Time-Unlimited Brief and Longer-Term Psychotherapy with Rural Clients

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This retrospective study examined the outcome of time-unlimited brief (four sessions or less) and longer-term (10 sessions or more) psychotherapy with 13 rural clients seen by two experienced therapists. Clients completed the Psychosocial Functioning Scale (PSF) before the first session and after each subsequent session, therapists completed the PSF after every session. Analysis of covariance (ANCOVA) replicated, in this previously unstudied population, earlier findings of no significant difference between brief and longer-term psychotherapy outcome. There was additional evidence of deterioration in longer-term clients who had made rapid improvement by the fourth session, which also replicates previous research with urban populations. It is concluded a) that urban and rural clients do not differ in their responsiveness to brief psychotherapy, b) that the hypothesized differential effectiveness of brief psychotherapy for clients with acute and chronic problems needs further study, and c) that differences between client and therapist ratings of client functioning need further study.

In a recent review of brief psychotherapy outcome research (Butcher & Koss, 1978), the authors conclude that there are no detectable differences in the effectiveness of brief (less than 10 sessions) and longer-term therapy. Furthermore, in at least a few studies (Cummings, 1977; Rosenthal & Frank, 1958; Shlien, Mosak & Dreikers, 1962; Strupp, Fox & Lessler, 1969; Weitz, Abramowitz, Steger, Calabria, Conable, & Yarus, 1975) it has been found that client improvement takes place within a few

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therapy sessions, after which clients' functioning reaches a plateau or deteriorates. These findings may be mitigated, however, by more research (Gottschalk, Fox & Bates, 1973; McKitrick & Gelso, 1978; Gelso, Note 1), the results of which suggest that a brief therapy is differentially effective for clients with acute and chronic problems.

The present study describes a retrospective field investigation that attempted to replicate the above findings in a previously unstudied population (i.e., rural mental health clients). Recent research and descriptive reports (Flax, Wagenfeld, Ivens, & Weiss, 1979) have delineated some important distinctions between rural and urban mental health clients: for example, rural clinical populations have been found to be less passive and more visibly deviant (Michaux, Foster, Dosinger, Chelst, & Primm, 1974a; Michaux, Foster, Dosinger, Chelst, & Primm, 1974b), less frequently schizophrenic (Eaton, 1974) and particularly appropriate for short-term intervention (e.g., Mazer, 1976). Demographically, rural mental health center clients have been found to be less frequently black, more frequently female, lower income, less educated, and more frequently married (Bachrach, 1974). Given these differences, and particularly since short-term intervention has been recommended for rural populations, the effectiveness of brief vs. longer-term psychotherapy with rural clients is an important area for study.

The research on brief psychotherapy is differentiated according to whether the length of treatment (i.e., number of sessions) is specified at the time of the initial session (defined as "time-limited therapy"). In the present study, length of therapy was not specified at intake, but was mutually determined post facto by therapist and client and, hence, is referred to as "time-unlimited therapy."1

Method

Subjects

Thirteen adult clients were seen by two (one male, one female) experienced (mean = 8 years experience) therapists at a rural community mental health center. Seven of these clients were seen in time-unlimited brief (median = 3 sessions; range = 2-4) psychotherapy and six were seen in longer-term psychotherapy (median = 12 sessions; range = 10-17). In

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1 For further discussion of time-limited and unlimited brief psychotherapy see Johnson & Gelso (Note 2).
the brief group, four clients were seen by therapist A (female) and three by therapist B (male); in the longer-term group, two clients were seen by therapist A and four by therapist B. Both client groups were predominantly female (one male in each group) ranging in age from 20 to 61. The median age for the brief (age 28) and longer-term (25) groups was nearly equivalent. Diagnostically, the brief group was characterized by a diagnosis of adjustment reaction (42%) while the longer-term group had a larger percentage (50%) of neurotic diagnoses. Prior to treatment, most (86%) of the brief clients indicated that they did not know how long they expected to be in treatment, while half of the longer-term clients indicated that they expected to be in treatment for six sessions or more. All but two clients (one from each group) completed treatment (i.e., formally terminated with their therapists).

Procedures

Clients completed a general information questionnaire and the Psychosocial Functioning Scale (PSF) (Fago, Note 3) prior to their first session. After each subsequent session clients completed the PSF only. Therapists completed the PSF at the end of each session. Weekly sessions consisted of 1 hour of individual psychotherapy; the method of treatment was active-eclectic, with both therapists using a variety of directive, supportive, behavioral, and nonbehavioral techniques.

Instrument

The Psychosocial Functioning Scale (PSF) is an unpublished instrument consisting of 16 problem statements related to psychological and social functioning (e.g., anxiety, depression, work, school, relationships). These statements are rated on a 5-point scale according to problem severity and can be completed from multiple perspectives (client, therapist, independent judge). For the analyses here, total PSF scores were used (higher score = greater dysfunction). Reliability and validity studies on this instrument are being completed and prepared for publication. Initial evidence indicates that the instrument has good reliability and validity coefficients. Total PSF (therapist) score has been found to correlate moderately ($r = .64$) with the Global Assessment Scale (Endicott, Spitzer, Fliess, & Cohen, 1976), and the correlation between client and therapist PSF totals has been
found to range between .55 and .88 and to increase over the course of treatment.2

Results

The outcome of brief versus longer-term psychotherapy was compared using Analysis of Covariance (ANCOVA) of clients' and therapists' termination PSF totals with their PSF total at admission used as the covariate. Neither client nor therapist analysis yielded a statistically significant F; hence, from the perspective of both clients and their therapists, the brief and longer-term treatments were not differentially effective. Pre- and posttreatment PSF means and standard deviations are presented in Table 1. As this table shows, there was a sizeable difference between brief and longer-term PSF scores at intake, clients, t (11) = 1.02, N.S.; therapists, t (11) = 2.27, p < .05, thus making ANCOVA the analysis of choice. This pretreatment group difference suggests that clients who opted for longer-term treatment were more dysfunctional at admission, which is consistent with the between-group diagnostic differences described previously.

<table>
<thead>
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<th></th>
<th>Admission</th>
<th>4th Session</th>
<th>Termination</th>
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<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
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Note. Greater score = greater dysfunction.

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2 A copy of the instrument and preliminary findings may be obtained from the author by writing to him at West Yavapai Guidance Clinic, P.O. Box 2190, Prescott, Arizona 86302.
Table 1 also presents PSF means and standards deviations for longer-term clients and therapists at the fourth session. These means, when compared with the other means in Table 1, indicate that, according to longer-term clients’ ratings, the greater average improvement occurred between admission and the fourth session, and that improvement between the fourth session and termination was negligible. This trend is illustrated further by the individual client data. Between the first and fourth sessions, five of six longer-term clients reported improvement (at least 10% decrease in PSF total); between the fourth session and termination only one longer-term client reported continued improvement, while three reported no change and two reported deterioration.

Finally, between intake and termination, clients in the brief treatment group were significantly improved according to clients’, \( t(12) = 2.04, p < .05 \), but not therapists’, \( t(10) = 0.59 \), N.S., PSF totals.

Discussion

It is important to acknowledge that the present study bears certain methodological flaws. First, because of the study’s retrospective nature, there is no assurance that the two treatment groups were equivalent. In fact, based on initial diagnosis and therapist/client ratings, the evidence suggests that the longer-term initially was more dysfunctional than the brief group. Although this between-group difference was statistically corrected through the use of ANCOVA, there may be other inherent differences that confound the results. A second methodological limitation is the small \( N \). The results, which confirm the null hypothesis, could be an artifact of small sample size and, hence, be an instance of Type II error. However, it is of no small importance that the results, though statistically nonsignificant, favored brief over longer-term therapy.

The above limitations notwithstanding, the present investigation has replicated the results of several previous studies. First, earlier research findings of no significant difference between brief and longer-term psychotherapy have for the first time, been replicated in a rural client sample. Thus, there now is empirical support for Mazer’s (1974) recommendation that short-term interventions be used with rural populations.

The present study also provides fairly compelling evidence that, as suggested by previous investigators, improvement often occurs within a few psychotherapy sessions, after which clients may hit a plateau or deteriorate. One of the most widely cited examples of this literature is the research at Kaiser-Permanente (Cummings, 1977; Cummings & Follette, 1976). Over several years, with numerous replications, Cummings and his associates consistently found a significant negative relationship between
psychotherapy outcome (vis-a-vis medical service utilization) and frequency and duration of outpatient psychotherapeutic treatment. Furthermore, they found that the resulting cost-benefit ratio for short-term therapy was more than twice that for long-term therapy. Relatedly, in their well-known theoretical work, Watzlawick, Weakland and Fisch (1974) have suggested a) that long-term psychotherapy aims at unattainable, "utopian" goals that are created by the therapist; b) that these goals can become a significant source of resistance in the client; and c) that under such circumstances, psychotherapy makes the transformation from solution to problem an obviously undesirable event. Watzlawick and his colleagues conclude:

that the limits of a responsible and humane psychotherapy may be much narrower than is generally thought. Lest therapy become its own pathology, it must limit itself to the relief of suffering; the quest for happiness cannot be its talk. (p. 57)

Certainly the continued replication of the finding that clients can and do respond quickly to psychotherapy has implications for the concern raised by Garfield (1978) that large percentages of clients are terminating "prematurely" after only a few sessions. The research accumulated to date suggests a) that many clients want to be seen for only a few sessions; b) that they can and do terminate appropriately after a brief period of treatment; and c) that clients get results after a few sessions.

A last finding from the present study that is of both practical and theoretical interest is therapists' ratings of longer-term, but not brief, clients as significantly improved, while the converse was true of clients' ratings of themselves. This finding replicates, with a different population and different outcome measure, the results of numerous other studies, as noted by Johnson and Gelso (Note 2). Gelso has interpreted this important difference between client and therapist outcome ratings as possibly related to therapists using different criteria for improvement for brief and longer-term psychotherapy. The present results, however, do not appear to support this "shifting criterion" hypothesis. Because, in this study, clients and therapists rated the outcomes of both brief and longer-term therapy with the same, behaviorally specific outcome measure (rather than a global improvement rating), it seems reasonably safe to assume that clients and therapists were judging the same criteria under both conditions. These seemingly inconsistent findings might be seen as supporting the counselor bias hypothesis ("more therapy is better therapy"), as discussed by Johnson and Gelso (Note 2). In addition, this difference, and perhaps bias on the part of therapists, might be related to a more specific measurement/criterion issue. It may be noted in Table 1 that therapists, in both treatment conditions and at all measurement points, rated clients as less
dysfunctional than clients rated themselves. Hence, there may be a ceiling effect operating for therapists, which is particularly regnant during the early phase of therapy. From the perspective of therapists, clients seem to have a more limited range for improvement, and this improvement may take longer to achieve. Further research will be needed on the source of this initial variance between client and therapist ratings of client functioning.

Further research also will need to examine more systematically the effects of brief and longer-term therapy, both time-limited and time-unlimited, on the outcomes of clients in different diagnostic and problem-severity groups. It is conceivable that at some future time clinicians, armed with the results of this research, may be able to predict what percentage of clients with what kinds of problems will show how much improvement by which psychotherapy session. Certainly the results of this research could have significant implications for third party and national health payment of mental health benefits in the rural as well as the urban sector.

Reference Notes


Fago, D.P. *The Psychosocial Functioning Scale for assessing psychotherapy outcome*. Unpublished report funded by the Arizona Department of Behavioral Health Services, Phoenix, Arizona, 1978. (Available from West Yavapai Guidance Clinic, P.O. Box 2190, Prescott, Arizona, 86302).

References


