond the limits of PSTT. The modal provision was extension of service by continuation with the same worker or therapist.

C. PSTT Case Criteria

(1) Most clinics and agencies (78.6 percent) used specific criteria in selecting cases for PSTT.

(2) When asked to specify (in narrative form) the criteria used for the selection of PSTT cases, the mean ranks for both samples for the top two categories ("clients or patients with relatively healthy ego functioning" and "clients or patients in a crisis situation") were not significantly different. There was, however, a significant difference in the preference given to "healthy ego functioning" versus "weak ego functioning" within the AAFCC sample. Cases involving environmental manipulation were ranked last for both samples.

(3) When asked to rank factors offered in the questionnaire as criteria for selecting cases for PSTT (six forced choices, not including "crisis," were given), the criterion of "relatively healthy clients (patients) with many ego strengths" was again given priority by both samples.
D. Treatment Factors

(1) When asked about treatment techniques used in PSTT, 90.8 percent of the respondents indicated a preference for the following item: "The techniques of PSTT are essentially similar to those used in long-term treatment but require special adaptations in short-term treatment."

(2) When asked about PSTT goal orientations, "major goals related to the presenting problem" were significantly more frequently chosen in preference to all of the following items: "minor goals related to the underlying problem"; "minor goals related to the presenting problem"; or "major goals related to the underlying problem."

(3) In reply to the query, "Why is planned short-term treatment effective?" the following responses were assigned first and second rank respectively by both the AAPCC and the FSAA samples: (a) "because help is offered immediately when the client needs it"; and (b) "because of the treatment skill of the worker."

(4) In reply to a forced-choice question concerning social class factors and their relationship to PSTT, 91.8 percent of the respondents chose the following: "We don't think that the client's (patient's) social class has anything to do with whether or not short-term treatment is effective for him."

(5) Replies to the query, "Do you find that lower class clients (patients) require a special approach?" indicated that 53.7 percent of the respondents believed that
lower class clients (patients) "usually" require a special approach; 43.2 percent thought that lower class clients (patients) "rarely" require a special approach.

(6) Clinics had a significantly greater proportion of group treatment services than family agencies.

(7) There was a strong trend for AAPCC clinics to report disadvantages to PSTT more frequently than their FSAA counterparts.

(8) The overwhelming majority of respondents (82.3 percent) preferred to think of PSTT mainly as a "treatment of choice" rather than as a "treatment based on expediency." Proportionately more clinics considered PSTT as a treatment of expediency.

3. Program Features

(1) In response to a query about reasons for initiating PSTT, "meeting the needs of clients (patients) in crisis situations" was chosen first by 75.3 percent of the respondents and was the modal first choice for both samples.

(2) Thirty-six (81.8 percent) of the AAPCC and 53 (93.1 percent) of the FSAA respondents mentioned one or more aspects of the crisis configuration in their definitions of crisis; of this group 21 (47.7 percent) of the clinics and 37 (68.5 percent) of the agencies also focused on "early accessibility" items ("immediacy of treatment" and/or a waiting period of less than four days) in their PSTT treatment arrangements. There was significantly greater accessibility among agencies than among clinics.
(3) In response to an open-ended question about the theoretical rationale underlying PSTD services, there was a significantly stronger preference for crisis formulations among agencies as compared with clinics.

(4) Systematic staff development training programs, established especially for PSTD services, were in operation in 24 (27 percent) of the 89 programs for which information was available. The difference between the AAPCC and the P3AA samples was not significant.

(5) Twenty-nine percent of those responding indicated that their PSTD programs included case evaluation procedures by staff after a set period of time. The difference between the samples was not significant.

(6) Clinics did significantly more follow-up work on PSTD cases than agencies. Interviews and telephone calls were the preferred methods of follow-up, rather than mailed questionnaires.

(7) Research relevant to PSTD was in progress in 16.3 percent of the agencies and clinics. There was no significant difference between the two samples in this respect. However, the AAPCC sample was significantly more research-oriented in relation to future projects.

(8) Within the two samples, staff opinions of PSTD (both when PSTD was first initiated and at the time of the inquiry) were significantly more positive than negative. The opinions of staff members whose sentiments changed after the PSTD program was initiated moved significantly in a positive direction.
A. Intake Procedures

Clinics had specialized or centralized intake procedures significantly more often than agencies, as indicated by the replies to the following query: "Is there a centralized or specialized intake service for all cases seen in your agency (clinic)?" The data are presented below.

<table>
<thead>
<tr>
<th>Special Intake</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAPCC</td>
<td>30</td>
<td>13</td>
</tr>
<tr>
<td>(N=43)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSAA</td>
<td>21</td>
<td>33</td>
</tr>
<tr>
<td>(N=54)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(x^2=9.1542, df=1, p&lt;.01)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Of the 51 agencies and clinics that used specialized intake procedures, 30 were located in the AAPCC sample. Thus, the clinics were somewhat more formal with respect to the processing of applications for service, probably because of the multidiscipline diagnostic procedures used in most clinics.

Use of Application Form

This difference is illustrated by the fact that clinics

1Although there were 44 AAPCC and 54 FSAA respondents in the study sample, on certain questionnaire items there were some non-respondents; on a few items, answers were not required of certain respondents because of the nature of their replies to other questions.
were significantly more likely than family agencies to use an application form prior to intake. The pertinent data are shown in Table 5.2.

**TABLE 5.2**

<table>
<thead>
<tr>
<th>Sample</th>
<th>Application Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>AAFCC</td>
<td>19</td>
</tr>
<tr>
<td>(N=44)</td>
<td></td>
</tr>
<tr>
<td>PSAA</td>
<td>5</td>
</tr>
<tr>
<td>(N=54)</td>
<td></td>
</tr>
</tbody>
</table>

($x^2=15.0871, df=1, p<.001$)

Only five of the 54 family agencies utilized an application form prior to intake in comparison with 19 in the AAFCC group. A number of clinics require application forms to obtain background information in advance from parents who are applying for assistance with their children's problems. Although the questionnaire did not obtain specific data on this item, it is also known that a number of clinics use application forms routinely to get parents' permission for the release of information from referral sources and caretaking agents in the community, including physicians and teachers.

While it may be speculated that clinics with a waiting list were more likely to use the application form as a
screening device; the data do not support such a notion.\(^1\)

As background for the general question of differential processing for PSTT as compared with non-PSTT cases, the following question was posed: "Is agency (clinic) intake procedure likely to be the same for cases assigned to planned short-term service as for other cases? The answer was "Yes" from 35 clinics and 45 agencies; the difference between the sample groups was not significant \((X^2=2.106, \text{df}=1)\).

**Exploratory Interviews**

Table 5.3 shows there was no significant difference between clinics and agencies regarding the use of a routine exploratory period for PSTT as compared with non-PSTT cases.

**TABLE 5.3**

<table>
<thead>
<tr>
<th>Sample</th>
<th>Exploratory Intake</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>AAPCC</td>
<td>26</td>
<td>18</td>
</tr>
<tr>
<td>(N=44)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSAA</td>
<td>33</td>
<td>21</td>
</tr>
<tr>
<td>(N=54)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\((X^2=0.0413, \text{df}=1, \text{n.s.})\)

The distribution of responses in the above table is surprising in that it might be expected that AAPCC clinics

\(^1\) The association between these two variables (waiting list and application form) was not significant. For AAPCC, \(X^2=0.0074, \text{df}=1\); for FSAA, \(X^2=1.0333, \text{df}=1\).
would make more frequent use of PSTT exploratory interviews for screening and diagnostic purposes than their PSAA counterparts, partly because of the multidiscipline evaluation procedures used in a number of clinics. Yet there was no significant difference between the two samples with respect to the use of exploratory interviews as part of the intake process.

The distribution of exploratory intake for non-PSTT is shown below.

<table>
<thead>
<tr>
<th>TABLE 5.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>DISTRIBUTION OF EXPLORATORY INTAKE FOR NON-PSTT BY NUMBER OF RESPONDENTS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exploratory Intake</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAPCC * (N=44)</td>
<td>33</td>
<td>11</td>
</tr>
<tr>
<td>PSAA * (N=54)</td>
<td>37</td>
<td>17</td>
</tr>
</tbody>
</table>

As with PSTT cases, the difference between the two samples was not significant. Seventy of the 98 respondents typically used exploratory intake interviews.

Table 5.5 indicates that the modal number of exploratory interviews in PSTT was three for clinics and two for the agencies, whereas for non-PSTT cases the modal number was five for the clinics but only two or three for the agencies (which had a bimodal distribution). In both samples, a
total of 17 respondents reported the use of five or more exploratory interviews in non-PSTT cases, as compared with only nine who used an equivalent number of exploratory interviews in PSTT cases.

### TABLE 5.5

<table>
<thead>
<tr>
<th>No. of Interviews</th>
<th>PSTT Cases</th>
<th>Non-PSTT Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinics (N=44)</td>
<td>Agencies (N=54)</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>3</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>6 or more</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>No set no.</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>No response</td>
<td>26</td>
<td>33</td>
</tr>
</tbody>
</table>

No routine exploratory interviews 18 21 11 17

When routine exploratory interviews were used for PSTT cases, they were significantly greater in number within the AAPCC sample than within the FSAA sample (by Kolmogorov-Smirnov test, $x^2=8.80$, df=2, $p<.02$). Clinics also showed a strong trend toward a slightly longer exploratory period for non-PSTT cases (by Kolmogorov-Smirnov test, $x^2=4.91$, df=2, $.05<p<.10$).

If it is assumed that the briefer the exploratory study or screening period, the greater the accessibility of
a given therapeutic service, it would seem that the agencies were typically more accessible than the clinics.

Case Reassignment

As indicated in Table 5.6, there was no significant difference between the AAPCC and FSAA samples with respect to the reassignment of non-PSTT cases after intake.

<table>
<thead>
<tr>
<th>Table 5.6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Sample</td>
</tr>
<tr>
<td>AAPCC (n=42)</td>
</tr>
<tr>
<td>FSAA (n=54)</td>
</tr>
<tr>
<td>(χ²=2.2172, df=1, n.s.)</td>
</tr>
</tbody>
</table>

However, there was a marked difference within both the FSAA and AAPCC samples with respect to case reassignment for PSTT as contrasted with non-PSTT cases. The difference for the FSAA sample is shown in Table 5.7.

Table 5.7 makes it clear that 32 out of the 54 FSAA respondents usually reassigned non-PSTT cases after intake; in sharp contrast only 12 respondents usually reassigned PSTT cases after intake.
As with the FSAE sample, only 12 of the AAPCC respondents usually reassigned PSTT cases after intake; whereas 30 typically reassigned non-PSTT cases after intake.

Furthermore, there was no statistically significant difference between AAPCC and FSAE with respect to reassignment of PSTT cases following intake ($X^2 = .5079$, df=1).

3. Time Factors

This section will consider the following factors which are pertinent to the structuring of the time dimension in terms of the immediacy and accessibility of help, as well as the length of the treatment period: frequency of waiting lists, time elapsing between the application and the initial interview, the use of a specific or approximate number of interviews or weeks for PSTT, and the practices used if service is needed beyond the agreed upon PSTT time limits.

Waiting List Problem

As expected, the proportion of clinics with waiting lists was significantly greater than the proportion of agencies with waiting lists.
TABLE 5.9

NUMBER OF RESPONDENTS
WITH WAITING LIST

<table>
<thead>
<tr>
<th>Waiting List</th>
<th>Sample</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AAPOG (N=44)</td>
<td>35</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>FSAA (N=54)</td>
<td>33</td>
<td>21</td>
</tr>
</tbody>
</table>

\[ x^2 = 3.8788, \, df = 1, \, p < .05 \]

It was earlier speculated that the presence of a waiting list might well be a major factor in initiating PSTT services. However, it must be noted that the waiting list problem is a subtle and somewhat elusive one, for the greater the accessibility of a given agency or clinic, the greater the likelihood that more people will want to use the service. Thus, paradoxically, the very establishment of PSTT services with high accessibility may increase the waiting list—even though the service was designed to reduce or even eliminate the waiting list. Also relevant here is the possibility that—although PSTT may have been started to reduce or eliminate the waiting list—the actual number of cases assigned to PSTT may be so small that the experimental PSTT stimulus made no impact on the waiting list problem.
Cases Under Care

To avoid misinterpretation of Table 5.10, two points should be kept in mind: (1) "waiting list" has been variably used by respondents to refer to cases awaiting intake (with or without an initial in-person interview), evaluation, or assignment to treatment; and (2) since only those agencies and clinics which gave statistics on both cases under care and cases on the waiting list are included, these figures should not be generalized to the total study sample.

TABLE 5.10

<table>
<thead>
<tr>
<th>Sample</th>
<th>Number on Waiting Lists</th>
<th>Number Under Care</th>
<th>Waiting List as Percent of No. Under Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPCC (N=34)</td>
<td>50</td>
<td>221</td>
<td>22.6</td>
</tr>
<tr>
<td>FSAA (N=31)</td>
<td>18</td>
<td>459</td>
<td>3.9</td>
</tr>
</tbody>
</table>

As of November 1, 1965.

As of October 1 to October 31, 1965.

The family agencies, in general, reported more than twice the number of cases than the clinics. Perhaps a more meaningful statistic is the median proportion of waiting list cases in relation to the number of cases under care, which for the clinics was 22.6 percent and for the agencies 3.9 percent. If this median proportion were to be viewed as a crude "index" of effective demand, then it would follow that service pressure is greater upon clinics than upon agencies in terms of unfulfilled
"need" in the community. The differences in crude index cannot be attributed to possible differences in the size of the population served by the two samples ($X^2=0.32$, df=1, n.s.). However, two caveats must be stressed: (1) this index cannot be generalized to all sample respondents or to all FSAA and AAPCC members; and (2) factors not included in the index, such as intake procedures, the number of individuals seen in families under care, staff size, and the proportion of staff assigned to training and research rather than service functions would require further study before a more refined index of unmet community need could be developed.

Early Accessibility

The time between the application for help and the initial interview was significantly longer in the clinics than in the agencies, as shown in Table 5.11.

**TABLE 5.11**

NUMBER OF DAYS USUALLY ELAPSING BETWEEN APPLICATION AND INITIAL INTERVIEW FOR PSTT CASES BY NUMBER OF RESPONDENTS

<table>
<thead>
<tr>
<th>Sample</th>
<th>Less than 2</th>
<th>2-5</th>
<th>5-7</th>
<th>8-14</th>
<th>More than 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPCC</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>(N=43)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSAA</td>
<td>5</td>
<td>16</td>
<td>22</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>(N=54)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(By Kolmogorov-Smirnov test, $X^2=30.36$, df=2, p<.001)
Whereas 43 out of the 56 FSAA respondents indicated that no more than seven days usually elapsed between the time of application for help and the initial interview, only 10 out of 43 clinic respondents indicated that this was the typical period for PSTT cases. Moreover, only two of the FSAA group specified an elapsed time of more than 14 days for PSTT cases, in contrast to 17 of the 43 clinics that responded to this item. This is consistent with the earlier finding that the AAPCC sample was more likely to have a waiting list and that this waiting list was significantly longer than that of the family agency sample.

Predetermined Number of Interviews or Weeks

A crucial question concerning the structured use of the time dimension is whether a predetermined number of interviews (or weeks of treatment) was specified for PSTT cases. Fourteen clinics and seven agencies employed a specific predetermined number of interviews or weeks for PSTT cases. The difference between the samples was statistically significant ($X^2 = 5.179$, df=1, $p<.05$).

Table 5.12 presents the available data concerning the use of a predetermined number of interviews. While all the FSAA respondents structured time limits in terms of a predetermined number of interviews, two clinics did not.
TABLE 5.12

DISTRIBUTION OF NUMBER OF PREDETERMINED INTERVIEWS

<table>
<thead>
<tr>
<th>No. of Interviews</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AAPCC ( N=14 )</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>25</td>
<td>1</td>
</tr>
<tr>
<td>No Response</td>
<td>2</td>
</tr>
</tbody>
</table>

The seven PSAA agencies utilized a range of six to 14 interviews; there was much more variation in the clinics, with 11 offering a range of three to 12 interviews. One clinic, with a special contract with a municipal agency, had a program which involved a predetermined number of 25 interviews.

Table 5.13 presents the available data concerning the use of a predetermined number of weeks by AAPCC and PSAA respondents.

Three AAPCC and four PSAA respondents could not answer the question about the number of weeks used for PSTT because their PSTT services were structured in terms of interviews. This table shows that ten of the AAPCC respondents offered PSTT for a period up to 12 weeks; the PSAA respondents who gave information on this item used 12-14 weeks for their PSTT services.
Ways of Arriving at Predetermined Number

As indicated by Table 5.14, the modal method for arriving at a specific predetermined number of interviews or weeks was informal staff discussion rather than systematic statistical or clinical study of interviews in closed cases.

TABLE 5.13

DISTRIBUTION OF USE OF PREDETERMINED NUMBER OF WEEKS

<table>
<thead>
<tr>
<th>Number of Weeks</th>
<th>Number of Respondents AAPCC (N=14)</th>
<th>Number of Respondents FSAA (N=7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>14</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>25</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>No Response</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

TABLE 5.14

METHOD FOR ARRIVING AT A PREDETERMINED NUMBER OF INTERVIEWS

<table>
<thead>
<tr>
<th>Method</th>
<th>Number of AAPCC Respondents (N=14)</th>
<th>Number of FSAA Respondents (N=7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical study of case records</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Statistical study of closed cases</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Informal staff discussions</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Other methods</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>
The family agency respondent that used one of the "other methods" mentioned that the predetermined number of interviews had been decided "through executive imposition of structure, timing, and expectation." With respect to the five clinics that used "other methods", one had a contract with a municipal health department; a second clinic mentioned that the choice of a specific number of interviews was the "director's decision"; a third gave as its rationale the "statistical study of the number of patients applying for service and the number of staff hours available"; a fourth referred to a state regulation which limited care to a period of 90 days of "short-term treatment for acutely disturbed children"; and a fifth clinic arrived at its decision "through a mutual discussion with a community health board as to the period of time in which one could attempt to deal with a specific presenting problem."

Range of Interviews or Weeks

The following table presents the relevant data for those agencies and clinics which used a range of interviews or weeks for PSTT rather than a specific predetermined number.

Table 5.15 shows a bimodal distribution of the range of interviews distribution; 16 agencies and clinics specified six as the upper limit for the number of interviews used in PSTT and 18 specified 12 for their upper limit. Of the 41 agencies responding to this query, 36 (87.8 percent) had an upper limit of 12 or fewer interviews; similarly, 25 of the 30 clinics responding to this item (83.3 percent) specified 12 or fewer
interviews as their upper limit. The median upper interview limit for both samples combined was 10.

### TABLE 3.15

**Distribution of the Upper Limit of the Range of Interviews and Weeks of Treatment for PSTD by Number of Respondents**

<table>
<thead>
<tr>
<th>No. of Interviews</th>
<th>FSAA AAPP</th>
<th>Total</th>
<th>No. of Weeks</th>
<th>FSAA AAPP</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>10</td>
<td>16</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>9</td>
<td>9</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>5</td>
<td>8</td>
<td>12</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>12</td>
<td>9</td>
<td>15</td>
<td>12</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>14</td>
<td>1</td>
<td>1</td>
<td>14</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>15</td>
<td>1</td>
<td>2</td>
<td>15</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>16</td>
<td>2</td>
<td>4</td>
<td>16</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>20+</td>
<td>2</td>
<td>4</td>
<td>20+</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>N.R.</td>
<td>6</td>
<td>6</td>
<td>N.R.</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>

The median upper limit for the number of weeks for the agencies and clinics was 12. As seen in the above table, 12 weeks, with a frequency of 17 agencies and clinics, was also the mode. Thirty-three of the 40 agencies replying to this question (82.5 percent) utilized 12 weeks or less as their cut-off point, whereas only 13 out of the 26 (69.2 percent) clinics replying to this question were within the same upper limit.

What were the differences between the two samples concerning the median limit of interviews, the median limit of
weeks, and the range for the number of interviews and weeks? First, with respect to the upper (median) limit of interviews, chi square analysis showed no significant difference between the two samples ($X^2 = 12.46, df=1$); similarly, there was no difference between the samples with respect to the median limit for the range of weeks ($X^2 = 5.414, df=1$).

Finally, chi square analysis was used to test whether there was any difference between the two samples regarding the use of the same range for the number of interviews and weeks. Table 5.16 presents the data below:

**TABLE 5.16**

<table>
<thead>
<tr>
<th>Sample</th>
<th>Same</th>
<th>Not Same</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPCC</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>(N=26)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FAAA</td>
<td>16</td>
<td>21</td>
</tr>
<tr>
<td>(N=39)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

($X^2 = 0.8398, df=1, n.s.$)

Table 5.16 shows there was an even split with respect to the use of the same range for the number of interviews and weeks: 33 used the same range and 32 a different range.

Thus, while it is clear that a wide variety of time sequences was used, the distribution of these sequences was remarkably similar for agencies and clinics. It is also clear that most agencies and clinics used 12 as the upper limit, whether time was structured in terms of number of interviews.
number of weeks, or both. PSTT, as typically used by the
gaseries and clinics in this sample, encompassed up to 12 in-
terviews which were offered over a period of about three
months.

The ranges used for the duration of treatment and for the
number of interviews showed considerable variation which
was, among other factors, attributable to the respondent's
preference in specifying a particular lower limit for each
range given.¹ Perhaps, too, estimates concerning likely
dropout rates were also taken into consideration in specify-
ing these lower limits. Partly because of these variations,
it seems appropriate to regard the upper limit as the more
important statistic for purposes of analyzing similarities
and differences in time patterns.

It is also instructive to check whether there were
differences between the samples concerning the span used to
delineate the range of interviews or weeks mentioned in the
above data. Chi square analysis again indicated no signifi-
cant differences with respect to both variables (for the
range of interviews \( x^2 = 1.700, \text{ df} = 1 \), and for the number of
weeks \( x^2 = 1.96, \text{ df} = 1 \)).

Finally, it should be stressed that only 31.8 percent
of the AAPCC and 12.9 percent of the PSAA respondents in-
dicated the typical use of a predetermined number of inter-
views or weeks. If the two samples are combined, it is

¹There were almost as many different combinations as
these were respondents; for example, respondents specifying
an upper limit of 12, indicated lower limits of 1, 2, 3, 4,
5, 6, 8, and 10 interviews.
obvious that the overwhelming majority (78.6 percent) of the respondents structured the time dimension through the use of an *approximate* range rather than a *specific* predetermined number of interviews or weeks. Thus, the manipulation of PSTT time limits was characterized by considerable flexibility.

Case Assignment After PSTT Limits

Table 5.17 presents the data concerning the typical practice utilized if service was needed beyond the PSTT limits (whether a specific predetermined number or an approximate range).

<table>
<thead>
<tr>
<th>Type of Practice</th>
<th>AAPCC (Percent)</th>
<th>FSAA (Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue with same worker</td>
<td>70.4</td>
<td>74.1</td>
</tr>
<tr>
<td>All other practices</td>
<td>27.3</td>
<td>24.1</td>
</tr>
<tr>
<td>No response</td>
<td>2.3</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

It is interesting that all 98 respondents replied positively to the question asking whether there was provision for service, transfer, or reassignment if the client or patient required service beyond the limits of PSTT. The first choice of the respondents was strikingly clear, namely, the continuation of interviews with the same worker
er therapist. Three FSAA respondents (5.6 percent) usually transferred a PSTT case that went beyond the time limits to another worker in the same agency. Only one FSAA respondent and two AAPCC respondents indicated that a client or patient would be referred to another agency if the PSTT limit was exceeded. Eight FSAA respondents and nine AAPCC respondents indicated that the client would be placed on a waiting list for further service if PSTT limits were exceeded.

C. PSTT Case Criteria

Narrative Responses

In reply to the query, "Are specific criteria used in selecting cases for PSTT?", 36 of the 44 clinic respondents and 41 of the 54 family agencies said "Yes". The difference between the samples was not significant.¹

Table 5:18 provides detailed information concerning the mean ranks of specific criteria utilized by both agencies and clinics in selecting cases for PSTT; respondents were asked to list criteria in order of importance and to

¹Six FSAA and four AAPCC respondents indicated in reply to a second question (directed to those who replied "No" to the above question) that they assigned cases arbitrarily or by chance; four FSAA agencies did not answer this second question. Three FSAA and four AAPCC respondents indicated that "no criteria are needed because PSTT can be effective with any type of case" (the second of the forced-choice items). One of the respondents mentioned that "cases are assigned arbitrarily or by chance; that is, one out of every four applicants is arbitrarily assigned to PSTT as part of an on-going research project."
TABLE 5.18
MEAN RANKS OF SPECIFIC CRITERIA USED
IN THE SELECTION OF CASES FOR PSSS

<table>
<thead>
<tr>
<th>Table Item No.</th>
<th>Criterion</th>
<th>Order</th>
<th>AAPCC</th>
<th>FSAA</th>
<th>AAPCC</th>
<th>FSAA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clients with relatively healthy age functioning (no mention of crisis)</td>
<td>1</td>
<td>2</td>
<td>3.73</td>
<td>4.84</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Clients in crisis situation (not elaborated further)</td>
<td>2</td>
<td>1</td>
<td>3.94</td>
<td>4.46</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>General treatment factors</td>
<td>3</td>
<td>7</td>
<td>5.15</td>
<td>5.70</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Clients who have specific and limited treatment goals</td>
<td>4</td>
<td>3</td>
<td>5.67</td>
<td>5.14</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Clients with multiple, chronic problems and poor age functioning (no mention of crisis)</td>
<td>5</td>
<td>4</td>
<td>5.79</td>
<td>5.30</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Administrative criteria (e.g., to reduce waiting list)</td>
<td>6</td>
<td>6</td>
<td>5.79</td>
<td>5.59</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Special client groupings (e.g., unwed mothers, school phobias)</td>
<td>7</td>
<td>9</td>
<td>6.48</td>
<td>6.24</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Clients in need of interim support and/or evaluation</td>
<td>8</td>
<td>8</td>
<td>6.52</td>
<td>6.00</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Crisis situation in clients with relatively healthy age functioning</td>
<td>9</td>
<td>5</td>
<td>6.55</td>
<td>5.35</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Crisis situations in clients with multiple, chronic problems and poor age functioning</td>
<td>10</td>
<td>11</td>
<td>6.55</td>
<td>6.73</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Clients in need of environmental manipulation (e.g., homemakers, legal aid)</td>
<td>11</td>
<td>10</td>
<td>6.55</td>
<td>6.24</td>
<td></td>
</tr>
</tbody>
</table>
append such agency policy statements as were available.\(^1\)

A Spearman rank order correlation coefficient of .81
\((p<.01)\) confirmed that the similarities between the AAPCC and
the FSAA samples, with respect to the criteria listed in Table
5.16, were significant beyond chance. The mean ranks for both
samples for the two top choices ("clients or patients in a
危机 situation") were not significantly different. There
was, however, for the AAPCC group a significant difference
in the preference given to "healthy ego functioning" as com-
pared with "weak ego functioning" ("multi-problem cases").
The table also indicates that cases involving environmental
manipulation were ranked last for both samples.

By making all possible pairwise comparisons through the
use of t tests of weighted scores, the following observations
can be made about the AAPCC sample: (a) Table items 1 and
2 were clearly the top two choices and there were no signif-
icant differences between them; (b) table items 3, 4, 5 and
6 formed a second group of criteria, all ranked lower than
the top two criteria but above the remaining ones;\(^2\) and (c)
items 7, 8, 9, 10 and 11, all constituting a third rank order
group, were not significantly different from each other.

---

\(^1\) The analyses of case criteria are based on narrative
rank order choices given by 33 AAPCC respondents and 37
FSAA respondents; these were coded in 11 possible cate-
gories. Four FSAA respondents and three AAPCC respondents
merely repeated the terms "clinical," "diagnostic," and
"administrative" (which were included in the original in-
structions as general areas in which specific criteria were
to be listed); hence these responses could not be used.
Eight AAPCC and 13 FSAA respondents were not expected to
reply to this question because they did not use criteria.

\(^2\) Although item 6 was not significantly ranked ahead
of item 7 \((.20>p>.30)\), it appeared that this item could more
appropriately be located in the second group of criteria.
Classification of the FSAA sample, on the other hand, was not so easily achieved; there were a considerable number of overlapping items which made it difficult to develop cut-off points. By t test, table items 2, 1, and 4 were not significantly different from each other, although in terms of the distribution of respondents' choices, they were preferred in the order presented. Item 2 was significantly more preferred than the remaining nine items. Finally, it is important to note, that item 10 was statistically significant as the last choice.

The fact that cases involving environmental manipulation were assigned a low rank order in the AAPCC group is not impressive. But it is surprising that this item occupied a low rank in the FSAA choices, particularly in the light of the family agency's traditional use of social resources. This phenomenon can perhaps be explained by the fact that in selecting agencies that were thought to meet the PSTT study definition, those that limited PSTT entirely to cases requiring the following types of concrete environmental services were excluded: homemaker service, routine legal aid referrals for "social evaluation", and requests for services for the aged which involved placement in homes or institutions for the aged.

A few illustrations may help to portray the rich range of narrative responses which were elicited by the question regarding specific criteria. For example, the following responses were coded as "clients with relatively healthy
ego functioning" (item 1): 1. "Key family members or individual client have realistic expectations of the kind of help the agency can give ... the key family members or individual client possess the degree of reality-testing, ability to make judgments, the physical health and available energy necessary to mobilize for early action or change on their own behalf". Another typical example of this item, from a family agency respondent, was: "In general the better integrated and less defensive the client or family is, the greater the possibility they may be served effectively through planned short-term treatment." A clinic respondent referred to "situational reactions with good ego resources in family—near normal problems requiring parent education."

As an example of "patients in crisis situation" (item 2) a clinic respondent offered the following criterion: "The child's symptom—potential or threatened suicide—has produced a crisis which endangers himself or others and where quick intervention or help in planning may avert tragedy." Another clinic, whose response was also coded as item 2, specified as a criterion: "a stressful situation—such as death of parent—which has precipitated symptoms in the child and disturbance in his relationship with the remaining parent."

The following are examples of "general treatment" criteria (item 3) which were ranked third by AAPDC respondents and seventh by FSAA respondents: "educational brief treatment"; "treatment not dependent on transference

1 Item numbers (in parentheses) refer to "Table Item Numbers" in Table 5.18 above.
relationship”; “in general, the client who requests that his problem be dealt with on a short-term basis may better use short-term planning”; and “when there is a developmental lag in psychosocial development.”

“Clients who have specific and limited treatment goals” (item 4) may be illustrated by the following vignettes:

The strength of desire to achieve appropriate goals is sufficient to mobilize key family members or individual client to action or change within the specified limits of interviews and time”; “when the treatment goal is concrete or objective”; “help for emotional or external factors in achieving realistic short-term goals”; “treatment objectives limited due to client’s limited ego strengths and capacity for change”; “patients for whom the overall prognosis is limited but for whom we have a very specific and limited goal”; “limitations in motivation, capacity, or opportunity which singly or in combination contra-indicate extended treatment”; and “short-term treatment for limited motivation cases, so that closing will be by plan instead of by client withdrawal.”

“Administrative criteria” (item 6) referred to external pressure from the community, manifested in long waiting lists and in public relations problems; or to internal pressures, related to staff and budgetary shortages. For example, the following responses were included in this item: “limitations

1Five clinics and five agencies gave first choice to this type of general treatment criterion which could not be meaningfully coded within the other 10 categories. Of the 210 coded criteria responses (from AAPCC and P3AA), 21 (10 percent) were classified in this general category.
in available worker time"; "pressure from community—labor, board members"; "lack of other resources"; and "administrative policy—no more than one-fifth of the total case load is handled on a long term basis."

"Special client groupings" (item 7) included the following two responses: "administrative decision involving people over 60—unmarried mothers, certain traveler's aid cases"; and "inability of staff to cope with more than a few interviews with impulse-ridden clients."

"Clients in need of interim support and/or evaluation" (item 8) included the following: "Case involves inability to tolerate waiting period"; and "short-term treatment to determine client's ability to withstand further waiting period."

"Crisis situation in clients with relatively healthy ego functioning" (item 9) encompassed a wide range of interesting criteria: "clients with good ego strength in crisis situations, ordinarily self-sufficient"; "crisis situation where some intense disruptive event or behavior has occurred that upsets the balance in a family which ordinarily functions quite constructively"; and "if nature of problem indicates a simple crisis which can be met in a few interviews and ego strengths are sufficient to carry on independently."

"Crisis situations in clients with multiple chronic problems and poor ego functioning" (item 10) included such responses as "client with long-standing, chronic problems who has short-term treatment experience during crisis period
and follow-up"; "poorly defended client but functioning until stress occurred"; and "stress in a chronic crisis situation."

Finally, "clients in need of environmental manipulation" (item 11) may be illustrated by the following response: "Environmental pressures responsible for impairment of social functioning can be removed or alleviated through resources readily available in agency or elsewhere in the community."

Forced-Choice Responses

As a supplement to the above narrative data, Table 5.19 gives information concerning the mean ranks of criteria for selecting PATT cases in response to a series of six forced-choice questions.

The Spearman rank order correlation coefficient is .83 (p<.05), indicating that similarities between the samples were significant.

Both the AAPCC and the FSAA samples gave first choice to item 1 (relatively healthy clients with many ego strengths); this choice indicates a strong element of internal consistency in the responses of the sample groups, since this item was also ranked first in the previous table. Item 2 was clearly a second choice in the FSAA sample, significantly lower than item 1 and significantly higher than item 4.

Within the AAPCC sample, items 2, 3, 4 and 5 formed a second grouping of rank orders.

Within the FSAA sample, item 4 was clearly in the third rank order position; respondents tended to prefer this item more strongly (p<.25) than item 5 which refers to clients who
are disturbed and who have few personality strengths. The emphasis in item 4 is on the time factor—that is, given the client's personality structure, it seems unlikely that he will sustain treatment contact for more than a few interviews.

Items 3 and 5 were tied for fourth place in the FSAA sample, since their mean ranks were not significantly different from each other.

**TABLE 5.19**

**MEAN RANKS OF FORCED-CHOICE CRITERIA FOR SELECTING CASES FOR PATF**

<table>
<thead>
<tr>
<th>Table Item No.</th>
<th>Criterion</th>
<th>Order AAPCC</th>
<th>Mean Rank AAPCC</th>
<th>Order FSAA</th>
<th>Mean Rank FSAA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Relatively healthy clients with many ego strengths</td>
<td>1</td>
<td>1.79</td>
<td>2.20</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Clients whose presenting request is for help with a concrete &quot;environmental&quot; problem rather than with a &quot;personality problem&quot;</td>
<td>2</td>
<td>3.59</td>
<td>2.81</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Clients in situations where environmental factors limit treatment possibilities</td>
<td>3</td>
<td>4.23</td>
<td>4.28</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Clients whose personality structure makes it unlikely that they will come back for more than a few interviews</td>
<td>4</td>
<td>4.23</td>
<td>3.44</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Quite disturbed clients with few ego strengths</td>
<td>5</td>
<td>4.74</td>
<td>4.15</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Clients who tend to project their problems onto other people</td>
<td>6</td>
<td>3.92</td>
<td>6.00</td>
<td></td>
</tr>
</tbody>
</table>
However, in both the FSAA and AAPCC groups, "clients who tend to project their problems onto other people" (item 6) were considered among the most undesirable candidates for FSTT since this item was significantly rated last in both samples.

"Environmental problems" (item 2), clearly in the second rank order for FSAA in this forced-choice question, was in a relatively low position in Table 5.18 where it achieved a mean rank of 6.24. This item was also in a lower rank for AAPCC in Table 5.18, as compared with a somewhat higher ranking in Table 5.19. This difference can perhaps be explained by the fact that the operative word in this forced-choice question (clients whose presenting request is for help with a concrete environmental problem rather than with a personality problem) is "concrete"—that is, a specific situational problem which may be quickly remedied, hence does not require long-term help.

Also noteworthy is the consistently low rating given to the category "quite disturbed clients with few ego strengths", both in Table 5.19 and in Table 5.18. This means that—although FSTT can be effective with relatively healthy clients at one end of the clinical spectrum and relatively disturbed ones at the other—therapists prefer to select the healthy clients for FSTT, when given a choice.
D. Treatment Factors

Techniques

When asked about the treatment techniques used in PSTT, 89 (90.8 percent of the respondents indicated a preference for the following item: "The techniques of PSTT are essentially similar to those used in long-term treatment but require special adaptations in short-term treatment." Only three respondents chose "The techniques are essentially the same as those used in long-term treatment," and only six preferred "The techniques differ markedly from those used in long-term treatment." This item would require further investigation to factor out precisely what techniques require "special adaptations." Such therapeutic practices as earlier diagnostic assessment, more active use of interpretation and confrontation, greater reliance on specific goals, and the more frequent use of multiple or family interviews—mentioned in informal comments appended to the formal questionnaire responses—should be studied systematically in any future inquiry into special adaptations of treatment techniques.

Treatment Goals

When asked about PSTT goal orientations, "major goals related to the presenting problem" were significantly more frequently chosen in preference to the other forced-choice items, which are detailed in Table 5.20. For both samples there was a significantly greater frequency in
the "major goal-presenting problem" category. Moreover, the difference between the samples was not significant ($X^2=1.95$, df=3).

**TABLE 5.20**

**DISTRIBUTION OF CHOICES REGARDING PETT GOAL ORIENTATION BY NUMBER OF RESPONDENTS**

<table>
<thead>
<tr>
<th>Sample</th>
<th>Goals Related to Presenting Problem</th>
<th>Goals Related to Underlying Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Minor</td>
<td>Major</td>
</tr>
<tr>
<td>AAPCC (N=42)</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td>FSAA (N=53)</td>
<td>8</td>
<td>34</td>
</tr>
<tr>
<td>Totals</td>
<td>18</td>
<td>57</td>
</tr>
</tbody>
</table>

The writer attempted in this query to probe opinions concerning a rather complex phenomenon, namely, orientations toward "depth" of treatment. Because of the considerable amount of stereotyped thinking regarding "symptomatic relief" versus "depth therapy" the writer phrased this questionnaire item in terms of two-dimensions: (a) major and minor goals, and (b) presenting and underlying problems. Interestingly enough, only two AAPCC respondents and one FSAA respondent failed to answer this question. If the items in this question are regarded as points along a

---

1 For FSAA, $X^2=46.70$, df=3, $p<.001$; For AAPCC, $X^2=22.95$, df=3, $p<.001$. 


continuum, minor goals related to the presenting problem would be regarded as the most limited objective and major goals related to the underlying problem as the most ambitious therapeutic objective. The modal response was clearly in the "conservative" area of major goals related to the presenting problem; only an insignificant number of respondents chose either the "minor" or "major" items in the underlying problem category.

Why is PSTT effective?

Table 5.21 indicates the distribution of the responses to another forced-choice rank order question concerned with reasons why PSTT is considered effective.

The Spearman rank order correlation coefficient is .90 (p<.05), thus indicating a significant similarity between the two samples regarding the rank ordering of reasons why PSTT is effective. Thirty-seven (68.5 percent) PSAA and 30 (68.2 percent) AAPCC respondents chose the first two items in the table ("help is offered immediately" and "treatment skill") as their top preferences. 1 The choice of item 1 seems consistent with the general crisis orientation which characterized a large majority of the respondents in this study. 2 That is, it may be assumed that those who think in terms of a crisis approach would tend to emphasize the

---

1 The difference between items 1 and 2 was not significant by t test.

2 See the discussion of program features, page 150 of this chapter.
importance of making treatment available immediately.

**Table 5.21**

*Mean Ranks for Reasons Why PSTT is Effective*

<table>
<thead>
<tr>
<th>Reason*</th>
<th>Order</th>
<th>AAPCC (N=42)</th>
<th>FSAA (N=53)</th>
<th>AAPCC Mean Rank</th>
<th>FSAA Mean Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Help is offered immediately when client needs it</td>
<td>1</td>
<td>1</td>
<td>2.49</td>
<td>1.89</td>
<td></td>
</tr>
<tr>
<td>2. Treatment skill of the worker</td>
<td>2</td>
<td>2</td>
<td>2.53</td>
<td>2.31</td>
<td></td>
</tr>
<tr>
<td>3. The time limit steps up the worker's pace</td>
<td>3</td>
<td>4</td>
<td>3.44</td>
<td>3.93</td>
<td></td>
</tr>
<tr>
<td>4. The client knows he will come for help for a limited number of interviews or limited period of time</td>
<td>4</td>
<td>3</td>
<td>4.09</td>
<td>3.56</td>
<td></td>
</tr>
<tr>
<td>5. The time limit steps up the client's pace</td>
<td>5</td>
<td>5</td>
<td>4.12</td>
<td>4.00</td>
<td></td>
</tr>
</tbody>
</table>

*When both the AAPCC and FSAA samples are included, "worker" and "therapist," and "client" and "patient" are equivalent terms.*

As previously indicated, most respondents chose "presenting problems" as their most frequent PSTT goal orientation. There was a strong trend for those who chose "help is offered immediately"—as their first preference as to why PSTT is effective—more frequently to choose "presenting problems" as their primary treatment goals ($\chi^2=2.76$, df=1, .05<p<.10).
Focus on the presenting problem was therefore associated with a tendency to view immediacy of help as a reason why FTP is effective. It should also be noted that in the questionnaire instrument, "immediacy of help" was deliberately located last in a series of five forced-choice questions; yet it was the modal first choice for both samples.

The respondents' emphasis on the importance of the treatment skill of the therapist illustrates a point made earlier, namely, that short-term treatment requires greater skill than open-ended long-term treatment and is not designed for the novice therapist. ¹

In the AAPCC sample, item 3 ("the time limit steps up the therapist's pace") was clearly in third place, significantly lower (by t test) than the first two items and significantly higher than the last two items in the table. The last two items ("patient knows he will come for help for a limited number of interviews or limited period of time," and "time limit steps up the patient's pace") were in the last rank order position, although they were not significantly different from each other.

Within the F3AA sample, the worker's treatment skill was significantly above the remaining three items, all of which tied for last place; since there was no statistically significant difference among them.

¹Supra, page 39.
Social Class

The review of the literature (in Chapter II of this report) included attention to a possible association between social class factors and PSTT. In reply to a forced-choice question concerning social class factors, 89 respondents (98.8 percent) chose the following item: "We don't think that the family's social class has anything to do with whether or not short-term treatment is effective." Thus, the notion that PSTT is "mainly effective" with lower class or working class families was overwhelmingly disavowed. Yet the replies to a related query ("Do you find that lower class clients require a special approach?") indicated that 29 agencies and 22 clinics (53.7 percent) believed that lower class clients "usually" require a special approach. The related data are presented in Table 5.22.

TABLE 5.22

DISTRIBUTION OF OPINIONS ABOUT SPECIAL APPROACHES TO LOWER CLASS CLIENTS BY NUMBER OF RESPONDENTS

<table>
<thead>
<tr>
<th>Lower Class Requires Special Approach</th>
<th>Sample</th>
<th>Usually</th>
<th>Rarely or Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPCC (N=42)</td>
<td>22</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>FSAA (N=53)</td>
<td>29</td>
<td>24</td>
<td></td>
</tr>
</tbody>
</table>

(x^2=0.0428, df=1, n.s.)
In theoretical terms one may speculate that the respondents struggled with a "dissociation" problem when confronted by these value-laden questionnaire stimuli regarding social class. That is, the response to the previous question demonstrated the power of the mental health egalitarian ethic—that social class is not an important factor in PSTT. But in the next query the respondents had to declare themselves more concretely in relation to differential treatment; hence the split in values—that is, the dissonant sentiments—were openly revealed.¹

Group Treatment

Table 5.23 records the replies to a query about the offering of group treatment services.

**Table 5.23**

**DISTRIBUTION OF GROUP TREATMENT SERVICES BY NUMBER OF RESPONDENTS**

<table>
<thead>
<tr>
<th>Sample</th>
<th>Have Group Treatment</th>
<th>Do Not Have Group Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPC</td>
<td>37</td>
<td>7</td>
</tr>
<tr>
<td>(N=44)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSAA</td>
<td>32</td>
<td>22</td>
</tr>
<tr>
<td>(N=51)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\( \chi^2 = 7.17, df = 1, p < .01 \)

This table shows that the clinics provided a significantly greater proportion of group treatment services than

the family agencies. Another issue is whether group treatment services were pertinent to FBTT. Analysis of the responses indicated that 21 of the agencies and clinics offered some form of time-limited group therapy that was related to FBTT. The data are presented in Table 5.24.

**Table 5.24**

<table>
<thead>
<tr>
<th>Sample</th>
<th>Have Time-Limited Group Treatment</th>
<th>Do Not Have Time-Limited Group Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPCC</td>
<td>14</td>
<td>30</td>
</tr>
<tr>
<td>(N=44)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSAA</td>
<td>7</td>
<td>47</td>
</tr>
<tr>
<td>(N=54)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(x²=5.1195, df=1, p<.05)

It is clear from the above table that clinics had twice as many time-limited group treatment services as family agencies and that the difference was significant. Thus, there was a stronger commitment to the use of time-limited group approaches in the clinic settings included in this study, probably because of their greater reliance on children's activity therapy groups.¹

¹Included in the coding of these responses were family therapy sessions when those were listed as a form of group therapy by the respondents. It is possible that some family agencies did not mention family therapy as a form of group treatment. In Stage III of the total FSAA-AAPCC study of planned short-term treatment services, the question of family therapy will be pursued further in empirical terms, through obtaining specific data about the number of family members seen and whether or not they were seen in a group.
Therapeutic Disadvantages

Another open-ended item requested respondents to list specific therapeutic disadvantages to PSTT if they thought that there were such disadvantages. Table 5.25 presents the number of responses:

<table>
<thead>
<tr>
<th>Therapeutic Disadvantages</th>
<th>Sample</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPCC (N=41)</td>
<td></td>
<td>28</td>
<td>13</td>
</tr>
<tr>
<td>FSAA (N=24)</td>
<td></td>
<td>27</td>
<td>27</td>
</tr>
</tbody>
</table>

\( \chi^2 = 3.25, df=1, .05 < p < .10 \)

Although the difference between the sample groups was not statistically significant, there was a strong trend for the AAPCC respondents to report disadvantages to PSTT more frequently than their FSAA counterparts.

Table 5.26 gives detailed information concerning the types of disadvantages which were mentioned.

"Limited effectiveness" was coded when responses referred to the fact that PSTT does not treat underlying problems, results in a higher reapplication rate, or somehow has less value than long-term treatment. For example, an AAPCC clinic cited the following disadvantage: "PSTT does not relieve basic underlying personality problems."
Therefore, under similar stress, patient may need additional treatment." Another respondent said, "In PSTT we often have to leave untreated many apparent problem areas." A family agency respondent referred to the tendency of certain clients to "take flight into health" in PSTT:

**TABLE 5.26**

NUMBER OF RESPONDENTS SELECTING SPECIFIC THERAPEUTIC DISADVANTAGES OF PSTT

<table>
<thead>
<tr>
<th>Disadvantages</th>
<th>AAPCC (N=28)</th>
<th>FSAA (N=27)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Limited effectiveness</td>
<td>11</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>2. Ineffective with certain client groups</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>3. Lack of skills and knowledge</td>
<td>5</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>4. Difficulties in training residents and students</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>5. Administrative problems</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>6. Attitudes toward time</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>7. No response indicated</td>
<td>13</td>
<td>27</td>
<td>40</td>
</tr>
<tr>
<td><strong>No response</strong></td>
<td><strong>3</strong></td>
<td><strong>0</strong></td>
<td><strong>3</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44</strong></td>
<td><strong>54</strong></td>
<td><strong>98</strong></td>
</tr>
</tbody>
</table>

*In a few responses more than one item was mentioned. The most salient item was then coded, following consensual discussion by an independent rater and the present writer.*

*That is, respondents did not mention disadvantages to PSTT.*

Another respondent expressed concern that "Some clients probably do not receive as much help as they need in PSTT;
if the worker's beginning assessment is wrong, the whole contact could be destructive rather than constructive."

Three respondents (two AAPCC and one PSAA) cited as a disadvantage the ineffectiveness of PSTT with certain "client groups"; for example, PSTT was thought to have "limited effectiveness with hyperactive children and those were severely disturbed."

Lack of skills and knowledge comprised a total of 17 responses which were related to lack of diagnostic criteria, lack of skill in selection and treatment, the need for greater diagnostic and treatment skill, and the therapist's difficulty in making the transition to PSTT. For example, one respondent referred to the "unevenness in practice and testing of results because of variation in the skill and interest of the workers." A second said, "Many times our wish to help is ahead of our skill to do so." A third pointed out, "PSTT requires more skilled therapists and a better team approach." A fourth said, "Our practice needs to be more closely examined by qualitative research methods."

Finally, a fifth respondent in a family agency said, "We sometimes try to do too much too soon—we are not yet skilled enough in the pace of this treatment."

Two AAPCC respondents referred to training difficulties. For example: "It is difficult to teach PSTT to psychiatric residents and social work students until they are well grounded in the dynamics of behavior. PSTT seems to work best for those residents and students during the
latter part of their training."

"Administrative problems" were mentioned by 10 respondents. These dealt with problems of case assignment, difficulties in putting PSTT cases on the waiting list, and the general problem of equity in the allocation of scarce resources. For example, the following response was offered by a family agency, "On starting to see clients when we first initiated PSTT, an avalanche ensued, since the community sensed our new availability. This has hurt our ability to follow all cases immediately." A clinic respondent said, "We do not have enough therapy time with experienced therapists who do best in this role, nor do we have enough treatment time available to move cases quickly."

Another referred to the fact that immediately available PSTT "delays service to others on the waiting list."

"Attitudes toward time" were mentioned by four respondents. For example: "We find that parents are constructively aware of the time limit but the child is often not aware. Therapists have feelings about termination." Another respondent said, "Perhaps we are not time-conscious enough and might accomplish more if we structured more time limitations within which to work." Interestingly enough, a family agency respondent, from whom no response was indicated (because no disadvantages were checked) appended the following statement: "In our present research project which is studying every fourth application assigned to PSTT to check the usefulness of the service, we are concerned about
other applications which we think could best be served by PSTT and an immediate professional response."

Table 5.27 provides detailed information concerning the number of respondents who mentioned lack of skill and knowledge as compared with all other PSTT disadvantages.

The table indicates that of those respondents who selected specific disadvantages to PSTT, those in FSAA were significantly more likely than those in AAPCC to refer to lack of skill and knowledge. Perhaps the multidiscipline team relationships (especially diagnostic staff conferences) contribute to a somewhat stronger feeling of competency in PSTT in the clinic as compared to the family agency which is entirely under social work auspices.

**Table 5.27**

<table>
<thead>
<tr>
<th>Sample</th>
<th>Lack of Skill and Knowledge</th>
<th>All Other PSTT Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPCC</td>
<td>5</td>
<td>23</td>
</tr>
<tr>
<td>(N=28)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSAA</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>(N=27)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(x^2 = 5.50, df=1, p<.05\)

The question of therapeutic disadvantages would require further probing through direct interviews with respondents— as well as systematic case study—to understand the full dimensions of the problem. The available data, however,
demonstrate that the respondents are a sophisticated professional group who did not regard PSTT as a panacea and therefore did not hesitate to express their reservations about PSTT as a treatment modality.

Choice Versus Expediency

Another question related to the evaluation of PSTT as a treatment approach is the extent to which PSTT is viewed as a treatment of choice or as a treatment based on expediency. Table 5.28 presents the distribution of sentiments on this item.

<table>
<thead>
<tr>
<th>Sample</th>
<th>Choice</th>
<th>Expediency</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAFCC</td>
<td>31</td>
<td>11</td>
</tr>
<tr>
<td>(N=42)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSAA</td>
<td>48</td>
<td>6</td>
</tr>
<tr>
<td>(N=54)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>((X^2=3.6864, df=1, p&lt;.10))</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There was a strong tendency toward a difference between these two samples; proportionately more clinics were frank to admit that they regard PSTT as a treatment based on expediency. However, it should be kept in mind that an impressive majority of respondents (82.3 percent) evaluated PSTT as a treatment of choice rather than as a
treatment based on expedience. It is possible that this type of question regarding opinions of PSTT is more likely to tap a kind of "good will response" than a candid professional evaluation. For when specific questions about the disadvantages of PSTT were posed, half of the PSAA and more than two-thirds of the AAPCC respondents indicated that there were drawbacks. The reply to the query about social class, which activated expression of an egalitarian mental health ethic, is perhaps similar in that both of these general questions evoked "good" responses.

E. Program Features

Use of Separate Unit

In most clinics and agencies, PSTT was offered through an "integrated" part of the ongoing clinic or agency program rather than through a "special" or "separate" administrative unit. Only three clinics and six agency respondents indicated the use of a separate administrative unit for PSTT. There was no significant difference between the two sample groups in this respect ($\chi^2 = 0.4861$, df=1).

Reasons for Initiating PSTT

Table 5:29 details the mean ranks for reasons for initiating PSTT, given in response to a forced-choice question.¹

¹The Spearman rank order correlation coefficient was, .89, which was not statistically significant. However, there was a strong trend toward similarity between the rank order choices of the two samples.
Both samples clearly ranked "crisis" first, as compared with all other reasons. Forty-five of the 54 PSAA respondents (83.3 percent) and 28 of the 49 AAPCC respondents (65.1 percent) gave crisis first preference. Thus, crisis was chosen significantly more frequently by the agencies than by the clinics ($X^2=4.22$, df=1, $p<.05$). For both samples, 75.3 percent of the respondents chose the crisis response, thus indicating that a clear majority of the respondents in this study were "crisis-oriented" with respect to this item. It is also important to report that crisis was chosen first although it was deliberately located last in the series of five forced-choice rank-order questions which are listed in Table 5.29.

TABLE 5.29

<table>
<thead>
<tr>
<th>Table Item No.</th>
<th>Reason</th>
<th>Order</th>
<th>Mean Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>AAPCC</td>
<td>FSAA</td>
</tr>
<tr>
<td>1.</td>
<td>Meeting the needs of clients in crisis situations</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2.</td>
<td>Dealing with the pressures of a long waiting list</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>Utilizing scarce professional personnel</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4.</td>
<td>Offering a training experience for students (and residents)*</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5.</td>
<td>Handling purely informational requests</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

*"And residents" was included in the AAPCC questionnaire.
The second and third choices for both samples ("waiting list" and "scarce professional personnel") form a second group of choices; both of these practical reasons for instituting PSTT services may be described as "expedient" factors. Within the AAPCC sample, the second, third, and fourth items were not significantly different from each other (by t test) but they were all significantly lower than the first item and significantly higher than the fifth item ("informational requests"). The fifth item was significantly lower than all the rest within the AAPCC sample.

Within the FSAA group, the second and third choices were tied for second place. Item 5 ("informational requests") was significantly in the fourth place, followed by item 4 ("training experience for students"). The fact that training experience for students was significantly last in the FSAA sample reflected the belief that PSTT, while perhaps appropriate for student training, was obviously not considered a major reason for initiating PSTT in agencies. However, the training item tended to be more frequently preferred by the clinics than by the agencies, probably because a number of the clinics are accredited psychiatric training centers where psychiatric residents and other trainees spend a predetermined period of time that is compatible with the time limits of PSTT. The data also supported the view that the FSAA respondents did not place a high premium on purely informational services as a reason
for initiating PSTT.¹

After ranking the above five reasons for initiating PSTT, respondents were asked to list any other reasons for initiating PSTT services. Quantification of the responses to this open-ended question—other than to note that 46 of the agencies and 34 of the clinics did respond—is of less interest than the nature of the responses.

Dissatisfaction with the status quo was one of the major motivating factors for initiating PSTT. For example: "We were guilty about the lack of precision in treatment that resulted in our seeing clients too long thereby wasting community money; and the communities which are served have the right to expect that professional help... is available (without delay) to all persons who are experiencing family and/or personal problems."

Some responses questioned the goals of open-ended long-term treatment. For example: "We wonder if it isn't a more hopeful, workable approach to have a short-term approach, and less emphasis on long-term, 'intensive' treatment based on more far-reaching (out of reach?) goals. Immediate short-term focus may be more helpful toward family's mobilizing resources and getting started to help themselves." Other examples included: (1) We question the validity of long-term therapy, quite apart from the ever-present danger of possible deleterious effects of prolonged

¹When the sample was selected, those whose PSTT services were exclusively limited to purely informational requests were eliminated from the original study group.
dependency—that is, need gratification, which may be mutually satisfying to client and therapist". (2) "It is our opinion that in some cases traditional intensive treatment might not be too reality-oriented; therefore unconstructive". (3) "In some cases patient and therapist get 'stuck' in working toward unattainable solutions; patients case because therapists expected them but there were no shared 'open' goals."

An empirical or pragmatic approach led others to start PSIT. For example: (1) "Statistical analysis of cases demands a new look at the drop-outs; significant data are already published; we began to look at our facts of life; that many clients closed with two to five interviews, that our treatment goals were not tied as closely as could be to capacity for modification". (2) "We noticed that our healthiest clients were receiving the longest attention and the sickest were getting the shortest time—in trying to understand and overcome this problem, more attention was paid to short-term treatment". (3) "We wanted to provide better service to that large group of families who on a statistical basis come to clinics for a small number of times". (4) "We observed that families and children use services more effectively when factors unrelated to therapy (e.g., family summer vacations, moves) set a termination date."

The following are examples of responses indicating more positive reasons for initiating PSIT programs:
(1) "There is a feeling that short-term treatment may be more effective as well as more economical; thus serving the needs of both client and agency"; and (2) "We think this can be an important treatment method; not everyone can use or needs long-term treatment; we are doing planned short-term treatment to develop staff knowledge and skill in this method, in order to offer more efficient service to clients."

The following responses demonstrated the positive values of PSTT for various client and patient population groups: (1) "Clients often think in terms of short-term treatment and are not motivated to remain in long-term treatment. Consequently we thought in terms of making short-term treatment as effective as possible". (2) "We would be serving families that we would ordinarily not be able to reach with the traditional approach". (3) "We have a conviction that people with ego strength can be helped rather quickly to focus on their problems in treatment, as a result of which they can either resolve their problems in treatment or determine how to proceed in treatment". (4) "PSTT was an outgrowth of our realization that certain clients, through help with one facet of their life situation (not necessarily crisis), could go on independent of help". (5) "PSTT is a way of meeting needs of a culturally deprived group who may be ready for brief therapy in relation to a specific problem but who, in many cases, lack motivation for a continuing long-term treatment process."
In several instances, clinic responses reflected the pressure of community demands and waiting lists. For example, in one clinic PSTT was initiated, at least in part, "to improve public relations with the community." Unlike the agencies which generally thought that student training was not a reason for starting PSTT, a few clinics cited training needs as a major reason for initiating the program: "The trend of public demand for varied types of psychiatric intervention requires increased emphasis on short-term therapy in the training program for residents."

Finally the response of one clinic seems to incorporate many of the above-mentioned points: "As a newly organized clinic (some 4 years ago) we did not wish to close ourselves off from the community. We feel it is necessary for clinics to meet the needs of more people than long-term therapy permits. We are interested in learning about and trying new methods that make it possible to help people more effectively."

PSTT Theoretical Rationales

In response to an open-ended question about the theoretical rationale underlying PSTT services, there was a significantly stronger preference for crisis formulations among agencies than among clinics. The data are presented in Table 5.30.
TABLE 5.30
CRISIS VERSUS NON-CRISIS RATIONALES
BY NUMBER OF RESPONDENTS

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Sample</th>
<th>Crisis</th>
<th>Non-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPCC</td>
<td>(N=41)</td>
<td>8</td>
<td>33</td>
</tr>
<tr>
<td>FGAA</td>
<td>(N=54)</td>
<td>24</td>
<td>30</td>
</tr>
</tbody>
</table>

(x^2=6.4854, df=1, p<.02)

Whereas 75.3 percent of the respondents had earlier indicated "meeting the needs of clients in crisis situations" as a reason for initiating their PSTT services, only 32 of the 95 respondents to this open-ended query, (33.7 percent) elected to formulate the theoretical rationale underlying their PSTT service in terms of a crisis formulation.

A non-crisis formulation (but one that included references to such conceptual themes as ego appraisal, time rationale, naturational mastery, partialization techniques, goal orientation, reality focus, and equilibrium theory) was chosen by 41 respondents (43.2 percent). Twenty-two respondents (23.2 percent) phrased their responses in "a-theoretical" terms that were neither conceptual nor crisis-oriented. Although this open-ended question prompted most respondents to reply in non-crisis terms, a few used an equilibrium-disorganization model--closely related to the crisis approach--without explicitly referring to crisis.
The coding requirement was stringent here; unless there was specific mention of crisis or stress factors, the response was not considered "crisis." Also to be noted is the importance of the mind-set of the respondent in answering this question. The agency's or clinic's "crisis rationale" was given in answer to the previous question.  
Thus, it is possible that some respondents did not wish to repeat information which had just been given.

Examples of Theoretical Rationales

Since further information about crisis rationales will be given in the following chapter, only one crisis formulation will be presented here to illustrate the type of response that was coded as "crisis": "If families in the midst of a crisis have to wait for help, the crisis may subside but likely with some crippling and sometimes tragic results for the child and family. Just a little help at the right time when the crisis is fresh may, for many families, be more effective and economical than a long period of help after the crisis has subsided. Some families can only work at times of crisis and for short periods. Limited treatment may serve to mobilize the constructive energies of some families in working toward specific goals."

The following three formulations were coded as "conceptual, non-crisis". The first one emphasized the use of

---

1Respondents who had checked "meeting the needs of clients in crisis situation" were asked to give a brief formulation of their use of the term "crisis."
time limits: "Time is an elastic, relativistic factor, inadequately weighed in analysis of ordinary treatment procedures. Ordinarily treatment proceeds along a time dimension that seems to have little to do with the nature of the problem, client, etc. Our interest is to compare clinical change and movement resulting from the usual time procedures with instances where some external, arbitrary limit in time is imposed."

A second example used goal orientation and homeostasis as key conceptual themes: "The goal that client has set is an indication of what he or she sees as the problem, therefore what the client needs help with may be different from the problem the caseworker sees. This could be the difference between the ideal and the practical. The need may be to regain former homeostasis and help with a current problem and not an 'overhaul'."

A third example focused on the use of specific goals as well as on the structuring of time limits: "Every applicant is not motivated for, nor does he need, long intensive treatment. Expert diagnostic evaluation is needed at the intake level to determine clients and situations which can be effectively handled on a short-term basis. Treatment offered quickly in preference to sitting on a waiting list for weeks or months is always desirable. Goal-directed therapy with a time limit stimulates both client and caseworker to concentrate on the problem at hand and seek effective solutions."
Finally, the following two vignettes illustrate the type of response that was coded as "a-theoretical," that is, neither "conceptual" nor crisis-oriented: "We have adopted no theoretical rationale as a basis for our program but rather have arrived at our criteria in a pragmatic way: a short-term case is one in which service is offered on the basis of: (a) agreed-upon goals, and (b) a limited span of time either by number of interviews or a set termination date." Another respondent in the a-theoretical group, concentrating on frankly expedient factors, indicated that their PSTT program was based on the "realization that some patients need help but cannot for various reasons utilize or even obtain long-term treatment. Therefore, short-term treatment is offered as being the most effective under the circumstances."

Use of the Crisis Approach

One of the general study questions in this inquiry is the extent to which the crisis approach was used by agency and clinic respondents. In Chapter III a preliminary paradigm specified two dimensions which were thought to differentiate a PSTT crisis approach from a non-crisis-oriented PSTT approach: (1) special attention to one or more aspects of the crisis configuration, and (2) early accessibility (or prompt availability) of PSTT services.¹

¹A third feature of the preliminary paradigm, the use of PSTT time limits, was of course characteristic of all 98 respondents as a precondition for inclusion in the study. As earlier indicated, 21 of the 98 respondents utilized a pre-determined number of interviews or weeks; the remaining 77 used an approximate range as a way of structuring the time dimension.
This section will present information about these two dimensions.

Crisis configuration data were derived from (a) the respondent's brief "formulation of crisis" (completed by those who checked "meeting the needs of clients in crisis situations" as a reason for initiating PSTT); and (b) supplementary narrative comments about the crisis aspects of PSTT (included in or appended to the last part of the Stage II questionnaire).

These narrative responses were coded in terms of the presence or absence of the four components of the crisis configuration which were included in the preliminary paradigm for crisis-oriented PSTT services: the precipitating (stressful) event; the perception of the event (as meaningful and threatening); the response to the event (signs of disequilibrium); and the resolution of the crisis (coping and interventive efforts). A fifth component—"person(s) affected"—was added to code specific narrative references to the types of clients or patients affected by the crisis event. Each of the five components in the crisis configuration item was scored as one point; thus, the maximum score for this crisis item was five. The distribution of these scores is presented in Table 5.31.

---

1 There were two independent judges for these items—a professionally trained caseworker and the present writer. Inter-rater reliability for these five crisis components was 85.9 percent for the FSAA sample and 87.1 percent for the AAFCC sample.
TABLE 5.31
CRISIS CONFIGURATION SCORES BY
NUMBER OF RESPONDENTS

<table>
<thead>
<tr>
<th>Sample</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPCC</td>
<td>5</td>
<td>1</td>
<td>9</td>
<td>11</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>(N=54)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSAA</td>
<td>6</td>
<td>6</td>
<td>14</td>
<td>14</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>(N=54)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(By Kolmogorov-Smirnov test,
$X^2=2.614$, df=2, n.s.)

This table indicates that 36 (81.8 percent) of the
AAPCC respondents and 53 (96.1 percent) of the FSAA respondents
mentioned one or more of the five crisis components. Two
conclusions may be drawn: (1) the respondents in both
AAPCC and FSAA were generally oriented to at least one aspect
of the crisis configuration in their own operational formulations
of crisis; and (2) there was no significant
difference between the two samples with respect to this item.

Also mentioned in the preliminary paradigm of Chapter
III was the importance of the early availability or accessibility
of crisis-oriented PSTT. This component was considered present if "immediacy of treatment" was ranked first
(in the questionnaire item that was concerned with reasons
why PSTT is considered effective) and/or if the time elapsing
between the application for help and the first interview
was "less than four days." Twenty-two (50 percent) AAPCC
and 38 (70.4 percent) FSAA respondents met this criterion ($X^2=4.2391, df=1, p<.05$). Thus, FSAA agencies showed significantly greater accessibility than clinics with respect to this item.\(^1\)

Twenty-one of the 36 clinics (47.7 percent) and 37 of the 53 agencies (68.5 percent) that focused on one or more aspects of the crisis configuration also scored on the accessibility item.

The relevant data are summarized in Table 5.32.

<table>
<thead>
<tr>
<th>TABLE 5.32</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLASSIFICATION OF PSST PROGRAMS BY CRISIS CONFIGURATION AND EARLY ACCESSIBILITY ITEMS</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th align="right">AAPCC</th>
<th align="right">FSAA</th>
<th align="right">Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td align="right">No.</td>
<td align="right">Percent</td>
<td align="right">No.</td>
</tr>
<tr>
<td>Crisis Configuration(^a)</td>
<td align="right">36</td>
<td align="right">61.8</td>
<td align="right">53</td>
</tr>
<tr>
<td>Early Accessibility(^b)</td>
<td align="right">22</td>
<td align="right">35.8</td>
<td align="right">35</td>
</tr>
<tr>
<td>Crisis Configuration and Early Accessibility</td>
<td align="right">21</td>
<td align="right">47.7</td>
<td align="right">37</td>
</tr>
</tbody>
</table>

\(^a\)Includes one or more crisis configuration items.

\(^b\)There were nine respondents who did not specify any aspect of the crisis configuration.

\(^c\)Includes "immediacy of treatment" and/or "seen within four day."

\(^1\)The responses of 22 agencies and only two clinics were coded as "less than four days"; 29 agencies and 21 clinics ranked "immediacy of treatment" as a first choice. Thirteen agencies and only one clinic scored on both items.
This table indicates that slightly more than half of all the respondents combined attention to one or more aspects of the crisis configuration with a degree of emphasis on an early accessibility approach; and that the PSAA respondents more frequently combined the use of the crisis configuration with early accessibility than their AAPCC counterparts ($X^2=4.27$, df=1, $p<.05$).

Staff Training

Systematic staff development training programs, established especially for PSTT services, were in operation in 24 (27 percent) of the 89 programs from which information on staff training was available. The difference between the AAPCC and the PSAA samples was not significant. These special staff training activities included preliminary meetings set up to develop criteria for case selection or special consultation by outside professionals for starting PSTT services. An additional 45 (50.1 percent) agencies and clinics indicated that PSTT services were frequently discussed in regular staff meeting.

Case Evaluation

An open-ended question related to case evaluation posed the following query: "Is there a pre-arranged procedure for case evaluation at the end of a specified treatment period?" Of the 97 respondents to this item,
28 (29 percent) indicated that their P3TT programs had some form of case evaluation by staff after a set period of time; the differences between the samples were not significant. A total of 58 (59.2 percent) of the respondents indicated that some type of case evaluation was regularly employed. Thus, it appears that only slightly more than half of the P3TT programs had some form of systematic case evaluation procedure and of this group only about half had a structured procedure that involved evaluation at a predetermined time period.

Follow-up

Table 5.33 shows that clinics did significantly more follow-up work on P3TT cases than agencies.

<table>
<thead>
<tr>
<th>TABLE 5.33</th>
</tr>
</thead>
<tbody>
<tr>
<td>USE OF PLANNED FOLLOW-UP BY NUMBER OF RESPONDENTS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Follow-up</th>
<th>Sample</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AAPCC</td>
<td>17</td>
<td>27</td>
</tr>
<tr>
<td>(N=44)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FSAA</td>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td>(N=54)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(X²=14.0436, df=1, p&lt;.001)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When asked which method of follow-up was most frequently used, respondents indicated that interviews and telephone calls were the preferred method of follow-up.
rather than mailed questionnaires. Of the 21 respondents who indicated the use of follow-up activity on PSTT cases, 19 preferred in-person interviews or telephone calls; only one used a letter. In 14 of the 21 agencies and clinics with follow-up activities, the interviews were completed by the worker carrying the case.

Ten of the 17 clinics indicated that their follow-up interviews were completed within three months, six within six months, and one within nine months. Two of the family agencies completed their follow-up interviews within six months, one within three months, and a fourth specified a series of follow-up contacts (part of a special study project) beginning at six weeks following the termination of PSTT and ending after a two year period.

Current Research

Research related to PSTT was in progress in eight agencies and eight clinics that participated in the study. There was no significant difference between the two samples in this respect.

Two brief vignettes will illustrate the type of on-going research associated with PSTT. In one family agency, for example, it was agreed by staff that certain family situations would probably respond to a "short-term crisis treatment approach." Short-term was considered to be five interviews. Assignment to the caseworker took place almost immediately following application. A record was kept of all
cases. The workers discussed progress, prognosis, and degree of effectiveness. Files were checked at six-month intervals to learn about the outcome. Cases were also checked through the social service index to investigate other agency involvements. As of the time of the present study, only the first six month assessment had been completed. For the most part, cases treated through PSTT had not been reopened or re-registered with other agencies. However, several did return to the agency for further service with different problems. The agency thought that if services were helpful, clients would return if additional problems occurred and for this reason felt "encouraged" in introducing a PSTT service.

An agency in a large metropolitan area developed a research design which included plans for determining clients' social-psychological characteristics, quantitative analysis of services offered, and workers' subjective rating of treatment outcome. Research was in progress at the time of the present survey.

Perhaps the most sophisticated research concerning PSTT services is the project now in progress at Community Service Society of New York.\(^1\) This agency is now conducting a study whereby cases are assigned on a random basis to PSTT or continued service. The purpose of the study is to investigate, among other factors, the type of change that can be effected through the use of time-limited casework while certain important variables are controlled.

Future Research

Twelve AAPCC clinics and six PSAA agencies reported definite PSTT research plans for the future ($X^2=4.1029$, $df=2; p<.05$). Thus, AAPCC was significantly more research-oriented in this respect.

One agency research project, for example, will involve "sharing with the client the estimated time of service needed for PSTT and studying the effects of case reassign- ment in relation to families who do or do not continue beyond the application interviews as compared with those who remain with the intake worker."

A clinic respondent reported a projected follow-up study concerning a special family group consultation pro- gram. The purpose of the study is to determine program effectiveness and to try to establish criteria for selection of families on the basis of family composition and the nature of the presenting problem.

Another clinic is launching a study of PSTT cases in which a year or more has elapsed since the termination of treatment and in which there have been no subsequent re- quests for service. A total of 100 cases will be selected. The study instrument will be a modification of a form previ- ously used in a research project concerned with long-term cases. Similarly, another child guidance clinic is planning to compare case flow data with patients seen under PSTT with a previous method of dealing with patients in long-term open-ended treatment. This clinic is also working on an
instrument to evaluate parents' attitudes and expectations toward their children and the changes that occur in these expectations as a result of PSTT.

Staff Opinions About PSTT

It will be recalled from Chapter IV that there was a highly significant difference (p<.001) between the PSAA and AAPCC study samples and their respective national memberships concerning the proportion of staff members who held positive opinions about the professional advisability of offering PSTT services. Within the two samples, staff opinions regarding PSTT (both when PSTT was first initiated and later, at the time of the present inquiry) were significantly more positive than negative. And, as indicated by Tables, 5.34, 5.35, and 5.36, the opinions of staff members whose attitudes changed after the PSTT program was initiated moved significantly in a positive direction.

Table 5.34 indicates that of the 49 PSAA respondents (whose general opinions about PSTT were reported in the response to Stage II questionnaire) 24 changed, all but five in a positive direction. Responses were in relation to the following instructions: "(a) Characterize your staff's general opinion of PSTT when it was initiated by checking the one item that best describes the staff's first reaction." (The choices were "strongly opposed," "slightly opposed," "mixed feelings," "moderately enthusiastic," "very enthusiastic."); "(b) What in general is your staff's current opinion of PSTT?" (The choices were the same.)
### TABLE 5.34

CHANGES IN FSAA STAFF OPINIONS OF PSTT

BY NUMBER OF RESPONDENTS

<table>
<thead>
<tr>
<th>Time I&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Strongly Opposed</th>
<th>Slightly Opposed</th>
<th>Mixed Feelings</th>
<th>Moderately Enthusiastic</th>
<th>Very Enthusiastic</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Opposed</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Slightly Opposed</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mixed Feelings</td>
<td>20</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Moderately</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Enthusiastic</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Very Enthusiastic</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>No Response</td>
<td>54</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>29</td>
<td>16</td>
</tr>
</tbody>
</table>

<sup>a</sup>When PSTT was initiated.

<sup>b</sup>Current opinion (as of October, 1965)
By the McNemar test for significance of changes, the change in FSAA staff attitudes was significant beyond the .01 level.¹ Twenty-seven of the FSAA respondents were moderately enthusiastic or very enthusiastic at Time I (when PSTT was initiated) as compared with 45 who were moderately or very enthusiastic at Time II (October, 1965, the time of the Stage II general program questionnaire). Of this latter group, 16 were very enthusiastic, representing a change of seven in a positive direction. A number of the changes in staff opinions about PSTT, from Time I to Time II, are obviously attributable to the fact that of the 25 respondents who originally had mixed feelings toward PSTT, 15 changed as of Time II; 12 to a position of moderately enthusiastic, two to a position of very enthusiastic, and one in a negative direction to slightly opposed.

Table 5.35 presents comparable data for the AAPCC social work staff group.

Table 5.36 presents similar data regarding the psychiatrists within the AAPCC staffs for Times I and II. Among the 41 respondents, there were 14 changes, 13 in a positive direction, and only one in a negative direction (p<.001). Thus, as with the social workers, if psychiatrists changed in their opinion, they changed significantly in a positive direction.

### TABLE 5.35

**CHANGES IN AAPCC SOCIAL WORKERS' OPINIONS OF PSTT BY NUMBER OF RESPONDENTS**

<table>
<thead>
<tr>
<th>Time Ia</th>
<th>Strongly Opposed</th>
<th>Slightly Opposed</th>
<th>Mixed Feelings</th>
<th>Moderately Enthusiastic</th>
<th>Very Enthusiastic</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Opposed</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Slightly Opposed</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Mixed Feelings</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Moderately Enthusiastic</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Very Enthusiastic</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>No Response</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>19</td>
<td>16</td>
</tr>
</tbody>
</table>

*aWhen PSTT was initiated*

*bCurrent opinion (As of October, 1965)*
<table>
<thead>
<tr>
<th>Time II&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Strongly Opposed</th>
<th>Slightly Opposed</th>
<th>Mixed Feelings</th>
<th>Moderately Enthusiastic</th>
<th>Very Enthusiastic</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Opposed</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Slightly Opposed</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Mixed Feelings</td>
<td>14</td>
<td>0</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Moderately Enthusiastic</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Very Enthusiastic</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>No Response</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>0</td>
<td>5</td>
<td>22</td>
<td>14</td>
<td>3</td>
</tr>
</tbody>
</table>

<sup>a</sup>When PSTT was initiated

<sup>b</sup>Current opinion (as of October, 1965)
The psychologists,¹ as indicated in Table 5.37, showed the smallest number of changes, seven in a positive direction and three in a negative direction. Although the changes were more frequently in a positive direction, the difference was not significant, as determined by the McNemar significance-of-changes test (p=.172). It should be noted, however, that the size of the sample is very small.

In summary, then, these data about staff opinions toward PSTT indicate that once a planned short-term treatment service program was established—with very few exceptions—the positive sentiments of staff tended to be self-reinforcing and self-fulfilling. If there were changes, they tended significantly to be in a positive direction. This finding may be interpreted in terms of the positive self-fulfilling prophecy which was discussed in Chapter II; that is, once a staff group has had a positive experience with PSTT—perhaps with even a very small number of cases—staff sentiments become positive and tend to be further reinforced by subsequent experience with PSTT.

---

¹Since the psychologists in 33 clinics and the psychiatrists in 43 clinics in the AAPCC sample participated in the completion of the questionnaires on which the staff opinions were recorded, it can be reasonably assumed that the views of these two disciplines were taken into consideration in filling out this questionnaire item.
TABLE 5.37

CHANGES IN AAPCC PSYCHOLOGISTS' OPINIONS OF PTT
BY NUMBER OF RESPONDENTS

<table>
<thead>
<tr>
<th>Time II^b</th>
<th>Strongly Opposed</th>
<th>Slightly Opposed</th>
<th>Mixed Feelings</th>
<th>Moderately Enthusiastic</th>
<th>Very Enthusiastic</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time I^a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Opposed</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Slightly Opposed</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mixed Feelings</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Moderately Enthusiastic</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Very Enthusiastic</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>No Response</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>15</td>
<td>13</td>
</tr>
</tbody>
</table>

^aWhen PTT was initiated

^bCurrent opinion (as of October, 1965)
CHAPTER VI
TOWARD A PROGRAM ASSESSMENT SCALE

The preceding chapter on "Findings" has presented an aggregate statistical picture of PCTT programs in AAPCC and FSAA with respect to a number of areas of inquiry, including intake procedures, time factors, case criteria, treatment factors, and program features. However, such a presentation does not specify how individual agencies and clinics "score" within this total picture. The purpose of this chapter is to describe a preliminary effort at developing a study instrument—a "Program Assessment Scale"—to differentiate those agencies and clinics with a "strong" (high score) orientation toward crisis-oriented PCTT from those with a "moderate" (medium score) or "minimal" (low score) investment in this type of approach. If properly validated, this scale would prove useful in future investigations of time-limited crisis approaches, not only in AAPCC and FSAA programs but in a wide variety of mental health services. While this chapter will outline the stages involved in formulating the Program Assessment Scale (hereafter abbreviated as "PAS"), it must be emphasized that the validation of this instrument will require additional research that is beyond the scope of the present study.
As pointed out by Polansky, there are basically two approaches to the development of a composite scale.\(^1\) Items can be combined *rationally* on the basis of theory; they may also be combined *empirically* on the basis of statistical manipulation. Both approaches were used in the formulation of the FAS.

First, on *a priori* grounds, those questionnaire items thought to be relevant to the development of a strong, crisis-oriented FSTI program were specified; relevance was defined in terms of selected crisis, time, and administrative factors. This first effort at developing a FAS included 35 items which are listed in Appendix D (Table D. 2 for AAPCC and Table D. 3 for PSEAA) together with their respective correlations with the total FAS scores. The coding instructions for these items are given in Appendix D (Code Sheet C. 5).

For the PSEAA sample, 17 of the original 35 FAS items were found to be correlated (as measured by phi correlation coefficients) with the total FAS scores at or beyond the .10 level of significance; for the AAPCC sample, 17 of the original items were found to be similarly correlated. Ten of the 35 items were found to be correlated with the total FAS scores in both samples and are thus included in the

final cross-validated PAS.\(^1\)

These 10 items seem to differentiate, by empirical test, those programs with the strongest orientation to crisis-related PSTT services. By definition, these items that were characteristic of a large number of respondents were not included in the PAS because they did not discriminate programs with a strong investment in crisis-oriented PSTT from those with a minimal investment. This does not mean that such items, though excluded from the PAS, do not contribute to the strength of a given PSTT service. For example, "immediacy of treatment" (as a response to the question, "Why is PSTT effective?"), while not differentiating among the various programs, would nevertheless be considered an important component of a strong PSTT crisis approach.

The final PAS items are listed in Table 6.1. Briefly, four of the items are related to crisis, two to the time dimension, and four to certain administrative arrangements that apparently facilitate the organization and delivery of PSTT services.

---

\(^1\) of the 35 items, 24 were correlated with the total PAS scores for at least one of the two independent samples. (These are presented in Appendix B, Table D. 4.) Ten of these 24 items were correlated with the total PAS scores for both samples; thus, seven items were unique to each sample. There was a dual justification for the use of a cross-validated PAS: (a) to tap the common features in both samples; and (b) to provide a scaling instrument of more general utility to study PSTT programs in settings different from those of the present investigation.
<table>
<thead>
<tr>
<th>Item No.</th>
<th>Program Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Crisis and stress (used as criterion for case selection)</td>
</tr>
<tr>
<td>5</td>
<td>Crisis event (included in &quot;crisis&quot; definition)</td>
</tr>
<tr>
<td>7</td>
<td>Perception of stress (included in &quot;crisis&quot; definition)</td>
</tr>
<tr>
<td>9</td>
<td>Resolution of crisis (included in &quot;crisis&quot; definition)</td>
</tr>
<tr>
<td>12</td>
<td>Predetermined number of interviews</td>
</tr>
<tr>
<td>17</td>
<td>Time rationale (basis for number of interviews)</td>
</tr>
<tr>
<td>22</td>
<td>No exploratory interviews</td>
</tr>
<tr>
<td>24</td>
<td>Different PSTT intake</td>
</tr>
<tr>
<td>33</td>
<td>Research on-going</td>
</tr>
<tr>
<td>35</td>
<td>Staff training (specially designed for PSTT)</td>
</tr>
</tbody>
</table>

*All items were correlated in both of the independent samples with total PAS scores at or beyond the .10 level.*

*Item numbers are taken from Appendix C (Code Sheet C. 5) where all of the original 35 PAS items are listed.*

The description and scoring details of these 10 cross-validated items are included in the PAS Code Instruction Sheet (Appendix C. 5). The distribution of scores for the PAS is presented in Table 6.2.
### Table 6.2

**Distribution of PAS Scores for AAPCC and PSAA Samples**

<table>
<thead>
<tr>
<th>Score</th>
<th>AAPCC</th>
<th>PSAA</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>1</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>54</td>
</tr>
</tbody>
</table>

*The difference in PAS scores between the two samples was not significant (by Kolmogorov-Smirnov test, $X^2=2.59$, df=2).*

The above data may be divided into three broad scoring categories: high (5 to 10), medium (3 or 4), and low (0 to 2). Fifteen (34 percent) clinics and 10 (18.5 percent) agencies had high scores; 15 (34 percent) clinics and 18 (33.3 percent) agencies, medium scores; and 14 (32 percent) clinics and 26 (48.2 percent) agencies, low scores. Again, the differences between the samples were not significant ($X^2=3.95$, df=2).
Program Profiles

Although the PAS cannot be validated here, it can be illustrated by examples of high, medium, and low scores that are based on the available questionnaire data.

In a large AAPCC clinic with a high score, intake arrangements were more accessible for PSTT cases as compared with open-ended long-term cases. After only one exploratory interview, a new case was directly assigned to PSTT; non-PSTT cases usually were seen for five or more diagnostic interviews. Cases were carried by the same worker throughout the treatment period; in contrast, non-PSTT cases were usually reassigned after the exploratory study period. PSTT cases were seen for a predetermined number of 12 sessions over a three month period, with follow-up interviews pre-arranged at three, six, and 12 month intervals. The number of predetermined interviews was arrived at through informal staff discussion and exploration with a municipal community mental health agency to determine "the period of time in which one could attempt to deal with a specific presenting problem." Treatment planning emphasized early diagnostic understanding and a goal-focused approach.

Criteria for case selection referred to the existence of an accidental (external) crisis, the sudden occurrence of a symptom in an otherwise intact personality, or the acute eruption of a chronic crisis problem. Typical stressful situations included children's behavior problems, school
phobias, reactive maladjustment to bereavement, reactions to illness, separation of parents, and a variety of developmental crises (for example, those associated with puberty). In dealing with these situations, all aspects of the crisis configuration were taken into account. In a recent study of more than 260 families treated by this PSTR program, the treatment goal (according to the research team's ratings) was significantly achieved for 71 percent of the children, 75 percent of the mothers, and 58 percent of the fathers. It was thought that termination caused no "special difficulties" in the majority of the cases. A special training program for brief therapy has been offered to staff through weekly conferences.

An AAPCC clinic with a medium score was located in a large teaching center. At the time of this study it had a substantial waiting list. The time elapsing between the submission of an application form by the parent and the first interview was usually between two and eight weeks—but sometimes longer. Thus, this clinic was consistent in rating "immediacy of help" last as a reason for the effectiveness of PSTR. However, to enhance treatment accessibility, there were no routine exploratory interviews, nor was the case transferred after intake. Organized as a separate service, the PSTR program was primarily established for the clinical teaching and training of second year psychiatric residents. The child and parents were seen for ten to twelve sessions over a period of six weeks. The family
was usually placed on a waiting list if service was needed beyond the six week period. The rationale for the six week PSTT limit was arrived at through informal staff discussion, rather than through systematic research.

Preference was given to relatively healthy children whose parents were well motivated to use "a counseling type of help." Treatment was focused on symptomatic improvement ("minor goals related to the presenting problem"). The parent's knowledge that he will come to the clinic for only six interviews was thought to be a major reason why PSTT was effective.

While highly structured with respect to the use of the time dimension, this PSTT service was not crisis-oriented and was characterized by low accessibility. A good deal of emphasis, however, was given to the follow-up contact with the clinic social worker, after the child's treatment had been terminated. This follow-up service gave the family "the feeling of the clinic's continued interest" and served as a protactive measure to assure parents "that they could look to the clinic for further guidance."

The clinic frankly acknowledged that its PSTT service, from the very outset, was regarded as an expedient measure—to fit in with a phase of the resident's training requirements—rather than as a treatment of choice. Consistent with this point of view was the clinic's observation that the main disadvantage to its service was that "the choice of patients is limited by the teaching requirements
and possibilities. For example, emphasis on the teaching aspects of the program "limited such auxiliary services as school visits" and other types of community activity which were considered important to the clinic's total program. Despite these disadvantages, staff members were surprised to note "the overt and subtle changes of attitude and behavior" that took place during the brief six week treatment period. It was speculated that PST's time limits enabled the "therapists to assert their confidence to both child and parents that they can move ahead on their own (when appropriate)" after treatment was terminated.

The following is an example of a child guidance clinic with a low score. This clinic has offered only short-term treatment. After a waiting period of one week or more, applicants were seen for four to six diagnostic interviews. Cases were then routinely reassigned to a therapist for another 10 to 12 interviews over a period of 10 to 12 weeks. No rationale for the selection of this time period was given in the questionnaire. If help was needed beyond the 12 week maximum allowed, with very few exceptions the case was referred to another clinic for long-term treatment.

Criteria for case selection did not include crisis or emergency factors but rather vaguely mentioned that priority was given to a given case if it was thought that "the family would respond favorably to PST." The therapist's skill and optimism, as well as the pressures that the time limit created for the therapist—to achieve results in a
short period—were considered the main factors in bringing about a successful treatment outcome.

"Dealing with the pressure of a long waiting list" was ranked as the first reason for establishing PSTT service. There were no follow-up, special staff development, or research activities in operation at the time of the study. Finally, this was one of the few clinics that expressed mixed feelings about the professional advisibility of PSTT; the staff particularly noted their feelings of frustration about their inability to treat some cases for more than a three month period.

The following is an example of a large metropolitan high-scoring family agency, which for the past several years has purposefully differentiated "planned short-term" from continued-service cases. PSTT had the following characteristics: (1) It was completed by design through no more than eight in-person interviews within a period of three months; (2) there were only minor delays between the request for help and the assignment to the worker—that is, there was no formal waiting list; (3) the same worker carried the case from intake to completion. The rationale for the selection of a predetermined number of eight interviews was based on a systematic study of closed cases which indicated that a substantial number of cases were closed with five or fewer interviews, but not by plan. In a follow-up study, however, these clients often indicated they had been helped to deal with the problems that troubled them.
Also guiding this agency's PRT service was the belief that family casework practice has often been ineffective because caseworkers, in their desire to bring about a "cure," have set unrealistic and unrealizable goals, thus leading to a feeling of frustration for both client and worker. This agency's statement of theoretical rationale included the observation that "There has been a tendency to regard short-term treatment as superficial without sufficient appreciation of the cumulative effect that improvement in one area of social functioning can have on other aspects of the family situation. Identification with the psycho-analytical model has seemingly been a factor in the 'timelessness' with which some workers approach case study and treatment." PRTT was therefore unambiguously considered as a treatment of choice, not expediency--despite the fact that the demand for services in the area covered by this agency has always exceeded the available staff resources.

Crisis was briefly defined as an event "occurring within or outside the family, resulting in family disequilibrium." Other aspects of the crisis configuration were not mentioned. However, this agency scored high in terms of on-going research and staff training. Certain cases were interviewed by a researcher (by prearrangement) at the time of case closing and six months later. In preparation for PRTT, a series of special seminars were instituted, followed by an on-going staff development
program especially geared to brief treatment. Finally, this agency is using an experimental research design for a systematic study of the type of change that can be brought about through time-limited casework.

The following is an example of a family agency (serving a community with a population under 500,000) which received a medium PAS score. Clients were routinely seen for one or two exploratory interviews and cases were routinely reassigned after intake. But treatment was relatively accessible since the waiting period—between the client's application for help and the initial interview—was not more than four days. A range of four to 12 interviews, over a period up to 12 weeks, was used for FSTT rather than a specific predetermined number of interviews. Since there was no waiting list to create the usual staff pressures, clients who needed help beyond the period of 12 weeks simply continued treatment with the same caseworker.

The principal criterion for selecting cases for FSTT was the presence of a situational or developmental "crisis" in an ordinarily self-sufficient client or family. In addition, some cases were assigned to FSTT as part of a special arrangement with a court program. FSTT was considered especially appropriate for "relatively healthy clients with many ego strengths." The emphasis in treatment was on the presenting problem—"the here and now" situation. Two factors were considered important in the efficacy of FSTT: the worker's treatment skill and the fact that treatment
was offered immediately. Moreover, the early accessibility and prompt timing of treatment were "helpful in marshalling one's strength sufficiently to break through the impasse features of the crisis."

The agency offered a general definition of crisis as "any situation in which family imbalance occurs due to illness, emergency or change resulting in trauma." Problems in saturation were considered "occasional crises"—for example, "the expectation of marital bliss" in a young couple. Also mentioned was the "realization that certain clients, through help with one facet of their life situation, could go on independent of help;"

The agency expressed an interest in taking a more "formalized" approach to the organization and study of PST services, and, in response to the study questionnaire, has begun to clarify its theoretical rationale, beginning with the point that "setting mutual goals gives impetus both to client and worker in achieving equilibrium." In more specific terms, the staff intends to undertake a study of cases involving unplanned terminations (that is, terminations against professional advice), using retrospective case analyses to check whether a preplanned short-term service might have been helpful to these families. The agency expressed the hope that "participating in this national PSWA study will help us evaluate results and establish a more specific policy for PST service."

The following is an example of a family agency
(serving a community of more than 500,000) which scored low on the PSE. Believing in the importance of a strong centralized intake service, this agency routinely used an exploratory study period for all clients, offering as many as five such diagnostic interviews. Because of the emphasis on centralized intake, most cases were reassigned after the exploratory period was completed. Clients had to wait for service because of a waiting list, but usually not for more than two weeks. There was considerable flexibility in the structuring of the time dimension, with a range of four to 12 interviews offered over a period of one to three months. Occasionally, cases were selected for a specific predetermined number of interviews "by casework plan."

Criteria used for PSTT were brief and very general: "assessment of what is wanted by the client and what is needed to meet the client's request." An effort was made to select those clients who, in the opinion of the intake worker, were unlikely to continue treatment for more than a few interviews. While emphasis was on "major goals relating to the presenting problem," the agency pointed out that these "major goals may touch the underlying problem."

As with most respondents, the worker's treatment skill was regarded as a major factor in the efficacy of PSTT. However, also stressed were "the importance of the caseworker's belief that short-term casework can be effective" and "the caseworker's acceptance of the client's goals." Although there was no group treatment service at
the time of the study, the agency was considering the
advicability of forming a parents' group which would meet
for 12 structured sessions.

While "meeting the needs of clients in crisis situa-
tions" was ranked first as a reason for initiating PATT
services, the agency offered no definition of crisis beyond
the concept that its "practice philosophy is that all
clients are in crisis when they apply." There was no agency
policy for the follow-up of PATT cases, although occasion-
ally caseworkers did conduct follow-up interviews as a matter
of individual preference. No current research was in opera-
tion nor was future research planned. However, there was
an extensive staff development program, involving study of
"stress factors" and both short-term and long-term family
therapy. Finally, it should be emphasized that, because
of the presence of two "walk-in crisis clinics" in the
community, this agency did not believe that it should con-
centrate on a similar type of crisis-oriented short-term
program.

Need for Further Research

As earlier indicated, validation of this 10 item scale
will require further research that is beyond the scope of
the present inquiry. There are at least two types of re-
search that would provide evidence of such validation.
First, field visits could be made to stratified random
samples of high, medium, and low scorers. Transcripts of
tape-recorded interviews (based on both structured and
semi-structured questions) would provide data on which
scoring judgments (high, medium, low) could then be made
by two independent judges who have not been engaged in the
scoring of PAS items in the present study. A second and
perhaps more definitive method of PAS validation would of
course be through the use of empirical case data, includ-
ing information concerning (a) the extent to which selected
components of the crisis configuration were actually used
in PSTT; (b) whether a predetermined number of interviews
was really utilized in a given PSTT case (through "before"
and "after" measurements); and (c) whether follow-up and
research activities were in fact operative in specific
PSTT services.
CHAPTER VII
SUMMARY AND IMPLICATIONS

Study Questions

The overall purpose of this investigation was to conduct an exploratory-descriptive survey of crisis-oriented planned short-term treatment services operating within 155 AAPCC clinics and 327 FSAA agencies as of February 15, 1965. The general study questions were:

(1) What are the common and special features of these programs?

(2) To what extent are formulations about the crisis approach and the structuring of the time dimension being utilized by practitioners in these clinics and agencies?

(3) Can a study instrument be developed to profile some of the important features of time-limited crisis intervention programs—to be used as a conceptual and measurement tool in future studies of brief crisis-oriented services in mental health programs?

The following factors contributed to the relevance of this inquiry: society's continued concern about the persistent and widespread problems of personal and family dysfunctioning; the chronically plaguing personnel shortages that put a premium on the maximal utilization of scarce
professional mental health resources of time and manpower; the perennial concern about the waiting-list problem; and the alarming number of treatment dropouts—that is, cases that are prematurely terminated as unplanned brief services. All these concerns have combined to create a mood of professional soul-searching and a critical interest in program evaluation which are preconditions for the discovery of new methods of offering effective mental health services to increasingly larger segments of the population. Planned short-term crisis-oriented services have been suggested as one such method.

The Time Dimension

A review of the literature indicated that short-term treatment, one variant of the structured use of the time dimension, has perhaps as many different connotations as time itself. Although many clinicians prefer to consider all treatment as open-ended and therefore do not regard time as an important treatment variable, an increasing number have become interested in the planful manipulation of time, either through a specific or approximate number of interviews or weeks.

Many reasons for this growing interest have been cited. Some prefer to use time limits as a matter of philosophical choice; others, as a matter of practicality to provide more effective service to larger numbers of people. There are also those who, viewing time as an intrinsic part of the
therapeutic process, utilize time limits to enhance the client's or the worker's motivation. To others, time is of interest only in relation to the frequency, length, or spacing of therapeutic sessions. Finally, some clinicians and researchers are interested in time largely as a factor in continuity or follow-up studies of those who do or do not continue in therapy.

For purposes of this study, "planned" short-term treatment (PSTT) was defined to mean that certain cases were designated during the intake period or shortly thereafter to be seen for (a) a more or less limited number of in-person interviews and/or (b) a more or less limited period of time. Excluded from this operational definition were services which were short-term because treatment was ended on an "unplanned" basis against the advice of the caseworker (or therapist), or because an early closing was mutually agreed upon by the client (or patient) and the worker (or therapist) at the point of termination.

The Crisis Approach

Since their earliest beginnings, social work and psychiatry have regarded helping people in crisis situations as their proper domain. In this study, the "crisis approach" was assumed to include attention to the stress-crisis configuration—that is, the precipitating event; the perception of the event by the persons affected as meaningful and threatening; the response to the event in terms of signs of tension and disequilibrium; and the resolution of the ensuing
problems through coping and interventive efforts. The crisis approach was also assumed to emphasize the prompt accessibility of treatment, as close as possible to the time of crisis impact and response.

Selection of Sample

A total of 54 FSAA agencies and 44 AAPCC clinics met the following criteria for inclusion in the sample:

1. The agency or clinic reported in a preliminary locator questionnaire that it offered short-term services which seemed to meet the study definition of PSTT.

2. The agency or clinic indicated that a PSTT program was apparently in operation at the time of the present investigation by completing all study instruments, including a detailed program questionnaire (the focus of this study) and schedules on individual cases assigned to PSTT (beyond the scope of this study).

Major Findings

The proportion of AAPCC clinics with an experimental or on-going PSTT service at the time of the study (February to December, 1965) was much greater than that of the FSAA agencies. A possible reason is that the clinics had longer waiting lists, hence greater pressure from the

1 Since there was substantial shrinkage of the preliminary "locator" sample (62 agencies and clinics, thought to have some form of PSTT, did not participate in the study), the findings presented here cannot be generalized to the group of non-respondents. A separate study of these non-respondents (outside the scope of this inquiry) would be needed to compare their short-term services (which may or may not be PSTT) with those of the study sample.
community for service as compared with their family agency counterparts. Another possible explanation is that the multidiscipline team relationships in the clinic, through the cross-fertilization of ideas, provided greater stimulation for departures from traditional practice approaches.

Most agencies and clinics (82.3 percent) viewed PSTT as a treatment of choice rather than expediency. The goals of PSTT were generally focused on the client's "presenting" rather than his "underlying" problem. The primary reason for initiating PSTT was to meet the needs of clients in crisis situations. It was not surprising that the major criteria in case selection for PSTT referred to clients with relatively healthy ego functioning and to those who were in crisis situations. Agencies, however, were more likely to present crisis formulations in their theoretical rationales for PSTT. Basic to the crisis rationale was the opinion that PSTT was mainly effective because help was offered immediately when needed. Agencies and clinics agreed that a factor of equal importance in effectiveness was the treatment skill of the worker. Treatment techniques, considered essentially similar to those used in long-term treatment, were thought to require special adaptations in PSTT.

The clinics reported therapeutic disadvantages to PSTT more frequently than the agencies. "Limited

1To avoid repetition, the term "client" is used here as the equivalent of "patient"; and "worker," as the equivalent of "therapist."
effectiveness," lack of knowledge about criteria, and lack of skill were the most frequently mentioned disadvantages. The respondents were sophisticated professionals who did not regard PBT as a panacea for all mental health problems.¹

With respect to administrative procedures for PBT, the clinics—as compared to the agencies—were more likely to (1) have longer waiting lists; (2) use an application form as a screening device; (3) have centralized or specialized intake services; (4) have a longer time lapse between the application for help and the initial interview; and (5) use a larger number of exploratory interviews before the case was assigned to PBT. Thus, in terms of these administrative factors, the clinics seemed less accessible for early crisis intervention activities. 

¹In this context, it is appropriate to acknowledge the criticisms offered by certain professional writers (not study respondents) who believe that the efficacy of the crisis concept has been exaggerated. For example, a British critic, Harrington, has warned advocates of the crisis approach against giving the impression that "here at last is the means of establishing the future mental health of mankind." In a recent lecture, Littner has cautioned against the indiscriminate use of crisis therapy "for all comers" and has expressed the fear that some clinicians, "in their avid flirtation with these new techniques may become their slave, rather than their master." And in the absence of substantial empirical evidence, Hassel has issued a caveat against glib acceptance of "crisis theory statements" concerning the relationship between certain crisis-inducing events and the risk of "subsequent behavior disorder." See E. Harrington, Review of Prevention of Mental Disorders in Children, ed. Gerald Caplan, in British Journal of Psychiatry, 1962, 211; Nor Littner, lecture presented to the Smith College School for Social Work Alumni Association, Chicago, Illinois, November 6, 1965, to be published in a forthcoming issue of the Smith College Studies in Social Work; and Leonard Hassel, "Community Mental Health: Opportunities and Pitfalls," Newsletter, VIII (Quincy, Mass.: Mass. Psychological Association, October, 1964), 4.
pressures and multidiscipline case evaluation arrangements--
the same factors that probably influenced the initiation of
PSTT services in clinics--may also have combined to reduce
their accessibility.

Clinics employed a specific predetermined number of
interviews in their PSTT programs more frequently than
agencies. Another important difference was apparent in the
fact that the clinics did significantly more follow-up work
in PSTT cases; moreover, they reported more research pro-
jects in the planning stage than agencies.

However, both the AAFCS and FSAA study samples ex-
hibited common features in regard to: (1) the integration
of PSTT into overall clinic or agency program (only three
clinic and six agency respondents indicated the use of a
special administrative unit for PSTT); (2) the upper limit
most frequently used in the range of interviews employed
in PSTT (12 interviews for both samples); (3) continuation
of PSTT cases with the same worker after intake (in contrast,
non-PSTT cases were generally reassigned); (4) the use of
case evaluation procedures after a specified treatment
period; (5) provision for continuation of cases with the
same worker after expiration of the PSTT time limit; (6) the
use of special staff development or training programs in
preparation for or as part of PSTT; (7) current research
in connection with PSTT programs; and (8) staff opinions
concerning the professional advisability of PSTT (both when
PSTT was first initiated and at the time of this study).
In both sample groups, these opinions were overwhelmingly positive, and when they changed—after PSTT was initiated—they did so in a positive rather than a negative direction.

Finally, a preliminary "Program Assessment Scale" (PAS) was developed to profile differences among respondents with a strong, moderate, or minimal investment in crisis-oriented PSTT. The PAS included 10 cross-validated items (for AAPCC and FSAA) related to crisis formulations, time factors, intake procedures, staff training, and research. Further study will be needed to test this study instrument.

Discussion

It is noteworthy that only 21 clinics and agencies reported the use of a specific predetermined number of interviews or weeks of treatment for PSTT cases; the remaining 77 respondents used an approximate range of interviews or weeks as a way of structuring the time dimension. PSTT, as typically used by the respondents in this sample, encompassed up to 12 interviews which were offered over a period of up to three months.\(^1\) Thus, the manipulation of PSTT time limits was characterized by considerable flexibility rather than rigidity. This flexible approach was further illustrated by (a) most respondents reported that clients usually continued with the same worker if the PSTT

---

\(^1\)Since, as indicated in the review of the literature in Chapter II, the length of short-term treatment is often unspecified, this finding may be of some practical use to mental health programs that are about to experiment with PSTT.
time limits were exceeded;\(^1\) and (b) a number of agencies and clinics indicated they had an "open-door" policy which made it easy for clients to return for help with new or recurrent problems after the termination of PSTT.

Only 21 respondents (including only four of the FSAF agencies) made systematic use of follow-up interviews after PSTT cases were closed. This seems unfortunate because brief telephone follow-up conversations provide a valuable feedback concerning the apparent effectiveness of PSTT, as well as an opportunity to reassure the client about the agency's continued interest and the availability of further help if it should be needed. A few respondents spoke positively about the use of "built-in" or prearranged follow-up interviews, which were discussed with the client during the intake period.

The fact that only eight agencies and eight clinics were involved in research activities dramatically reflected the ad hoc nature of many of the PSTT programs, as well as the urgent need for a greater research investment to improve practice theory which would ultimately enhance service effectiveness.

One of the important questions in this inquiry was the extent to which the crisis approach was used by agency and clinic practitioners. In a preliminary paradigm

\(^1\)In some programs, treatment was extended for another specific, or approximate number of interviews, with the understanding that worker and client would then re-evaluate future treatment plans.
(Chapter III; Table 3.1) two dimensions were suggested to
differentiate a PSTT-crisis approach from a non-crisis PSTT
approach: (a) special attention to one or more components
of the crisis configuration, and (b) early accessibility
(or prompt availability) of PSTT services. While almost
all respondents (90.8 percent) were oriented to at least
one aspect of the crisis configuration, only slightly more
than half (59.2 percent) combined an interest in crisis with
"early access" approaches (that is, emphasis on "immediacy
of treatment" or a waiting period of no more than four days
between the application for help and the first interview).¹

The reasons for the relative neglect of early accessi-
bility by almost half of the respondents seem related to
somewhat rigid administrative procedures (such as prolonged
intake and case reassignment) and long waiting lists, which
were obviously influenced by staff shortages as well as
client demand. A crucial question—which would require
further empirical study— is whether the often serious lack
of treatment accessibility and service coverage in PSTT
programs was due to the fact that only a small, perhaps in-
significant proportion of cases were actually assigned to
PSTT in certain agencies and clinics. In this connection,
it is noteworthy that a number of programs with high case

¹Cooper has discussed the importance of being attuned
to the "life crises" of patients and of providing appro-
priate emergency intervention on the grounds that "the wait-
ing period between a patient's application move and his
therapy is, in most instances, an obstacle to good therapy."
Shirley Cooper, "Emergencies in a Psychiatric Clinic,"
Social Casework, XLII (March, 1960), 13h.
loads were able to implement an early access approach even though their theoretical formulations of crisis were relatively modest. It seems that for these respondents a relatively simple formulation of crisis had the power to sensitize the staff to the importance of streamlined intake procedures that were functionally oriented to client need rather than to agency convenience.

The data vividly demonstrated the positive sentiments of staff members regarding the professional advisability of PSTT services. At the time of this study, 65.2 percent of the FSAA and 84.1 percent of the AAPCC respondents were either "moderately" or "very" enthusiastic about their PSTT programs. Clinical study is needed to determine whether these positive attitudes are significantly correlated with the advisability of using PSTT in specific cases.

The questionnaire data also showed that when opinions about PSTT changed—after a given PSTT service was started—they changed significantly in a positive direction. This finding was interpreted in terms of the positive self-fulfilling prophecy. That is, once a group of staff members have had a successful experience with even a small number of PSTT cases, their positive sentiments tended to be self-re-enforcing in their subsequent clinical experiences in offering PSTT services. If, as often happens, these positive attitudes were implicitly or explicitly communicated to the client, then the client's faith in the efficacy of PSTT
was probably enhanced, thereby illustrating another benefi-
cial result of the widening effects of the self-fulfilling
prophecy.\(^1\)

Morgan has commented on the important role played by
the self-fulfilling prophecy in crisis-oriented therapy:

Social casework practice concerns itself principally
with human crises in which all too frequently the help
of all modern science seems unequal to meet the challenge
of the problem presented by the client. It will probably
always be true that caseworkers in emergency situations
will reach out artistically beyond their professional
training into their human heritage for the hope and
faith they need in order to define favorably the client's
situation, so that he may see some reason to continue
in efforts to ameliorate his lot . . . In crisis
situations, when action is required, the effective
practitioner does not dispassionately 'play the odds'
as if his client were a rat in a maze. Rather, he
cares deeply and in caring deeply and believing he can
help, he provides his client with enough freedom from
anxiety and vacillation so that together they can enter
into the problem-solving process. During crisis situa-
tions, it is essential for the social worker to feel
confident that he can in fact help his frightened
client.\(^2\)

Thus, Morgan concluded that not only is it scientific
to be optimistic but it is "in the mainstream of countless
ages of accumulated human wisdom which predates the scienc-
tific era."\(^3\)

---

\(^1\)Conversely, the implications of a negative self-
fulfilling prophecy—whereby the worker's doubts and re-
servations about PSTP may be communicated to the client—
should not be ignored. The negative effects of the worker's
lack of encouragement have been discussed by Ripple. See,
Motivation, Capacity, and Opportunity, 199.

\(^2\)Ralph Morgan, "Is It Scientific to be Optimistic?"
Social Work. VI (October, 1961), 19.

\(^3\)Ibid., 21.
Implications and Recommendations

What are the implications of this study for those interested in starting new or strengthening existing PSTT crisis-oriented services? 1

(1) In the light of the apparent advantages reported by many respondents in their descriptions of PSTT programs, it seems appropriate to recommend further experimentation with the deliberate and planned use of the time dimension. Thus, by making short-term services available to a greater number of applicants than those now served by agencies and clinics, progress might be made in mitigating—if not eliminating—the ubiquitous waiting list problem. The depressing details of the professional mental health manpower shortages that plague all the major helping professions do not require documentation here. But too often the truths about these shortages and the terrible service gaps resulting from them are allowed to recede into the background. After all, many practitioners may say, "Aren't we doing all that we can?" Obviously, every agency policy-maker and every practitioner must answer this question for himself. Yet it seems that the often-expressed fears about compromising such quality control operations as we have in treatment services agencies—if larger numbers of people are to

1 The observations and recommendations in this section are based on (a) an analysis of common themes and trends which are characteristic of a number of PSTT projects but especially those with a high score on the Program Assessment Scale (PAS); and (b) a review of the comments included by agencies and clinics in a rich variety of supplementary PSTT policy and program statements that were appended to the formal questionnaire responses.
be effectively served through PSTT programs—often provide a screen of rationalization to avoid developing new patterns of service coverage and technique. Paradoxically, in a number of questionnaires, respondents appended such comments as: "We would like to experiment with PSTT but we don't have the manpower," or "We don't have the time to experiment with time-limited treatment."

(2) In view of the importance attached to "immediacy of treatment" by respondents, individuals and families in crisis situations should be seen as soon as possible. Since such treatment should be easily available, crisis-oriented PSTT programs with low accessibility may well review those waiting list, intake, and screening procedures that seem to hinder the prompt delivery of their services.

(3) Since, within the framework of PSTT, most respondents found flexible time arrangements useful, it seems wise to experiment further with the timing of intervention—perhaps by beginning with frequent office and home interviews (when diagnostically indicated) during the period of high tension associated with crisis, then tapering off, with less frequent interviews, when a new equilibrium appears to have been restored. The profile of the agency's interventive activity might well resemble the profile of the family's crisis sequence.

(4) While virtually all the PSTT programs included in this study were oriented to family interaction processes (with many making selective use of multiple interviewing
techniques) a number of respondents mentioned the need for further study of such difficult questions as which members of the family play key roles in crisis-resolution and when they should be seen. Perhaps the law of persimmon might provide a guideline for action; the worker in crisis intervention should not assume that all members of the family must be seen in each interview.

(5) Although a few of the projects used in this study have reported experimental use of consultation techniques, activity in this area might well be expanded to promote community programs of preventive intervention. The psychiatrist, psychologist, or caseworker—as a "mental health consultant"—might profitably devote a certain proportion of his time for work with such "caretaking" agents as public health nurses, clergymen, and schoolteachers, who encounter larger numbers of persons than can possibly be seen on a one-to-one basis in the agency or clinic.¹ Hence, the opportunity for enhancing the mental health and social functioning of a collectivity that is larger than the family is of paramount importance here.

(6) Significant in a number of the projects surveyed in this study has been an effort to depart in meaningful ways from the "classical" treatment model. To oversimplify:

This model may be said to include the expectation that the client or patient will present himself well motivated for help; willing to wait for help as long as necessary; eager and willing to be introspective and to communicate with a kind of verbal sophistication typically associated with middle-class and upper middle-class cultural patterns; able to tolerate anxiety and delayed gratification; and willing to be interviewed by a variety of personnel (particularly in a clinic setting) during what may well be a prolonged intake phase. In most agencies, routinely planned office interviews are held each week, "usually lasting about an hour, taken up with 'talk,' most of which is expected to be done by the client or patient."1

As indicated in the rich range of narrative responses contributed to this study, there is great need for continued experimentation with departures from this traditional treatment model, including: (a) special attention to a positive controlled transference (with avoidance of a regressive type of transference often associated with long-term analytically oriented therapy); (b) disciplined use of active techniques of confrontation; thoughtful use of advice-giving, and liberal use of anticipatory guidance; (c) a strong commitment on the part of the worker to tangible results in helping the client to solve problems within a

---

period of time easily encompassed by the client's ego span.\(^1\)

However, it must be emphasized that these departures, though modeled on such life-processes as growth, trial and error, and restitution—rather than on psychoanalysis—are definitely based on adaptations of psychoanalytic ego psychology and presume a high level of clinical competence (including substantial experience in traditional long-term treatment). Thus, this type of time-limited crisis-oriented treatment is not to be equated with wild or "superficial" therapeutic management.

(7) Viewed as a treatment of choice by a striking majority of participants in this study, PSTT deserves an important place in the total spectrum of community mental health services.\(^2\) The respondents who believed that PSTT is essentially a treatment of expediency inevitably raised the controversial question: Does PSTT merely relieve symptoms and not treat underlying causes? Of necessity, in focused, goal-oriented PSTT, many underlying problems are untouched, since the therapist's efforts are directed to selected, emotionally relevant issues. Although this type of PSTT approach focuses on conscious and pre-conscious derivatives rather than on the core pathology, is this altogether different from traditional long-term open-ended "intensive"

\(^1\)See Charlotte G. Babcock, "Inner Stress in Illness and Disability," in Eco-Oriented Casework: Problems and Perspectives; ed. Parad and Miller, 63.

\(^2\)A few agency and clinic respondents, believing that PSTT is the treatment of choice for virtually all cases, indicated that only the exceptional case should be carried on a long-term basis — and only following supervisory approval.
treatment in which some issues are worked on and others ignored? Of course, psychoanalysis does not pretend to deal with all issues for all time; indeed, it has often been said that the main purpose of analysis is to enable people to face the vicissitudes of life in a mature way, not to provide a talisman for all life's problems.¹ Thus, in the kind of therapeutic activity discussed here it is somewhat artificial to differentiate between outward changes in functioning based on environmental manipulation, and changes in ego-adaptation patterns based on internal shifts in the defenses, since the two really go hand-in-hand. Typically, alterations in social functioning reflect improvement in such basic ego functions as perception, object-relatedness, control, and mastery.

Related to the problem of treatment goals is the fact a number of the PSTT projects explicitly avoided the myth associated with an adaptation of the medical model of "cure."² The notion that an "ill" person presents himself to the healing agent for a more or less prolonged period of diagnostic study and history-taking and then receives some sort of cure has often plagued traditional services because of its false commitment to a type of change which may be grossly impractical. In such an approach, the worker is

¹It is also worth mentioning that the time dimension is highly structured in psychoanalysis through the frequency and duration, if not through the number of analytic sessions.

²For a discussion of treatment goals, see Helen H. Perlman, "Some Notes on the Waiting List," Social Casework, XLIV (April, 1963), 200-205.
often left with a great deal of useless diagnostic information while the client is left with his painful, unsolved problems.

It is of crucial importance that there be a realistic treatment goal in PSTT services — indeed goals should be realistic in all clinically oriented services. As indicated in Chapter V, most clinics and agencies in this study tended to settle for a reasonable degree of improvement in dealing with the presenting problem. The de-emphasis of a false concept of cure, however, by no means should preclude efforts aimed at substantial improvement in ego coping and adaptive patterns that will help prepare the patient or client for dealing with the business of life.

Moreover, precise differentiation of "deep" from less ambitious forms of treatment is a complex process that still awaits definitive research. In a recent critique of research in the family service field, Briar has questioned the validity of the assumption that long-term treatment is ipso facto "deeper" or "better."¹ The crucial issue, according to Briar, is not how to convert short-term cases to long-term cases but how "to increase the effectiveness of short-term casework." As Bandler has pointed out, it seems dubious that a scientific distinction between "deep" and "superficial" treatment can be made on the basis of the

use of techniques of "support."¹ In the last analysis, clients and patients under stress seem to care less about how "long" or "deep" their treatment is than they do about its usefulness in their everyday living relationships.

(8) Finally, in the light of the study respondents' many references to difficulties in making available the right therapy at the right time and place, there is urgent need for continued and bold experimentation with new organization models and service patterns which incorporate the fundamental principles of crisis-oriented PSTT, including the provision of on-the-spot treatment that is supported and implemented by a variety of environmental resources to meet problems of immediate concern to the individual in his day-to-day job, health, legal, and other entanglements. Service visibility, availability, and accessibility should be emphasized in the delivery of services; the ideal should be to make help available when, where, and as needed. Examples of such experimentation would include the introduction of "individualizing" family casework service units into large public assistance programs—which, with proper statutory sanctions, must be reoriented to across-the-board "flat" income-conditioned grants that are awarded with a minimum of eligibility investigation. These service units might well be oriented to relatively intact families

¹Bernard Sandler, "The Concept of Ego-Supportive Psychotherapy," in Ego-Oriented Casework, ed. Pavar and Miller, 27-44.
experiencing crisis reactions to the stress of income
less, as well as to the more chronically disturbed families
at crisis points which enhance the possibility of establish-
ing a meaningful and helpful relationship. Integrated
organizational models should also be developed for family
social work programs in experimentally merged public assist-
ance and child welfare programs, family service and child
welfare, family service and child guidance, family service
and mental health,\(^1\) family service and legal aid services,
and family service and day care centers.

If an appropriate number of such diverse experimental
efforts can be launched—with built in action research—
planners in the mental health field may soon be in a position
to develop and evaluate working propositions concerning the
differential use of special techniques to deter further
fragmentation in community services. Thus, there would be
an opportunity to promote integrated service programs that
are basic to truly effective comprehensive mental health
and social welfare planning. The organization of packages
of services—with access to financial aid, medical and
dental care, visiting homemakers, and other social resources—
expandable or contractable to meet local neighborhood needs,
is imperative if the benefits suggested by the PSEI projects
surveyed in this report are to be fully exploited. The
establishment of early access crisis-oriented PSEI services

\(^1\)Eighteen FSAA agencies now include mental health
services in their programs.
within such experimental organizational frameworks
would—if made available to all citizens—provide a valuable
"social utility."). Properly organized neighborhood multi-
service centers would, as pointed out by Kahn and others,
help achieve a "larger measure of case accountability and
service integration. The overwhelming and distressing
evidence of case loss, service discontinuity . . . over-
specialization, and failures in problem-solving would become
points of departures for major reforms."\(^2\)

Continued experimentation with various types of multi-
service neighborhood centers would, by providing prompt
emotional and social first-aid in a way that is meaningful
to the client's own definition of the problem, help avoid
ineffective and wasteful referrals. The type of referral,
re-referral, and even re-re-referral that characterizes many
urban centers has been vividly described as the "referral
army-go-round" in a recent mental health study.\(^3\)

Press, 1966), 176-177.

\(^2\)Ibid., 185-186. See also Alfred J. Kahn et al.,
Neighborhood Information Centers: A Study and Some Proposals
(New York: Columbia University School of Social Work, 1966);
and Robert Parish and David Jones, Neighborhood Service
Centers (Washington, D.C.: U.S. Department of Health,
of a "systems analysis" approach to neighborhood social
service centers; see Helen C. Nicol, "Guaranteed Income
Maintenance: A Public Welfare Systems Model," Welfare in
Britain, IV (November, 1966), 6-11.

\(^3\)William Ryan, "Report of the Boston Mental Health
Survey," (mimeographed report, United Community Services,
Boston, June, 1962).
Almost four decades ago, the classic Milford Conference report stressed the importance of integrated social services:

A social agency should do a complete social casework job with its cases and should transfer a case only when the services of another agency are clearly indicated. Every social casework agency should be prepared to do broad in scope, as precise in procedure and as complete in the extension of its services as the demand of the individual case requires.¹

Innovative community and organizational planning in these directions would enhance the contributions of social work education and community mental health practice to each other. It would provide a creative, comprehensive, real-life laboratory for training students in understanding crisis phenomena and in acquiring professional treatment and research skills. However, it is important that the students' casework experiences be balanced by the inclusion of traditional casework learning experiences, for competency in FET cannot be developed by the student without appropriate experience in open-ended long-term casework. And while providing exciting experiences in the dynamics of clinical practice, administration, and community organization, such experimental field instruction would also provide

¹Social Casework: Generic and Specific (New York: American Association of Social Workers, 1959), 64, with a relevance as cogent today as when it was first written, the Report developed as a second corollary: "There should be no diagnostic authority without treatment responsibility and no treatment responsibility without diagnostic authority; ... treatment loses the opportunity to be completely effective unless it is continuously in the hands of one agency at the time of application."
a valuable feedback and stimulus for the entire social work curriculum.¹

Research Possibilities

Since the present study has been concerned with opinions and formulations about PSTT programs, the next important research task is to undertake comprehensive and systematic empirical studies of actual clinical performance in cases carried through PSTT.² Validating evidence concerning the ten-item PAS (described in the previous chapter) could be provided by field visits to stratified random samples of high, medium, and low PAS scorers. A second and perhaps more definitive method of validation would involve study of empirical case data, including information concerning (a) the use of selected components of the crisis configuration; (b) the actual number of predetermined or approximate interviews or weeks which were utilized in a given PSTT case; and (c) whether follow-up and research activities were utilized in specific PSTT services.

The following are additional examples of the kinds of problems that deserve careful investigation concerning the use of crisis formulations and time-limited mental health services.

¹The University of Chicago School of Social Service Administration is now completing plans for the operation of a school-sponsored neighborhood social service center that incorporates a number of these features.

²The case schedules included in Stage III of the longer AAPCS-PSAA Study of Planned Short-Term Treatment—of which the present inquiry is a part—will provide some data in this area.
There is a need for conceptual refinements of stress and crisis. Is it truly helpful to differentiate stress from crisis and, if so, under what circumstances does stress become a crisis in the judgment of practitioners on the firing line? Is crisis merely a faddist redefinition of the time-honored social work term "problem"? If so, is it perhaps meaningless? After all, a term that means all things means nothing.

The term "short" in short-term treatment, as shown in the present study has a variety of meanings, ranging from one interview to perhaps seven, 12, or more. Obviously, there is no magic in the number seven or 12 as an arbitrary limit on the number of interviews in a given P3TT program. But it is necessary to have some cut-off point, say, after a period of approximately three months, which is the modal period used by the P3TT services in the present study. The question of how "short" short-term treatment should be is obviously a complex one, as easily answered as the question: "How big is a house?" It is important, then, that studies (with appropriate experimental designs) be undertaken to investigate whether there is an optimal number of interviews or treatment period that is significantly associated with positive outcome rates—if, of course, other crucial variables can be controlled. Also worth studying in this context are such sub-questions as (a) Does the time deadline associated with planned termination heighten the client's and worker's motivation, that is, the desire for change?
And (b) Does the time pressure of PSTT accelerate case movement, that is, the rate of change?

Other relevant questions that have been suggested by the present study include: (1) Do PSTT programs have significantly lower treatment dropout rates than non-PSTT programs? (a) Do PSTT cases carried by a single family worker—rather than by the traditional orthopsychiatric team of psychiatrist, psychologist, and social worker—show significantly lower dropout rates and significantly higher improvement, if other important variables are controlled? (3) Is PSTT more effective with lower and working-class clients than with middle-class and upper-class clients? (4) Are lower and working-class clients receiving proportionately more short-term treatment services than middle-class and upper-class clients within the AAPCC and FSAA programs? According to Dorothy F. Beck, Director of Research, FSAA, such an empirical study of PSTT cases would be fruitful since the PSTT sample cases can be compared with the FSAA universe with respect to socioeconomic position.¹

In addition, from a practical clinical point of view, the most pressing need is for the development of uniform and validated criteria for the selection of cases for PSTT. Research in this area is still in its infancy. There is a special need for research employing experimental designs.

of the type now being used by the Community Service Society of New York in its study of PSTT. Since it is known from clinical experience that any case may be long-term or short-term—depending on a complex of variables such as professional judgment concerning the nature and severity of the problem, appraisal of client motivation, availability of agency resources, and level of clinical skill—strenuous efforts must be made to put clinical judgments to the acid test of systematic research in order to develop reliable and valid criteria. Informal agency and clinic deliberations about criteria of the type surveyed in this report, while useful and necessary, constitute only a first step toward such systematic tests.

In this sense, the PSTT programs which have been studied in this investigation are structured without regard to im-
portant diagnostic variables concerning the nature of the client's disorder. While preference was demonstrated for related principles of brief therapeutic intervention here working with "clients with healthy ego functioning;" a large number of programs selected poorly motivated clients and agencies and child guidance clinics to help individuals and patients with ego disorders for PSTT. Thus, it seems that families who have been exposed to acutely stressful situations, as well as to the acute episodes of morbid personality, in investigating PSTT cases at both ends of the continuum—series and family disorders, that is, the "strong" or healthy clients who actually need only a short period of help and the "weak" or "sick" or "multitasked" patients." Social Casework 41:11 (September-October 1959), 369.

The writer makes no pretense that the crisis approach discussed in this investigation will provide magical solutions to our pressing mental health problems. Yet there is evidence to suggest that continued careful experimentation with crisis-oriented PSTT programs in a variety of mental health services—using highly qualified professional staff—shows promise of (1) reducing the number of unplanned terminations by offering families under stress a more meaningful and definitive type of service; and (2) serving, through the redeployment of available professional resources, an increasingly larger number of individuals and families in stressful situations.

Two related goals deserve emphasis in assigning priority for the use of mental health resources: (1) Families in acutely stressful situations should have first call on the healing and helping services of social work; they have a special kind of priority need which must be met by the way in which scarce resources of money, time, and manpower are allocated; and (2) time-limited treatment programs involving various types of short-term family focused techniques might well be the treatment of choice for large numbers of families and thus deserve an important place in the spectrum of community mental health services.

This study has already suggested some of the practical implications of these policies, such as immediate diagnostic assessment; selected emphasis on history-taking procedures; focusing on specific and achievable treatment
goals, avoidance of overly specialized intake assignments that often require an inordinate number of case transfers; an open-door policy that invites people to return for help with recurrent crisis situations; and planned follow-up safeguards to make sure that families know, without being unduly hovered over, that although the formal period of help may have terminated, the agency's or clinic's interest continues if further service should be required.

The fact that further research is needed and that the findings of crisis-oriented PSTT projects now in operation are not "proven" should not obscure the substantial progress already made; nor should it deter practitioners from undertaking further efforts on the basis of available practice theory.

The action imperatives of social work, as a socially responsible and socially sanctioned profession, cannot await final and definitive results. The efforts at intervention described here seem to be supported by criteria of clinical utility which provide at least a beginning and should lead to more rigorous experimental research as time goes on.

The value system of our democratic, humanistic society provides the social capital to encourage such efforts. The family service and the mental health movements provide a sturdy tradition of broad social concern and responsible innovation of new patterns for the organization and distribution of services. Our affluent society is capable of
providing the economic capital necessary for extending geographic and service coverage. Our task now is to con-
vert this social and economic capital into palpable social programs that will serve an increasingly wider segment of American families under stress.

And what better time than now?
APPENDIX
APPENDIX A

QUESTIONNAIRE A. 1

"LOCATOR QUESTIONNAIRE"

From: Howard J. Parad, Director
Smith College
School for Social Work
Gateway House
Northampton, Mass.

QUESTIONNAIRE FOR THE STUDY OF
SHORT-TERM TREATMENT PROGRAMS

Sponsored by the Family Service Association of America

PURPOSE

We recognize that there are many different ideas about
and approaches to short-term treatment. The questions in this
study are designed to obtain information about your agency's
program and your staff's thinking about this area of service.

INSTRUCTIONS

This questionnaire is to be filled out by the Director
of Casework (or the person in charge of the casework program)
after consultation with the Executive Director, agency super-
visors, and other staff members. Please answer questions 4,
5, 10, 11, and 12 whether your response to question 1a is YES
or NO. Feel free to add any additional comments or informa-
tion you consider relevant; add extra pages if necessary.

Please return the completed questionnaire in the enclosed
stamped, addressed envelope as soon as possible, hopefully
by February 26, 1965.

IDENTIFYING DATA

Name of Agency ________________________________

Address ______________________________________

Telephone Number _____________________________

Name and title of person completing this reply________

Date _________________________________________

Names and titles of staff persons consulted for help in
completing this questionnaire: ____________________
IMPORTANT - PLEASE NOTE: If your answer to question 1a is YES, please answer questions 1b, 3, 4, 5, 10, 11, and 12.

If your answer to question 1a is NO, please answer questions 2, 4, 5, 6, 7, 8, 9, 10, 11, and 12.

1. a) Does your agency now have in operation a planned "short-term treatment program"?

DEFINITION: Planned "short-term treatment program" means that cases are designated at the point of application, referral, intake, or shortly thereafter, to receive a more or less limited number of in-person interviews and/or to be seen over a more or less limited period of time. It does not refer to case situations where the agency contact is ended on an "unplanned" basis against the advice of the case worker, nor to those where an early closing is mutually agreed upon by family and worker at the point of termination.

YES 14-1
NO 2

b) If YES, please check the items below that apply to your agency:

(1) Certain cases are designated at intake or shortly thereafter to receive an approximate number of interviews or to be seen over an approximate period of time.

(2) Certain cases are designated at intake or shortly thereafter to receive a specific predetermined number of interviews or to be seen over a specific predetermined period of time.

2. a) If your answer to question 1a is NO, do you have an informal program of short-term service which you do not think meets the above definition?

YES 16-1
NO 2

b) If YES, please describe your program below. (Use an extra page if necessary.)

(17-18)

(Please ignore the numbers in the right-hand margins; they are merely to facilitate the analysis of the answers.)
3. If your answer to question 1a is YES, please answer the following:
   a) When was your planned short-term treatment program started?
      (Write date here.) Month____ Year____  19-
   b) How many families were served by this program through one or more in-person interviews with a family member during the period January 1, 1965 to January 31, 1965?
      (Write number here)_________  20-22
4. a) Does your agency provide any special services for emergency or crisis situations?
      YES_________  23-1
      NO_________  -2
    b) If YES, please describe.  24-25
   c) Are these services usually short-term?
      YES_________  26-1
      NO_________  -2
5. a) On December 31, 1964, did your agency have a waiting list, that is, a list of clients and/or applicants for whom regular services were delayed?
      YES_________  27-1
      NO_________  -2
(Please do not fill in the space below)
   b)_________  28-30
   c)_________  31-33
   d)_________  34-36
6. a) If not now in operation, is a planned short-term treatment program contemplated for the future?  
   YES ___________  37-1  
   NO ___________  -2  

   b) If YES, please fill in the appropriate item below:
      
      (1) Some preliminary staff discussion has been held concerning the possibility of starting such a program but no definite plans have been made ______ (check here if applicable)  38-1  
      
      (2) Program is now being planned and will begin on or about (insert date) _______  -2  
      
      (3) Program is all set to go, will begin on (insert date) _______  -3  

7. a) If not now in operation, was a planned short-term treatment program initiated but discontinued within the past five years?  
   YES ___________  39-1  
   NO ___________  -2  

   b) If YES, please state the reasons for discontinuance.  40-  

8. a) Was a proposal for a planned short-term treatment program considered within the last five years but not initiated?  
   YES ___________  41-1  
   NO ___________  -2  

   b) If YES, state reasons why program was not initiated.  42-
9. If your agency does not have a planned short-term treatment program, please give your thinking about the pros and cons of starting such a program.

   a) about the pros of starting such a program . . . 43-

   b) about the cons of starting such a program . . . 44-

10. Please check the one item below that most nearly describes your agency's thinking about the professional advisability of offering planned short-term treatment services:

   (1)    (2)    (3)    45-1
   strongly disapprove disapprove mixed
   disapprove disapprove opinion
   approve approve no
   approve approve opinion
11. a) How many families were under the care of your agency (that is, "open") during the period January 1, 1965 to January 31, 1965? (11a) 46-48

b) Of the number listed above in item 11a, how many had received one or more in-person interviews with a family member as of January 31, 1965? (11b) 49-51

c) Of the number listed above in item 11b, how many cases were closed during the period January 1, 1965 to January 31, 1965? (11c) 52-54

(1) How many of the number listed above in item 11c were closed with:

(a) one in-person interview with family? 55-57

(b) 2 - 5 in-person interviews with family? 58-60

(c) 6 or more in-person interviews with family? 61-63

(2) How many of the number listed above in item 11c were "referred elsewhere"? 64-66

(FSAA definition: Family "referred elsewhere" because the service needed can be more appropriately given by another resource.)

(3) How many of this number (listed above in 11c) were "terminated by agency plan"? 67-69

(FSAA definition of service "terminated by agency plan: Service terminated because the family's need has been met by the agency, or it is felt that no further service is indicated at this time. This does not mean that the family may not return at a later date or that all problems seen by the caseworker and/or the family have been satisfactorily resolved.")

(4) How many of this number (listed above in 11c) "terminated service against agency advice"? 70-72

(Question 11. c) continued on the next page.)
11. a) (4) (FSAA definition of "terminated service against agency advice: Unplanned termination due to family's withdrawal or termination in which the family decides to withdraw against professional advice. Includes a family on waiting list who refuses appointment when offered, if an in-person interview with family was previously held.")

(5) How many of this same number (listed on the previous page in item 11e) were terminated for reasons other than those cited above in sub-items (2), (3), and (4)?

\[ 11e(5) \]

(a) Of this number, just cited above in item 11e(5), how many were terminated primarily because of external factors which preclude continuing contact (e.g., family moving away)?

\[ 75-76 \]

(b) Of the same number, cited above in item 11e(5), how many were terminated primarily because of limitations within the agency which preclude continuing contact (e.g., staff changes or shortages)?

\[ 77-78 \]

12. Please add any comments or information you consider relevant to this study.

REMINDER: PLEASE ANSWER QUESTIONS 4, 5, 10, 11, and 12 whether your answer to question 1a is YES or NO.

THANK YOU FOR YOUR HELP WITH THIS STUDY! PLEASE BE SURE TO RETURN THE COMPLETED QUESTIONNAIRE AS SOON AS POSSIBLE IN THE RETURN ENVELOPE PROVIDED FOR THIS PURPOSE.
APPENDIX A

QUESTIONNAIRE A. 2

"LOCATOR QUESTIONNAIRE"

From: Howard J. Parad, Director 2/1/65
Smith College #1 AAPCC
School for Social Work
Gateway House
Northampton, Mass.

QUESTIONNAIRE FOR THE STUDY OF
SHORT-TERM TREATMENT PROGRAMS

Sponsored by the American Association of
Psychiatric Clinics for Children

PURPOSE

We recognize that there are many different ideas about
and approaches to short-term treatment. The questions in
this study are designed to obtain information about your
clinic's program and your staff's thinking about this area
of service.

INSTRUCTIONS

This questionnaire is to be filled out by the clinic's
Chief Psychiatric Social Worker after consultation with the
Chief Psychiatrist, Chief Psychologist, clinic supervisors,
and other staff members. Please answer questions 4, 5, 10,
11, and 12 whether your response to question 1a is YES or
NO. Feel free to add any additional comments or information
you consider relevant; add extra pages if necessary.

Please return the completed questionnaire in the enclosed
stamped, addressed envelope as soon as possible, hopefully
by February 26, 1965.

IDENTIFYING DATA

Name of Clinic

Address

Telephone Number

Name and title of person completing this reply

Date

Names and titles of staff persons consulted for help in com-
pleting this questionnaire:
IMPORTANT - PLEASE NOTE: If your answer to question la is YES, please answer questions 1b, 3, 4, 5, 10, 11, and 12.

1. a) Does your clinic now have in operation a planned "short-term treatment program"?

DEFINITION: Planned "short-term treatment program" means that cases are designated at the point of application, referral, intake, or shortly thereafter, to receive a more or less limited number of in-person interviews and/or to be seen over a more or less limited period of time. It does not refer to case situations where the clinical contact is ended on an "unplanned" basis against the advice of the therapist, nor to those where an early closing is mutually agreed upon by family members and therapist at the point of termination.

YES

NO

b) If YES, please check the items below that apply to your clinic:

(1) Certain cases are designated at intake or shortly thereafter to receive an approximate number of interviews or to be seen over an approximate period of time.  

YES

NO

(2) Certain cases are designated at intake or shortly thereafter to receive a specific predetermined number of interviews or to be seen over a specific predetermined period of time.

YES

NO

2. a) If your answer to question la is NO, do you have an informal program of short-term service which you do not think meets the above definition?

YES

NO

b) If YES, please describe your program below.

(Use an extra page if necessary.)

(Please ignore the numbers in the right-hand margins; they are merely to facilitate the analysis of the answers.)
3. If your answer to question 1a is YES, please answer the following:

a) When was your planned short-term treatment program started?
   (Write date here.) Month______Year_______ 19-

b) How many family units were served by this program through one or more in-person interviews with any family member(s) during the period January 1, 1965 to January 31, 1965?
   (Write number here.) 20-22

(Definition of family unit: persons living together in household who are related by blood, marriage, or adoption. When members of same family are living in separate households on apparently permanent basis, count each household receiving service as separate family unit.)

4. a) Does your clinic provide any special services for emergency or crisis situations?
   YES_______ 23-1
   NO_________ -2

b) If YES, please describe. 24-25

c) Are these services usually short-term?
   YES_______ 26-1
   NO_________ -2

5. a) On December 31, 1964, did your clinic have a waiting list, that is, a list of patients and/or applicants for whom regular services were delayed?
   YES_______ 27-1
   NO_________ -2

b) If YES, please indicate the total number of names on this list on December 31, 1964.
   b)_________ 28-30

c) Of this total number (item b above), how many had received one or more in-person interviews?
   c)_________ 31-33

d) Of this same total number (item b above), how many had not yet received any in-person interviews?
   d)_________ 34-36

(Please Note: Items c + d = b)
6. a) If not now in operation, is a planned short-term treatment program contemplated for the future?

<table>
<thead>
<tr>
<th>YES</th>
<th>37-1</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>-2</td>
</tr>
</tbody>
</table>

b) If YES, please fill in the appropriate item below:

1. Some preliminary staff discussion has been held concerning the possibility of starting such a program but no definite plans have been made (check here if applicable) 38-1

2. Program is now being planned and will begin on or about (insert date) 39-1

3. Program is all set to go, will begin on (insert date) 40-

7. a) If not now in operation, was a planned short-term treatment program initiated but discontinued within the past five years?

<table>
<thead>
<tr>
<th>YES</th>
<th>39-1</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>-2</td>
</tr>
</tbody>
</table>

b) If YES, please state the reasons for discontinuance. 41-

8. a) Was a proposal for a planned short-term treatment program considered within the last five years but not initiated?

<table>
<thead>
<tr>
<th>YES</th>
<th>41-1</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>-2</td>
</tr>
</tbody>
</table>

b) If YES, state reasons why program was not initiated. 42-
9. If your clinic does not have a planned short-term program, please give your thinking about the pros and cons of starting such a program.
   a) about the pros of starting such a program . . . 43-

   b) about the cons of starting such a program . . . 44-

10. Please check the one item below that most nearly describes your clinic's thinking about the professional advisability of offering planned short-term treatment services:

   (1) ____  (2) ____  (3) ____  
   strongly disapprove disapprove mixed opinion 
   (4) ____  (5) ____  (6) ____  
   approve strongly approve no opinion 

   45-1
Note: We realize that there are variations in ways of keeping service statistics and that the following questions may not conform to your clinic's present classification system. Since the information requested here is essential (in order to have uniform data for this study), we will greatly appreciate your cooperation in completing this section.

(Please see definition of "family unit" on page 3)

11. a) How many different family units were under the care of your clinic (that is, "open") during the period January 1, 1965 to January 31, 1965? (11a) 46-48

b) Of the number listed above in item 11a, how many had received one or more in-person interviews with a family member as of January 31, 1965? (11b) 49-51

c) Of the number listed above in item 11b, how many cases were closed during the period January 1, 1965 to January 31, 1965? (11c) 52-54

(Definition: "Closed" here means that no further service is being given to any member of the family unit, as of the time of closing.)

(1) How many of the number listed above in item 11c were closed with:

(a) one in-person interview with any family member? ______ 55-57

(b) a total of 2 - 5 in-person interviews with one or more family members? ______ 58-60

(c) a total of 6 or more in-person interviews with one or more family members? ______ 61-63

(2) How many of the number listed above in item 11c were "referred elsewhere"? ______ 64-66

(Definition: Child or family "referred elsewhere" because the service needed can be more appropriately given by another resource.)

(3) How many of this number (listed above in 11c) were "terminated by clinic plan"? ______ 67-69

(Definition: Service ended because the child's or family's need has been met by

(Question 11. c) continued on the next page.)
the clinic, or it is felt that no further service is indicated at this time. This does not mean that the child or family may not return at a later date or that all problems seen by the clinic and/or the family have been satisfactorily resolved.)

(4) How many of this number (listed above in 11a) "terminated service against clinic advice"?

(Definition: Unplanned terminations due to child's or family's withdrawal against professional advice. Includes a family on waiting list whose members refuse appointment when offered, if an in-person interview with a family member was previously held.)

11. c) (5) How many of this same number (listed on the previous page in item 11c) were terminated for reasons other than those cited above in sub-items (2), (3), and (4)?

11e(5)

(a) Of this number, just cited above in item 11e(5), how many were terminated primarily because of external factors which preclude continuing contact (e.g., family moving away)?

(b) Of the same number, cited above in 11e(5), how many were terminated primarily because of limitations within the clinic which preclude continuing contact (e.g., staff changes or shortages)?

12. Please add any comments or information you consider relevant to this study.

REMINDER: PLEASE ANSWER QUESTIONS 4, 5, 10, 11, and 12 WHETHER YOUR ANSWER TO QUESTION 1a IS YES OR NO.

THANK YOU FOR YOUR HELP WITH THIS STUDY! PLEASE BE SURE TO RETURN THE COMPLETED QUESTIONNAIRE AS SOON AS POSSIBLE IN THE RETURN ENVELOPE PROVIDED FOR THIS PURPOSE.
APPENDIX A

QUESTIONNAIRE A. 3

ABBREVIATED "LOCATOR QUESTIONNAIRE"

From: Howard J. Parad, Director
Smith College
School for Social Work
Gateway House
Northampton, Massachusetts

ABBREVIATED QUESTIONNAIRE FOR THE STUDY
OF SHORT-TERM TREATMENT PROGRAMS

Sponsored by the Family Service Association of America

Dear

More than 90 per cent of the FSAA agencies have responded to our initial questionnaire for the FSAA-sponsored study of short-term treatment programs. Your prompt response to the enclosed brief questionnaire will enable us to have 100 per cent cooperation.

This inquiry will take only ten minutes to fill out. Please return your completed questionnaire in the enclosed envelope by October 1, 1965. (An extra copy of the questionnaire is enclosed for your files.)

Many thanks for your cooperation!

Sincerely,

Howard J. Parad

IDENTIFYING DATA

Name of Agency________________________________________

Address______________________________________________

Telephone Number_____________________________________

Name and Title of person completing this reply____________

Date__________________________________________________
1. a) Does your agency now have in operation a planned 'short-term treatment program'?  

**DEFINITION:** Planned "short-term treatment program" means that some cases are designated at the point of application, referral, intake, or shortly thereafter, to receive a more or less limited number of in-person interviews and/or to be seen over a more or less limited period of time. It does not refer to case situations where the agency contact is ended on an "unplanned" basis against the advice of the caseworker, nor to those where an early closing is mutually agreed upon by family and worker at the point of termination.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-1</td>
<td>14-2</td>
</tr>
</tbody>
</table>

b) If YES, please check the item(s) below that apply to your agency:

(1) Certain cases are designated at intake or shortly thereafter to receive an approximate number of interviews or to be seen over an approximate period of time.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-1</td>
<td>15-2</td>
</tr>
</tbody>
</table>

(2) Certain cases are designated at intake or shortly thereafter to receive a specific predetermined number of interviews or to be seen over a specific predetermined period of time.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

2. a) If your answer to question la is NO, do you have an informal program of short-term service which you do not think meets the above definition?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-1</td>
<td>16-2</td>
</tr>
</tbody>
</table>

b) If YES, please describe your program below. (Use other side if necessary.)

17-18

3. If not now in operation, is a planned short-term treatment program contemplated for the future?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>37-1</td>
<td>37-2</td>
</tr>
</tbody>
</table>

4. Please check the one item below that most nearly describes your agency's thinking about the professional advisability of offering planned short-term treatment services:

- Strongly disapprove
- Mixed opinion
- Disapprove

(Question 4 continued on next page)
(4) ______ (5) ______ (6) ______

approve  strongly  no  opinion

(Please ignore the numbers in the right-hand margin; they are merely to facilitate the analysis of the answers.)
APPENDIX A

QUESTIONNAIRE A. 4

ABBREVIATED "LOCATOR QUESTIONNAIRE"

From: Howard J. Parad, Director
Smith College
School for Social Work
Gateway House
Northampton, Massachusetts

9/15/65
Stage #1 AAPCC
Follow-up

ABBREVIATED QUESTIONNAIRE FOR THE STUDY
OF SHORT-TERM TREATMENT PROGRAMS

Sponsored by the American Association of
Psychiatric Clinics for Children

Dear

More than 90 per cent of the AAPCC clinics have re-
sponsible to our initial questionnaire for the AAPCC-spon-
sored study of short-term treatment programs. Your prompt
response to the enclosed brief questionnaire will enable us
to have 100 per cent cooperation.

This inquiry will take only ten minutes to fill out.
Please return your completed questionnaire in the enclosed
envelope by October 1, 1965. (An extra questionnaire is
enclosed for your files.)

Many thanks for your cooperation!

Sincerely,

Howard J. Parad

IDENTIFYING DATA

Name of Clinic__________________________________________

Address________________________________________________

Telephone Number_______________________________________

Name and Title of person completing this reply_______________

Date____________________________________________________
1. a) Does your clinic now have in operation a planned "short-term treatment program"?

DETECTION: Planned "short-term treatment program" means that some cases are designated at the point of application, referral, intake, or shortly thereafter, to receive a more or less limited number of in-person interviews and/or to be seen over a more or less limited period of time. It does not refer to case situations where the clinic contact is ended on an "unplanned" basis against the advice of the therapist, nor to those where an early closing is mutually agreed upon by family and therapist at the point of termination.

YES ________ 14-1
NO __________ -2

b) If YES, please check the item(s) below that apply to your clinic:

(1) Certain cases are designated at intake or shortly thereafter to receive an approximate number of interviews or to be seen over an approximate period of time.

__________ 15-1

(2) Certain cases are designated at intake or shortly thereafter to receive a specific predetermined number of interviews or to be seen over a specific predetermined period of time.

__________ -2

2. a) If your answer to question 1a is NO, do you have an informal program of short-term service which you do not think meets the above definition?

YES ________ 16-1
NO __________ -2

b) If YES, please describe your program below.
(Use other side if necessary.) 17-18

3. If not now in operation, is a planned short-term treatment program contemplated for the future?

YES ________ 37-1
NO __________ -2

4. Please check the one item below that most nearly describes your clinic's thinking about the professional advisability of offering planned short-term treatment services:

(45-1) -2

(Question 4 continued on next page)
(1) ___ (2) ___ (3) ___ -3
strongly disapprove disapprove mixed opinion -4
(4) ___ (5) ___ (6) ___ -5
approve strongly approve no opinion -6

(Please ignore the numbers in the right-hand margin; they are merely to facilitate the analysis of the answers.)
APPENDIX A

QUESTIONNAIRE A. 5

PROGRAM QUESTIONNAIRE

From:
Edward J. Parad, Director
Smith College
School for Social Work
Northampton, Massachusetts

10/7/65
Stage #2 PSAA

GENERAL QUESTIONNAIRE FOR THE STUDY OF
PLANNED SHORT-TERM TREATMENT SERVICES

Sponsored by the Family Service
Association of America

PURPOSE

We recognize that there are many different ideas
about and approaches to planned short-term treatment.
The questions in this part of the study are designed to
obtain specific information about your agency's program
and your staff's thinking about this area of service.

INSTRUCTIONS

This questionnaire is to be filled out by the
Director of Casework (or the person in charge of the
casework program) after consultation with the Executive
Director, agency supervisors, and other staff members.

Please return the completed questionnaire in the
attached (white), stamped envelope (marked "General
Questionnaire") as soon as possible, hopefully by
November 24, 1965.

IDENTIFYING DATA

Name of Agency____________________City____________________
Address__________________________Telephone________________

Name and title of person completing this reply__________________

Date______________________________

Names and titles of staff persons consulted in com-
pleting this questionnaire:

_________________________________________________________________

_________________________________________________________________
Population of community served: (Check one) 6-1
(1) Under 100,000 0
(2) 100,000 to 199,999 0
(3) 200,000 to 499,999 0
(4) 500,000 or more 0

Size of professional staff:
No. of full-time professional staff 3
No. of part-time professional staff 4

Does your agency offer:
(a) An adoption service? 7-1
Yes 0
No 0
(b) Homemaker service? 10-1
Yes 0
No 0

c) Foster placement for children? 7-1
Yes 0
No 0
d) Traveler's Aid? 10-1
Yes 0
No 0

(Please ignore the code numbers in the right-hand margins; they are merely to facilitate analysis of the answers.)

A. INTAKE PROCEDURE

1. Is there a centralized, or specialized intake service for all cases seen in your agency? 8-1
Yes 0
No 0

2. Are clients asked to fill out an application form before intake? 9-1
Yes 0
No 0

3. (a) Are short-term cases usually seen for a routine "exploratory study period" at intake? 10-1
Yes 0
No 0

If YES, for how many interviews? 11-
(Specify)

(b) Are other (non short-term) cases usually seen for a routine "exploratory study period" at intake? 12-1
Yes 0
No 0

If YES, for how many interviews? 13-
(Specify)

4. Is agency intake procedure likely to be the same for cases assigned to planned short-term service as for other cases? 14-1
Yes 0
No 0
5. (a) Are planned short-term cases reassigned after intake?  
   (1) Usually  (2) Rarely  (3) Never  
15-1

(b) Are other (non short-term) cases reassigned after intake?  
   (1) Usually  (2) Rarely  (3) Never  
16-1

6. Is planned short-term treatment offered by a special (separate? experimental?) administrative unit or an established, integrated part of your ongoing agency service?  
   Special  Integrated  
17-1

7. In planned short-term cases, how much time usually elapses between the client's application for help and the initial interview?  
   Less than 2 days  2 - 4 days  5 - 7 days  8 - 14 days  More than 14 days  
18-1

8. Does your agency now have a waiting list?  
   Yes  No  
19-1

   If YES, how many cases are on waiting list as of November 1, 1965?  
20- 

9. How many families were under the care of your agency (that is, "open") during the period October 1, 1965 to October 31, 1965?  
21- 

3. TIME FACTORS

1. As a matter of policy, is a pre-determined number of interviews (or weeks of treatment) specified for planned short-term treatment cases?  
   Yes  No  
22-1

   If YES, answer item(s) that apply below:

   (a) Number of interviews specified (Circle proper number)  
   1 2 3 4 5 6 7 8 9 10 11 12 13 14  
   more than 14 (specify)  
23- 

   (Question B. L. continued on next page.)
(b) Length of treatment (in weeks) specified
(Circle proper number)
1 2 3 4 5 6 7 8 9 10 11 12 13 14
more than 14 (specify)______ 24-

2. If there is no one specific number of interviews
(or time allocation) that is the range in the
number of interviews (or number of weeks) con-
sidered typical of your program with respect to
planned short-term cases closed during the last
three months?

(a) Typical range in number of interviews
From______to______ 25-
(b) Typical range in length of treatment
(in weeks) From______to______ 26-

3. If a specific pre-determined number of interviews
is used in your program, how was this number
arrived at? Please check the one item that most
nearly describes your procedure.

(1) Through clinical study of agency case
records 27-1

(2) Through systematic statistical study of the
number of interviews in closed cases ______ 2-

(3) Through informal staff discussion ______ 3-

(4) Through other factors (Please specify) ______ 4-

4. Is there provision for extension of service,
transfer, referral, or reassignment if client
needs service beyond limits of planned short-term
treatment? Yes______ 28-1
No______ 2-

If YES, please check the one item below that
would best describe your typical practice if
service is needed beyond the limits of planned

(1) Treatment interviews would be continued
with same worker ______ 29-1

(2) Client would be transferred to another
worker in the same agency ______ 2-

(Question B. # continued on next page.)
(3) Client would be referred to another agency. ________ -3

(4) Client would be placed on a waiting list for further service ________ -4

(5) Other provision would be made. (Please describe) ___________________________ -5

C. CASE CRITERIA

1. Are specific criteria used in selecting cases for planned short-term treatment? Yes ________ 30-1
   No ________ -2

   (a) If YES, what specific criteria (clinical, diagnostic, administrative) are used for the selection of cases? (Please append agency policy statement concerning such criteria if one is available). List your criteria in order of importance below. (Put the most important item on the first line, the next most important item on the second line, etc.)

   (1) ___________________________ 31,32
   (2) ___________________________ 33,34
   (3) ___________________________ 35,36
   (4) ___________________________ 37,38
   (5) ___________________________ 39,40
   (6) ___________________________ 41,42

   (b) If NO, please check one of the following:

   (1) Cases are assigned arbitrarily or by chance ________ 43-1

   (2) No criteria are needed because planned short-term treatment can be effective with any type of case. ________ -2

2. In the light of your agency's experience, please rank order the following factors as criteria for selecting cases for planned short-term treatment. Write the number 1 next to the item you consider most relevant, the number 2 next to the next most important item, etc. Number only those items which you consider applicable. (Question C.2. continued on next page.)
Planned short-term treatment is a way of helping:

1. Relatively healthy clients with many ego-strengths, or those related to the underlying problem.

2. Quite disturbed clients with few ego-strengths, or those related to the underlying problem.

3. Clients whose personality structure makes it unlikely that they will come back for more than a few interviews.

4. Clients whose presenting request is for help with a "environmental problem" rather than with a "personality problem".

5. Clients who tend to project their problems on to other people.

6. Clients in situations where environmental factors limit treatment possibilities.

D. TREATMENT FACTORS

1. Which one of the following statements most accurately expresses your opinion about the therapeutic techniques used in planned short-term treatment?

- Are essentially the same as those used in long-term treatment.
- Differ markedly from those used in long-term treatment.

2. In your agency practice, what is the most frequent goal orientation in cases of planned short-term treatment?

- Minor goals related to the presenting problem.
- Major goals related to the social crisis, or working class clients.

(Question 2. continued on next page.)
6. Do you find that lower-class clients require a special approach?  
   (1) Never   (2) Rarely  (3) Usually

7. Does your agency have a group treatment program?  
   Yes__________  No__________
   If YES, how is the group program related to planned short-term treatment?

(Please attach separate sheet if necessary)

8. Are there specific therapeutic disadvantages in your planned short-term treatment service?  
   Yes__________  No__________
   If YES, please list disadvantages:

(Please attach separate sheet if necessary)

9. Expediency vs. Choice (Check one):
   (1) In our view, planned short-term treatment is mainly a "treatment based on expediency" rather than a "treatment of choice".

   (2) In our view, planned short-term treatment is mainly a "treatment of choice" rather than a "treatment based on expediency".

E. PROGRAM FACTORS

1. In the light of your agency's experience, please rank order the following items, often referred to as reasons for initiating planned short-term treatment. Write the number 1 next to the item you consider most relevant, the number 2 to the next most important item, etc. Number only those items that apply to your program.
   (1) Dealing with the pressures of a long waiting list
(2) Utilizing scarce professional personnel

(3) Handling purely informational requests

(4) Offering a training experience for students

(5) Meeting the needs of clients in crisis situations

2. Please list any reasons for initiating your planned short-term treatment services other than those mentioned above.

3. If you checked sub-item (5) above, please give a brief definition of your agency's formulation of "crisis". It will be helpful if you give one or two specific brief examples of the kinds of crisis situation to which your service is oriented. (Attach a separate sheet if needed.)

4. Is there a pre-arranged procedure for case evaluation at the end of a specified treatment period?

   Yes
   No

   If YES, please describe.

5. Is there a planned follow-up (through in-person interviews, letters, or phone calls with client) for reviewing planned short-term treatment cases after they are closed by your agency?

   Yes
   No

   If YES, please answer items (a) through (c) below.

   (a) Which method is used most frequently?
      (Check one)
      (Question E. 5. continued on next page.)
(1) In-person interview______
(2) Phone call______
(3) Letter______

(b) Which staff member usually does this follow-up work?
(1) Worker who carried case______
(2) Other: Who?______________

(c) How many months usually elapse between case closing and the first follow-up contact?
Write in number of months__________

(Please append any agency statements - no matter how preliminary - concerning evaluative criteria or related matters that may be available concerning follow-up studies.)

6. Is research now being conducted in connection with this short-term treatment activity?
Yes______
No______

7. Is future research definitely planned in this area?
Yes______
No______

If YES (to question 6 or 7), briefly characterize research activity and give names of staff persons in charge of research or name of research consultant. Please append reprints of published papers or mimeographed copies of other relevant materials concerning research that has been conducted, whether exploratory, experimental or whatever, (Please use extra pages as needed.)

3. (a) Characterize your staff's general opinion of planned short-term treatment when it was initiated by checking the one item that best describes the staff's first reaction.

(1) Strongly opposed ______
(2) Slightly opposed ______
(3) Mixed feelings ______
(4) Moderately enthusiastic ______
(5) Very enthusiastic ______

(Question E. 8. continued on next page.)
(b) What, in general, is your staff's current opinion of planned short-term treatment? (Check one) 77-1

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly opposed</td>
<td>-2</td>
</tr>
<tr>
<td>Slightly opposed</td>
<td>-3</td>
</tr>
<tr>
<td>Mixed feelings</td>
<td>-4</td>
</tr>
<tr>
<td>Moderately enthusiastic</td>
<td>-5</td>
</tr>
<tr>
<td>Very enthusiastic</td>
<td></td>
</tr>
</tbody>
</table>

9. Comments about staff's opinions: ____________________________

10. Briefly, what is the theoretical rationale that underlies your planned short-term treatment services? 78- 

(Please use extra pages if you wish)

11. Please list professional writers, lecturers, books, articles, institutes, and other professional programs that have influenced the philosophy and rationale of your planned short-term services. (Attach a separate sheet if needed.) 

12. Please describe special staff development or training programs established in preparation for or as part of your on-going planned short-term treatment services. 79- 

13. Briefly, what are your agency's problems of geographic and service coverage? How do these relate to the scope, accessibility, and effectiveness of your planned short-term treatment services?
14. Do any other agencies or clinics in your community offer planned short-term treatment services?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don't Know</td>
<td>3</td>
</tr>
</tbody>
</table>

15. Please add any additional comments or observations you may have about the theoretical, policy, administrative, therapeutic, community planning, public relations, or other aspects of your planned short-term treatment services. Also, please append any copies of agency reports or other materials that will give a more vivid picture of the operation of your agency's planned short-term treatment services. (Please add extra pages if needed.)
APPENDIX A

QUESTIONNAIRE A. 6

PROGRAM QUESTIONNAIRE

From: Howard J. Parad, Director
Smith College
School for Social Work
Northampton, Massachusetts

10/7/65
Stage #2 AAPC

GENERAL QUESTIONNAIRE FOR THE STUDY OF
PLANNED SHORT-TERM TREATMENT SERVICES

Sponsored by the American Association of
Psychiatric Clinics for Children

PURPOSE

We recognize that there are many different ideas about and approaches to planned short-term treatment. The questions in this part of the study are designed to obtain specific information about your clinic's program and your staff's thinking about this area of service.

INSTRUCTIONS

This questionnaire is to be filled out by the Chief Psychiatric Social Worker after consultation with the Chief Psychiatrist, Chief Psychologist, clinic supervisors, and other staff members.

Please return the completed questionnaire in the attached (white) envelope (marked "General Questionnaire") as soon as possible, hopefully by November 24, 1965.

IDENTIFYING DATA

Name of Clinic __________________________ City __________________________
Address __________________________ Telephone __________________________

Name and title of person completing this reply __________________________

Date __________________________

Names and titles of staff persons consulted in completing this questionnaire:

________________________________________________________________________
________________________________________________________________________
Population of community served:  (Check one)  
(1) Under 100,000 ______  6-1  
(2) 100,000 to 199,999 ______  -2  
(3) 200,000 to 499,999 ______  -3  
(4) 500,000 or more ______  -4  

Size of professional staff:  
No. of full-time professional staff ______  7-1  
No. of part-time professional staff ______  -2  

(Please ignore the code numbers in the right-hand margins; they are merely to facilitate analysis of the answers.)

A.  INTAKE PROCEDURE  

1. Is there a centralized or specialized intake service for all cases in your clinic?  
   Yes_______  8-1  
   No_______  -2  

2. Are families asked to fill out an application form before intake?  
   Yes_______  9-1  
   No_______  -2  

3. (a) Are short-term cases usually seen for a routine "exploratory study period" at intake?  
   Yes_______  10-1  
   No_______  -2  

   If YES, for how many interviews?  (Specify)_______  11-  

   (b) Are other (non short-term) cases usually seen for a routine "exploratory study period" at intake?  
   Yes_______  12-1  
   No_______  -2  

   If YES, for how many interviews?  (Specify)_______  13-  

4. Is clinic intake procedure likely to be the same for cases assigned to planned short-term service as for other cases?  
   Yes_______  14-1  
   No_______  -2  

5. (a) Are planned short-term cases reassigned after intake?  
   (1) Usually____ (2) Rarely____ (3) Never____  15-1  
   (b) Are other (non short-term) cases reassigned after intake?  
   (1) Usually____ (2) Rarely____ (3) Never____  16-1  
   -2  
   -3
6. Is planned short-term treatment offered by a special (separate? experimental?) administrative unit or an established, integrated part of your ongoing clinic service? Special __________ 17-1
Integrated __________ -2

7. In planned short-term cases, how much time usually elapses between the family's application for help and the initial interview? (Check one)

Less than 2 days __________ 18-1
2 - 4 days __________ -2
5 - 7 days __________ -3
8 - 14 days __________ -4
More than 14 days __________ -5

8. Does your clinic now have a waiting list?

Yes __________ 19-1
No __________ -2

If YES, how many cases are on waiting list as of November 1, 1965?

9. How many cases were under the care of your clinic (that is, "open") during the period October 1, 1965 to October 31, 1965?

21-

B. TIME FACTORS

1. As a matter of policy, is a pre-determined number of interviews (or weeks of treatment) specified for planned short-term treatment cases?

Yes __________ 22-1
No __________ -2

If YES, answer item(s) that apply below:

(a) Number of interviews specified
(Circle proper number)

1 2 3 4 5 6 7 8 9 10 11 12 13 14
More than 14 (specify) __________ 23-

(b) Length of treatment (in weeks) specified
(Circle proper number)

1 2 3 4 5 6 7 8 9 10 11 12 13 14
More than 14 (specify) __________ 24-

2. If there is no one specific number of interviews (or time allocation) what is the range in the number of interviews (or number of weeks) considered typical of your program with respect to planned short-term cases closed during the last three months?

(Question B. 2. continued on next page.)
(a) Typical range in number of interviews
From____to_____

(b) Typical range in length of treatment (in weeks)
From____to_____

3. If a specific pre-determined number of interviews is used in your program, how was this number arrived at? Please check the one item that most nearly describes your procedure.

(1) Through clinical study of case records

(2) Through systematic statistical study of the number of interviews in closed cases

(3) Through informal staff discussion

(4) Through other factors (Please specify)

4. Is there provision for extension of service, transfer, referral, or reassignment if patient needs service beyond limits of planned short-term treatment?

Yes__________ 28-1
No__________ -2

If YES, please check the one item below that would best describe your typical practice if service is needed beyond the limits of planned short-term treatment.

(1) Treatment interviews would be continued with same therapist

(2) Patient would be transferred to another therapist in the same clinic

(3) Patient would be referred to another clinic or agency

(4) Patient would be placed on a waiting list for further service

(5) Other provisions would be made. (Please describe)

C. CASE CRITERIA

1. Are specific criteria used in selecting cases for planned short-term treatment? 30-1

Yes__________
No__________ -2

(Question C. 1. continued on next page.)
(a) If YES, what specific criteria (clinical, diagnostic, administrative) are used for the selection of cases? (Please append clinic policy statement concerning such criteria if one is available). List your criteria in order of importance below. (Put the most important item on the first line, the next most important item on the second line, etc.)

(1) ___________________________________________ 31,32
(2) ___________________________________________ 33,34
(3) ___________________________________________ 35,36
(4) ___________________________________________ 37,38
(5) ___________________________________________ 39,40
(6) ___________________________________________ 41,42

(b) If NO, please check one of the following:

(1) Cases are assigned arbitrarily or by chance 43-1
(2) No criteria are needed because planned short-term treatment can be effective with any type of case. 44-2

2. In the light of your clinic's experience, please rank order the following factors as criteria for selecting cases for planned short-term treatment. Write the number 1 next to the item you consider most relevant, the number 2 next to the next most important item, etc. Number only those items which you consider applicable.

Planned short-term treatment is a way of helping:

(1) Relatively healthy patients with many ego strengths. 44-1
(2) Quite disturbed patients with few ego strengths. 45-1
(3) Patients whose personality structure makes it unlikely that they will come back for more than a few interviews. 46-1

(Question C. 2. continued on next page.)
(4) Patients whose presenting request is for help with a concrete "environmental problem" rather than with a "personality problem".

(5) Patients who tend to project their problems on to other people.

(6) Patients in situations where environmental factors limit treatment possibilities.

D. TREATMENT FACTORS

1. Which one of the following statements most accurately expresses your opinion about the therapeutic techniques used in planned short-term treatment?

The techniques:

(1) Are essentially the same as those used in long-term treatment.

(2) Differ markedly from those used in long-term treatment.

(3) Are essentially similar to those used in long-term treatment, but require special adaptations in short-term treatment.

2. In your clinic's practice, what is the most frequent goal orientation in cases of planned short-term treatment?

Planned short-term treatment most frequently focuses on: (Check one item)

(1) Minor goals related to the presenting problem

(2) Major goals related to the presenting problem

(3) Minor goals related to the underlying problem

(4) Major goals related to the underlying problem
3. Why is planned short-term treatment effective? (Rank order by placing number 1 next to the most important item, 2 to next important, etc.)

(1) Because of the treatment skill of the therapist. 52-
(2) Because the patient knows that he will come for help for a limited number of interviews or a limited period of time. 53-
(3) Because the time limit steps up patient’s pace. 54-
(4) Because the time limit steps up therapist’s pace. 55-
(5) Because help is offered immediately when the patient needs it. 56-

4. What other factors do you think contribute to the effectiveness of planned short-term treatment? (Please list below). 57, 58

5. Social class factors (Check one)

(1) We find that planned short-term treatment is mainly effective with lower class or working class families. 59-
(2) We find that planned short-term treatment is mainly effective with middle class or upper class families. -2
(3) We don’t think that the family’s social class has anything to do with whether or not short-term treatment is effective. -3

6. Do you find that lower class families require a special approach? 60-

(1) Never (2) Rarely (3) Usually (4) Usually -3

7. Does your clinic have a group therapy program? 61

Yes________ No________

If YES, how is the group program related to planned short-term treatment?_________
8. Are there specific therapeutic disadvantages in your planned short-term treatment service?

Yes ________

No ________

If YES, please list disadvantages:

(Please attach separate sheet if necessary)

9. Expediency vs. Choice (Check one):

(a) In our view, planned short-term treatment is mainly a "treatment based on expediency" rather than a "treatment of choice". ________

(b) In our view, planned short-term treatment is mainly a "treatment of choice" rather than a "treatment based on expediency". ________

E. PROGRAM FACTORS

1. In the light of your clinic's experience, please rank order the following items, often referred to as reasons for initiating planned short-term treatment. Write the number 1 next to the item you consider most relevant, the number 2 to the next most important item, etc. Number only those items that apply to your program.

(1) Dealing with the pressures of a long waiting list ________
(2) Utilizing scarce professional personnel ________
(3) Handling purely informational requests ________
(4) Offering a training experience for students and residents ________
(5) Meeting the needs of patients in crisis situations ________

2. Please list any reasons for initiating your planned short-term treatment services other than those mentioned above.

3. If you numbered sub-item (5) above, please give a brief definition of your clinic's formulation of "crisis". It will be helpful if you give one or

(Question E. 3. continued on next page.)
two specific brief examples of the kinds of crisis situation to which your service is oriented. (Attach a separate sheet if needed.)

4. Is there a pre-arranged procedure for case evaluation at the end of a specified treatment period? 69-1
   Yes__________ No__________ -2

If YES, please describe

5. Is there a planned follow-up (through in-person interviews, letters, or phone calls with family) for reviewing planned short-term treatment cases after they are closed by your clinic? 70-1
   Yes__________ No__________ -2

If YES, please answer items (a) through (c) below.

(a) Which method is used most frequently?
   Check one) (1) In-person interview____ (2) Phone call____ (3) Letter____ -2

(b) Which staff member usually does this follow-up work?
   (1) Therapist who saw parents ____
   (2) Other: Who?______________ -2

(c) How many months usually elapse between case closing and the first follow-up contact? Write in number of months 73-

(Please append any clinic statements - no matter how preliminary - concerning evaluative criteria or related matters that may be available concerning follow-up studies.)

6. Is research now being conducted in connection with this short-term treatment activity? 74-1
   Yes__________ No__________ -2

7. Is future research definitely planned in this area? 75-1
   Yes__________ No__________ -2

(Question E. 7. continued on next page.)
If YES (to question 6 or 7), briefly characterize research activity and give names of staff persons in charge of research or name of research consultant. Please append reprints of published papers or mimeographed copies of other relevant materials concerning research that has been conducted, whether exploratory, experimental, or whatever. (Please use extra pages as needed.)

---

8. Characterize each discipline's general opinion of planned short-term treatment:

(a) When planned short-term service was initiated

<table>
<thead>
<tr>
<th></th>
<th>Psychiatrists</th>
<th>Psychologists</th>
<th>Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Strongly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>opposed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Slightly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>opposed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Mixed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Moderately</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>enthusiastic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) Very</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>enthusiastic</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(b) Current opinion

<table>
<thead>
<tr>
<th></th>
<th>Psychiatrists</th>
<th>Psychologists</th>
<th>Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Strongly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>opposed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Slightly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>opposed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Mixed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Moderately</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>enthusiastic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) Very</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>enthusiastic</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
9. Comments about staff's opinions: ____________________________________________

10. Briefly, what is the theoretical rational that underlies your planned short-term treatment services?  

(Please use extra pages if you wish)

11. Please list professional writers, lecturers, books, articles, institutes, and other professional programs that have influenced the philosophy and rationale of your planned short-term treatment services. (Attach a separate sheet if needed.)

12. Please describe special staff development or training programs established in preparation for or as part of your on-going planned short-term treatment services.

13. Briefly, what are your clinic's problems of geographic and service coverage? How do these relate to the scope, accessibility, and effectiveness of your planned short-term treatment services?

14. Do any other clinics or agencies in your community offer planned short-term treatment services? 

Yes _____ No _____ Don't know ______

15. Please add any additional comments or observations you may have about the theoretical, policy, administrative, therapeutic, community planning, public relations, or other aspects of your planned short-term treatment services. Also, please append any copies of clinic reports or other materials that will give a more vivid picture of the operation of your clinic's planned short-term treatment services. (Please add extra pages if needed.)
APPENDIX B

This appendix does not include certain
AAPCC correspondence which (except for a few
minor differences in wording) was the same
as the FSAA material.
APPENDIX B

LETTER B. 1

FSAA COVERING LETTER SENT WITH LOCATOR QUESTIONNAIRE

Family Service Association
of America
44 East 23rd Street
New York, New York 10010
212 Oregon 4-5100

TO: Executives of Member Agencies and Pre-Member Affiliates

FROM: Clark W. Blackburn, General Director

DATE: February 1, 1965

RE: Questionnaire for the Study of Short-term Treatment Programs

I am writing to ask for your agency's cooperation in completing the enclosed questionnaire which is part of an investigation of the many different types of short-term treatment programs currently operating in family agencies and child guidance clinics. Directed by Professor Howard J. Parad of the Smith College School for Social Work, this study will identify and analyze the common as well as the special features of these programs.

The FSAA Board of Directors has endorsed this study and we hope for the participation of all member agencies. The fact finding should prove useful to the entire field.

This inquiry will focus on planned short-term treatment services, with particular attention to programs that are oriented to stressful, emergency, or crisis-inducing situations. The enclosed questionnaire is intended to locate the programs that are within the general scope of the survey. A second questionnaire will be used to collect additional information concerning the relevant programs selected for further study.

Instructions for replying to the questionnaire are simple:
(1) It should be completed by the Director of Casework (or staff member in charge of the casework program) after consultation with the Executive Director, agency supervisors,
and other staff members who are knowledgeable about the agency's program; and (2) it should be mailed in the enclosed, self-addressed stamped envelope as soon as possible, but not later than February 26, 1965.

A report of Mr. Parad's study findings will be sent to all cooperating agencies.

Many thanks for your help!

65/1-77
APPENDIX B

LETTER B. 2

AAPCC COVERING LETTER SENT WITH LOCATOR QUESTIONNAIRE

The American Association of Psychiatric
Clinics for Children
250 West 57th Street
New York 19, N. Y.
Judson 2-1555

TO: All AAPCC member clinics

FROM: Dr. Hyman S. Lippman, President
Jacqueline L. Friend, Executive Director

RE: Questionnaire for the Study of Short-Term
Treatment Programs

We are writing to ask for your clinic's cooperation in completing the enclosed questionnaire which is part of an investigation of the many different types of short-term treatment programs currently operating in child guidance clinics and family agencies. Directed by Professor Howard J. Parad of the Smith College School for Social Work, this study will identify and analyze the common as well as the special features of these programs.

The AAPCC Council, upon the recommendation of our Executive Committee, has endorsed the participation of member clinics in this important research project.

This inquiry will focus on planned short-term treatment services, with particular attention to programs that are oriented to stressful, emergency, or crisis-inducing situations. The enclosed questionnaire is intended to locate the programs that are within the general scope of the survey. A second questionnaire will be used to collect additional information concerning the relevant programs selected for further study.

Instructions for replying to the questionnaire are simple: (1) it should be completed by the Chief Psychiatric Social Worker after consultation with the Chief Psychiatrist, the Chief Psychologist, and other staff members who are knowledgeable about the clinic's program; and (2) it should be mailed in the enclosed, self-addressed stamped envelope as soon as possible, hopefully by February 26, 1965.
Because of the practical usefulness of this fact-finding study to the child guidance field, we urge the participation of our member clinics by responding to Mr. Parad's questionnaire.

A report of study findings will be sent to all cooperating clinics.

Many thanks for your help!
APPENDIX B

LETTER 3.3

FOLLOW UP LETTER NO. 1
FOR LOCATOR QUESTIONNAIRE

SMITH COLLEGE SCHOOL FOR SOCIAL WORK
GATEWAY HOUSE
NORTHAMPTON, MASSACHUSETTS 01060

March 19, 1965

Dear [Agency Director],

This is a gentle reminder.

Last month we sent you the FSAA questionnaire on short-term treatment programs. We would like very much to receive your completed questionnaire at the earliest possible date.

As you know, the practical usefulness of this study for the family service field depends on having responses from all FSAA member agencies.

We need your completed questionnaire. Would you please take a minute to fill out the enclosed postcard reply on the status of your questionnaire.

Thank you for your cooperation.

Sincerely,

Howard J. Parad
Director

P. S. All respondents will receive a report of study findings as soon as all questionnaire data are tabulated.
APPENDIX B

LETTER B. 4

POSTCARD REPLY FORM SENT WITH
FOLLOW UP LETTER NO. 1
FOR LOCATOR QUESTIONNAIRE

Follow up on FSAA Questionnaire on short-term treatment programs. PLEASE CHECK APPROPRIATE ITEM BELOW.

1. Our completed questionnaire is on the way.
2. We need more time to complete the questionnaire.
   You will receive it on or about____________
3. Apparently our questionnaire has been lost. We want to cooperate in this FSAA study, so please send us another one.

4. Other comments about answering this questionnaire:

Name________________________ Agency________________________
Dear [Agency Director],

This is another gentle reminder—and a plea for your help!

Some time ago we sent you the FSAA questionnaire on short-term treatment programs. We would like very much to receive your completed questionnaire at the earliest possible date.

As you know, the practical usefulness of this study for the family service field depends on having responses from all FSAA member agencies.

We need your completed questionnaire. Would you please take a minute to fill out the enclosed postcard reply on the status of your questionnaire.

Thank you for your cooperation.

Sincerely,

Howard J. Parad
Director

P.S. All respondents will receive a report of study findings as soon as all questionnaire data are tabulated.

HJP
Follow-up on FSAA questionnaire on short-term treatment programs. PLEASE CHECK APPROPRIATE ITEM BELOW.

1. Our completed questionnaire is on the way.

2. You will receive it on or about ______________________

3. Apparently our questionnaire has been lost. We want to cooperate in this FSAA study, so please send us another one. ______________________

4. Other comments about answering this questionnaire:

Name ___________________________ Agency ___________________________
APPENDIX B

LETTER B. 7

LETTER TO FSAA AGENCIES REQUESTING THEIR PARTICIPATION IN STAGE II

FSAA PLANNED SHORT-TERM TREATMENT PROJECT

Gateway House  
Howard J. Parad
Smith College School for Social Work  
Project Director
Northampton, Massachusetts 01060  
September 25, 1965

Dear [Agency Director],

Last spring all FSAA member agencies were asked to participate in the first stage of our study of short-term treatment services. Over 90 per cent of the FSAA agencies completed questionnaires for this phase of our survey, designed to locate agencies which offer formal or informal planned short-term treatment. "Planned" here means simply that certain cases are designated at intake or shortly thereafter to be seen for (a) a more or less limited number of impersonal interviews or (b) a more or less limited period of time.

I am pleased to inform you that yours is one of the programs that falls within the scope of our study. Review of the preliminary questionnaires concerning these programs indicates a rich range of time-limited family services aimed at helping families under stress.

In order to investigate more precisely the special and common features of these programs, we have developed a general questionnaire and a series of simple case schedules which will constitute the second stage of this national study. In the near future these will be mailed to those who recently completed the initial questionnaire for this project. Included in the forthcoming kit of study materials will be a set of easy-to-follow instructions and stamped pre-addressed return envelopes.

A similar study, sponsored by the American Association of Psychiatric Clinics for Children, will be directed to a group of child psychiatric clinics which will also participate in the second stage of this national project. A special report of study findings will be sent to all cooperating agencies.

Clark W. Blackburn, FSAA General Director, joins me in thanking you for your continued and generous participation in this important project.  

Sincerely,

HJP:re  
Howard J. Parad, Project Director

#Please write us within the next few days if you want your agency's study kit mailed to a different staff member.
APPENDIX B

LETTER B. 8

INVITATION TO ATTEND MEETING OF
FSAA AGENCY STUDY COORDINATORS*

FSAA PLANNED SHORT-TERM STUDY PROJECT

Smith College
Gateway House
Northampton, Mass. October 15, 1965

Dear [Agency Director]

In a recent letter to you, we indicated that your agency's FSAA SHORT-TERM STUDY KIT would be mailed to [staff member who completed Locator Questionnaire]. I am now writing to let you know that this study kit has just been mailed. For your information, we are enclosing copies of the Instructions, Definitions, and Case Schedules which are included in your agency's kit. Also included in your kit is a return postcard confirming, with your advice and approval, the name of your casework staff member (preferably the person in charge of your casework program) who will serve as Agency Study Coordinator. The Coordinator will facilitate your agency's continued participation in this national FSAA project. I look forward to receiving this postcard at the earliest possible date, hopefully within the next few days.

I am also writing to invite you and/or your Agency Study Coordinator to attend a brief, informal meeting to answer any questions you and other agency study participants may have about the forms used in this project. At this meeting, I shall present a preliminary report of some of the findings emerging from the first stage of this study in which your agency cooperated.

The meeting will be held at the FSAA Biennial, on Thursday afternoon, November 11, 1965, from 5 to 6, in Parlor "C" at the Hotel Statler-Hilton in Detroit.

Would you kindly indicate the name(s) of your agency's representative(s) to this meeting on the enclosed return postcard.

Clark W. Blackburn and I want you to know how much we appreciate the generous contribution which your agency is making to the family service field through its participation in this important FSAA project.

I look forward to seeing you at Biennial on November 11.

Sincerely,

Howard J. Parad, Project Director

*This letter was not sent to the clinics.
APPENDIX B

LETTER B. 9

POSTCARD REPLY FORMS SENT WITH INVITATION
TO ATTEND MEETING OF FSAA
AGENCY STUDY COORDINATORS*

Date ________________

Dear Mr. Parad,

We have received the FSAA SHORT-TERM STUDY KIT.
Our AGENCY STUDY COORDINATOR will be: (Check here if correct)

Our AGENCY STUDY COORDINATOR has been changed to:
(Please indicate correct name here)

Agency _______________________
City _______________________
(Signed) _______________________

Dear Mr. Parad,

We are glad to ___ (cannot ___ ) send a representative to the FSAA Biennial SHORT-TERM STUDY
PROJECT Question and Answer Meeting on Thursday, November 11, 1965, from 5:00 - 6:00 p.m., in
Parlor "C", at the Statler-Hilton in Detroit.

Our Agency Representative(s) will be:

Agency _______________________
City _______________________
Date __________ (Signed) _______________________

*These postcards were not sent to the clinics.
APPENDIX B

LETTER B. 10

FOLLOW UP LETTER No. 1
FOR STAGE II PROGRAM QUESTIONNAIRE

Gateway House
Smith College School for Social Work Howard J. Parad
Northampton, Massachusetts 01060 Project Director

Research Project on
PLANNED SHORT-TERM CRISIS-ORIENTED TREATMENT PROGRAMS

Sponsored by

FAMILY SERVICE and
ASSOCIATION OF THE AMERICAN ASSOCIA-
AMERICA TION OF PSYCHIATRIC

CLINICS FOR CHILDREN

December 14, 1965

Dear [Study Coordinator]

This is a gentle reminder - and a plea for your help!

Some time ago we sent you the PSAA General Questionnaire
(white) on short-term treatment programs. We would like very
much to receive your completed questionnaire at the earliest
possible date.

As you know, the practical usefulness of this study
for the family service field depends on having responses
from all participating PSAA member agencies.

We need your completed questionnaire. Would you
please take a minute to fill out the enclosed post card
reply on the status of your questionnaire.

Thank you for your cooperation.

With all best wishes for the coming holidays,

Sincerely,

Howard J. Parad
Project Director

P.S. Respondents will receive a report of study findings
as soon as all questionnaire data are tabulated.
APPENDIX B

LETTER B. 11

POSTCARD REPLY FORM SENT WITH FOLLOW UP LETTER NO. 1
FOR STAGE II PROGRAM QUESTIONNAIRE

Follow-up on FSAA GENERAL QUESTIONNAIRE on Short-Term Treatment Programs

PLEASE CHECK APPROPRIATE ITEM BELOW:

1. Our completed Questionnaire is on the way.

2. You will receive our Questionnaire on or about

3. Apparently our Questionnaire has been lost. We want to continue to cooperate in this national FSAA study, so please send us another one.

4. Other comments about answering this Questionnaire:

Name____________________ Agency____________________
APPENDIX B

LETTER B, 12

FOLLOW UP LETTER NO. 2 FOR STAGE II PROGRAM QUESTIONNAIRE TO PSAA AGENCIES FROM WHOM THERE HAD BEEN NO REPLY

research project on
PLANNED SHORT-TERM CRISIS-ORIENTED TREATMENT PROGRAMS
sponsored by
FAMILY SERVICE ASSOCIATION THE AMERICAN ASSOCIATION OF
OF AMERICA and PSYCHIATRIC CLINICS FOR
CHILDREN

January 28, 1966

Dear [Study Coordinator]

A few months ago we sent you a packet of material concerning the PSAA Short-Term Study Project. Included in this packet was a General Questionnaire, a copy of which is enclosed. While we appreciate the fact that your agency may be unable to fill out the case data schedules (blue and pink forms which were also included in your packet), we earnestly hope that your Director of Casework (or other staff member who is knowledgeable about your casework program) will complete the enclosed General Questionnaire and return it in the enclosed stamped envelope.

Because of our interest in having the widest possible representation in this study, we hope very much that you will find it possible to complete the enclosed form. If you cannot answer all the items on the form, please answer as many as you can. We are most eager to have the benefit of your staff's thinking about the area of short-term services.

Would you please take a minute to complete the enclosed postcard concerning your agency's interest in participating in this study?

Cordially,

Howard J. Parad
Project Director

Enclosures

P.S. If your agency has been able to fill out the blue "Opening Report" forms (please see enclosed sample), we shall look forward to receiving your completed forms on or about February 1.
APPENDIX B
LETTER B. 13
FOLLOW UP LETTER NO. 2 FOR STAGE II PROGRAM
QUESTIONNAIRE TO FSAA AGENCY STUDY
COORDINATORS WHO DID NOT ANSWER
FOLLOW UP LETTER NO. 1

research project on
PLANNED SHORT-TERM CRISIS-ORIENTED TREATMENT PROGRAMS
sponsored by
FAMILY SERVICE ASSOCIATION OF AMERICA
and
PSYCHIATRIC CLINICS FOR CHILDREN

January 28, 1966

Dear [Study Coordinator]/

This is another gentle reminder - and a plea for your help!

In October we sent you the FSAA General Questionnaire (white form, please see enclosed copy) on short-term treatment services. We would like very much to receive your completed questionnaire at the earliest possible date. We also look forward to receiving your completed blue forms (please see enclosed sample) on or about February 1.

As you know, the practical usefulness of this study for the family service field depends on having responses from all FSAA member agencies.

We need your completed questionnaire. Would you please take a minute to fill out the enclosed postcard reply on the status of your questionnaire.

Thank you for your cooperation.

With all best wishes,

Cordially,

Howard J. Parad
Project Director

Enclosures

P.S. Respondents will receive a report of study findings as soon as all questionnaire data are tabulated.
APPENDIX B

LETTER B. 14

FOLLOW UP LETTER NO. 2 FOR STAGE II PROGRAM
QUESTIONNAIRE TO FSAA AGENCIES WHO REFUSED
TO PARTICIPATE BUT SAID THEY WOULD TRY TO
DO GENERAL QUESTIONNAIRE

research project on
PLANNED SHORT-TERM CRISIS-ORIENTED TREATMENT PROGRAMS
sponsored by
FAMILY SERVICE ASSOCIATION THE AMERICAN ASSOCIATION OF
OF AMERICA and PSYCHIATRIC CLINICS FOR
CHILDREN

January 28, 1966

Dear [Study Coordinator],

In your postcard reply to the follow up inquiry concerning the FSAA Short-Term Study Project, you indicated that your agency would try to complete the General Questionnaire (white form, please see enclosed copy).

Since our project staff is eager to have information from a wide range of family agency programs, I hope very much that you will send us your completed General Questionnaire. If it is not possible for you to answer all the items on the enclosed form, please answer as many as you can.

We would be happy to send you one or more extra copies of the enclosed white form.

Please let us know the status of your General Questionnaire by replying on the enclosed postcard.

Many thanks for your cooperation.

Cordially,

Howard J. Parad
Project Director

HJP:rc
Enclosures
APPENDIX B

LETTER B. 15

FOLLOW UP LETTER NO. 2 FOR STAGE II PROGRAM

QUESTIONNAIRE TO FSAA AGENCY STUDY COORDINATOR WHO INDICATED THAT THE GENERAL QUESTIONNAIRE WOULD BE MAILED ON A CERTAIN DATE

research project on PLANNED SHORT-TERM CRISIS-ORIENTED TREATMENT PROGRAMS sponsored by FAMILY SERVICE ASSOCIATION THE AMERICAN ASSOCIATION OF OF AMERICA and PSYCHIATRIC CLINICS FOR CHILDREN

January 28, 1966

Dear [Study Coordinator],

We appreciate your kindness in returning the follow-up postcard on which you indicated that you planned to mail your completed General Questionnaire (white form, please see enclosed copy) on . This is another gentle reminder to let you know that, according to our records, we have not received your completed General Questionnaire.

Would you please indicate on the enclosed postcard the status of your Questionnaire so that our records will be up to date?

May I also remind you that we look forward to receiving your completed blue forms (see sample enclosed) on or about February 1.

I greatly appreciate your continued interest and participation in this project.

Cordially,

Howard J. Parad
Project Director

HJP:re
Enclosures
APPENDIX B

LETTER B. 16

POSTCARD REPLY FORM NO. 2 SENT WITH FOLLOW UP LETTER NO. 2 FOR STAGE II PROGRAM QUESTIONNAIRE

Follow-up on FSAA Study of Short-Term Treatment Services

Please answer appropriate items below:

1. Our completed General Questionnaire is on the way.

2. You will receive our General Questionnaire on or about ____________.

3. You will receive our completed blue forms on or about ____________.

4. Other comments:

Name ___________________________ ___________________________

*Letters B. 12, B. 13, B. 14, and B. 15 of this Appendix.
APPENDIX C

CODE SHEET C. 1

FSAA STAGE I

All IBM items not mentioned below are to be coded as marked on the questionnaires.
Code 8 for - No response, none indicated.
Code 9 for - No response where response is indicated.

IBM 1 - 5 - Identification numbers
   IBM 1 - Code 1 (FSAA)
   2 - Code 1 (Stage 1)
   3, 4, 5 - Identification number of agency

IBM 6 - Re statistics, pp. 6 and 7
   1 - All statistics O.K.
   2 - Partially O.K. (IBM 55 through 63 equals 52-54)
   3 - Partially O.K. (IBM 64 through 74 equals 52-54)
   4 - Both sets of statistics in error
   8 - Use for short form questionnaire only
   9 - No response on these items

Note - for any item with 4 digits, code it 777 and these will be handled by hand later

IBM 7 - Programs
   1 - Has program Included - asked to participate
   2 - Does not have program Excluded

IBM 8 -
   1 - Agreed to do white, blue, and pink forms as of date of punching IBM cards
   2 - Agreed to do white general questionnaire
   3 - Refused to participate
   8 - Excluded from Stage 2

IBM 9 - Open

IBM 10 - Program Features
   1 - Range of time explicit
   2 - Intake - worker continuity
   3 - Special structural factors
      a) special units
      b) rotating intakes
      c) clients seen jointly
   4 - Short-term refers mainly to intake or diagnostic study
   5 - Individual evaluation
   8 - No response, none indicated
   9 - Response indicated, but no response or uncodable response
   0 - All others
CODE SHEET C. 1  
(CONT'D)

IBM 11 - Region  
1 - North Atlantic  
2 - Middle Atlantic  
3 - Southeastern  
4 - Midwestern  
5 - Southwestern  
6 - Western

IBM 12 - Population  
1 - Under 100,000  
2 - 100,000 to 199,999  
3 - 200,000 to 499,999  
4 - 500,000 or more

IBM 13 - Size of professional staff  
1 - Professional employees = 2.5  
2 - " " = 4.5  
3 - " " = 6.5  
4 - " " = 8.5  
5 - " " = 10.5  
6 - " " = 15.5  
7 - " " = 19.5  
8 - " " = 49.5  
9 - " " = 99.5  
0 - " " = 100 or more

IBM 15 -  
3 - If both responses are checked

IBM 17 - Criteria for use of PSTT  
1 - In crisis situation (acute stress, specific crisis)  
2 - Environmental manipulation (evaluation and referral)  
   or limited goals  
3 - Negative factors, e.g., limited strengths or  
   capacities, severe pathology  
4 - Positive factors, for example, good ego strength,  
   quick resolution, mild pathology  
5 - All others, e.g., family intact, families without  
   young children  
8 - No response, none indicated  
9 - Indicated but no data, or N/A

Types of problems included 24 different types of statements.  
These were classified in three categories as follows:

IBM 18 - Types of Problem or Client Groups Served  
1 - Related to particular type of services, e.g., financial  
   aid, homemaker service, travelers aid, legal aid  

2 - Related to particular types of client, e.g., aged,  
   unwed mothers, and children
CODE SHEET C. 1
(CONT'D)

18 (Cont'd)
3 - Evaluation and referral services (exploration, evaluation and referral)
4 - Financial aid
5 - Other services rendered, unspecified
8 - No response, none indicated
9 - No data or N/A

IBM 19 - Beginning of PSTP (In months - base for period January 1, 1966)
1 - 1-24
2 - 25-48
3 - 49-72
4 - 73-96
5 - 97-120
6 - 121-144
7 - 145 or more
8 - No response, none indicated
9 - Indicated, no response

IBM 24 - Features
1 - Special emergency service - separate unit or a 24 hour service
2 - Accessibility (Timing)
   a) immediate intake
       same day
       2-3 days
       within a week
   b) priority for continued service
   c) more frequent appointments
   d) special effort on part of staff - e.g., lunch-hour or after-hour appointments, "flexibility" of staff in scheduling appointments
   e) home telephone number given to clients in on-going cases
3 - Case retained by intake worker for crisis period
8 - No answer indicated
9 - No answer although indicated

IBM 25 - Types of Problem or Client Groups Served
(Identical to IBM 18 for comparative reasons)
1 - Related to particular types of services, e.g., homemaker, traveler's aid, legal aid
2 - Related to types of clients
   a) aged
   b) unwed mothers
   c) teenagers
3 - Evaluation and referral services
4 - Financial aid
5 - Other services rendered, unspecified
8 - No response indicated
9 - N/A or no data
CODE SHEET C-1
(CONT'D)

IBM 40 - Reason for discontinuing PSTTP
1 - Integrated into informal programs
2 - Staff factors and lack of necessary operational knowledge
3 - Staff factors only
   a) apathy, lack of interest
   b) insufficient staff
   c) staff turnover, lack of continuity in leadership
4 - Lack of necessary operational knowledge, criteria
5 - Interim measure to meet agency pressures, of little value
6 - Other
7 - No response, none indicated
8 - Indicated, no response

IBM 42 - Reason for not initiating PSTTP
Use same code as Item 40 - above

IBM 43 - Pros
1 - Both quantitative and qualitative replies
2 - Quantitative only
   a) reduces waiting list
   b) serves more people
   c) reduces unplanned terminations
3 - Qualitative only
   a) enhances client motivation
   b) requires greater worker skill, focussing
8 - No reply indicated (1A = Yes on IBM #14)
9 - N/A or no response

IBM 44 - Cons
1 - Both individualizing and administrative factors
2 - Fails to treat cases on individualized basis
   a) arbitrary - difficulty in terminating client-centered responses
   b) superficial
   c) lack of diagnostic criteria
3 - Administrative-personnel factors
   a) lack of sufficiently skilled personnel
   b) resistance or apathy
   c) lack of sufficient staff or time
4 - Opposed on theoretical grounds, unspecified
6 - Unnecessary or unapplicable in that particular agency
   a) no shortages, i.e., adequate staff, no waiting list
   b) agency too small
   c) serves particular type of clientele
7 - See no cons
8 - No response indicated (1A = Yes on IBM #14)
9 - Indicated, no response
IBM 79 -
0 = Has PSTTP, positive comments (IBM 14-1)
1 = Has informal STTP, positive comments (IBM 16-1)
2 = Positive comment and plans PSTTP
3 = Positive comment and plans informal STTP
4 = Negative on theoretical grounds
5 = Negative on operational basis (e.g., criteria not explicit enough)
6 = Negative relative to design of questionnaire
7 = Ambivalent theme
8 = No response, none indicated
9 = Other comments not fitting above

A separate tally must be kept on "need for diagnostic criteria on skills" whether mentioned under IBM 17, 18, 43, 44 or 79.
APPENDIX C

CODE SHEET C. 2

AAPCC STAGE I

Note: This code sheet includes only those items that differ from the FSAA Stage I Code Sheet. (See Appendix C. 1)

IBM 1—Code 2 (AAPCC)
  3, 4, 5—Identification numbers of clinic

IBM 9—Approved training clinic in career child psychiatry
  1—Yes
  2—No

IBM 10—Program Features
  1—Range of time explicit— for diagnostic evaluation and treatment
  2—Range of time explicit— emphasis on treatment
  3—Range of time explicit— emphasis on diagnostic evaluation
  4—Prolonged diagnostic or exploratory (trial period)
  5—Diagnosis = treatment
  6—Special structural factors
    a) walk-in clinic
    b) multiple interviewing
    c) group treatment
  7—Individual evaluation
  8—No response—none indicated (If 1a is Yes 14-1)
     (or if 2a is No 15-2)
  9—Indicated but no response or N/A

IBM 17—Criteria for use of PSTT
  1—Crisis situation (acute stress, specific crisis)
  2—Negative factors
    a) chronic problem
    b) limited goals
    c) parents not accessible to treatment
  3—Positive factors
    a) problem limited to specific area of functioning
    b) gains made in diagnostic period
  4—Preschool children
  5—School phobias
  6—Clinic factors
    a) training needs
    b) clinic limitations
  8—No response/none indicated
  9—Indicated but no response or N/A
IBM 18 - Purpose of PSTTP
1 - Guidance for developmental or maturational problems
2 - Diagnostic evaluation and treatment/or referral
3 - Evaluation toward treatment plan
4 - Evaluation toward referral
5 - Evaluation or consultation for other agencies
6 - Preparation for placement/or referral & interim treatment
7 - Treatment or (other services rendered/unspecified)
8 - No response/none indicated
9 - Indicated but no response or N/A

IBM 24 - Features
1 - Special emergency service - separate unit or 24 hour service (round-the-clock) - hospitalization or beds available
2 - Accessibility
   a) need for immediate evaluation
   b) priority for intake - 2 or 3 days within a week
   c) priority out of turn on waiting list
3 - Handling of immediate crisis situation
4 - Changes in clinic staff patterns or treatment pattern
   a) multiple interviewing
8 - No response indicated
9 - Indicated but no response, or N/A

IBM 25 - Problems, types of patient, and service patterns
1 - School phobias, suicidal or homicidal, extreme acting out, bizarre symptoms - seen immediately
2 - Recent onset of problem, e.g., grief reaction, stress
3 - Referral for immediate psychiatric consultation (from professional staff)
4 - Referral from Court
5 - Evaluation and treatment
6 - Evaluation for hospitalization
7 - Evaluation and disposition
8 - No response indicated
9 - Indicated but no response, or N/A

IBM 43 - Pros
1 - Both quantitative and qualitative replies
2 - Quantitative only
   a) reduces waiting list
   b) serves more people
   c) reduces unplanned terminations
3 - Qualitative only
   a) enhances patient motivation
   b) requires greater worker skill, focussing
   c) suitable for patients formerly considered untreatable
   d) dynamics of time limit
CODE SHEET C. 2
(CONT'D)

43 (Cont'd)
4 - Unspecified approval (no reasons) or intend to start one
5 - Meets training needs
6 - Insufficient knowledge to evaluate
8 - No reply indicated (la = Yes on IBM #14)
9 - N/A or no response

IBM 44 - Cons
1 - Both individualizing-qualitative and administrative factors
2 - Fails to treat cases on individualized basis
   a) arbitrary - difficulty in terminating cases) Patient-
   b) superficial ) centered
   c) lack of diagnostic criteria ) responses
   d) difficulty of predicting time needed )
3 - Administrative factors
   a) limitation of personnel
      1) lack of sufficiently skilled personnel ) Clinic-
      2) resistance or apathy ) centered
      3) lack of sufficient staff or time ) responses
      4) conflicts with training needs )
4 - Short-term only after diagnostic study
5 - Opposed on theoretical grounds, unspecified, or not covered by other IBM #44 items
6 - Unnecessary or unapplicable in that particular agency
   a) no shortages, i.e., adequate staff, no waiting list
   b) clinic too small
   c) serves particular type of clientele
   d) provided by other agencies in the community
7 - See no cons
8 - No response indicated (la = Yes on IBM #14)
9 - Indicated but no response or N/A
APPENDIX C
CODE SHEET C. 3
PSAA STAGE II

IBM 1-5 - Identification numbers
IBM 1 - Code 1
2 - Code 2
3-5 are the arbitrarily assigned numbers as used in Stage 1

IBM 6 and 7. Services offered by agency*
01 - Adoption service only
02 - Homemaker service only
03 - Foster placement only
04 - Traveler's Aid only
05 - Adoption and Homemaker
06 - Adoption and Foster Placement
07 - Adoption and Traveler's Aid
08 - Adoption, Homemaker, and Foster Placement
09 - Adoption, Homemaker, and Traveler's Aid
10 - Adoption, Homemaker, Foster Placement, and Traveler's Aid
11 - Homemaker and Foster Placement
12 - Homemaker and Traveler's Aid
13 - Homemaker, Foster Placement, and Traveler's Aid
14 - Foster Placement and Traveler's Aid
15 - No response indicated (each of the four categories is checked "No")
16 - Adoption, Foster Placement, and Traveler's Aid
00 - No response - avoidance (none is checked)

IBM 8, 9, and 10 - Intake procedure
1 - Yes
2 - No
3 - No response

IBM 11 - "Exploratory interviews: at intake, short-term cases"
1 - 1 interview If a range of interviews is given, code the average.
2 - 1.1 - 2
3 - 2.1 - 3 If separate numbers are given for parents and children, add the two together before recording score.
4 - 3.2 - 4
5 - 4.1 - 6
6 - More than 6
7 - "No set number" or "Varies with the case," etc.
8 - No response indicated (i.e., "No" on IBM 10)
9 - No response, but one is indicated.

*Not included in AAPCC
CODE SHEET C. 3  
(CONT'D)

IBM 12 - "Exploratory interviews" at intake, other than short-term cases?
1 - Yes
2 - No
9 - No response

IBM 13 - Number of interviews at intake, other than short-term cases
Code as for IBM 11. N.B. "7" includes such responses as, "Depends on the situation," "2 or more," etc.

IBM 14, 15, 16, 17, 18, 19 - Intake procedure (continued)
Code as checked on schedule
9 - No response. (There will be no 8's.)

IBM 20 - Waiting List
1 - 1-12 cases
2 - 13-24
3 - 25-49
4 - 50-74
5 - 75-99
6 - 100 or more
9 - No response indicated ("No" on IBM 19)
9 - No response, but one indicated. ("Yes" on IBM 19)

IBM 21 - Number of open cases
1 - 0-100 families
2 - 101-200
3 - 201-300
4 - 301-400
5 - 401-500
6 - 501-1000
7 - Over 1000
9 - No response

IBM 22 - Policy to specify pre-determined number of interviews?
1 - Yes
2 - No
3 - Both 23-24 and 25-26 answered
9 - No response

IBM 23 and 24 - Specified number of interviews and weeks of treatment
1 - 1
2 - 2-3
3 - 4
4 - 5-6
5 - 7-11
6 - 12
7 - 13-15
9 - 16 or more

Almost all of IBM 23-24 will be "8".
If range of interviews or weeks is given, then edit IBM 22 to "No" and score the response in IBM 25-26.
CODE SHEET C.3
(CONT'D)

IBM 23 and 24 (Cont'd)

8 - No response indicated ("No" on IBM 22, or if a response is given on either 23 or 24, then code the unanswered item "8")

9 - No response but one is indicated. ("Yes" on 22 but no response to 23-24)

IBM 25 and 26 - Range of interviews and weeks considered typical.

1 - 4-6
2 - 4-8
3 - Less than 4 (upper limit of range is 4 or less)
4 - Less than 5 (upper limit of range is 5 or 6; except range of 4-6)
5 - Less than 8 (upper limit of range is 7 or 8; except range of 6-8)
6 - Less than 10 (upper limit of range is 9 or 10)
7 - Less than 12 (upper limit of range is 11 or 12)
8 - Over 12 (upper limit of range is more than 12)
9 - No response indicated (IBM 22 is "Yes")

IBM 27 - How is specific number of interviews determined?
Code as indicated

8 - No response indicated (IBM 22 is "No")

9 - No response although indicated (IBM 22 is "Yes")

IBM 28 - Provision for time extension?

1 - Yes
2 - No

9 - No response

IBM 29 - Typical practice if case exceeds planned limits
Code as indicated

8 - No response indicated (IBM 28 is "No")

9 - No response although indicated (IBM 28 is "Yes")

IBM 30 - Specific criteria used in selecting cases?

1 - Yes
2 - No

9 - No response

IBM 31 - 41 - Specific criteria
31 - (Stress) Crisis situation plus one or more of the following:
- strong ego
- strong motivation for help
- recency of onset
- specific etiology
- maturational stress
CODE SHEET C. 3
(CONT'D)

32 - (Stress) Crisis situation (state) plus one or more of
the following:
- weak ego (pathological or borderline personality
  problems)
- weak or poor motivation for help
- multiple problems ("multi problem" or "hard core"
  or chronic individual or family situation)
- reopened case - recurrent crisis; acute eruption of
  chronic crisis

33 - (Stress) Crisis situation - no elaboration (e.g., in
terms of healthy ego, high motivation, recency of onset,
specific etiology) but includes:
- stress (situational, temporary, transitory)
- emergency situation or urgency of need
- need for environmental planning
- decompensation
- anxiety out of control

34 - One or more of the following without explicit mention
of crisis or stress:
- strong (healthy) ego
- strong motivation for help - "client's ability to
  use service"
- recency of onset, "acute" onset
- specific etiology

35 - One or more of the following without explicit mention
of crisis or stress:
- weak ego (pathological or borderline personality
  problems)
- weak (poor, low) motivation for help
- multiple problems (multi-problem or hard core family)
- resistant to "deeper" or "intensive" treatment
  chronic

36 - Treatment Goals (symptomatic relief)
- specific (e.g., need to make life decision in re
  job, marriage, move, school, etc.)
- achievable
- limited
- minor
- "focused"
- "reality oriented" (not in terms of "in-depth"
  approach)
- "restoring neurotic balance"

37 - Client Groupings in terms of
- age (e.g., adolescents)
- problem (e.g., unwed mothers, school phobias)
CODE SHEET C. 3
(CONT'D)

37 (Cont'd)
"retread" - reapplication for help or check-up but no mention of stress, chronicity, or crisis diagnostic entity (e.g., hysterical, compulsive, "character disorder")

38 - Administrative (Quantitative)
desire to reduce waiting list
staff shortages - lack of resources
client geographically inaccessible
client able to come only for few interviews for physical reasons
serve more people
unable to pay fee
time set by court
pressure from community (for coverage of cases, public relations aspect)
to serve training needs - related to staff resources

39 - Environmental factors - social resources
need for homemaker, job, financial, health, legal, dental, etc., help without mention of crisis

40 - Interim Support and Evaluation
during pre-referral period (to other agency or clinic)
testing to tolerate waiting list or inability to tolerate w.l.
"lack of other resource"
evaluation as an aid to other agencies - consultation role

41 - General Treatment Factors
For treatment items that do not fit into other categories; use only for final coding; use as often as needed for reliability study

Assign code-number 1 to 6 under appropriate criteria (IBM 31-41) as ranked by respondent. (There may be fewer than 6.)
Code 7 under any criterion not mentioned by respondent.
Code 8 under each if IBM 30 was "No".
Code 9 under each if IBM 30 was "Yes" but no criteria given or if IBM 30 was not answered at all.

IBM 42
1 - Responded meaningfully to IBM 31-41
7 - Merely repeated "clinical, diagnostic, administrative"
    (parenthetical statement in Question 1a)
8 - No response to IBM 31-41, none indicated (IBM 30 was "No")
9 - No response to IBM 31-41, although indicated (IBM 30 was "Yes")
CODE SHEET C. 3
(CONT'D)

IBM 43 - Reason for no criteria for PSTT
Code as marked
8 - No response indicated (IBM 30 is "Yes")
9 - No response although indicated (IBM 30 is "No")

IBM 44 - 49 - Rank order of criteria factors
Code as marked for each of the six IBM numbers. If an
IBM number is left blank it is assumed that it was not
considered applicable, and it is coded 7.
8 - No response indicated. (IBM 30 is "No" and IBM
44-49 are all blank, each will be "8")
9 - All of the six IBM numbers are left blank. (IBM
44-49 will each be coded "9").

IBM 50 and 51 - Treatment techniques and goals
Code as marked by respondent
9 - No response

IBM 52 - 56 - Why effective?
Code as marked for each of the five IBM numbers
7 - If an IBM number is left blank although others are
ranked. (See above.)
9 - Only if all are left blank. (IBM 52-56 will each be
coded "9").

IBM 57 - Stages 3 and 4
1 - Agency participated in Stages 3 and 4
2 - Agency did not participate in Stages 3 and 4

IBM 58 - Population of community served (question on Page 1
of schedule)
1 - Under 100,000
2 - 100,000 to 199,999
3 - 200,000 to 499,999
4 - 500,000 or more

IBM 59 and 60 - Class factors
Code as marked
9 - No response

IBM 61 - Group treatment program
1 - Have a time-limited group therapy program (includes
family therapy). Closely tied in with the overall
time-limited treatment program.
2 - Group program not restricted to time-limited approach,
but related to it in that it accepts referrals for
clients who are in PSTT. Clients are seen concurrently
in both. This includes cases where group treatment
and PSTT overlap in any way.
3 - Have group program but not related to PSTT.
61 (Cont'd)

4 - Have group program (i.e., responded "Yes" to Q. 7) but did not respond meaningfully to question asking how related to PSTT.

8 - Response to Q. 7 is "No."

9 - No response.

IBM 62 - Specific therapeutic disadvantages?

1 - Yes

2 - No

9 - No response

IBM 63 - Expediency vs. Choice

1 - Expediency

2 - Choice

3 - Both checked

9 - No response

IBM 64 - 68 - Reasons for initiating PSTT

Code as marked for each of the five IBM numbers

7 - If an IBM number is left blank although others are ranked

9 - Only if all are left blank (IBM 64-68 will each be coded "9")

IBM 68a, i.e., Question 2, page 9, will be handled narratively

IBM 68b, Question 3, page 9, will be done on separate IBM deck by MJF

IBM 69 - Case evaluation

1 - Case evaluation by staff after a set number of interviews or elapsed time; or at point of termination - point is mentioned.

2 - Case evaluation by worker and supervisor after a set number of interviews or elapsed time.

3 - Case evaluation by staff but not after any set period - somewhat on a casual or intermittent basis.

4 - Case evaluation by worker and supervisor on a casual or intermittent basis but not after any set period.

5 - Case evaluation (with or without a set time) by worker and client (parents or family). Whenever family is involved

6 - Evaluation by worker alone after set time period.

7 - Evaluation by worker alone, no set time limit.

8 - (Informal or vague) evaluation process which does not fit into other categories.

9 - No response although one indicated. Answer to Q. 4 is "Yes"

0 - No pre-arranged procedure. This includes "No" on IBM 69 of answer sheet
IBM 70 - Follow up?
1 = Yes
2 = No
9 = No response

IBM 71 and 72 - Method of follow-up and staff member who does it.
Code as marked
8 = No response indicated. (Answer to IBM 70 is "No."
9 = No response although indicated. (Answer to IBM 70 is "Yes."

Question 50, Number of months before follow-up, will be handled narratively.

IBM 73 - Size of professional staff (question on page 1)
1 = Under 5
2 = 5 - 5.5
3 = 7 - 10.5
4 = 11 - 13.5
5 = 14 - 19.5
6 = 20 - 49.5
7 = 50 and over
9 = No response

IBM 74, 75 - PSTT Research
Code as marked
9 = No response

Additional information under IBM 74 and 75 will be handled narratively. (As will Question 9, page 2 (comments about staff's opinions), which follows IBM 77.)

IBM 76, 77 - Staff Opinion of PSTT
Code as marked
9 = No response

IBM 78 - Theoretical rationale underlying PSTT
1 = Crisis, stress, emergency, trauma
2 = Non-crisis but includes one or more "conceptual" themes or formulations: ego, time, developmental-maturational, mastery, partialization, goal, reality focus, here and now focus, equilibrium-disorganization
3 = A-theoretical or non "conceptual," and non crisis
9 = No response

IBM 79 - Training
1 = On-going, systematic program of training, set up especially for this project; or,
One or more planned seminars or meetings to discuss this program, but no continuing training. This includes preliminary meetings to set up criteria for
79 (Cont'd)

1 (Cont'd)

Case selection or special consultations by outside professionals prior to starting program.

2 - Training carried on as part of regular staff meetings at which all other agency business is discussed (i.e., not specific to PSTT); or,

Training handled through ordinary supervisory conferences; or,

Informal, casual, multiple approaches to training; fragmentary response; or,

General reading of the literature program, whether systematic or not.

3 - Other, unclassifiable.

0 - No special training offered. "None"

9 - No response although on indicated

IBM 30 - Other agencies offer PSTT?

1 - Yes

2 - No

3 - Don't know

9 - No Response
APPENDIX C

CODE SHEET C. 4

AAPCC STAGE II

Note: This code sheet includes only those items that differ from the FSAA Stage II Code Sheet. (See Appendix C. 3)

IBM 1-5 - Identification numbers
1 = Code 2
2 = Code 2
3 - 5 are the arbitrarily assigned numbers as used in Stage I

IBM 6 - Population of community served
1 = Under 100,000
2 = 100,000 to 199,999
3 = 200,000 to 499,999
4 = 500,000 or more

IBM 7 - Size of professional staff
1 = Under 5
2 = 5 - 6.5
3 = 7 - 10.5
4 = 11 - 19.5
5 = 20 - 49.5
6 = 50 and over

Weighted totals are used, i.e., two part-time employees equal one full-time employee.

IBM 57 - General opinion of psychiatrist toward PSTT when PSTT was initiated
Code as indicated
9 = No response

IBM 58 - General current opinion of psychiatrist toward PSTT
Code as marked
9 = No response

IBM 62 - General opinion of psychologist toward PSTT when PSTT was initiated.
Code as marked
9 = No response

IBM 73 - General current opinion of psychologist toward PSTT
Code as marked
9 = No response

IBM 76 and 77 - General opinion of social worker toward PSTT when PSTT was initiated, current opinion of social worker
Code as marked
9 = No response
IBM 80 - Stages 3 and 4
1 - Clinic participated in Stages 3 and 4.
2 - Clinic did not participate in Stages 3 and 4.
### APPENDIX C

#### CODE SHEET C. 5

**INSTRUCTIONS FOR THIRTY-FIVE ITEM PROGRAM ASSESSMENT SCALE FOR FSAA AND AAPCC**

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Brief Description</th>
<th>IBM No. (Program Questionnaire)</th>
<th>Scoring Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Crisis and strong ego</td>
<td>31</td>
<td>Listed in rankings</td>
</tr>
<tr>
<td>2</td>
<td>Crisis and weak ego</td>
<td>32</td>
<td>&quot;  &quot;  &quot;</td>
</tr>
<tr>
<td>3</td>
<td>Crisis and stress</td>
<td>33</td>
<td>&quot;  &quot;  &quot;</td>
</tr>
<tr>
<td>4</td>
<td>Crisis first reason for program</td>
<td>68</td>
<td>&quot;  &quot;  &quot;</td>
</tr>
<tr>
<td>5</td>
<td>Crisis event</td>
<td>68a, 80a, and Appendices</td>
<td>Stressful event included in the definition of crisis</td>
</tr>
<tr>
<td>6</td>
<td>Person in crisis</td>
<td>&quot;</td>
<td>Person(s) affected included in def.</td>
</tr>
<tr>
<td>7</td>
<td>Perception of crisis</td>
<td>&quot;</td>
<td>Perception of the event included in def.</td>
</tr>
<tr>
<td>8</td>
<td>Response to crisis</td>
<td>&quot;</td>
<td>Response included in definition</td>
</tr>
<tr>
<td>9</td>
<td>Resolution of crisis</td>
<td>&quot;</td>
<td>Resolution included in definition</td>
</tr>
<tr>
<td>10</td>
<td>Crisis rationale</td>
<td>78</td>
<td>Coded 1</td>
</tr>
<tr>
<td>11</td>
<td>Seen within 4 days</td>
<td>18</td>
<td>Coded either 1 or 2</td>
</tr>
<tr>
<td>12</td>
<td>Predetermined no. of int.</td>
<td>22</td>
<td>Coded 1</td>
</tr>
<tr>
<td>13</td>
<td>No. of interviews 12 or less</td>
<td>23</td>
<td>Item answered and is 12 or less</td>
</tr>
<tr>
<td>14</td>
<td>No. of weeks is 12 or less</td>
<td>24</td>
<td>Item answered and is 12 or less</td>
</tr>
<tr>
<td>Item No.</td>
<td>Brief Description</td>
<td>IBM No.</td>
<td>Scoring Instructions</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------</td>
<td>---------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>15</td>
<td>Limited range of interviews</td>
<td>25</td>
<td>SCORE 1 IF: Width of range is 4 or less and if the upper limit of the range is 12 or less</td>
</tr>
<tr>
<td>16</td>
<td>Limited range of weeks</td>
<td>26</td>
<td>Width of range is 4 or less and if the upper limit of the range is 12 or less</td>
</tr>
<tr>
<td>17</td>
<td>Time rationale</td>
<td>27</td>
<td>Any response is given</td>
</tr>
<tr>
<td>18</td>
<td>Practice after time limit</td>
<td>29</td>
<td>Coded anything but 1</td>
</tr>
<tr>
<td>19</td>
<td>Reason PSTT effective</td>
<td>52-55</td>
<td>First ranking is given 52, 53, 54, or 55</td>
</tr>
<tr>
<td>20</td>
<td>PSTT group therapy</td>
<td>61</td>
<td>Coded 1</td>
</tr>
<tr>
<td>21</td>
<td>Evaluation after set period</td>
<td>69</td>
<td>Coded 1, 2, or 6</td>
</tr>
<tr>
<td>22</td>
<td>No exploratory interviews</td>
<td>10</td>
<td>Coded 2</td>
</tr>
<tr>
<td>23</td>
<td>1 or 2 exploratory inter-</td>
<td>11</td>
<td>Coded 1 or 2</td>
</tr>
<tr>
<td></td>
<td>views</td>
<td></td>
<td>Coded 2</td>
</tr>
<tr>
<td>24</td>
<td>Different PSTT intake</td>
<td>14</td>
<td>Coded 2 or 3</td>
</tr>
<tr>
<td>25</td>
<td>Case reassignment</td>
<td>15</td>
<td>Coded 1</td>
</tr>
<tr>
<td>26</td>
<td>PSTT in special unit</td>
<td>17</td>
<td>Coded 2</td>
</tr>
<tr>
<td>27</td>
<td>PSTT techniques differ</td>
<td>50</td>
<td>Coded 2</td>
</tr>
<tr>
<td>28</td>
<td>Treatment goals</td>
<td>51</td>
<td>Coded 1</td>
</tr>
<tr>
<td>29</td>
<td>Immediacy of treatment</td>
<td>56</td>
<td>Ranked first</td>
</tr>
<tr>
<td>30</td>
<td>Reduces waiting list</td>
<td>64</td>
<td>&quot;                                          &quot;</td>
</tr>
<tr>
<td>31</td>
<td>Worker utilization</td>
<td>65</td>
<td>&quot;                                          &quot;</td>
</tr>
<tr>
<td>32</td>
<td>Planned follow up</td>
<td>70</td>
<td>Coded 1</td>
</tr>
</tbody>
</table>
### CODE SHEET C. 3

(Continued)

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Brief Description</th>
<th>IBM No.</th>
<th>Scoring Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td>Research on-going</td>
<td>74</td>
<td>Coded 1</td>
</tr>
<tr>
<td>34</td>
<td>Research planned</td>
<td>75</td>
<td>&quot; &quot;</td>
</tr>
<tr>
<td>35</td>
<td>Staff training</td>
<td>79</td>
<td>&quot; &quot;</td>
</tr>
</tbody>
</table>

**SCORE 1 IF:**

- 33 Research on-going
- 34 Research planned
- 35 Staff training

Item Nos. 1 - 10 = Crisis sub-score, maximum sub-score = 9 or 10

Item Nos. 11 - 21 = Time sub-score, maximum sub-score = 8 or 9

Item Nos. 22 - 35 = Administrative sub-score, maximum sub-score = 12

Total possible program assessment score = 29-31

**Notes on scoring:**

1. **Crisis** - Maximum sub-score = 9 if IBM 64 or 65 is rated 1.
2. **Time** - IBM 23/24 and 25/26 are mutually exclusive. IBM 27 can be scored 1 only if IBM 56 is not rated 1.
3. **Administrative** - The following are mutually exclusive: IBM 10 and 11; 64 and 65.
APPENDIX D - TABLE D.1

SAMPLE LOSS FROM 98 FSAA AGENCIES AND 94 AAPCC CLINICS BY ORIGINAL DESIGNATION AS FORMAL OR INFORMAL PROGRAM\(^a\) AND REASON FOR NON-PARTICIPATION\(^b\)

<table>
<thead>
<tr>
<th>Reason given for non-participation</th>
<th>Formal</th>
<th>Informal</th>
<th>Total</th>
<th>AAPCC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reason given</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No P SST</td>
<td>1</td>
<td>10</td>
<td>11</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Lack of time or staff</td>
<td>8</td>
<td>3</td>
<td>11</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Change of staff</td>
<td>4</td>
<td>4</td>
<td>8</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>22</td>
<td>44</td>
<td>33</td>
<td>17</td>
</tr>
</tbody>
</table>

\(^a\) "Formal" means that the respondent indicated the presence of P SST services in accordance with the locator questionnaire definition. "Informal" means that although the respondent indicated the absence of P SST which would meet the "formal" study definition, an independent judge and the present writer thought that the respondent's narrative description of an "informal" program justified a preliminary definition of P SST; hence an invitation to participate in the study.

\(^b\) Reasons for non-participation were obtained from follow-up correspondence with non-respondents.
### APPENDIX B

#### TABLE B

**PHI CORRELATION COEFFICIENTS BETWEEN 35 A PRIORI PROGRAM ASSESSMENT ITEMS AND TOTAL SCORES FOR AAPCC SAMPLE**

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Description</th>
<th>Phi Coefficient&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Different PSTT intake</td>
<td>.5407</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>Perception of crisis</td>
<td>.5346</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>Response to crisis</td>
<td>.4376</td>
<td>3</td>
</tr>
<tr>
<td>33</td>
<td>Research on-going</td>
<td>.4218</td>
<td>4</td>
</tr>
<tr>
<td>14</td>
<td>No. of weeks 12 or less</td>
<td>.4031</td>
<td>5</td>
</tr>
<tr>
<td>34</td>
<td>Research planned</td>
<td>.3934</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>Crisis and weak ego</td>
<td>.3627</td>
<td>7</td>
</tr>
<tr>
<td>35</td>
<td>Staff training</td>
<td>.3444</td>
<td>8</td>
</tr>
<tr>
<td>17</td>
<td>Time rationale</td>
<td>.3410</td>
<td>9</td>
</tr>
<tr>
<td>1</td>
<td>Crisis and strong ego</td>
<td>.3103</td>
<td>10</td>
</tr>
<tr>
<td>10</td>
<td>Crisis rationale</td>
<td>.3028</td>
<td>11</td>
</tr>
<tr>
<td>22</td>
<td>No exploratory interviews</td>
<td>.3012&lt;sup&gt;b&lt;/sup&gt;</td>
<td>12</td>
</tr>
<tr>
<td>9</td>
<td>Resolution of crisis</td>
<td>.3012&lt;sup&gt;b&lt;/sup&gt;</td>
<td>13</td>
</tr>
<tr>
<td>5</td>
<td>Crisis event</td>
<td>.3000</td>
<td>14</td>
</tr>
<tr>
<td>28</td>
<td>Treatment goals</td>
<td>.2936</td>
<td>15</td>
</tr>
<tr>
<td>12</td>
<td>Predetermined no. of interviews</td>
<td>.2911</td>
<td>16</td>
</tr>
<tr>
<td>3</td>
<td>Crisis and stress</td>
<td>.2559</td>
<td>17</td>
</tr>
<tr>
<td>25</td>
<td>Case reassignment</td>
<td>.2384</td>
<td>18</td>
</tr>
<tr>
<td>13</td>
<td>No. of interviews 12 or less</td>
<td>.2384</td>
<td>19</td>
</tr>
<tr>
<td>11</td>
<td>Worker utilization</td>
<td>.2356</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>Crisis first reason for program</td>
<td>.2206</td>
<td>21</td>
</tr>
<tr>
<td>19</td>
<td>Reason PSTT effective</td>
<td>.2127</td>
<td>22</td>
</tr>
<tr>
<td>20</td>
<td>PST group therapy</td>
<td>.2015</td>
<td>23</td>
</tr>
<tr>
<td>6</td>
<td>Person in crisis</td>
<td>.1875&lt;sup&gt;b&lt;/sup&gt;</td>
<td>24</td>
</tr>
<tr>
<td>18</td>
<td>Practice after time limit</td>
<td>.1875&lt;sup&gt;b&lt;/sup&gt;</td>
<td>25</td>
</tr>
<tr>
<td>59</td>
<td>Reduces waiting list</td>
<td>.1730</td>
<td>26</td>
</tr>
<tr>
<td>29</td>
<td>Immediacy of treatment</td>
<td>.1376</td>
<td>27</td>
</tr>
<tr>
<td>26</td>
<td>PSTT in special unit</td>
<td>.1263</td>
<td>28</td>
</tr>
<tr>
<td>15</td>
<td>Limited range of interviews</td>
<td>.0795</td>
<td>29</td>
</tr>
<tr>
<td>23</td>
<td>1 or 2 exploratory interviews</td>
<td>.0649</td>
<td>30</td>
</tr>
<tr>
<td>32</td>
<td>Planned follow-up</td>
<td>.0621</td>
<td>31</td>
</tr>
<tr>
<td>27</td>
<td>PSTT techniques differ</td>
<td>.0538</td>
<td>32</td>
</tr>
<tr>
<td>16</td>
<td>Limited range of weeks</td>
<td>.0348</td>
<td>33</td>
</tr>
<tr>
<td>11</td>
<td>Seen within 4 days</td>
<td>.0300</td>
<td>34</td>
</tr>
<tr>
<td>21</td>
<td>Evaluation after set period</td>
<td>.0265</td>
<td>35</td>
</tr>
</tbody>
</table>

<sup>a</sup>Phi coefficients above .2589 are significant at or beyond the .10 level.

<sup>b</sup>Ranks 12-13, and 24-25 have the same phi coefficients.
### APPENDIX B

#### TABLE B.3

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Description</th>
<th>Phi Coefficient (^{a})</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td>Research on-going</td>
<td>.4309</td>
<td>1</td>
</tr>
<tr>
<td>24</td>
<td>Different PSTT intake</td>
<td>.3019</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Person in crisis</td>
<td>.3803</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Perception of crisis</td>
<td>.3464 (^{b})</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>Seen within 4 days</td>
<td>.3464 (^{b})</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>No. of interviews 12 or less</td>
<td>.3407 (^{b})</td>
<td>6</td>
</tr>
<tr>
<td>26</td>
<td>PSTT in special unit</td>
<td>.3407 (^{b})</td>
<td>7</td>
</tr>
<tr>
<td>9</td>
<td>Resolution of crisis</td>
<td>.3396</td>
<td>8</td>
</tr>
<tr>
<td>5</td>
<td>Crisis event</td>
<td>.3044</td>
<td>9</td>
</tr>
<tr>
<td>17</td>
<td>Time rationale</td>
<td>.2975</td>
<td>10</td>
</tr>
<tr>
<td>35</td>
<td>Staff training</td>
<td>.2825</td>
<td>11</td>
</tr>
<tr>
<td>32</td>
<td>Planned follow-up</td>
<td>.2726</td>
<td>12</td>
</tr>
<tr>
<td>12</td>
<td>Predetermined no. of interviews</td>
<td>.2615</td>
<td>13</td>
</tr>
<tr>
<td>3</td>
<td>Crisis and stress</td>
<td>.2542</td>
<td>14</td>
</tr>
<tr>
<td>21</td>
<td>Evaluation after set period</td>
<td>.2476</td>
<td>15</td>
</tr>
<tr>
<td>22</td>
<td>No exploratory interviews</td>
<td>.2365</td>
<td>16</td>
</tr>
<tr>
<td>27</td>
<td>PSTT techniques differ</td>
<td>.2337</td>
<td>17</td>
</tr>
<tr>
<td>34</td>
<td>Research planned</td>
<td>.2228</td>
<td>18</td>
</tr>
<tr>
<td>31</td>
<td>Worker utilization</td>
<td>.2035</td>
<td>19</td>
</tr>
<tr>
<td>25</td>
<td>Case reassignment</td>
<td>.1981</td>
<td>20</td>
</tr>
<tr>
<td>14</td>
<td>No. of weeks 12 or less</td>
<td>.1890</td>
<td>21</td>
</tr>
<tr>
<td>18</td>
<td>Practice after time limit</td>
<td>.1585 (^{b})</td>
<td>22</td>
</tr>
<tr>
<td>1</td>
<td>Crisis and strong ego</td>
<td>.1585 (^{b})</td>
<td>23</td>
</tr>
<tr>
<td>30</td>
<td>Reduces waiting list</td>
<td>.1310</td>
<td>24</td>
</tr>
<tr>
<td>28</td>
<td>Treatment goals</td>
<td>.0839</td>
<td>25</td>
</tr>
<tr>
<td>2</td>
<td>Crisis and weak ego</td>
<td>.0719</td>
<td>26</td>
</tr>
<tr>
<td>10</td>
<td>Crisis rationale</td>
<td>.0716</td>
<td>27</td>
</tr>
<tr>
<td>20</td>
<td>PST group therapy</td>
<td>.0695</td>
<td>28</td>
</tr>
<tr>
<td>4</td>
<td>Crisis first reason for program</td>
<td>.0663</td>
<td>29</td>
</tr>
<tr>
<td>23</td>
<td>1 or 2 exploratory interviews</td>
<td>.0483</td>
<td>30</td>
</tr>
<tr>
<td>16</td>
<td>Limited range of weeks</td>
<td>.0331</td>
<td>31</td>
</tr>
<tr>
<td>15</td>
<td>Limited range of interviews</td>
<td>.0148</td>
<td>32</td>
</tr>
<tr>
<td>19</td>
<td>Reason PSTT effective</td>
<td>.0131</td>
<td>33</td>
</tr>
<tr>
<td>8</td>
<td>Response to crisis</td>
<td>.0056</td>
<td>34</td>
</tr>
<tr>
<td>29</td>
<td>Immediate of treatment</td>
<td>.0028</td>
<td>35</td>
</tr>
</tbody>
</table>

\(^{a}\)Phi coefficients above .2337 are significant at or beyond the .10 level.

\(^{b}\)Ranks 4-5, 6-7, and 22-23 have the same phi coefficients.
### APPENDIX D

### TABLE D.4

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Description</th>
<th>PSAA</th>
<th>AAPCC</th>
<th>dated PAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Crisis and strong ego</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Crisis and weak ego</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Crisis and stress</td>
<td>X&lt;sup&gt;0&lt;/sup&gt;</td>
<td>X&lt;sup&gt;0&lt;/sup&gt;</td>
<td>X</td>
</tr>
<tr>
<td>4</td>
<td>Crisis event</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Person in crisis</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Perception of crisis</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Response to crisis</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Resolution of crisis</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Crisis rationale</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Seen within 4 days</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Freq. no. of interviews</td>
<td>X&lt;sup&gt;0&lt;/sup&gt;</td>
<td>X&lt;sup&gt;0&lt;/sup&gt;</td>
<td>X</td>
</tr>
<tr>
<td>12</td>
<td>No. of interviews 12 or less</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>No. of weeks 12 or less</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Time rationale</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Evaluation after set period</td>
<td>X&lt;sup&gt;0&lt;/sup&gt;</td>
<td>X&lt;sup&gt;0&lt;/sup&gt;</td>
<td>X</td>
</tr>
<tr>
<td>16</td>
<td>No exploratory interviews</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Different SSTT intake</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>SSTT in special unit</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>SSTT techniques differ</td>
<td>X&lt;sup&gt;0&lt;/sup&gt;</td>
<td>X&lt;sup&gt;0&lt;/sup&gt;</td>
<td>X</td>
</tr>
<tr>
<td>20</td>
<td>Treatment goals</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Planned follow-up</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Research on-going</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Research planned</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Staff training</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup>p<.05 unless otherwise indicated; phi coefficients for all items, ranked by level of significance, are detailed in Appendix D, Tables D.2 and D.3.

<sup>b</sup>Item numbers are taken from Appendix C (Code Sheet C.5) where all of the original 35 PAS items are described.

<sup>c</sup>.05<p<.10
BIBLIOGRAPHY

BOOKS


BOOKS (Cont'd)


<table>
<thead>
<tr>
<th>Title</th>
<th>Authors/Contributors</th>
<th>Publisher/Institution</th>
<th>Publication Date</th>
</tr>
</thead>
</table>
ARTICLES


ARTICLES (Cont'd)


ARTICLES (Cont'd)


ARTICLES (Cont'd)


_____. "Casework Principles for Guiding the Worker in Contacts of Short Duration," Social Service Review, XXII (June, 1948), 234-239.


ARTICLES (Cont'd)


ARTICLES (Cont'd)


UNPUBLISHED MATERIALS


