THE DEVELOPMENT AND EVALUATION
OF THE GOAL ATTAINMENT SCALING PROCESS

by

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ABSTRACT

The purpose of this study was to develop a group process to assist clients in a goal-oriented problem-solving approach to brief therapy. The Goal Attainment Scaling Process (GASP) described in this paper was to become an important part of the treatment program of a voluntary inpatient psychiatric unit. An evaluation was conducted, comparing hospitalization with and without the GASP.

The theoretical rationale underlying the GASP is based upon the assumption that as people work on minute steps of progress they will receive reinforcement at their lower levels of goal attainment. Such reinforcement will serve as an impetus for attaining higher levels of goal attainment. Further, as clients identify themselves as responsible for change, they gain more control over their fate. Thus as the clients clarify their expectations and goals, they are less likely to feel anxious about their lives. As they exercise decisions and choices for control, there is an expected increase in assertiveness. With a concrete life-focus, such as the GASP provides via small sequential steps, it is logical to assume that clients' enthusiasm for both themselves and life in general would rise as the goals are attained. Concomitantly, as their goals are attained, clients become more self-reliant, enthusiastic, and less anxious. Then, less time is spent worrying about "where I went wrong" or the guilt of past mistakes.
This process is consistent with the notions of: time limited goals, talking about present events, fostering ventilation, and rapidly developing a facilitative interpersonal relationship. The therapist managed the problem-solving session directly; supportive administrative interventions screened appropriate clients and fostered therapeutic flexibility. The GASP taught clients self-control through a direct assessment strategy that encouraged clients to regulate their own behavior by examining the definition of the problem and coping skills.

The conclusion was that the afore-mentioned factors could be combined in developing a needed therapy for a short-term psychiatric hospitalization program. Specifically, an instrument used to measure psychotherapeutic outcome, the Goal Attainment Scale, could be modified into a procedure to aid voluntarily hospitalized psychiatric patients.

The subjects were 32 voluntarily hospitalized patients of the psychiatric unit of Valley General Hospital. An adaptation of the non-equivalent control group design was chosen. They were administered the Rotter Internal-External Locus of Control Scale, the Target Outcome Assessment Sheet, and the Sixteen Personality Factor Questionnaire upon admission, and again eight days after their initial interview. Eleven subjects in both treatment groups and a pre-experimental group were administered the Ward Atmosphere
Scale. The purpose was to see if the atmosphere during hospitalization with the GASP was different than the atmosphere of hospitalization without the GASP.

It was hypothesized that there would be no differences in the ward environment six months before testing and during the two evaluation periods, that there would be no differences between pretest scores, that there would be a difference in attaining both the clients' "most important" goal, as well as all their other goals; that there would be a difference in the subjects' subsequent scores of self-control; that the clients would have more personality integration, be more assertive and enthusiastic, and less guilty and anxious; and that the length of hospitalization time would be shortened.

A multivariate analysis of variance did not reveal any differences in ward atmosphere during the two treatments and for the six months prior to the evaluation. Further, the pretest scores of both groups at admission were not found to be different. For the most part the goals identified at admission were in the same categories as those identified during the GASP. Also, clients' goals at admission and during the GASP were stated in the same direction.

Analysis of the posttest revealed there was no significant difference between the groups relative to goal achievement, ego strength, assertiveness, and guilt. The GASP clients were significantly more internal, more enthusiastic, and less anxious. Finally, hospitalization with the
GASP was shorter by 16.3 per cent, but this was not statistically significant.
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CHAPTER I

INTRODUCTION

Three of the more interesting recent developments in psychotherapy have been the advancement of brief psychotherapy, the growth of problem-solving/self-control therapies, and the development of Goal Attainment Scaling. Brief psychotherapy is a result of a search for a more efficient means to meet client needs. Problem-solving psychotherapy has developed from research in cognitive therapy within the boundaries of behavior therapy. Goal Attainment Scaling is a response to the demands of measurement, precision, and accountability in psychotherapy.

Lorion (1974) reported that the National Center for Health Statistics found that for 979,000 clients, the average number of contacts with a therapist was 4.7. Whether or not this number of contacts is due to premature termination, it nevertheless demonstrates a need for brief therapies. Mahonev and Arknoff (1978) extensively reviewed completed research and development in the area of self-control therapies and concluded that these approaches showed great promise as a technology for therapeutic change. Goal Attainment Scaling has been used as an instrument for
evaluating the outcome of psychotherapy and can also be used as a treatment itself (Smith, 1974). Goal Attainment Scaling lends itself to being used as a therapeutic method because it is a very concrete system for establishing goals. Taken together, these three developments in psychotherapy have the potential to be synthesized into a short-term treatment procedure.

There are indications that a synthesis of problem-solving psychotherapy, brief psychotherapy, and Goal Attainment Scaling could prove successful. The literature suggests the integration should include many therapeutic aspects. The synthesized process should take into account the importance of: time limited goals, talking about present events, fostering ventilation, and rapidly developing an interpersonal relationship. The therapist should manage the problem-solving session directly. Supportive administrative interventions should place appropriate clients in treatment quickly and should foster therapeutic flexibility. The process should teach clients self-control through a direct assessment strategy that encourages clients to regulate their own behavior. Finally, the therapy should emphasize problem definition and broad coping skills. In order to pursue this synthesis, four issues were addressed in the present study. These were: (1) meeting the requirements of the hospital; (2) evaluating the components of short-term psychotherapy; (3) identifying the promising aspects of
problem-solving psychotherapy; and (4) examining the Goal Attainment Scaling procedure.

The Hospital Administration's Need

The integration of the program components briefly described above, and the subsequent evaluation of the effectiveness of the resulting procedure was completed at Valley General Hospital in Seattle, Washington. While a number of other hospitals were approached, this site was chosen for two reasons. First, the hospital administrators wanted a procedure that could be conducted daily within sixty minutes, given that clients would be hospitalized for an average of two weeks. The procedure was also required to fit into the administration's ideas of openness and ward milieu. Second, as the process was to be based upon existing empirically validated practices, the hospital administrators contracted to evaluate the effectiveness of the procedure.

Promising Components of Short-Term Psychotherapy

As people were being seen for a relatively small number of sessions, therapists had to develop a technology to meet this need for brief treatment. In their review of research on brief and crisis-oriented therapies, Butcher and Koss (1978) noted that, in spite of differing theoretical
assumptions and treatment strategies, most brief treatments have a number of characteristics in common. These are:

1. Therapy is managed within a specified period of time. Butcher and Koss (1978) suggested that informing the client of the time limits accomplished two therapeutic goals. It encouraged client optimism that change was possible in a short time and provided therapy with a structure of a beginning, a middle, and an end.

2. Therapeutic goals are limited. Both Malan (1963) and Wolberg (1965a) reported that brief psychotherapy abandoned notions of "therapeutic perfection" and "the prejudices of depth" that are generated with ideas of extensive personality reconstruction. Goals established for brief psychotherapy are limited to establishing emotional equilibrium within the time framework of therapy.

3. Therapeutic content is centered in the present. Butcher and Koss (1978) suggested that the goals of brief psychotherapy could be accomplished most effectively if therapeutic attention is focused on a thorough exploration of the primary problem area, which more often than not is a current problem in the client's life. Childhood memories, dreams, and interpretations of transference should be employed only as they come to bear on the present problem.

4. The session is managed directly by the therapist. Strupp (1973) demonstrated that after clarification, direct guidance was the second most frequent therapeutic activity in brief psychotherapy. Short-term behavioral therapists
are also significantly more directive than psychoanalytically oriented therapists (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975). Gelb and Ullman (1967) argued that working in a brief psychotherapy framework, therapists must guide the client to methods of behavior and interaction that are different from the client's customary mode of operating.

5. The client is assessed rapidly and early. Brief therapy makes it imperative that the therapists understand the precipitating events (Harris, Kalis, & Freeman, 1963; Jacobson, Wilner, Morley, Schneider, Strickler, & Sommer, 1965; Sifneos, 1975). Small (1971) suggested tentative guides whereby the clients identified the complaint, the precipitating causes, the variations of the present behavior, the meaning of the behavior, and their own strengths and weaknesses.

6. Therapeutic interventions are adapted to meet the requirements of the individual. Alexander and French (1946) concluded that the primary technical principle in short-term psychotherapy was adapting the treatment to the client. Consequently, short-term psychotherapy requires a variety of psychotherapeutic techniques which come from psychiatry, psychoanalysis, psychology, and sociology (Wolberg, 1965b).

7. Intervention is prompt. This action is necessary as there may not be another session. Many researchers (Bellak & Small, 1965; Caplan, 1961; Lindemann, 1944; Wolkon, 1972) suggest it is advantageous to treat people as quickly as possible. Prompt intervention parallels the
earlier idea that the emphasis in brief psychotherapy centers on current life problems and thus the practitioners should offer therapy when the client has awareness of the problem and is ready to work on it.

8. Emotional tension is ventilated. In reviewing all of the major approaches to brief and crisis-oriented therapy, ventilation was found to be important (Alexander & French, 1946; Baker, 1947; Butcher & Koss, 1978; Butcher & Maudal, 1976; Frank, 1974b; Lindemann, 1944; Mann, 1973; Semrad, Binstock, & White, 1966; Wolberg, 1965b; Wolpe & Lazarus, 1966). Within a cathartic environment, clients can experience and express their feelings spontaneously and naturally.

9. A facilitative interpersonal relationship is established quickly. This relationship is seen as desirable by any school of therapy (Bergin & Suinn, 1975) and may be enhanced by many factors. Two of these factors are the client's expectation of therapeutic gain (Lick & Bootzin, 1975) and the therapist's enthusiasm and involvement (Malan, 1963, 1976a).

10. Appropriate clients are selected. According to the review by Butcher and Koss (1978), four types of clients were recognized as best suited for brief psychotherapy: those in whom the behavioral problem is acute; those in whom previous adjustment has been good; those with good ability to relate; and those with high motivation. Clients whom
Butcher and Koss thought were unsuited for short-term therapy were: those who desire personality reconstruction, are deeply dependent, persistently act out, or are unrestrainably anxious; those who are outspokenly self-centered, passively-dependent, masochistic, or self-destructive; and those who are not educated beyond fifth grade, psychotic, mentally defective, or toxic due to illness or organicity.

These ten components have generally been integrated into most short-term psychotherapies (Butcher & Koss, 1978). The challenge is to synthesize the contemporary practice of short-term psychotherapy with problem-solving therapy and Goal Attainment Scaling.

Promising Developments of Problem-Solving Therapies

One way to enhance the goal directedness of brief psychotherapy is to encourage clients to change their behavior (Frank, 1974a; Liberman, Imber, Stone, Hoehn-Saric, & Frank, 1974). "Available research evidence supports the widely held view among brief therapists that concrete implementation of new roles or behaviors is an important and effective process in brief treatment approaches" (Butcher & Koss, 1978, p. 748). In this regard, Mahoney and Arnkoff (1978) speculated that of all the cognitive and self-control therapies identified as behavioral, the problem-solving therapies, which view psychological problems as the result of ineffective behavior, might yield the most encouraging
Problem-solving therapists do not look upon problems as abnormal behavior or emotional disturbance. The problem-solving therapists explore the situational problems in the client's life. Problem-solving therapists also examine the client's inadequate attempts to solve these problems which may create such undesirable effects as anxiety, depression, or indecisiveness. Mahoney and Arnkoff (1978) suggested therapies of this nature may in part be effective due to:

1. the teaching of coping skills,
2. the direct strategies of assessment,
3. an emphasis on problem definition,
4. the self-regulatory nature of these approaches, and/or
5. the active and responsible participation of client and therapist.

Goal Attainment Scaling

Intended as a behavioral measure of therapeutic outcome, the Goal Attainment Scale (Kiresuk & Sherman, 1968) is used to identify therapeutic goals and to break down, step-by-step, the behaviors a person engages in to achieve each goal. The final behaviors are then charted, and a judgment is made as to whether or not the therapy assisted or hindered that person's goal attainment.
Using Goal Attainment Scaling, the following is a list of some behaviors clients have identified for change (Garwick & Lampman, 1972): 1. aggression, 2. alcohol use, 3. anxiety, 4. psychopathological symptoms, 5. decisions, 6. depression, 7. drug use, 8. education, 9. family or marital concerns, 10. finances, 11. interpersonal problems, 12. legal problems, 13. living arrangements, 14. medical problems, 15. self references, 16. sexuality, 17. suicide, 18. treatment, and 19. work.

Smith (1974, 1976) proposed that the Goal Attainment Scale itself possessed psychotherapeutic properties. He evaluated the difference between individuals who had completed the Goal Attainment Scale in therapy and those who had not. He concluded that by identifying goals using the Goal Attainment Scale, clients improved more than if they had not used this instrument.

Smith's effort was laudable in that he creatively examined the notion that the instrument (the Goal Attainment Scale) itself possessed properties conducive to fostering good mental health. In a preliminary way, Smith demonstrated that the Goal Attainment Scale was adjunctive to therapy. Kiresuk (1977) stated that Smith was the only researcher demonstrating the psychotherapeutic properties of Goal Attainment Scaling. Further, Kiresuk was unaware of any attempts to employ the Goal Attainment Scale in groups.

The generalizability of Smith's effort to identify the psychotherapeutic properties of the Goal Attainment Scale is
limited to individual therapy and to suburban white adolescents in guidance centers. This generalizability would be increased by these operations:

1. Employing a different treatment setting,
2. Examining more subjects,
3. Representing different age groups,
4. Delineating degrees of psychological disturbances,
5. Examining group psychotherapy instead of individual therapy, and
6. Integrating relevant research in this area in order to articulate the process specifically.

Statement of the Problem

Brief psychotherapy, problem-solving therapy, and Goal Attainment Scaling provide the building blocks for a short-term, goal-oriented, problem-solving group treatment. It was thought that by combining these areas it would be possible to develop a short-term therapeutic process with operationalized objectives for use with groups of clients.

The purpose of the current study was two-fold: first, using the three developments described briefly above, to develop a short-term (two week) group treatment procedure to be used in a psychiatric unit; and second, to conduct an exploratory evaluation of this procedure. The name of the therapeutic procedure developed in this study is the Goal Attainment Scaling Process (GASP), a multicomponent therapy which goes beyond Goal Attainment Scaling.
Organization of Dissertation

The characteristics of brief and problem-solving therapies, and Goal Attainment Scaling are reviewed and synthesized in Chapter II. In Chapter III, the development of the GASP is presented, followed by the hypotheses which were addressed in the exploratory evaluation of the Goal Attainment Scaling Process. Chapter IV includes a description of the design used for this evaluation. The evaluation results are presented in Chapter V and discussed in Chapter VI.
CHAPTER II

SURVEY OF THE LITERATURE

It is necessary to have a thorough understanding of brief psychotherapy, problem-solving therapy, and Goal Attainment Scaling in order to have a clearer comprehension of the Goal Attainment Scaling Process (GASP). Each of these three areas is examined in building the justification for the GASP, and their implications to the GASP are identified.

Brief Psychotherapy

Psychotherapy can be classified in many ways. Some examples are: group versus individual; child versus adult versus family; behavioral versus analytic; long versus short. The most pertinent to the subject at hand is the long-short distinction. Long-term therapy is usually defined as treatment consisting of more than 25 sessions, and brief psychotherapy is distinguished by less than 25 sessions (Butcher & Koss, 1978).
Whereas both brief and long-term treatment are designed to change client behavior, brief psychotherapy is necessarily very specific in regard to the goals of therapy. This emphasis is unlike the broader aspirations of long-term therapies which focus on "personality reconstruction" or a "thorough understanding of oneself" (Wolberg, 1965a). Therefore, although it may be applied in various settings, brief psychotherapy is more often concerned with limited goals. Thus brief psychotherapy is not simply abbreviated long-term therapy. While the processes may be similar, the goals are different. They are separate treatments altogether.

This distinction between their goals does not mean that the research in one field could not or does not influence the other field. It certainly can and does. However, the clinical application of any research would look different, depending upon the length of time therapy is expected to last.

After the historical development of brief psychotherapy is presented, the characteristics common to most brief psychotherapies are examined. Finally, evidence for the efficacy of brief psychotherapy is presented.

**Historical development of brief psychotherapy**

Brief psychotherapy is not new (Kardiner, 1941; Malan, 1963; Wolberg, 1965a). Ferenczi (1920) tried to keep analysis brief by instructing analysts to be active and
directive in therapy rather than passive and non-directive. The effectiveness of brief psychotherapy was explored by Alexander and French (1946) when they shortened treatment time by identifying early signs of maladjustment in clients. Malan (1963) pointed out in a review of brief psychotherapy that initially psychoanalysis was short and became longer when the focus of therapy shifted from symptom relief to transference interpretation.

Butcher and Koss (1978) pointed to three historical developments that led to the acceptance of brief psychotherapy into the mainstream of psychology. The three events were: the Second World War and its related transient emotional disturbances; the beginning of free clinics; and the development of behavior modification techniques. They argued that in World War II, combatants suffered severe stresses and anxieties that were usually of a short duration and specific to a particular situation. Individuals who worked with these soldiers attempted to provide therapy as soon as decompensation occurred. Their aim was to decrease stress, relieve symptoms, restore self-esteem, and avoid further maladjustment (Grinker & Spiegel, 1944a, 1944b; 1945; Kardiner, 1941).

Janis (1951) did an extensive study of emotional stress resulting from World War II. He reviewed the literature of the Americans, the British, the Germans, and the Japanese and found the results strikingly similar. In all four
countries air attacks did not increase chronic psychopathological disorders in civilians. There was relatively no difference in the number of admissions to psychiatric hospitals two weeks before an attack, and two weeks after (Weatherby, 1943). However, there was an increase in acute disturbances. Transient emotional disturbances took the form of acute anxiety, mild depression, and apathy (Kardiner, 1941). Dunsdon (1941) claimed bombings frequently produced acute anxiety in the British civilians. Clients who absented themselves from work on the pretext of fatigue were really missing work because of anxiety. In these instances Janis (1951) described a treatment of "psychiatric first aid: rest, sympathy, and suggestion" (p. 86). While Janis (1951) was unable to locate definite evidence of any increase in depression, he obtained verbal accounts of increased apathy, pessimism and related depressive manifestations that followed air attacks. According to Denny-Brown (1943), Japanese and English military personnel were also subject to various transient conditions of exhaustion, anxiety, depression, and irritation.

Butcher and Maudal (1976) noted that the stress reactions that are characteristic of life are not unlike the stress of war. Personal troubles are often a response to social problems. The two stresses are often a reaction to the society at large, and need not be considered abnormal (Grossack, 1965). In both cases the stress is brief and acute in nature, results in high anxiety and the loss of
control, and is often related to a specific situation. For this reason Butcher and Maudal (1976) argued that therapists began to apply the techniques of the war-front psychiatric centers to the homefront clinics. Therapists modified those techniques to fit their own theories and therapies for working with acute clients.

Specifically, Stanley Cobb at Massachusetts General Hospital is credited with developing one of these early programs for emergency psychiatric service in 1934 (Malan, 1976a). Later, Erich Lindemann, one of Cobb's early recruits, crystalized his ideas on crisis intervention as a result of his involvement with the devastating fire at the nightclub called "The Coconut Grove". A large number of people had lost their lives in this fire. Survivors were subsequently stressed and traumatized with grief (Lindemann, 1944). Lindemann organized emergency facilities to assist them.

Another example of this adaptation from the Second World War is the Community Mental Health Program at the Harvard School of Public Medicine (Parad, 1967). Advocates of the Program believed people must learn to live in the world by meeting stresses and strains of living and change. Following much data gathering, they identified five critical transition points in the normal development of the family life cycle: getting married, birth of the first child, children going to school, death of a spouse, and children leaving home. The school set about developing programs in
preventive intervention to help people respond to these predictable family stresses.

The second historical development came in the 1960's with the advent of free clinics. Butcher and Koss (1978) pointed out that this movement was in response to social changes in politics, drug accessibility, and changing morals. They, and others (Glasscote, Raybin, Reifler, & Kane, 1975), mentioned that during this period, people sought help from less traditional mental health sources such as drop-in centers, "rap" groups, and crisis center "hotlines" (Rappaport, 1977). From these informal settings, short-term mental health programs have been developed to confront: old age (Sloate, 1974); drug abuse (Klebeler, 1974); alcoholism (Chafetz, 1974); suicide prevention, rape, or other life crises (Rappaport, 1977); and divorce, separation, death, homosexuality, adolescent crisis, depression, and suicidal, homicidal, or assaultive behavior (Slaby, Lieb, & Tahcred, 1975).

The development of free clinics was part of a vigorous movement in the United States toward community mental health (Bellak & Small, 1965; Chu & Trotter, 1974; Malan, 1976a; Rappaport, 1977). A large amount of money was provided by the government to establish mental health centers for treatment. Located in the community so that people would not have to be taken away from their neighbourhoods, these centers were specifically required to include a provision for early, easy access to psychotherapy like the treatment
that most emergency rooms in hospitals offer to medical clients.

The third historical development that Butcher and Koss (1978) cited was the use of behavioral techniques to modify behavior. They pointed out that even though Watson and Rayner (1920) demonstrated the phenomena of "unlearning", the application of learning principles to psychotherapy was not in the mainstream until Wolpe (1958) examined neurosis as a function of learned behavior. This was not to say that there had been no earlier application of learning principles to therapy, for indeed other clinicians had employed these principles (Holmes, 1936; Jones, 1931; Terhune, 1949). What they were saying was that after Wolpe the technology of behavior change blossomed.

Malan (1976a) said therapy is a learning process and its operations are concerned with facilitating that process. In talking about a patient's experience in brief therapy, Malan (1976a) states, "Not only does he learn about himself, he learns new ways of solving emotional problems, which, it is hoped, he will be able to make use of in the future" (Malan, 1976a, p. 24). More directly, the behaviorists have developed techniques which clinicians have used such as modeling and behavioral rehearsal (Bandura, 1971). This technology brought with it procedures, language, and data gathering techniques that were quickly amenable to short-term treatment. Essentially no attempt was made to create
any one school of brief psychotherapy, but clinicians adapted the philosophy and the research where they could.

**Characteristics common to brief psychotherapy**

An efficient way to review this literature is to use the format presented in Chapter I for organizing the discussion of brief psychotherapy. In this section the relevant literature in these areas is summarized.

**Time**

By definition brief therapy is of short duration. Time then is one of the primary variables that distinguishes brief psychotherapy from other approaches. Most therapists in brief psychotherapy carefully define the maximum number of sessions therapy will last. In their summary of the research on brief and crisis-oriented therapy, Butcher and Koss (1978) identified that although the time limits for brief therapy vary with client and problem, clients should be informed at the beginning of therapy of that time limit. In the following studies, change is demonstrated in one to thirteen sessions with a cross-section of clients and problems.

Many therapists recommended telling clients in the first session that the therapy they would receive would be brief (Bellak & Small, 1965; Frankel, 1973; Koegler & Cannon, 1966; Spoerl, 1975). This was done for three reasons. First it was to increase client optimism through
therapist confidence that change was possible in a short time. Secondly, this time definition was to keep therapy focused. Thirdly such a structure was to give therapy a beginning, a middle, and an end. As Malan (1976a) wrote regarding time limits:

... A time limit ... helps to concentrate both the patient's material and the therapist's work, and to prevent therapy from becoming diffuse and aimless and drifting into a long-term involvement. It enables the prospect of termination to be brought in quite naturally as the time for this approaches; and often this enables a therapy that had been in danger of becoming diffuse to become clear and focal again.

(Malan, 1976a, p. 257)

In line with Butcher and Koss's (1978) observation that as many brief clinicians recommend "... courses of treatment lasting from one to six sessions, as the longer 10-25 session treatment" (p. 730), this review divides attention between those studies that show change in less than six sessions and more than six sessions. The review is organized from the least to the greatest number of sessions, and will deal with both individual and group treatments.

Atkins (1976) demonstrated change in homosexuals in one to three individual sessions. She treated 16 male and 16 female homosexuals and clients reported improvements in areas of depression, anxiety, family relations, and ability to confront the community's reactions. In a case study by Brink (1977), a 64 year old widow was seen for four one-hour therapy sessions over 15 days and reported an increased ability to identify problems and solutions. A two-year follow-up indicated the client's progress had continued.
Werman, Agle, McDaniel, and Schoof (1976) treated 80 clients between 17 and 62 years of age in individual therapy. Treatment ranged from four to six sessions. In a follow-up two months after treatment, 75 per cent reported they had improved and 25 per cent reported no improvement. Cabral and Patterson (1975) showed improvement using a group therapy format with 19 adult clients whose mean age was 24. Clients stated they felt more accepted by their peers after five weekly sessions of two hours in length. Newton and Stein (1974) also employed group therapy with alcoholics and reported positive changes after six sessions. They compared three types of treatment: general milieu, an anxiety reduction approach, and brief psychotherapy that was limited to only six sessions. In all three the clients' perceived level of distress was lowered and they felt they had been helped to overcome their sense of helplessness. Hayes, Griffin, Mooney, and Parise (1975) saw 21 college students in individual therapy. The students were treated for six sessions that were 30 minutes in length. All clients reported a decrease in headaches and an increased ability to relax. Thus, the conclusion may be drawn that there is evidence for change in therapy in the range of one to six sessions.

For therapy lasting more than six sessions, Turner and Velkers (1975) were able to report a decrease in insecurity after seeing people in group therapy for seven sessions. Thomas (1976) demonstrated that a group therapy program of
eight sessions was a sufficient number for 30 female undergraduates to report an increase in security. Killeen and Jacobs (1976) also studied women college students who were seen in eight one-hour group therapy sessions. Their students reported a decrease in anxiety. Forty college students were seen in eight weekly sessions by Foulks and Hannigan (1976). These sessions were four hours in length. Pre-post testing demonstrated clients felt they were more socially desirable after the experience. Smith (1976) reported a more internal locus of control, a greater symptom reduction, and a greater attainment of treatment goals over eight individual sessions with adolescents. Karle (1976) and Woldenberg (1976) were able to demonstrate clients made more positive self-statements after 10 one-hour sessions of group therapy. Bonetti (1975) worked with people who had an identified common problem (a conflict situation). After 10 one-hour sessions of group psychotherapy, his clients reported either a decrease or absence of their conflict. Deutsch and Kramer (1977) were able to decrease reported problematic behaviors, like loneliness, in the elderly by employing 12 ninety-minute sessions of group psychotherapy. Withersty, Porterfield, and Spradlin (1975) were able to reduce the frequency of family problems over 13 consecutive days when they were treating hospitalized adolescents.

In summary, these results do not suggest total recuperation, but they highlight that change is possible within a short period of time. Although literature from clinicians
suggested that identifying the expected time frame of therapy in the initial session as well as advising clients of the time limit early on was an important part of the process of short-term therapy, there were no data to support this contention. However there was an abundance of research that demonstrates that various kinds of psychological change are possible within a brief period of time. Consequently, it is not unreasonable to expect psychological changes in two weeks.

Limited goals

Due to the time limitation, brief therapy and long-term therapy explore goals of a different nature. Long-term goals such as extensive personality restructuring and dynamic insights about psychogenetic origins of behavior are impossible in brief psychotherapy. Ursano and Dressler (1974) found that long-term therapy is more explorative, while short-term therapy is more supportive in nature. According to some clinicians (Bellak & Small, 1965; Jacobson, 1965; Kris, 1960; Parad, 1967; Sifneos, 1972; Wolberg, 1965b) short-term therapists believe that such therapy could accomplish one or more of the following goals: removal or amelioration of the most disabling symptoms as soon as possible, prompt reestablishment of previous equilibrium, development of the clients' understanding of their current disturbance, and an increase in future coping ability.
One must restrict one's vision for change in order to work in brief psychotherapy. The object of brief therapy is to put people back to their normal life as quickly as possible; it is not a goal to stay in therapy until all their problems are resolved. So, while again there were no empirical data to support the position of limited goals, there appeared to be an overwhelming persuasiveness both from the clinicians and logic that says the goals of brief therapy must be limited.

Focused interviewing and present centeredness

The goals of therapy could be reached if therapeutic attention was focused on a complete explanation of the primary problem area, usually a current problem in the client's life. Small (1971) wrote: "Achievement and maintenance of a focus can be regarded as the single most important aspect of brief psychotherapy..." (p. 121). Malan (1976b) pointed out that short, successful therapy must present such a focus early in treatment. Malan (1963) and Wolberg (1965b) have stressed that this focus on the primary problem should be done early in the first interview when describing to the client the terms and the structure of therapy.

Harris, Kalis, and Freeman (1963) said that one of the more important differences between brief and traditional forms of therapy was the systematic focusing on the current situation. Malan (1963, 1976b), Pumpian-Mindlin (1953),
Small (1971), and Wolberg (1965b) agreed that the goals of therapy can be best accomplished if the therapist explores only a primary problem area and either ignores or directs the person away from such areas as childhood memories, dreams, or birth order. Malan (1976b) said: "Those cases tend to be successful who present a focus early and have the motivation to work through it. This will lead to a short, successful therapy" (p. 203). Thus the brief therapist keeps much of the conversation in the present and on the problem at hand.

Activity and directiveness

The question then becomes: How does one maintain this focus on the present problem? Butcher and Koss (1978) put forward the argument that brief therapists must be more active than many long-term therapists. Active means talking more, directing topics of conversation, exploring areas of interest, giving support and guidance, and developing a course of action for the client to follow. Thus brief psychotherapists referred to the importance of teaching the client problem-solving methods. The problem-solving methods are a vehicle for therapist action (Gelb & Ullman, 1967; McGuire & Sifneos, 1970; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975). In Malan's extensive review of brief psychotherapy the point is made:

... that the area of greatest agreement in the whole literature on brief therapy was that passivity must be replaced by activity in various forms. This starts with the strategic planning of
a limited aim from the beginning. Earlier authors who emphasized this aspect were Alexander and French (1946), Finesinger ("goal-directed planning and management," 1948), and Deutsch ("goal-limited adjustment," "sector therapy," 1949). The limited aim can be formulated in terms of a desired therapeutic effect ... there arises the necessity for a more tactical form of "activity", namely guiding the selective attention, and selective neglect. For this it is very natural to use the metaphorical verb "focus"; the therapist "focuses" attention, and tries to cause the patient to focus attention, on the chosen area. This area itself then becomes known by the metaphorical noun, the "focus" of the therapy ... Almost every author who studies brief therapy comes to realize the need for planning and activity, and many of them come to use the word focus and its derivatives to describe these elements in their techniques.

(Malan, 1976a, p. 32-33)

Barten (1971), Harris, Kalis, and Freeman (1963), and Swartz (1969) are all adamant about the importance for brief therapists to be directive and active. Perhaps Wolberg is the most succinct, stating:

[An] anathema to short-term therapy is passivity in the therapist. Where time is no object, the therapist can settle back and let the patient pick his way through the lush jungles of his psyche ... Treatment failures are often the product of lack of proper activity.

(Wolberg, 1965b, p. 135)

Therapist activity and direction, and the aforementioned development of behavioral technology are also important components of the GASP.

Early assessment

Establishing the focus in brief psychotherapy requires an understanding of the person's psychiatric classification. Clinicians need full knowledge of the precipitating events
of the crises and their meaning to clients in order to make a proper assessment of their problems (Harris, Kalis, & Freeman, 1963; Jacobson, Wilner, Morley, Schneider, Strickler & Sommer, 1965; Sifneos, 1972).

Two authors provide differing guides for this type of assessment. Small (1971) explored the target complaint, the causes for the complaint, previous behavior, and the meaning of all this to the client, as well as a listing of the client's strengths and weaknesses. Wolberg (1965b) recommended an alternative style. He wanted to understand what the client does and how the client believes that behavior to be problematic. Thus Wolberg explored the degree of anxiety, defensiveness, self-esteem, dependence-independence, interpersonal relationships, and the client's potential to decompensate.

The remainder of this section will explore notions relative to the issue of dependence-independence. The idea of dependence-independence refers to how people perceive themselves in relationship to the world around them. This perception of the world is an existential viewpoint. Extentialism will be briefly discussed. Finally the existential concept of self-responsibility will be related to Rotter's (1954) thinking and research on the Locus of Control.

Relative to the issue of dependence-independence, a large number of theoreticians argued with varying degrees of fervor that people are actors subject to certain environ-
mental constraints. Ellis (1973b), Fiedler (1951), Glasser (1965), Perls (1969), and Rogers (1961b) emphasized the importance of how individuals perceive and evaluate their internal needs and external events. According to this view, persons act on the world rather than the world acting on them. In the extreme, all human behavior is moderated by the subjective perception. People evaluate their own experience and act on that evaluation. In essence, the above clinicians said that everyone was responsible for their actions and the consequences of those actions. The clinicians believe that people possess the power to control themselves. These same clinicians believe that behavior change, the general goal of therapy, is achieved more readily if people are not controlled by external forces. It was much like the difference between an actor and a marionette: one performed, while the other was caused to perform. The clients functioned better if they perceived themselves as having "no strings attached".

The concern with understanding the client's perception of the world is the basis of an "existential" approach to psychotherapy (Patterson, 1966). However, there is no one existential therapy. Although these approaches have much in common, they differ, so it is not possible to refer to the existential method. The fundamental character of existential psychotherapy is that it is concerned with the nature of being and the client's existence. The task of the therapist is to understand the client as a being and as a
being in his or her world. Clients should then come to understand themselves better as a result of this inward reference to and struggle with their directly felt experiencing.

Heine's (1962) research supports this philosophy that what is important are the clients' perception of how they are understood by the therapist and whether they have independence in making choices and decisions. Heine evaluated individuals who had gone for psychotherapeutic help to psychoanalytic, client-centered, and Adlerian therapists. All clients reported similar changes in all three therapies. However what is of interest here is their perception of the therapeutic relationship. All clients agreed that trust, understanding, and the feeling of independence they had experienced accounted for the changes in themselves.

When he writes of the importance of being free from external evaluation, Rogers (1961b) stated:

... In almost every phase of our lives -- at home, at work -- we find ourselves under the rewards and punishments of external judgements. "That's good." "That's naughty." "That's worth an A." "That's a failure." "That's good counseling." "That's poor counseling." Such judgements are a part of our lives from infancy to old age. I believe they have a certain social usefulness to institutions and organizations such as schools and professions. Like everyone else, I find myself all too often making such evaluations. But, in my experience, they do not make for personal growth and hence, I do not believe they are part of a helping relationship. Curiously enough, a positive evaluation is as threatening in the long run as a negative one, since to inform someone he is good implies that one also has the right to tell him he is bad. So I have come to feel that
the more I can keep a relationship free of judgement and evaluation, the more this will permit the other person to reach the point where he recognizes the locus of evaluation, the center of responsibility, lies within himself. The meaning and value of his experience is in the last analysis something which is up to him, and no amount of external judgement can alter this. So I should like to work toward a relationship in which I am not, even in my own feeling, evaluating him. This, I believe, can set him free to be a self-responsible person. ... There does seem to be within the biological organism feedback mechanisms, evaluational systems -- whatever you might call them -- which enable the organism to discriminate, although not always with immediate accuracy, between experiences which are favorable to its own growth and development and those which are unfavorable. Although such natural tendencies can certainly be deceived and thrown out of kilter by various distorting experiences, nevertheless, the fundamental ability of the organism to distinguish between experiences which favor its own development and those which do not seem to be the capacity on which not only therapy but a great many other processes depend.

(p. 108-109)

Rotter's idea (1954) that another psychotherapeutic task is to increase the client's internal locus of control parallels the notion of self-responsibility. Rotter believes that as clients attend more to what they want to do, the more satisfied they will be. The existential notion of self-responsibility is stressed. Clients are taught to decide for themselves what they like, rather than to have their likes and dislikes determined by others.

The degree to which people believed their behavior is determined by themselves or by persons and events outside themselves is more than a theoretical construct. The construct can be measured by the Rotter Internal-External Locus of Control Scale (Rotter, 1966). If people believe
external factors control them, they are said to have an external locus of control. Such people tend to believe in chance, luck, or fate, or may also suppose they are totally or partially under the influence of powerful others. If people believe most events are determined by their own thoughts and feelings, they are said to have an internal locus of control. Thus Rotter has provided an instrument to assess what some existential clinicians consider a crucial component of psychological growth and change, the locus of evaluation.

Recent research has shown a positive relationship between goal achievement and an internal locus of control (Prociuk, Breen, & Lussier, 1976). A positive relationship has also been shown between successful therapy and an internal locus of control (Henson, 1976). These areas of research indicate that instructing people on how to take command of their lives and become more internal should prove beneficial.

Therefore it is helpful in making an early assessment if the therapist understands the degree of dependence-independence a client experiences and tries to increase client self-control. If a method for increasing self-control were incorporated into therapy, a positive relationship between an internal locus of control and therapeutic success could be expected. As clients gained control over their lives, this experience of self-determination could be self-reinforcing.
Therapeutic flexibility

Brief and crisis therapists treat a variety of people who can benefit from a diversity of therapeutic techniques. No one therapeutic technique has been shown to have a clear-cut relationship to all diagnoses (Smith & Glass, 1977). In fact, the argument has been made that a therapist who adheres to only one set of techniques would not perform well in the brief psychotherapy setting (Butcher & Koss, 1978).

In Barten's review of brief psychotherapy he described the importance of therapeutic flexibility:

> Short-term therapies were inevitably rediscovered as psychiatrists embraced a growing eclecticism... Traditional techniques have by no means been discarded, but they have come to be used more judiciously. In some cases, they have worked better. Brief techniques themselves have expanded to include brief group and family therapies, behavior therapies, drug therapies, suggestive therapies such as hypnosis, re-educative therapies, and role-induction therapies.

The traditional psychotherapist may view this as a regrettable compromise, an ignoble surrender to the pressures of circumstances which produce transient, superficial or token results. To the eclectic, brief therapies are innovative, pragmatic developing approaches which may change our conception of the nature, objectives, possibilities and limitations of psychotherapy. We should neither exaggerate the results of short-term therapy nor deprecate the rationale and objectives of long-term therapy.

(Barten, 1971, p. 3-4)

A given therapist would not be expected to be experienced in all therapeutic techniques. It does seem reasonable to expect a clinic's staff collectively to offer a
range of techniques appropriate to the respective client needs. Thus the personnel of a short-term psychiatric hospital should be better than any single clinician to provide therapeutic flexibility.

Promptness of intervention

The emphasis in brief therapy has been on the client's immediate problem. The literature has emphasized the timeliness of providing therapy when a client who seeks therapy is motivated to work on a solution. Butcher and Koss (1978) discouraged multiple intake interviews or lengthy psychometric assessment batteries. Since the crises are about a present life problem, it is important to offer therapy as quickly as possible (Caplan, 1961; Lindemann, 1944). Bellak and Small (1965) recognized this urgency and developed mobile counseling units to reach people immediately during a disaster. Empirical support for this recommendation was given by Wolkon (1972) who demonstrated faster symptom remission when clients are seen immediately than when the people were asked to wait several days for an appointment.

This evidence suggests that any psychiatric facility that engages in brief psychotherapy should see clients promptly, avoiding waiting lists, and minimizing in-take testing procedures.
Ventilation

Regardless of treatment approach, most therapists attempt to create an environment in which the client feels secure. A secure atmosphere enhances the client's experience as well as a brief psychotherapy program. The Butcher and Koss (1978) review acknowledged that "... all major approaches to brief and crisis-oriented psychotherapy recognizes the value of allowing the client to ventilate emotional tension" (p. 737). Now although there is little empirical support for this position in brief psychotherapy, the clinicians argue that to experience some sort of catharsis or identification and expression of feelings enhances a short-term psychotherapy program.

As Shaffer and Shoben (1956) wrote:

It is not surprising, then, that therapeutic conversations are centered on the client's anxiety, guilt feelings, and feelings of inferiority, or inadequacy, and on the occurrences that engender them. Obviously, such topics are precisely the ones that are most difficult for the client to talk about. One of the hiderances to successful counseling is that it depends on discussing the very things that the client is least inclined to discuss and which are most susceptible to repression.

Moreover, some therapists purposely attempted to elicit strong emotions to facilitate tension release (Nichols, 1974; Nichols & Reifler, 1973; Stampfl & Levis, 1967). Among these, Nichols (1974) noted that Janov's (1970) primal therapy had received much attention, but that other approaches including gestalt therapy (Perls, 1969), new
identity groups (Casriel, 1972), reevaluation counseling (Jackins, 1965), and bioenergetics (Lowen, 1967) emphasized the release of emotion.

These new approaches are not a discovery but a revival of interest in the therapeutic properties of ventilation. Cathartic techniques have played a central role in healing in rituals (Frank, 1961; LaBarre, 1964; Zilboorg, 1941), religious revivalism (Davenport, 1917), Alcoholics Anonymous and Synanon (Zax & Cowen, 1972), hypnotherapy (Brenman & Gill, 1947), and drug-assisted abreactive therapy (Grinker & Spiegel, 1945). Although Freud (Freud & Breuer, 1966) used catharsis to resolve hysteria, he later abandoned his dependence on this technique. However, modern psychoanalysis still employs catharsis as a tool to reduce tension and to aid the remembering of memories (Greenson, 1967). Catharsis is also a major technique in play therapy (Levy, 1943), psychodrama (Moreno, 1958), and traditional group psychotherapy (Yalom, 1970).

There has been little empirical research on the cathartic approaches (Butcher & Koss, 1978). In a review of ventilation up to 1974, Nichols (1974) wrote:

As yet, little has been done to base the various cathartic approaches on empirical evidence or even well rounded theories. In fact, there does not exist a body of controlled studies in therapy in which catharsis is the independent variable. Theoretical reports have often singled out catharsis as one of the key elements in successful therapy (e.g., Frank, 1971; Rosenzweig, 1936), but only a few studies have shown catharsis to be effective in leading to improvement in psychotherapy (Janov, 1971; Lifshitz & Blair,
Gendlin and his colleagues have repeatedly found that clients who express their feelings directly improve more than those who merely report them (Gendlin, Beebe, Cassens, Klein, & Oberlander, 1968; Gendlin, Jenny, & Schlien, 1960; Gendlin & Olsen, 1970).

(p. 403-404)

As was noted earlier many of the brief clinicians mention ventilation of emotion as important. Here two examples of its effectiveness are detailed. In Nichols' (1974) article he explored the notion that catharsis leads to improvement in short-term therapy. He compared an emotive treatment against a non-emotive treatment. Clients were 22 university students, 17-28 years old, with a median age of 20. They were seen individually from four to twenty-five sessions, with the mean number of sessions being nine. The non-emotive treatment condition was a traditional insight therapy. In the emotive treatment condition clients role-played, repeated affect laden phrases, and/or engaged in expressive movement like striking a couch. The non-emotive group significantly changed their pre-post MMPI scores, while the emotive group attained significantly greater remission of their behavioral target complaints and reported significantly more satisfaction with their treatment. These results lead to partial support for catharsis.

The study by Bierenbaum, Nichols, and Schwartz (1976) found similar results. They saw 41 clients under three various cathartic therapy conditions. The conditions were one half hour two times per week, one hour once per week,
and two hours every other week. Clients never switched conditions and were pretested on the MMPI and their target complaints. Posttesting included these instruments and a client rating of satisfaction. Under the one hour per week condition clients who expressed the most affective expression were the most satisfied and had met most of their targeted objectives. Under the condition of one half hour two times per week, clients' MMPI scores were the most improved. When clients were seen two hours every other week, they demonstrated the least amount of change.

Evidence is available that abreaction is beneficial to psychotherapy only for some people. Perhaps in some people emotive therapy increases their anxiety and therefore inhibits their progress. However, further studies are required to re-evaluate this position. Until that research is forthcoming, it is prudent to include an aspect of ventilation in the development of the GASP.

A facilitative therapeutic relationship

A facilitative therapeutic relationship is fundamental to any theoretical perspective (Bergin & Suinn, 1975). Brief psychotherapy is characterized by a therapeutic relationship of a relatively short duration. However views of the importance of the facilitative conditions have changed. Two extensive reviews of the research on therapist variables in relation to process and outcome have been written by Truax and Mitchell (1971) and Parloff, Waskow,
and Wolfe (1978). In this section the relevant research related only to studies of therapists independent of the client are highlighted.

Rogers (1951, 1961b, 1975) stated that there were six necessary and sufficient conditions for constructive personality change. Three of these conditions were "attitudinal characteristics" of the therapist: genuineness, unconditional positive regard, and empathy. The fourth condition required the client to perceive these attitudinal characteristics. The remaining two have been dropped from any serious discussion as being too self-evident: the client and therapist must be aware of each other, and the client should be incongruent, vulnerable, or anxious. The list of necessary and sufficient conditions was pared to the first three.

The initial research results of Rogers' hypothesis were very enthusiastically received (Barrett-Lennard, 1962; Truax & Carkhuff, 1967). Scales had been developed to measure these basic conditions and initial research confirmed Rogers' position. Based on their extensive review of the pertinent literature up to 1970, Truax and Mitchell (1971) concluded:

These studies taken together suggest that therapists or counselors who are accurately empathic, nonpossessively warm in attitude, and genuine are indeed effective. Also, these findings seem to hold with a wide variety of therapists and counselors, regardless of their training or theoretic orientation, with a wide variety of clients or patients, including college underachievers, juvenile delinquents, hospitalized schizophrenics, college counselors, mild to severe
outpatient neurotics, and the mixed variety of hospitalized patients. Further, the evidence suggests that these findings hold in a variety of therapeutic contexts and in both individual and group psychotherapy or counseling.

(p. 310)

Not only did Truax and Mitchell believe that there was overwhelming evidence for the necessary and sufficient conditions of accurate empathy, warmth, and genuineness. They also believed that these were necessary and sufficient regardless of the type of problem or school of therapy. Further, they went on to conclude that low levels of any of these factors contributed to client deterioration.

There are a number of studies to support the notion that positive therapeutic outcome is related to one or more of these interpersonal dimensions (Cairns, 1972; Minsel, Bommert, Bastine, Langer, Nickel, & Tausch, 1971; Truax & Wittmer, 1971; Truax, Wittmer, & Wargo, 1971). However, doubt began to grow as other researchers offered results that were in conflict with the conclusion of Truax and Mitchell (1971). Other investigators reported there was little or no evidence of an association (Beutler, Johnson, Neville, & Workman, 1972; Beutler, Johnson, Neville, Workman, & Elkins, 1973; Garfield & Bergin, 1971; Kurtz & Grummon, 1972; Mintz, Luborsky, & Auerbach, 1971; Mullen & Abeles, 1971; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975).
Two later reviews (Mitchell, Bozarth, Truax, & Krauft, 1973; Parloff, Waskow, & Wolfe, 1978) reach similar conclusions in that empathy, warmth, and genuineness are seen as related to client change but their potency and generalizability is less than initially expected. Parloff, Waskow, and Wolfe (1978) wrote:

In response to the fact that more recent studies have failed to support the initial enthusiastic claims for validity of the basic hypothesis concerning the necessary and sufficient conditions, increased effort has been devoted to trying to reconcile the apparent discrepancies. Prominent among such analyses have been attempts to identify flaws and limitations in the non-conforming studies. ... Two of the most frequently cited objections [were]: (a) failure to provide the prerequisite minimal levels of therapeutic conditions, and (b) the use of different sources of ratings.

(p. 248)

The time constraints of short-term psychotherapy require that a facilitative relationship be developed quickly. Although a complex issue, it is apparent that the facilitative therapeutic relationship is very important. It is the challenge of brief psychotherapy to establish a facilitative relationship within the time constraints of this kind of therapy.

Client selection

Psychotherapy researchers have attempted to define what treatment works for which people and under what conditions. Brief psychotherapy is no different. Researchers have undertaken projects to specify who is and who is not suited for brief psychotherapy.
Relative to selection, Butcher and Koss (1978) summarized:

Selecting the appropriate patients for brief treatment is an important consideration. Patients who have had a good premorbid adjustment and an acute onset of symptoms are considered by many to be better candidates for short-term therapy than the more severely disturbed patients. However, recent evidence, both clinical and research, suggests that some short-term therapeutic interventions might be highly successful with more severely disturbed patients. Patients who have a good ability to relate are also considered to be better candidates for brief therapy than those who have difficulty forming relationships.

(p. 740)

The remarks of Sifneos (1972) may be summarized by saying that it is a necessary, but not a sufficient condition, that the client have the ability to see a circumscribed problem. Additionally, he believed that at least three of the following conditions must be met if the client is to be accepted for treatment:

1. above average intelligence,
2. at least one meaningful relationship during the client's lifetime,
3. an emotional crisis,
4. an ability to interact well with the therapist and to express feelings,
5. motivation to change, and
6. a specific chief complaint.

In order to assess motivation, Sifneos examined the person's willingness to be an honest, realistic, curious,
eager, active participant who recognizes that the symptoms are psychological in nature.

Malan (1976a) is more terse in his summary of selection procedures. He says, "Although the process of assessment is thus very complex, the process of selection can really be formulated very briefly: A focus can be found, the client has already responded to it positively, motivation is sufficient, and certain specific dangers [such as active psychosis] do not seem inevitable" (p. 256).

Butcher and Koss (1978) suggested that the following people are best suited for short-term therapy:

1. those in whom the behavioral problem is acute at the onset of therapy,
2. those whose previous adjustment has been good,
3. those with a good ability to relate positively, and
4. those with high motivations.

Criteria for exclusion from brief psychotherapy have also been generated. Malan (1976a) excluded anyone who: had made serious suicide attempts; was a drug addict; was a convinced homosexual; required long-term hospitalization; had experienced more than one course of electro-convulsive therapy; was chronically alcoholic; endured chronic obsession or phobic symptoms; or who ruinously acted out.

Three other researchers have identified the characteristics of people who are ill-suited for short-term therapy.
This would include the client who wants personality reconstruction, is highly anxious, or persistently anxious or acts out (Wolbert, 1965a); is outspoken and self-centered, passive-dependent, masochistic, or self-destructive (Castelnuovo-Tedesco, 1966); or the client with less than fifth-grade education, ill for toxic or organic reasons, mentally deficient, or psychotic (Frank, 1974b).

In summary, Dumont's (1968) caution about client selection is important. "Psychotherapy as it is generally practiced, requires a person who is verbal, insightful, and motivated, one who can delay gratification, and who, more or less, shares the values of the therapist, thereby virtually excluding the lower-class person from treatment" (p. 25). The possibility exists that those who use the public community mental health centers are homely, old, ugly, nonverbal, and of lower intelligence. Obviously a mental health program can not exclude everyone from treatment. However, a short-term therapy program might succeed if the administration were to define who it would and would not accept.

Outcome research with brief psychotherapy

Although comparative studies between brief behavioral therapy and unlimited therapies showed essentially no differences in outcome effectiveness (Levene, Breger, & Patterson, 1972; Moleski & Tosi, 1976; Nichols, 1974; Nichols & Reifler, 1973; Patterson, Levene, & Breger, 1971;
Paul, 1966, 1967; Sloan, Staples, Criston, Yorkston, & Whipple, 1975, 1976), it is clear that brief psychotherapy and long term psychotherapy are different. Brief psychotherapy can reach more people on a per-client basis; if the average number of visits is five, one short-term therapist can successfully treat six people, while the long-term therapist can see only one in the same time period.

Yet, the sequencing of events during brief psychotherapy has not been established. Although the content for any two clients may differ, a consistent procedure could be established. This lack of a defined process is curious for two reasons. First, short-term psychotherapy is very amenable to research. It provides more opportunity to control the research design than does long-term therapy. Logistically monitoring research for a short period of time is easier than for a long period of time. The criterion for outcome is generally goal-oriented. It is substantially easier to articulate short-term goals. Because short-term therapy techniques have usually been developed to deal with either specific populations or problems, the follow-up criteria are easier to identify. For these reasons it could be assumed that a clearly defined procedure could be identified to help achieve the therapeutic goals. Since the process of short-term therapy is similar to the process of long-term therapy, notions gleaned from the short-term approach might be applied to long-term therapy. While
research on short-term therapy may be easier than on long-term, it does not mean there are no problems with short-term therapy. There are, and they will be addressed later.

The second reason why it is odd that short-term psychotherapy lacks specificity is that behavior modification provides an excellent model. The behavior modification therapists have been good at specifying the process of their techniques. Beginning with Wolpe and Lazarus (1966) the behaviorists have continued to specify the "how to" aspects of their approaches. These delineations are then helpful both in the conduct of follow-up research as well as exploring the particulars of the process itself. It appears entirely possible to develop a specific behavioral process to be employed in the context of short-term therapy.

Again the necessity for a well defined process is mentioned. Do we not already have such processes, especially from behavior modification? The answer is "no". What has gone before gives the therapeutic process form. What is being developed here is the content -- a very detailed content such that should someone desire to replicate the technique, he could do so exactly. It would be analogous to following a cooking recipe, where the directions are precisely and explicitly detailed.

Now that brief psychotherapy has been described, the elements of problem-solving therapy will be examined.
Problem-Solving Therapy

According to Mahoney and Arnkoff (1978), there are three major divisions within the area of the cognitive learning therapies:

1. problem-solving therapies,
2. coping skills therapies,
3. cognitive restructuring.

Of the three cognitive learning therapies, the problem-solving therapies have been the most supported by clinical outcome research (Mahoney & Arnkoff, 1978). It is of interest here because of the emphasis on setting goals and developing a strategy to achieve these goals. An attempt is being made to link a process for establishing goals (the GASP) to the broad notions of problem-solving.

D'Zurilla and Goldfried (1971) were the first to note the need to explore problem-solving strategies from a behavioral viewpoint. After noting that the phenomenon of problem-solving had long been of interest to experimental and cognitive psychologists, they concluded:

Much of what we view clinically as abnormal behavior or 'emotional disturbance' may be viewed as ineffective behavior and its consequences, in which the individual is unable to resolve certain situational problems in his life and his inadequate attempts to do so are having undesirable effects, such as anxiety, depression, and the creation of additional problems.

(p. 107)

Spivack and his colleagues deserve much of the credit for the growth in problem-solving therapies for their work.
with pre-schoolers, emotionally disturbed children, adolescents, and institutionalized psychiatric clients (Platt, Scura, & Hannon, 1973; Platt & Spivack, 1972a, 1972b, 1973, 1974; Shure & Spivack, 1972; Shure, Spivack, & Jaeger, 1971; Siegel & Spivack, 1976; Spivack, Platt, & Shure, 1976; Spivack & Shure, 1974). Essentially the two important conclusions were: first, there were differences in problem-solving skills between the "normal" and "deviant" populations; and second, there was preliminary success in several projects in which "deviant" subjects were given systematic training in personal problem-solving.

A number of promising studies have supplemented the research of Spivack and others. Instruction in and practice of problem-solving skills were beneficial in decreasing conflict situations with predelinquent youths (Kifer, Lewis, Green, & Phillips, 1974). MacPherson, Candee, and Hohman (1974) evaluated an experiment where aides were instructed to manage the lunchroom behavior of children aged six to thirteen. The children were evenly divided into three lunch periods with differing treatments. The first was behavior modification, for example positive reinforcement, praise, and attention contingent upon behavior. In the second condition behavior modification plus a punishment essay were used. If children disobeyed they were given an essay [sic] to write ("Write 'I will not chew gum' 50 times"). In the third condition children were exposed to behavior modification plus a meditation essay. If they disobeyed they were
told to copy an essay the experimenters had devised on "What did I do wrong." This third cognitive condition was significantly more effective in reducing interruptions of the aides, quarreling, and out of seat behavior. Coche and Flick (1975) examined small group therapy over eight sessions with hospitalized psychiatric clients. There were three treatment conditions: the teaching of problem-solving skills, a placebo control, and a wait-list control. All three groups were administered the Means End Problem-Solving Procedure as a pre and posttest measure. The treatment group had the highest post-score on the Means End Problem-Solving Procedure. Not only did the treatment group increase its score on the Means End Problem-Solving Procedure, both that group and the placebo control had significantly shorter stays in the hospital than did the wait-list control group. Stone, Hinds, and Schmidt (1975) were successful in teaching information seeking skills to third, fourth, and fifth graders in two elementary schools. The 144 children were randomly assigned to either a treatment or control group. In three sessions the treatment group was taught three tasks: information seeking, generation of alternatives, and the setting of personal goals. Both groups were pre and posttested on their responses to videotaped situations. An example of the questions asked is:

a. How can Tommy get more information about his problem? Name the ways you can. (Facts)

b. How many ways could Tommy solve his problem? Name the ways you can. (Choices)
c. What could Tommy do? (Solution)

(Stone, Hinds, & Schmidt, 1975, p. 37)
The results show that the treatment group had higher frequencies in all three categories.

Mendonca and Siess (1976) discovered that a combination of both anxiety-management and problem-solving skills had a greater effect than either anxiety-management or problem-solving alone in treating anxious vocational indecision. Thirty-two university undergraduates (18-25 years old) were randomly assigned to one of five conditions for seven sessions. The three treatment groups were: anxiety-management, problem-solving, and a combination of both. The two control groups were discussion placebo and no treatment. The anxiety-management group was treated with desensitization. The problem-solving group was taught defining problems and goals, generating alternatives, exploring the consequences of the alternatives, and selecting a plan. The discussion control examined how career biases effect employment decisions. The results were that the anxiety management group and the combination group demonstrated greater pre-post differences on a paper and pencil test of vocational exploratory behaviors. There was no difference between groups on a pre-post anxiety measure, with the exception of the wait list control group where anxiety level remained unchanged. All three treatment groups self-reported equivalent satisfaction with their problem-solving skills.
Jacobson (1977) treated ten married couples under a wait-list versus treatment design. All couples reported marital dissatisfaction. The treatment group was seen for eight sessions. During treatment they were taught to interact positively, problem-solve, and to develop written contingency contracts. Nine weeks following treatment, the treatment group behaved more positively toward each other and were more satisfied with their respective spouses. Finally, Blechman (1974) has devised a family problem-solving game. Blechman, Olson, Schornagel, Halsdorf, and Turner (1976) examined the effectiveness of this Family Contract Game. The game is a board game for family members and is designed to resolve specific intra-family problems by reducing conflict and identifying mutually acceptable problem solutions. The game prompts and contingently reinforces a chain of family interaction beginning with the selection of a problem to be solved. The game is to end with an agreement signed by all players. This is all done without the assistance of a therapist. Using the N=1 reversal design the researchers demonstrated that the frequency of arguments, insults, and interruptions had decreased with the demands of the game, but were increased when the game was not in effect. Later, Blechman, Olson, and Hellman (1976) were able to replicate these results with eight subjects, using the same N=1 reversal design.

Clinical practitioners have also included problem-solving training in their treatment packages (Haley, 1976;
Weiss, Hops, & Patterson, 1973). For example, an effective strategy for the treatment of obesity has been developed using the mnemonic SCIENCE (Mahoney, 1977b; Mahoney & Mahoney, 1976a, 1976b):

- **S** Specify general problem
- **C** Collect information
- **I** Identify causes or patterns
- **E** Examine options
- **N** Narrow options and experiment
- **C** Compare data
- **E** Extend, revise, or replace

In the various stages of problem-solving, the client develops additional skills like self-monitoring, means-ends thinking, evaluation of probable consequences, and rehearsal of options.

Mahoney and Arnkoff (1978) are of the opinion that problem-solving perspectives yield encouraging results because they also encompass aspects from both the cognitive restructuring and coping skills therapies. In fact, with the problem-solving approaches, Mahoney and Arnkoff (1978) reported that clients are taught not only broad coping skills, but also the more general strategies from cognitive restructuring such as assessment and problem definition. They argue that with the problem-solving type of approach the therapist teaches the client to be a student of effective self-regulation.

As with brief psychotherapy, the research on problem-solving approaches allows substantial room for the client's uniqueness. The focus in problem-solving therapy is on helping the individual discover and implement whatever
adjustment strategies are necessary. Thus this type of approach is geared toward personal effectiveness. Mahoney and Arnkoff (1978) noted that because the problem-solving therapies stress broad coping skills, they may fare better than others in terms of generalizability. That is, to the extent that clients learn personal adjustment skills, they would "... enhance their independent ability to cope and grow with a changing environment" (p. 710). The clients can generalize this learning to other problems at other times in their lives.

In summary it appears the data support that the problem-solving therapies have the following positive components: (1) the teaching of broad coping skills; (2) direct assessment; (3) emphasis on problem definition; (4) engaging clients to regulate their own behavior; (5) identifying goals; (6) developing a treatment plan.

Problems and short-comings of brief and problem-solving research

Below is a listing of problems and short-comings from both the brief and the problem-solving therapies that suggest the need to articulate the sequencing of events in therapy. As mentioned earlier, brief psychotherapy research has its problems. First of all, Butcher and Koss (1978) cautioned that research on brief psychotherapy is difficult to do not only because of client mobility but also because of the heterogeneous populations that frequent brief
treatment centers. A mobile client population does not easily permit follow-up. A heterogeneous population is difficult to research because sample specifications do not fit neatly into research designs concerned with the type of client seen. Second, the reviewers cautioned that most of the research on outcomes of psychotherapy has been plagued with the problems associated with control groups. In their review the authors pointed out that control groups were either not employed or the procedures for the control group were not specified. Third, and perhaps most important, the existing outcome studies fail to delineate the operations of the process, making follow-up and further examination extremely difficult, if not impossible.

In their extensive review of the problem-solving literature, Mahoney and Arnkoff (1978) criticized the problem-solving research for two reasons. First, problem-solving therapies lack a specific and sound theoretical model; it is often difficult to examine what the domain of problem-solving therapy is. Consequently, the studies which result have poor internal and/or external validity (Mahoney & Arnkoff, 1978). Second, the researchers have not specified the therapeutic procedures. This ultimately must be done to permit replication.

There seems to be a natural compatibility between the brief and problem-solving psychotherapies. It should be
possible to combine the strengths from each approach into a specifically defined set of procedures which could be standardized for use in an "in vivo" clinical setting. This process should include:

1. a time limit for therapy,
2. limited goals,
3. conversation centered in the present,
4. direct therapist management,
5. rapid early assessment,
6. therapeutic flexibility,
7. prompt intervention,
8. ventilation of emotion,
9. a facilitative interpersonal relationship,
10. appropriate client selection,
11. emphasis on problem definition, goals, and plans to achieve the goals,
12. an active therapist using direct assessment strategies.

Historical Development of the Goal Attainment Scale

Mention has been made earlier in this chapter of how important the identification of goals are to both brief and problem-solving therapies. The literature suggests it is helpful to instruct people as to how they can regulate their lives, or exert self control. However, as yet there has been no explicitly detailed process to accomplish this.
An instrument to measure therapeutic outcome, the Goal Attainment Scale, has been developed, and that instrument has been shown to possess some therapeutic properties itself. Since the Goal Attainment Scale attempts to measure the success of therapy and does, in a preliminary way, have psychotherapeutic properties, it might prove helpful to articulate a process that is in part developed from the Goal Attainment Scale.

**Theoretical underpinnings of the goal attainment scale**

Kiresuk and Sherman (1968) were charged with measuring the outcome of the mental health enterprise at the Hennepin County Mental Health Service. Their solution is called the Goal Attainment Scale. It was developed from the following sources:

1. They drew upon the schools of motivation and dynamic psychology which indicate that people strive to reach some end. They relied upon the level of aspiration studies of Lewin, Dembo, Festinger, and Sears (1965) which compared the actual performance of a subject to his hoped-for expectations. Kiresuk and Sherman were also influenced by the studies of McClelland and Winter (1969) who developed a goal attainment measure to determine progress towards a set of goals that was unique for each subject in the area of economic achievement.
2. Kiresuk and Sherman were influenced by Cowle (1971, 1972) who employed a management-by-objectives approach to personal management. Essentially management-by-objectives presses for identified goals, and a measurement of their achievement.

3. Kiresuk and Sherman believed the work of Ullman and Krasner (1965) was important. Ullman and Krasner required careful documentation of the current problem and specification of the behavioral change to be achieved. Kiresuk and Sherman felt that a natural extension of this procedure would be to list these behavioral goals in a goal attainment format.

4. Kiresuk and Sherman drew upon the work of Pollard and Mitchell (1972) which stated that behavior is a function of the probability outcomes or consequences and the importance of these consequences. Thus the Goal Attainment Scale requires defining expected levels of therapeutic outcome.

5. Kiresuk and Sherman relied on Kiesler (1966) who stated that any assumptions of client or therapist uniformity were fallacies in the field of therapy research. While also believing that general principles of behavior are important, Kiresuk and Sherman (1968) attempted to honor both
the idiosyncratic and nomothetic traditions in their evaluation system.

The goal attainment scale

The Goal Attainment Scale may be outlined in the following manner. After an initial screening process, and before assignment to treatment, the goal selector decides upon a realistic set of mental health goals for the client. For each specified goal, a scale of probable outcomes ranging from the least to most favorable is also decided upon by either a staff member or the client, whichever is customary in that institution. The scales are to be precise and objectively described so that an observer unfamiliar with the treatment and the client can determine to which level the client has progressed with respect to each goal. Each individual scale is to be "a judgmental transformation of therapeutic outcome, into approximately a random variable with zero mean and variance once [sic]" (Kiresuk & Sherman, 1968, p. 477). These scales are to be specific to an individual client, with a defined possible outcome, potentially directly related to the goal. For example, a client's goal may be "less dependency on mother", with a possible outcome being "a return to school". Writing the possible outcomes in terms of events is important so that a follow-up worker who has had no contact with the client can determine to which level the client has advanced in relationship to this goal.
Kiresuk and Sherman (1968) recommended at least one goal but no maximum number. Their rationale is that one goal might be sufficient with clients who have explicit problems like an environmental dilemma, or vocational or financial concerns. By not limiting the number of goals, Kiresuk and Sherman hoped to have their scaling process reflect the clinical realities of the treatment unit.

Therapeutic treatment is then to be administered, and after a predetermined interval, the case is called to the attention of the follow-up unit personnel, who can then assess progress. A standardized composite Goal Attainment Score is derived so that outcome can be assessed irrespective of the type of treatment offered.

Essentially, then, the Goal Attainment Scale has the following characteristics: (1) a set of goals for an individual; (2) a system of weights for these goals; (3) a set of expected outcomes for these goals ranging from "most unfavorable" to "most favorable"; (4) a follow-up scoring of these outcomes; and (5) a score summarizing the outcome across all goals (Kiresuk, 1973).

Mauger, Audette, Simonini, and Stolberg (1974) analyzed the Goal Attainment Scale against the MMPI for validity. They found a correlation of .30 between MMPI scores and the Goal Attainment Scale ratings. Reliability was found to be .71 for different follow-up raters in initial goal setting, .70 after two months, and .47 after six months (Garwick,
The two week test-retest reliability has been reported as .57 (Sherman, Baxter, & Audette, 1974).

**Development of the goal attainment scale as therapy**

In 1974, Smith alleged that the Goal Attainment Scale itself possessed psychotherapeutic properties. This notion that Goal Attainment Scaling had a therapeutic impact was also later reported by Calsyn and Davidson (1978). Smith (1974, 1976) evaluated the difference between individuals who had completed the Goal Attainment Scale in therapy and those who had not. His comparison was between test scores of a treatment group using the Goal Attainment Scale, and a treatment group not using the Goal Attainment Scale. The instruments he employed were the Personal Orientation Inventory, the Norwicki-Strickland Locus of Control Scale, a Consumer Satisfaction Scale, and the level of functioning on the Outcome Assessment Sheet. He concluded that when employing the Goal Attainment Scale in individual psychotherapy, the Goal Attainment Scale was itself therapeutic. When used in this way with suburban white adolescents (13-17 years old), Smith showed that Goal Attainment Scaling had psychotherapeutic properties beyond the measurement of goals.
Integration

A review of the limited Goal Attainment Scale literature showed that Smith (1974, 1976) has been able to explore the psychotherapeutic properties of the instrument. Smith's research touched on the idea of the measuring instrument as therapeutic (Greenberg & Clarke, 1979). This led to the question as to whether the Goal Attainment Scale could be expanded into an actual therapeutic process.

From a review of the literature discussing brief psychotherapy, problem-solving therapy, and the Goal Attainment Scale, integrating the beneficial aspects of these three areas into a clearly specified procedure of psychotherapy seemed entirely possible. It would be an explicit treatment process that would be aimed at clients of brief psychotherapy. It would be of a broad problem-solving nature, using Goal Attainment Scaling as a model.
CHAPTER III

DEVELOPMENT OF THE GASP

The GASP procedure

The GASP is a procedure whereby client and therapist jointly identify the expected outcome of therapy. The procedure involves 14 steps, listed below in the form of instructions to be given to participating therapists:

1. Obtain a room with chairs for everyone, a blackboard, and chalk.

2. Introduce new members, staff, and clients, to the community.

3. Inform new members of the purpose of the GASP, either by telling them directly or by having a client tell them. The purpose is threefold:
   a. To identify goals for this hospitalization to be accomplished within two weeks. It is not an attempt to solve all the client's difficulties.
   b. To let the group know what brings the person to the hospital.
   c. To inform the community of what goals and behaviors the person is working on so that the community can support the client.

4. Complete any topics remaining from the previous day before starting with a new client. This is a standardized
process to be completed within 60 minutes. It is expected most clients will complete this process within this time frame. However, due to client and therapist idiosyncracies, some clients may require more time. It is proper to finish all topics before starting with a new client.

5. Ask if there are clients who would like to work on their other goals; if no one volunteers, identify a person to be the focus for the procedure.

6. Write the word "events" at the top left corner of the blackboard. The individual is to enumerate the precipitating events leading up to this hospitalization. These events are to be written on the board by the staff person. To assist the client in developing this list, the following probes may be helpful:

   a. What brings you to the hospital at this time?
   b. What has been happening in your life during the past six months?
   c. Why are you here now?

The purpose of this list is for the clients and staff to understand why the client is seeking treatment at this time. Further, it is hoped that clients will see why they are in their present situation. The rationale in listing these events on the blackboard has been best articulated by Meichenbaum (1975). He suggested that it is important to understand the nature of the client's presenting problems.
and to formulate an initial treatment plan. In this way the client's anxiety about his or her situation is lessened. Later in the process, community members assist the client along with the therapist in the formulation of goals. To make this formulation the group members, including the client and the therapist, must be able to make some sense of the behavior, that is, to understand what happened.

7. Write the word "feelings" at the head of the next column on the board. The individual is now to recount the feelings s/he had as the previous event occurred. The following probes may be used:

a. What were your different feelings as these things happened?

b. What did you feel like when "such and such" happened?

All of the feelings the client expresses are to be written on the board. When the client believes the list is complete, it is proper to ask the group members what they might have felt if these events had happened to them. The client is free to accept or reject these suggestions. Suggestions which are accepted are to be written on the blackboard.

The purpose of this step is twofold. First, the exercise assists both the client and the group in understanding the client. Second, having others suggest feelings helps the client explore and consolidate his or her conceptualization of the problem (Meichenbaum, 1975).
helps the client explore and consolidate his or her conceptualization of the problem (Meichenbaum, 1975).

8. Write the word "strengths" in the next column. This exercise, as the caption indicates, focuses on the individual's strengths. The client may be asked the following questions:

   a. What do you like about yourself?
   b. What do others say they like about you?
   c. You have lived "x" years; how have you lived so long?
   d. What do you think will get you through this crisis?

   The rationale for this concentration is to permit the client to see therapy as adding to what he or she already is. The client should realize that he or she does possess positive attributes and qualities and that he or she is not merely an empty container to be filled by whatever the hospitalization can offer.

9. Next, the community members are asked to say what they perceive the client's strengths to be. These comments are to be transcribed on the board without the client's exercising an editorial prerogative. The reason here is threefold:

   a. To direct the members of the group to see themselves in some way similar to and to be empathic with another human being; to
c. To induce group cohesion.

10. Write the word "problem" on the board at the head of the next column. At this point the client is to list what he or she assumes his or her problems to be. The client may be assisted by the following questions:

a. What are the areas you would say you have problems with?

b. Looking at what you have described, do you see any pattern as having developed?

11. Next, the others in the community are asked if they see problem areas the client does not recognize.

Here, again, everyone is to participate as fully as possible by creating a comprehensive list of problems. By identifying problem areas, it is hoped that clients will gain greater cognizance of their difficulties, perhaps even some problems they had not thought about. With such a complete list, the client will then be in a position to make a more informed choice regarding goals on which to focus.

12. Write the word "goals" on the board. The client is to list no more than four goals s/he will work on for the next two weeks. As the goals are identified, it is helpful to check off the problems that the client perceives each goal to be alleviating. The more behaviorally specific a goal is, the easier it will be to write levels for that goal. For example, the goal "to get in touch with my feelings" is less desirable than "to express my anger."
13. Write the levels of success, 

\[-2, -1, 0, +1, +2\],

on the board. Clients will require the assistance of the staff member in specifying what behaviors they will engage in at each level.

Level \(-2\) is the least expected outcome. The less-than-expected level of success is \(-1\); what the client can reasonably hope to attain within the hospitalization is \(0\). The more than expected level of success is \(+1\), and \(+2\) is the most desired outcome.

In order for clients to understand more clearly their range and control of behavior, the therapist will start with level \(-1\), the less-than-expected level of success. The goal "express my anger" is used throughout the remainder of this section as an example. The therapist begins by asking the client, "What are you doing now in relation to this goal?" If the client says s/he now lets his or her anger build up then "explodes" over minor issues, the therapist should complete the \(-1\) cell with "never express my anger except to explode."

It may occur that the client thinks the initial level of success should be in the \(-2\) cell. This is never to be the case; the client can always become worse. By beginning with the \(-1\) level, it is hoped that the client will see how much more flexible than rigid he or she is. Further, it is anticipated clients will experience their condition as being not as unfavorable as they had thought. The next movement is to identify the \(-2\) level. "What would you be doing if
you became worse?" is an appropriate question. With the goal of expressing angry feelings, two possibilities for this level might be "never express angry feelings", or "attempt suicide."

Now the client and the therapist identify what the client would be doing in order to reach the expected level of success, 0. Finally, the two will ascertain the +1 and +2 levels, the more-than-expected and the most favorable outcome expected. For example, the client who has the goal of expressing anger may have the following levels of success:

-2 Attempt suicide.
-1 Express anger only in explosive manner.
0 List each time I feel angry, the situation, and the reason.
+1 Share the list with hospital community.
+2 Have a meeting to share the list with my family.

14. Once a week ask community members to read their goals and their goal levels and to identify the level on which they think they are. The other community members are to give feedback as to whether they agree or disagree with the client's perception and why. In this way clients receive information about their behavior and have a reference group to say whether they are in agreement with the client's self perception. (See Appendix A for an example of
the process. For an example of completed scales, see Appendix B.)

The GASP includes all the important components identified earlier in Chapter II. The hospital administration has taken care to see that a broad group of treatment skills are represented in their psychiatric staff, thus increasing the potential for therapeutic flexibility. After an early assessment by the admitting psychiatrist, the client is referred to the most appropriate treatment facility. Clinical intervention is begun promptly within 24 hours of admittance. At the first GASP session clients are told that the purpose of the GASP is: (1) an emphasis on problem definition, goals, and plans, and (2) an estimate of what can be accomplished in two weeks, since that is the average length of stay at the hospital. In order to use the GASP, the therapist must be actively asking questions and soliciting information. There is no room, nor time, for passive, reflective listening. In order to keep the conversation in the present, the client is informed that the process will be concerned with the events leading up to the hospitalization. This may necessitate the listing of an event six months earlier, but for the most part no attention will be given to birth order, early memories, or dreams. This is a process engineered to assess what has happened now and what direction clients are going to take to rectify the problem. In order to begin to give ventilation to emotions, the issue of
the client's feelings is addressed directly. Finally, it is believed that by assisting clients to articulate their plans, the clients would find this relationship helpful.

Implementation of the GASP

Need for cohesive treatment approach

In April of 1974, the author was employed by Valley General Hospital as a psychotherapist. A month later he met with the psychiatric unit's medical director, head nurse, and staff psychologist to explore additional treatment the unit could offer clients. He pointed to the need for cohesion within each client's therapeutic treatment and suggested such cohesion could be gained from employing Kiresuk and Sherman's (1968) Goal Attainment Scale. That suggestion was adopted and the author was given the responsibility of training other staff in its implementation for individual clients.

Adoption of the goal attainment scale and its adaptation to group therapy

Over the next twelve months the staff became skilled at developing the goals with clients in one-to-one settings. The information gained from the therapists' observations and recommendations about the one-to-one process was shared with the author. The author sought opinions and comments about the Goal Attainment Scale from every staff member. Then, in the Spring of 1975, the author again met with the medical
director, the head nurse, and the staff psychologist to request that the identification of goals be modified. It was noted that while the identification and scaling of goals was being done effectively, the procedure was not efficient. Other staff members resented the time it took to instruct clients. Moreover, the unit had expressed belief in the philosophy of a therapeutic community, with openness of communication. It seemed to the author that the Goal Attainment Scale (Kiresuk & Sherman, 1968) could be beneficial for the clients and the unit if it were done in the context of group therapy. This change was opted for in the belief that a group: (a) was more economical, (b) offered a vicarious learning experience similar to other forms of group therapy, and (c) had the advantage of enabling the clients to know about each other's goals and comment on them. This last purpose was also congruent with the hospital's philosophy of openness. Again the author monitored this formation of goals in groups by daily sitting in on the group. The analysis of information was shared in monthly staff meetings where the staff expressed their opinions of the group goals process, and how it could be improved. By the Spring of 1976, the end result of this development was identified as the GASP. The hospital requested the author to standardize and conduct the preliminary evaluation of the GASP as developed over the previous three years. The process was standardized in October of
1976. In April of 1977 the hospital administration contracted with the author for a six month evaluation as to whether hospitalization in Valley General Hospital's psychiatric unit was more beneficial with or without the GASP.

Psychiatric Unit, Valley General Hospital

Purpose

The psychiatric unit at Valley General Hospital was opened in 1974. It was to serve as a short-term treatment facility for the southern portion of King County, Washington. Other public and private facilities specialized in treatment of particular problems such as alcohol abuse, drug abuse, violent behavior (assault, arson), and long-term care. The psychiatric unit of Valley General Hospital was designed not to duplicate or overlap with these other facilities. The psychiatric unit identified its target population as anyone who volunteered for treatment and was not suitable for the other treatment programs.

By the end of its first twelve months of operation, it was an established mental health resource in the community to which other mental health professionals turned. By the end of the second year of operation, the unit was offering a stable and standardized treatment program, an integral part of which was the GASP.
Clientele

The unit treats people who are for the most part, in crisis and believe they need help. They could see someone outside the hospital for therapy once a week, but they have chosen, after consulting a mental health practitioner, to admit themselves to the hospital for a short, self-defined period of time. They are told that in order to leave they must have the approval of the therapeutic community as well as their admitting psychiatrist. However, they may leave any time they desire, regardless of the medical advice, provided they are not dangerous to themselves or others. The mean length of stay at Valley General Hospital during 1974 to 1976 was 12.4 days, but persons did leave on occasion after only a few days. Whatever the length of stay in the psychiatric unit, for many people it may be the only contact with therapy they are ever likely to have. For that reason the therapy provided must be specifically geared to short-term treatment.

Treatment philosophy

Valley General Hospital does not have a primary-therapist orientation. No one therapist works exclusively with one client. Rather, each client is the responsibility of every therapist. Treatment is very open. The staff share information regarding the clients, and each client has access to information about his or her own case during
"chart group", the time set aside each day for reading the staff's remarks in one's own chart.

Introduction of GASP

Between October and November, 1976, the author trained the psychotherapists and psychiatric nurses at the hospital to administer the GASP to the clients hospitalized then. There were 10 psychiatric nurses and 10 psychotherapists on the staff. Due to staff rotation, not every staff member was present at all 40 (five times per week for eight weeks) of these trial runs. However every staff member was present at at least two of these trials per week. The author conducted eight weekly meetings to standardize the GASP process. These meetings were 50 minutes each. At the first meeting the staff was informed of how important this element of uniformity was to research. They were then given the 14-point outline presented at the beginning of this chapter. The session concluded by mentioning that the author would be sitting in on their sessions as they employed the GASP and that his observations and the staff's problems would be discussed over the next seven weekly training sessions. At sessions 2 through 8, the staff received feedback on their individual progress (See Appendix C for Training Agenda). At these times, too, the importance of uniformity was reiterated. The staff's perception of others' attention to detail was also discussed as well as the rationale for each step. By the end of the seventh session all staff could
conduct the GASP from memory. At the eighth session, the staff discussed cues they had developed to remember the process, and shared their feelings about this experience.

Problems presented when standardizing

Interesting problems developed when the GASP was being standardized. As the GASP took shape, there were initial discrepancies concerning the time frame in which the goals should be accomplished. It was necessary to direct the therapists away from global, all-encompassing life changes. This experience was not going to be an attempt to solve all the client's problems. Rather the process was to focus upon what could be accomplished in two weeks. The issue of brevity had other ramifications which will be addressed later.

Another problematic area was to direct the staff to focus upon behavior. As their therapeutic orientations were diverse, it was important to avoid opening a forum for the "best" or "right" school of therapy. The issue of behavior was accepted by the staff when they experienced the difficulty of writing goals and levels that were not focused on behavior. The staff also discovered how much easier it was to observe changes in behavior, and what difficulty clients had changing their behavior. This in part might have been because it is easier to observe and agree someone is doing something like "talking with people" than it is to have consensus that someone is "not getting angry". As mentioned
above it was necessary to remind the staff that this process was to focus on what clients could accomplish in two weeks. The importance of consolidating the group leaders' time within the process also became apparent.

The GASP is open-ended with regard to membership but not in terms of content. It does not have a varied agenda. It requires a more active role on the part of the therapist. The therapist must therefore structure the session tightly. One way to do this was to make the listing of "Events" brief. Rather than examine the client's whole life, the purpose is to create a rough outline of the significant events of the previous six months. The process could also be speeded up by listing the client's feelings as they are mentioned. Again, it was important to remind the therapists that these lists were not to be exhaustive, but overviews.

Finally, the staff noticed an occasional problem when a client would not or could not articulate "Goals". There was a feeling of forcing the client to accept what the staff wanted rather than what the client wanted. In an instance like this the therapist was encouraged to consult other staff with the concern and then decide how to proceed.

**Stability and Integrity of GASP Goals**

After the GASP had been adopted, a qualitative evaluation was conducted. It was important to know whether or not clients switched their goals as a result of this process.
If clients did not change their goals, it was important to know if the goal directions had been altered. If the goals changed in either kind or direction, the subsequent results would be meaningless.

An examination of the goals identified upon admission and those identified during the GASP was undertaken. Three independent therapists classified the goals into the following four categories: self, family, friends, and work. Reliability among raters was established through use of Scott's (1955) coefficient. There was a .995 agreement among the therapists with regard to assignment to goal category.

It was ascertained that, of the goals identified upon admission, 90 per cent were in the same category during the GASP. All of these goals identified during the GASP were in the same direction as those identified by the clients at admission. The goals had stability.

**Comparative Evaluation**

Two purposes were addressed in the present study. The first was the development of the GASP as described in the preceding section. The second was to conduct an exploratory comparative evaluation of the effectiveness of hospitalization with the GASP as compared to hospitalization without the GASP. In the following discussion, hospitalization without the GASP is referred to as the non-equivalent
control group. This evaluation was divided into two sections corresponding to two control hypotheses, and five evaluation hypotheses.

**Hypotheses related to control issues**

Initial analysis of the ward atmosphere was performed to control for environmental press. This was done for two reasons. First, there was a lack of random assignment to treatment condition; and second, hospital size was limited to only one ward. These two reasons meant that the GASP and the non-equivalent control groups could not run concurrently.

Normal monitoring of the behaviors the clients engaged in during the GASP was performed but it was decided that simple monitoring of overt behaviors was not enough to counter the effect of any covert behaviors and attitudes on the part of the staff. For that reason, the environmental press as perceived by the clients was monitored, to ascertain whether the client perceived the environment differently between the times when research was and was not being conducted. The environmental press was measured on the ten subscales of the Ward Atmosphere Scale:

- a. Involvement
- b. Support
- c. Spontaneity
- d. Autonomy
- e. Practical Orientation
f. Personal Problem Orientation

g. Anger and Aggression

h. Order and Organization

i. Program Clarity

j. Staff Control

Moos (1974) demonstrated that his Ward Atmosphere Scale measured aspects of the treatment environment that may remain stable even though there has been a complete turnover in the client population; that is different populations perceived the same environment in the same way. Further, Pierce, Trickett, and Moos (1972) demonstrated the Ward Atmosphere Scale to be sensitive to changes in ward treatment programs. The instrument is discussed in more detail in Chapter IV.

Figure 1 presents the time sequence for the three administrations of the Ward Atmosphere Scale. In January 1977, the client population was sampled with the

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FIGURE 1

Ward Atmosphere Test Schedule

<table>
<thead>
<tr>
<th>January 1977</th>
<th>June 1977</th>
<th>August 1977</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Experimental Condition</td>
<td>GASP Condition</td>
<td>Non-equivalent Control Condition</td>
</tr>
<tr>
<td>Test 1 with Ward Atmosphere Scale</td>
<td>Test 2 with Ward Atmosphere Scale</td>
<td>Test 3 with Ward Atmosphere Scale</td>
</tr>
</tbody>
</table>

Ward Atmosphere Scale to provide a perception of the pre-experimental environment. A second test was made in June of 1977, after the GASP had been in operation for six
weeks. A third testing was taken in August of 1977, during the Non-Equivalent control condition, (when the GASP had been absent for six weeks).

Since there was no prior research of the GASP, there was no reason to postulate directionality in the hypotheses. The hypotheses were therefore written in the null form.

Hypothesis 1

There is no difference in the environmental press measured by the Ward Atmosphere Scale in January, June, and August.

Non-significant results would indicate that the internal validity of the evaluation was not contaminated by history, person, or Hawthorne effect, and interaction of therapists and treatment (Campbell & Stanley, 1963). This more rigorous criterion for controlling these extraneous threats to validity increases the potency of the study.

Hypothesis 2

There is no difference between the pretest scores of the GASP group and the non-equivalent control group on the Sixteen Personality Factor Questionnaire, and the Rotter Internal-External Locus of Control Scale, and the number of goals on the Target Outcome Assessment Sheet.

Since both groups had the same composition of neurotics and psychotics, their scores were anticipated to be the same. Non-significant results would indicate that the two
groups began at essentially the same place on their pre-tests.

Evaluation hypotheses

In order to test the viability of the GASP as an effective psychiatric treatment method, the effectiveness of psychiatric hospitalization with the GASP and psychiatric hospitalization without the GASP were compared. The mean performances of each group were compared on three dependent measures (The Sixteen Personality Factor Questionnaire, Rotter's Locus of Control Scale, and the Target Outcome Assessment Sheet) together with the length of time clients stayed in the hospital under each condition.

Hypothesis 3

There is no difference between the GASP group and the non-equivalent control group mean posttest scores on the Target Outcome Assessment Sheet.

The GASP identifies minute increments of progress toward a goal with clear and concrete directions. Attainment at the lower levels of the goal should reinforce the type of behavior necessary to attain the higher levels of the goal hierarchy. The present hypothesis focuses upon which treatment procedure produces the greater reported
behavioral changes. Clients achieve their goals by attaining higher levels of success.

Hypothesis 4

There is no difference between the GASP group and the non-equivalent control group mean posttest scores on the "most important goal" of the Target Outcome Assessment Sheet.

With some clients all other goals may take a permanent second place to a particular goal. Thus it is possible to lower the grand mean of the Target Outcome Assessment Sheet by concentrating on the achievement of one goal to the relative exclusion of the rest. In such an instance clients might make progress on their "most important goal" and little or no progress on the other goals.

Therefore, consideration was given to having the clients rank-order their goals or to have them weighted relative to each other as Kiresuk and Sherman (1978) suggested. Rank-ordering implies a weighting procedure of which the client and/or therapist may not be aware. To the degree that both client and therapist become aware of the inherent weighing and meaning, they seriously disrupt the therapeutic process. For this reason rank-ordering was excluded.

In their early work, Kiresuk and Sherman (1968) referred to weighting the client's goals in such a way that this problem might be solved. Originally they were employed
as evaluators, and had a cadre of employees whose sole responsibility was to collect data. This team of evaluators asked clients what their priorities were. The team employed a verbal/conversational manner. Valley General Hospital did not have such a research team available to obtain this information. If the technique had been used, the responsibility would have been left with staff members whose primary interest was psychotherapy, not research. Moreover, the conversational approach to this issue is disruptive to the course of therapy. The written approach was too cumbersome and inaccurate since there was no way of knowing whether the respondent understood the directions.

A compromise was arrived at by asking the clients to mark which of their goals was "most important" to them and proceeding with the evaluation from there. Thus, at both pre and posttesting times clients were asked which one of their goals was "most important" to them and the mean achievement on this goal was assessed and compared between the GASP and non-equivalent control group.

The rationale for this hypothesis is the same as in Hypotheses 3. It is more finely focused to be concerned with just one goal. If clients identify a goal as "most important", it is conceivable that they will work harder on that one than on others. The present hypothesis focuses on which treatment produces the most change with regard to the goal the client determines as "most important".
Hypothesis 5

There is no difference between the GASP group and the non-equivalent control group on the mean posttest scores of the Rotter Internal-External Locus of Control Scale.

As was stated earlier, the GASP identifies small, clear, and concrete steps of progress toward a goal. As clients move both through the GASP itself and toward their desired goals, as identified on the Target Outcome Assessment Sheet, it is reasonable to assume that they will experience more responsibility for their life situations. One could expect that people would see their behavior as more determined by their own thoughts and feelings, rather than by fate or "bad karma," or some outside influence. In this evaluation it is appropriate to determine if one particular treatment gives the client a greater internal locus of control. The present hypothesis focuses on which treatment produces more internality in clients.

Hypothesis 6

There are no differences between the GASP group and the non-equivalent control group mean posttest scores on the following five subscales of the Sixteen Personality Factor Questionnaire:

a. Factor C, ego strength
b. Factor E, assertiveness
c. Factor F, surgency
d. Factor O, guilt
e. Factor $Q_4$, anxiety.

Cattell (1966) and Cattell, Eber and Tatsuoka (1970) pointed out that people showed improvement on five of the subscales of the Sixteen Personality Factor Questionnaire when therapy was successful. Therefore the same five subscales of the Sixteen Personality Factor Questionnaire were chosen in this research because they seemed to indicate what occurred in the GASP. It was thought that the GASP would decrease anxiety and guilt and at the same time increase enthusiasm, self-direction, and assertiveness. While this thinking was the main consideration for selecting the Sixteen Personality Factor Questionnaire, it was also important that the instrument be reliable, and quick and easy for clients to mark. The Sixteen Personality Factor Questionnaire met these criteria.

The assumptions for the desired change on the five subscales listed above are as follows: As the clients clarify their expectations and goals for the future, they likely will feel less anxious about their life situation. As clients exercise their decisions and choices for control of their situations, increases in assertiveness are anticipated. With a concrete life focus such as the GASP provides via small sequential steps, it is logical to expect that clients' enthusiasm for both themselves and life in general should rise as each step is attained. Concomitantly, as
clients becomes more self-confident, resilient, and enthusiastic, and less anxious as their goals are attained, less time should be spent worrying about "where I went wrong" or the guilt of past mistakes.

Hypothesis 7

There is no difference between the experimental (GASP) group and the non-equivalent control group mean lengths of stay in the hospital.

In addition to the theoretical and behavioral reasons for choosing the GASP, the relative expense of the two procedures is also important. Do the treatments cost the same in terms of effectiveness and efficiency? On this issue of accountability, length of hospitalization speaks to efficiency of treatment. As people identify appropriate life goals and attain those goals via a concrete life focus, it is expected that they will move through treatment faster. An attempt was made to ascertain under which treatment clients were discharged more quickly.

Significance levels

There are two kinds of errors that have to be guarded against when testing any hypothesis: Type I and Type II. The former error suggests a difference when none exists. The latter error suggests there is no difference when in fact a difference does exist.
Every researcher must comprehend the degree of risk implicit in these errors. For example, in a study involving an evaluation of the stress on metal under flight conditions, it would be wise to maintain the conservative levels of significance. A Type I error could be very expensive, if not catastrophic; the actual use of a metal that cannot withstand stress in an aircraft could result in a crash and loss of human life. However, in setting a conservative alpha level, .001, the probability of a Type II error increases. That is the researcher is more likely to reject metal that would actually do the job properly.

The present evaluation, however, does not involve the same kinds of risks as the above example, because the question being asked is: "Is hospitalization with the GASP effective?" Since this is an exploratory evaluation of the GASP, it is suggested that the evaluation should be as broad as possible in order to determine potential areas for future research.

Considering the cost of the Type I and Type II errors, the alpha level was set at the conventional .05 for the final comparative evaluations, and at .25 for the control evaluations. By lowering the probability of a Type II error with this larger (.25) alpha level, one is reasonably sure if no differences are found, no differences exist; the groups are equivalent at the pretest.
After the GASP had been standardized, the evaluation was conducted. The formal testing and its results are the subject of the following chapters.
CHAPTER IV

EVALUATION METHOD

Comparative evaluation of the GASP

As a preliminary evaluation of the viability of the GASP as a psychiatric treatment method, the effectiveness of psychiatric hospitalization with the GASP and psychiatric hospitalization without the GASP were compared. The mean performances of each group were compared on three dependent measures (The Sixteen Personality Factor Questionnaire, Rotter's Locus of Control Scale, and the Target Outcome Assessment Sheet), together with the length of time clients stayed in hospital under each treatment procedure. The following is a discussion of the method used in making these comparisons.

Design

An adaptation of the non-equivalent control group quasi-experimental design (Campbell & Stanley, 1963, p. 42) was employed in the evaluation. This design was chosen because random assignment of subjects to treatment was not
possible. Further, a second comparable hospital was not available. Both groups had to use the same facility. The physical structure of the unit limited the number of people that could be treated at any one time. Even if there had been additional bed space, it would not have been possible to isolate both groups totally. The contact with each other would have resulted in contamination. Therefore one group was seen during one trial period, the second was seen during the second trial period, as shown in Figure 2.

---

**Figure 2**

**Actual design**

GASP group
n = 16
01 X₁ 02

Non-equivalent control group
n = 16
01 X₂ 02

---

n = Sample size
01 = pretest
02 = posttest

X₁ = GASP intervention of 8 days (May 1 to June 15)
X₂ = normal ward activity (July 1 to August 15)
Group one, the GASP group, consisted of the first 16 people who voluntarily sought treatment in May and June of 1977. Group two, the non-equivalent control group, was composed of the first 16 people who voluntarily sought treatment in July and August of 1977. The GASP was made available to the May and June group only. In all other respects the groups were treated the same. The groups were similar in the recruitment procedure (voluntary) and in psychological composition (twice as many neurotics as psychotics).

This design attempts to control for the influences of history, maturation, testing, and instrumentation (Campbell & Stanley, 1963). Thus, if any differences are noted at the posttest, they are not usually attributed to specific external events between the pretest and posttests. However, the design employed was an adaptation of the non-equivalent control group design. The treatment and the control group could not run concurrently. This adaptation could be criticized with respect to history, Hawthorne effect, and the interaction of treatment and therapist bias.

In order to insure the pre-treatment equivalences of the two groups further, the comparability of pretest measures of both groups was evaluated. The pretests were five scales of the Sixteen Personality Factor Questionnaire, the Rotter Locus of Control Scale, and the Target Outcome Assessment Sheet.

Due to the shift in the modified non-equivalent control group design, an additional check on factors that might
influence the validity of the results was gained by using the Ward Atmosphere Scale. Although both the experimental group and the non-equivalent control group were conducted relatively close to each other, they were not conducted at precisely the same time. The Ward Atmosphere Scale was employed to detect any subtle influences of history and to assess whether or not both environments were comparable.

**Instruments**

**Ward Atmosphere Scale**

The Ward Atmosphere Scale, which incorporated Murray's need-press model of the individual and environment, was selected because it is the most widely used and researched environmental instrument available. Designed to measure the shared environmental perceptions of psychiatric treatment settings, the scale consists of ten subscales from nine to twelve items each. The items describe typical behaviors on psychiatric wards. Clients are asked to indicate whether the items are true or false for their ward. (See Appendix D.)

There are three scales (support, involvement, and spontaneity) to measure relationship variables. Four scales, (autonomy, practical orientation, personal problem orientation, and anger) assess aspects of the treatment program. The final three scales (order, clarity, and staff control) measure variables in administration structure.
The scores of all clients on the ward are averaged and the mean used as an index of environmental press. Moos (1974) assumed that a measure of consensual perception is more accurate than subjective individual perceptions. The Ward Atmosphere Scale Subscales have adequate internal consistency and test-retest reliability. Stern (1970) calculated internal consistencies by using the average within program variances for the items. He indicated that the internal consistencies are all within an acceptable range, varying from moderate (Spontaneity at .55) to moderately strong (Involvement at .78). Stern's (1970) test-retest reliabilities of 42 clients after one week of therapy ranged from .68 for Practical Orientation to .83 for Personal Problem Orientation. A test-retest profile of stability, obtained by calculating interclass correlations on standard scores of the different administrations on each program, range from .92 after one week through .76 after one to two months to .77 at four to seven months (Stern, 1970). Very few if any of the same clients were tested on both occasions when the test-retest intervals were six months or more. This would indicate that the Ward Atmosphere Scale measures aspects of the treatment environment that may remain stable even with a complete turnover in client population.

Pierce, Trickett, and Moos (1972) demonstrated that the Ward Atmosphere Scale is sensitive to changes in ward treatment programs. In their study, the Ward Atmosphere
Scale was first used as a diagnostic pretest. Subsequently, the environment was manipulated to raise some scores and lower others. Posttesting with the Ward Atmosphere Scale demonstrated that significant changes had occurred in the appropriate directions.

In the present evaluation, the Ward Atmosphere Scale was administered three times at Valley General Hospital in an effort to assess possible threats to internal validity from three sources: history, the Hawthorne effect, and the interaction of treatment and therapists. The scale was administered in January before the research began; in June, when the first phase of the research corresponding to the use of the GASP had been in operation for one month; and again in August, when the second phase of the research had been in operation for one month. (See Figure 1, p. 78)

History included the specific events that occurred between the first and second treatment conditions (Campbell & Stanley, 1963). History was an important consideration since both treatment groups were not being offered at the same time. If there were no significant differences during the intervals among January, June, and August as measured by the Ward Atmosphere Scale, the events of history did not significantly affect the environmental press.

Occasionally the effects that are shown in research stem from the evaluation process itself (Campbell & Stanley, 1963). That is, the environment may exert a subtle difference by virtue of the way in which the experiment is
designed. The evaluation may be obtrusive. Non-significant differences between the three test periods using the Ward Atmosphere Scale would demonstrate that the environmental press was about the same whether or not the psychiatric unit was involved with an evaluation effort.

Psychotherapy research may be criticized because the therapist and treatment combine in a unique way. This unique combination may be what accounts for the changes. A different therapist would not produce the same results. This evaluation was not likely to have a therapist bias because of the therapists' rotating work hours. However it could be possible that this therapy team could be under particular pressures to assist or to undermine a research effort. It was expected that if the therapy team did experience such pressure around the research issues, the pressure would be demonstrated in the environment and measured by the Ward Atmosphere Scale. Non-significant differences among the three test periods using the Ward Atmosphere Scale demonstrate that whatever the team's feelings about the therapy, this interaction did not significantly alter the clients' perception of the environment.
The Target Outcome Assessment Sheet

The Target Outcome Assessment Sheet (TOAS) was developed for the purpose of this study to provide behavioral criteria for determining change resulting in therapy. Derived from Smith's (1974) Outcome Assessment Sheet, it is in essence the "expected outcome" portion of the Goal Attainment Scale followup guide (Kiresuk & Sherman, 1968).

A staff member asks the client what the problems are that brought him/her to the hospital, and what s/he expects to be different in each area at the end of this hospitalization. The client's present level of functioning is also recorded. This was the sole agenda of what was called an Initial Treatment Conference. This meeting took place within 24 hours of admission (See Figure 3).

---

**FIGURE 3**

Tests Administration Schedule

<table>
<thead>
<tr>
<th>Upon Admission</th>
<th>Initial Treatment Conference Within 24 Hours of Admission</th>
<th>Eight Days After Goal Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 PF Locus of Control</td>
<td>TOAS</td>
<td>16 PF Locus of Control TOAS</td>
</tr>
</tbody>
</table>

At post-treatment, the client is asked to report his/her behavior in each of the original concern areas. If his/her behavior has not reached the expected level, the client is asked to classify the behavior in one of the four
remaining categories: worse, much worse, better, or much better. This five-point scale is scored in the same manner as the Goal Attainment Scale follow-up guide. Since all the clients began at the same level (-1, less than expected level of success), any prescore analysis would have yielded the same means, with zero variance. Therefore the number of goals was analyzed to see if there was any difference based on the number of goals individuals identified. The post-scores were analyzed to determine if there had been any differential attainment of goals.

The Rotter Internal-External Locus of Control Scale

In Smith's (1974, 1976) work, one of the measures employed for outcome was the Nowicki-Strickland Locus of Control Scale for Children. In this research an outcome measure that was more applicable to adults was needed. The Rotter Internal-External Locus of Control Scale (Rotter, 1966) was selected.

The Rotter Locus of Control Scale was used to measure the degree to which people believed their behavior was determined by other people and external events. As mentioned earlier, if most decisions were seen as being determined by external events, it was said that that person had an external locus of control. People were said to have an internal locus of control if their behavior was determined by their own thoughts and feelings (Rotter, 1966).
The Rotter Internal-External Locus of Control Scale (See Appendix F) is composed of 23 internal-external items and six filler items. Researchers (Scheek, 1973; Stephens, 1972) have used the Internal-External Locus of Control Scale with adult populations ranging from schizophrenic through normal. The test has indicated a relationship between the concept of internality/externality and a variety of behaviors, including learning situations, conformity situations, risk taking, difference among known groups, changes in attitudes, skill and chance rewards, resistance to suggestion, and attempts to control the environment. Test-retest reliability was .79 at 14 days (Rotter, 1966). Operationally, the locus of control is defined as the score on the Locus of Control Scale (Rotter, 1966). A lower score means more internal; a higher score means more external.

The Sixteen Personality Factor Questionnaire

The Sixteen Personality Factor Questionnaire was used to test various aspects of actual personality change. Cattell, Eber, and Tatsuoka (1970) have demonstrated that five of the 16 factors are applicable for psychiatric inpatients. In other words, five of these factors usually change as a result of psychotherapy. The five factors are: Ego strength (Factor C), Assertiveness (Factor E), Surgency (Factor F), Guilt proneness (Factor O), and Anxiety (Factor Q4). Ego strength refers to personality integration or maturity and is operationally defined as the total Factor C
score. Assertiveness is the expression of what one wants and is operationally defined as the total Factor E score. Surgency means enthusiasm and is operationally defined as the total Factor F score. Guilt proneness is the feeling one has after doing wrong and is operationally defined as the total Factor O score. Anxiety is the affective state of feeling uneasy, apprehensive, and worried. Operationally it is defined as the total Factor $Q_4$ score. (See Appendices F and G for test.)

The Sixteen Personality Factor Questionnaire was originally developed by Cattell (1950a) and revised to its final form by Cattell, Eber, and Tatsuoka (1970). Norms for the Sixteen Personality Factor Questionnaire were drawn from 3,600 people who represented the American census population at large almost exactly according to area representation, population density, age group, and family income groups. The test-retest reliabilities at seven days were 0.74 for C, 0.85 for E, 0.87 for F, 0.79 for O, and 0.91 for $Q_4$. At two months the test-retest scores were: 0.75, 0.84, 0.78, 0.77, 0.78, respectively. Evidence of its construct validity was provided in terms of correlations with the MMPI scales: between C and masculine-feminine, 0.95; between E and introversion-extroversion, 0.93; between F and hypomania, 0.91; between O and paranoia, 0.84; and between $Q_4$ and anxiety, 0.93.
Procedure

Subjects

Of the 80 clients admitted during the duration of the evaluation (May-August), 55 clients agreed to participate in the evaluation. The attrition was attributed to either the client's refusal or, for those who wanted to remain in the study, failure to meet this evaluation's requirement of eight days hospitalization after identifying goals. All accepted subjects had the approval of their admitting psychiatrists and all signed an informed consent letter. (See Appendix H.)

The final sample included two neurotic clients for every psychotic client, a ratio which reflected the composition of the 1200 clients the hospital had treated over the previous 24 months. Of these 1200, 395 were psychotic and 805 were neurotic. The assigning of a "psychotic" designation to a client upon admission was based on the diagnostic criteria of the World Health Organization. The term psychotic:

... includes those conditions in which impairment of mental functions has developed to the degree that it interferes grossly with insight, ability to meet some ordinary demands of life or adequate contact with reality. It is not an exact or well defined term. Mental retardation excluded.

(World Health Organization, 1974, p. 19)
The assigning of a "neurotic" designation to a client upon admission was also based on the diagnostic criteria of the World Health Organization. The term neurotic:

... includes mental disorders without any demonstrable organic basis in which the client may have considerable insight and unimpaired reality testing, in that he usually does not confuse his morbid subjective experiences and fantasies with external reality. Behavior may be greatly affected, although remaining within socially acceptable limits, but personality is not disorganized. The principal manifestations include excessive anxiety, hysterical symptoms, phobias, obsessional and compulsive symptoms, and depression. Neuroses exclude physical disorders presumably psychogenic; and non-psychotic mental disorders associated with physical conditions.


As shown in Table 1, there were four males and 12 females in the GASP group, and two males and 14 females in the non-equivalent control group. The mean age was 35.9 years for the GASP group and 36.8 years for the non-equivalent control group. Of the 1200 clients seen over the previous two years, 238 were male and 962 were female, with a mean age of 36.5 years. This 1:4 male/female ratio is close to the 6:26 ratio here. In terms of age, sex, and diagnosis, the sample of clients in this evaluation was representative of the clients who had come to the hospital over the previous 24 months.

Test administration

Each client was administered the Sixteen Personality Factor Questionnaire and the Locus of Control Scale upon
<table>
<thead>
<tr>
<th></th>
<th>GASP</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Sex</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Mean Age</td>
<td>43.0</td>
<td>33.6</td>
</tr>
<tr>
<td>Age Range</td>
<td>28-69</td>
<td>19-57</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td>Psychotic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neurotic</td>
</tr>
<tr>
<td></td>
<td>Non-equivalent</td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Sex</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Mean Age</td>
<td>67.5</td>
<td>32.4</td>
</tr>
<tr>
<td>Age Range</td>
<td>51-84</td>
<td>20-52</td>
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<td>Psychotic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neurotic</td>
</tr>
</tbody>
</table>

admission. These tests were individually administered to the clients in their rooms. Within 24 hours of admission all clients were seen in an initial interview to determine their psychological histories and goals for hospitalization. This interview was conducted in a private consultation room on the unit. At this time the Target Outcome Assessment Sheet was completed jointly by the clients and the staff. Eight days after the initial interview the Sixteen Personality Factor Questionnaire, the Target Outcome Assessment Sheet, and the Locus of Control were re-administered as a posttest (See Figure 3, p. 95). Subjects who withdrew from
treatment prior to the posttest eight days later were dropped from the study. (See Appendices I and J.)

**Therapists**

The psychiatric unit employed 20 therapists (13 male, 7 female). The staff was composed of 10 psychotherapists and 10 psychiatric nurses. Additionally, there was an occupational therapist, a social worker, and six admitting psychiatrists. These therapists had been together as a team for three years, and had experience ranging from four to ten years. All were trained by the researcher in how to conduct the GASP as described in Chapter III. However, the members of the staff had been trained in many approaches to therapy -- psychoanalytic, gestalt, traditional analysis, client-centered, and existential. The diversity of training allowed the therapists to employ a number of alternatives as their judgment dictated, but none used behavior modification as their primary therapeutic tool. If anything, the philosophical orientation of Valley General Hospital's therapists was away from, not toward, behaviorism. Thus, the chances of the therapists biasing in favor of the GASP procedure were minimal, and the possibility of the GASP procedures influencing other procedures was equally unlikely.
Psychiatric unit

The psychiatric unit had a maximum capacity for 14 clients. These clients were assigned to private rooms on the unit. The client's room consisted of a bed, private toilet, and closet for clothes. No private room had a television, although there was a television room on the unit which was accessible to all clients. The average number of staff members available per eight-hour shift was four, depending on the number of clients.

Treatments

As mentioned above, two groups were used in the course of this evaluation, the GASP group and the non-equivalent control group. Both of these groups were open entry groups.

Figures 4 and 5 show the admission and discharge dates of individuals within each group. Between June 16 and June 30 no clients were enlisted as evaluation subjects. The GASP was terminated when the final evaluation subject was discharged. To avoid contamination, the non-equivalent control group began only after clients who had had contact with the GASP were discharged from the hospital.

GASP condition

Every person admitted to the hospital during the GASP participated in the procedure described in Table 2. Every person admitted for treatment during this time took part in all of the required activities. (Required activities are
FIGURE 4

Admission and Discharge Dates for the GASP Group, May 1 - June 15

DATES

14 12 10 8 6 4
June 2 31 29 27 25 23 21 19 17 15 13 11 9 7 5 3

May 1

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
Client Number
FIGURE 5

Admission and Discharge Dates for the Non-equivalent Control Group, July 1 - August 15

Client Number
capitalized and underlined; if no time is listed it means this was "free time". On the schedule, "Goals Group" is written in place of GASP). Staff were told to conduct all facets of hospitalization as they usually do. The author met with the staff daily to observe their performance with the GASP and to answer any questions they might have had. There were 16 subjects. A GASP group consisted of a minimum of four clients and two staff members.

Non-equivalent control group treatment

The non-equivalent control condition consisted of hospitalization as outlined in the schedule presented in Table 3. Every person admitted for treatment during this time took part in all of the required activities. (Required activities are capitalized and underlined; "free time" was any time period not listed on the Schedule.) Sixteen subjects were seen. The single difference between the schedule for the GASP group and the non-equivalent control group was the presence of the "Goals Group". Therapeutic goals were not discussed in any systematic fashion during the course of treatment of the non-equivalent control group. (See Table 2.)

Within both treatment schedules, clients could find free-time. This was true because, with the exception of the required activities, not all clients participated in the opportunities. During these free-time periods, clients
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* Visiting Hours: 2:00-8:00
Table 4

Activities of Non-Equivalent Control Group

<table>
<thead>
<tr>
<th>Activity</th>
<th>Per cent of clients involved in activity</th>
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<tr>
<td>Socialized with others</td>
<td>61.5</td>
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<tr>
<td>Alone (watching television, reading, or sitting)</td>
<td>19.2</td>
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<tr>
<td>In conference with either psychiatrist or staff member</td>
<td>7.7</td>
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<tr>
<td>On Pass</td>
<td>7.7</td>
</tr>
<tr>
<td>Sleeping</td>
<td>3.8</td>
</tr>
<tr>
<td>Unsuccessful suicide attempt by wrist-slicing (one person)</td>
<td>.1</td>
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</table>

could be found visiting with family and friends, talking with staff or other clients, meeting with psychiatrists, walking on the hospital grounds, being on a pass to conduct personal business, or sleeping. For the non-equivalent control group, the author monitored the clients' activities by stationing himself in the central area of the unit during the usual hour of the GASP. These activities are listed in Table 4.

Staff members were available for consultation whenever a client asked. This procedure was followed for two reasons. First, there is an ethical/therapeutic concern that clients receive as much contact with staff as they required and desired. To do otherwise, Valley General
Hospital would have been guilty of denying necessary treatment to those when treatment could reasonably be forthcoming. Second, there was a desire to keep the therapeutic contact time for both groups constant.

**Statistical Analyses**

**Data preparation**

All tests were hand scored and verified by an assistant. These scores were then keypunched and 100 per cent verified. Files were constructed.

**Control hypotheses**

A one-way multivariate analysis of variance was used to examine the environmental press for January, June, and August. The 10 dependent variables corresponded to the 10 subscales of the Ward Atmosphere Scale.

Initial differences between the two groups were analyzed using one-way analyses of variance. A multivariate analysis, employing Wilk's likelihood ratio criterion, was used for the five subscales of the Sixteen Personality Factor Questionnaire. Univariate analyses were conducted for the Target Outcome Assessment Sheet and the Locus of Control Scale.
Evaluation hypotheses

The results of the above analyses, presented in detail in the next chapter, revealed that at the .25 level of significance there were no statistically significant differences among the pretest period in January and experimental periods in June and August. Therefore, it was decided to analyze the posttest results using a one-way analysis of variance. Again, a multivariate analysis was run for the five subscales of the Sixteen Personality Factor Questionnaire, and univariate analyses for the Target Outcome Assessment Sheet and the Locus of Control Scale.

All analyses were performed using *Multivariance: Univariate and Multivariate Analyses of Variance, Covariance, Regression, and Repeated Measures (Version VI)* (Finn, 1978). All computer analyses were completed on the Amdahl computer at the University of British Columbia.
CHAPTER V

RESULTS

First, control issues are examined through an analysis of the Ward Atmosphere Scale and of the pretest scores of the two groups. The five evaluation questions are then analyzed. The qualitative analyses of the goals are presented last.

In order to test the viability of the GASP, the effectiveness of hospitalization with the GASP was compared to hospitalization without the GASP. Throughout the remainder of this paper, these two groups will be referred to as the GASP group and the non-equivalent control group respectively. Further, as was mentioned earlier, all hypotheses are in the null form owing to a lack of research results that would suggest directionality.
Comparative Evaluation

Preliminary analysis of control issues

Hypothesis 1

There is no difference in the environmental press as measured by the Ward Atmosphere Scale in January, June, and August.

The January scores represent the atmosphere five months before the evaluation began. The June scores are measures on the atmosphere in the middle of the first phase of the evaluation when the GASP was employed. The August scores reflect the atmosphere in the middle of the second phase, when the GASP was not offered. For each of the three test administrations of the Ward Atmosphere Scale, n=11.

The results of the multivariate analysis revealed that for the 10 subscales there were no significant differences among January, June, and August as shown in Tables 5, 6, and 7.

The F-statistic for the multivariate test of equality was 0.5975, (p < 0.8923). Separate analyses of variance for each variable revealed that with the exception of subscale 2 (support) (F = 2.21; p < .13), all other subscales were non-significant at the .25 level of significance. Consequently, it was concluded that there were no significant differences
Table 5

Means and Standard Deviations of the Three Test Periods of the Ward Atmosphere Scale

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<th>June (Mean)</th>
<th>August (Mean)</th>
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<td>Deviation</td>
<td>Sub-Means</td>
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<td>8.2727 (1.6788)</td>
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<td>5.7272 (1.7373)</td>
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<td>5</td>
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<td>7.0000 (1.5491)</td>
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<td>8</td>
<td>5.7272 (1.4894)</td>
<td>5.2727 (1.6181)</td>
<td>5.0000 (2.2361)</td>
</tr>
<tr>
<td>9</td>
<td>6.6363 (1.7477)</td>
<td>6.7272 (1.5551)</td>
<td>5.7272 (1.4206)</td>
</tr>
<tr>
<td>10</td>
<td>1.7272 (1.0091)</td>
<td>1.0000 (0.8944)</td>
<td>1.6363 (1.9633)</td>
</tr>
</tbody>
</table>

Table 6

Multivariate Analysis of the Ward Atmosphere Scale at January, June, and August

<table>
<thead>
<tr>
<th>Source of Variability</th>
<th>Multivariate F-test</th>
<th>df</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occasion</td>
<td>.5975</td>
<td>20</td>
<td>0.8923</td>
</tr>
<tr>
<td>Within</td>
<td></td>
<td>42</td>
<td></td>
</tr>
</tbody>
</table>

\( F_{.75}(20,42) = 1.28 \)
Table 7

Univariate Analysis of Variance of the Ward Atmosphere Subscales

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean Square within</th>
<th>Univariate F</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5.4303</td>
<td>0.2902</td>
<td>0.7503</td>
</tr>
<tr>
<td>2</td>
<td>1.7393</td>
<td>2.2125</td>
<td>0.1270</td>
</tr>
<tr>
<td>3</td>
<td>2.6242</td>
<td>0.3460</td>
<td>0.9660</td>
</tr>
<tr>
<td>4</td>
<td>1.8000</td>
<td>1.0774</td>
<td>0.3533</td>
</tr>
<tr>
<td>5</td>
<td>1.0363</td>
<td>1.0819</td>
<td>0.3519</td>
</tr>
<tr>
<td>6</td>
<td>1.6000</td>
<td>0.5114</td>
<td>0.6049</td>
</tr>
<tr>
<td>7</td>
<td>2.3151</td>
<td>1.4136</td>
<td>0.2591</td>
</tr>
<tr>
<td>8</td>
<td>3.2788</td>
<td>0.4529</td>
<td>0.6401</td>
</tr>
<tr>
<td>9</td>
<td>2.4970</td>
<td>1.3471</td>
<td>0.2753</td>
</tr>
<tr>
<td>10</td>
<td>1.8909</td>
<td>0.9135</td>
<td>0.4121</td>
</tr>
</tbody>
</table>

$F_{.75}(2, 30) = 1.45$

in the environment among January, June, and August time periods.

Pre-treatment comparability of samples

Hypothesis 2

There is no difference between the pretest scores of the GASP group and the non-equivalent control group on the Sixteen Personality Factor Questionnaire, the Rotter Internal-External Locus of Control scale, and the number of goals on the Target Outcome Assessment Sheet.

In order to examine whether the two groups of clients were comparable at the beginning of their respective
treatments, their pretest scores on both the five subscales of the Sixteen Personality Factor Questionnaire, and the Locus of Control Scale were compared. In addition, the number of goals on the Target Outcome Assessment Sheet was examined. "Number of goals" on the Target Outcome Assessment Sheet was selected since all clients began at the -1 level of success, the less than expected outcome. Consequently there are no differences in the Target Outcome Assessment Sheet since all clients start at the same point. However, if clients had different numbers of goals, this difference could be influential. It could have been significant that one client had one goal for therapy, while another had four. For this reason, it was decided to compare the number of goals each client had before treatment.

For the Sixteen Personality Factor Questionnaire, the F-statistic for the multivariate test of equality was 0.6586, with a computed probability of 0.6579 (See Table 9). Again, to avoid a Type II error, a probability of .25 was selected. The corresponding univariate F's were never greater than 1.38 (p < .25) (See Table 10. The hypothesis of no significant differences on pretests was not rejected (See Tables 8, 9, and 10). The groups could be considered equal on the subscales of the Sixteen Personality Factor Questionnaire pretest because of the non-significant differences.
Table 8

Means and Standard Deviations of Pretest Scores on the Five Subscales of the Sixteen Personality Factor Questionnaire

<table>
<thead>
<tr>
<th>GASP</th>
<th>GASP</th>
<th>Non-</th>
<th>Non-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell Means</td>
<td>Standard Deviation</td>
<td>Equivalent Control Group Mean</td>
<td>Equivalent Control Group Standard Deviation</td>
</tr>
<tr>
<td>C</td>
<td>4.18</td>
<td>2.55</td>
<td>3.93</td>
</tr>
<tr>
<td>E</td>
<td>3.68</td>
<td>1.89</td>
<td>4.00</td>
</tr>
<tr>
<td>F</td>
<td>6.87</td>
<td>2.30</td>
<td>6.12</td>
</tr>
<tr>
<td>O</td>
<td>7.18</td>
<td>2.15</td>
<td>7.18</td>
</tr>
<tr>
<td>Q</td>
<td>6.00</td>
<td>2.19</td>
<td>6.56</td>
</tr>
</tbody>
</table>

Table 9

Multiple Analysis of Variance for Significant Differences Between Pretest Scores on the Sixteen Personality Factor Questionnaire

<table>
<thead>
<tr>
<th>Source of Variability</th>
<th>Multivariate F-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
</tr>
<tr>
<td>Occasion</td>
<td>0.6586</td>
</tr>
<tr>
<td>Within</td>
<td></td>
</tr>
</tbody>
</table>

\[ F_{.75}(5,26) = 1.42 \]

Table 10

Univariate F-Ratios of Difference on the Pretest Scores on the Five Subscales of the Sixteen Personality Factor Questionnaire

<table>
<thead>
<tr>
<th>Hypothesis Mean Sq.</th>
<th>Univariate F</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>0.50</td>
<td>0.07</td>
</tr>
<tr>
<td>E</td>
<td>0.78</td>
<td>0.21</td>
</tr>
<tr>
<td>F</td>
<td>4.50</td>
<td>0.84</td>
</tr>
<tr>
<td>O</td>
<td>3.12</td>
<td>0.67</td>
</tr>
<tr>
<td>Q_4</td>
<td>2.53</td>
<td>0.52</td>
</tr>
</tbody>
</table>

\[ F_{.75}(1,30) = 1.38 \]
The two analyses of variance for the Target Outcome Assessment Sheet and the Locus of Control Scale yielded F-values of .29 and 1.10 respectively. These were not significant when compared to a tabled F_{75}(1,30) = 1.38 (See Tables 11 and 12). Therefore the two groups were considered to be equivalent on the Target Outcome Assessment Sheet and Locus of Control Scale.

Evaluation Hypotheses

Hypothesis 3
There is no significant difference between the GASP and the non-equivalent control group mean posttest scores of the Target Outcome Assessment Sheet.

The value of the F-statistic corresponding to this hypothesis was 3.59 (p < 0.067). Thus, the hypothesis of no significant difference between treatment group and control was not rejected (See Table 13).

Deleting Hypothesis 4
It was hypothesized that there would be a difference in achievement with regard to goals the client defined upon admission. It was thought that the client might expend more energy on accomplishing what s/he identified as the "most important" goal, and less on the remaining goals.
Table 11

Means and Standard Deviations of Pretest Scores on the Locus of Control Scale and the Number of Goals on the Target Outcome Assessment Sheet

<table>
<thead>
<tr>
<th></th>
<th>GASP Cell Means</th>
<th>GASP Standard Deviation</th>
<th>Non-Equivalent Control Group Cell Means</th>
<th>Non-Equivalent Control Group Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOAS</td>
<td>3.62</td>
<td>0.72</td>
<td>3.75</td>
<td>0.58</td>
</tr>
<tr>
<td>LOC</td>
<td>12.06</td>
<td>3.40</td>
<td>13.56</td>
<td>4.59</td>
</tr>
</tbody>
</table>

Table 12

Multivariate Analysis of Variance for Significant Differences Between Pretest Score of the Locus of Control Scale and the Number of Goals on the Target Outcome Assessment Sheet

<table>
<thead>
<tr>
<th></th>
<th>Univariate F</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOAS</td>
<td>0.29</td>
<td>0.59</td>
</tr>
<tr>
<td>LOC</td>
<td>1.10</td>
<td>0.30</td>
</tr>
</tbody>
</table>

\[ F_{.75}^{(1,30)}=1.38 \]

Table 13

Analysis of Variance and Means of Posttest Scores for the Target Outcome Assessment Sheet

<table>
<thead>
<tr>
<th>Degrees of Freedom</th>
<th>F-Value</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1,30)</td>
<td>3.59</td>
<td>0.067</td>
</tr>
</tbody>
</table>

\[ F_{.95}^{(1,30)}=4.17 \]

Mean Posttest Score

<table>
<thead>
<tr>
<th></th>
<th>Non-Equivalent Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>GASP</td>
<td>3.05</td>
</tr>
</tbody>
</table>
However, only one person in both groups identified a single goal as the "most important". All other subjects rated every goal as the "most important". Given this failure to differentiate among the goals chosen, the hypothesis related to the "most important" goal could not be tested.

Hypothesis 5

There is no significant difference between the GASP group and the non-equivalent control group as measured on the mean posttest scores of the Rotter Internal-External Locus of Control Scale.

The F-statistic revealed that there was a significant difference in Locus of Control between the group receiving the GASP and the group that did not (F = 6.70; p < .01). The GASP group attained a significantly more internal score on the Rotter Internal-External Locus of Control Scale than did the non-GASP group. (See Table 14).

Hypothesis 6

There are no differences between the GASP group and non-equivalent control group mean posttest score of the following five subscales of the Sixteen Personality Factor Questionnaire:

a. Factor C, ego strength.

b. Factor E, assertiveness.

c. Factor F, surgency or enthusiasm.
Table 14

Analysis of Variance and Means of Posttest Scores for the Locus of Control Scale

<table>
<thead>
<tr>
<th>Degrees of Freedom</th>
<th>F-Value</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1,30)</td>
<td>6.70</td>
<td>0.01</td>
</tr>
</tbody>
</table>

**Mean Posttest Scores**

<table>
<thead>
<tr>
<th>GASP</th>
<th>Non-Equivalent Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.90</td>
<td>11.00</td>
</tr>
</tbody>
</table>

\[ F_{.95}(1,30) = 4.17 \]

d. Factor O, guilt.
e. Factor Q₄, anxiety.

The multivariate analysis for the two groups resulted in an F-statistic of 4.81, which was significant at the .05 level of significance. The hypothesis of no significant differences between the GASP and the non-GASP group was rejected. Therefore, it was possible to explore further which factors were contributing to the significance (See Table 15).

Examination of the univariate F-ratio (Hummel & Sligo, 1971) corresponding to the five subscales of the Sixteen
Table 15

Multiple Analysis of Variance for Posttest Scores on the Sixteen Personality Factor Questionnaire

<table>
<thead>
<tr>
<th>Source of Variability</th>
<th>Multivariate F-test</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occasion</td>
<td>4.8143</td>
<td>0.0031</td>
</tr>
<tr>
<td>Within</td>
<td>26</td>
<td></td>
</tr>
</tbody>
</table>

F₁₀₀(5,26) = 1.42

Personality Factor Questionnaire reported in Tables 16 and 17 reveal differences in favor of the GASP on Surgency (F) (F = 5.14; p < .03), and Anxiety (Q₄) (F = 8.11; p < .008). For the remaining three tests, the F-values were not significant.

Hypothesis 7

There is no significant difference between the GASP group and the non-equivalent control group on the mean length of stay in the hospital.

The average time in the hospital for the GASP group was 13.375 days, and the average time in the hospital for the non-equivalent control group was 15.5625 days. The difference between the two groups was 2.1875 days. This was a 16.3 per cent difference. A comparison of these groups yielded a t-value of 1.338 with 30 degrees of freedom, (p < .08). The hypothesis of no significant differences between treatment and control group was not rejected (See Table 18).
### Table 16

Means and Standard Deviations for Sixteen Personality Factor Questionnaire Posttest

<table>
<thead>
<tr>
<th></th>
<th>GASP Cell Means</th>
<th>GASP Cell Means</th>
<th>Non-Equivalent Control Group Cell Means</th>
<th>Non-Equivalent Control Group Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>6.81</td>
<td>5.06</td>
<td>2.88</td>
<td>2.76</td>
</tr>
<tr>
<td>E</td>
<td>5.19</td>
<td>4.75</td>
<td>2.07</td>
<td>1.76</td>
</tr>
<tr>
<td>F</td>
<td>7.75</td>
<td>6.50</td>
<td>1.57</td>
<td>1.56</td>
</tr>
<tr>
<td>O</td>
<td>6.63</td>
<td>6.63</td>
<td>2.55</td>
<td>2.00</td>
</tr>
<tr>
<td>Q</td>
<td>5.44</td>
<td>7.50</td>
<td>2.28</td>
<td>2.04</td>
</tr>
</tbody>
</table>

F.95(1,30)=4.17

### Table 17

Analysis of Variance for Sixteen Personality Factor Questionnaire Posttest

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Mean Sq.</th>
<th>Univariate F</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>24.50</td>
<td>3.20</td>
<td>0.08</td>
</tr>
<tr>
<td>E</td>
<td>1.53</td>
<td>0.05</td>
<td>0.49</td>
</tr>
<tr>
<td>F</td>
<td>12.50</td>
<td>5.14</td>
<td>0.03</td>
</tr>
<tr>
<td>O</td>
<td>0.00</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Q</td>
<td>34.03</td>
<td>8.11</td>
<td>0.008</td>
</tr>
</tbody>
</table>
Table 18

<table>
<thead>
<tr>
<th>Source</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>t-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>GASP</td>
<td>13.3750</td>
<td>4.52953</td>
<td>-1.338</td>
</tr>
<tr>
<td>Non-equivalent Control Group</td>
<td>15.5625</td>
<td>4.71832</td>
<td></td>
</tr>
</tbody>
</table>

\[ t_{.975(30)} = \pm 2.04 \]

Table 19

Summary of Posttest Results

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Significantly Different</td>
</tr>
<tr>
<td>NO</td>
</tr>
<tr>
<td>Probability</td>
</tr>
</tbody>
</table>

Summary

The results of the posttest hypotheses reveal that the GASP group was significantly more internal on the Locus of Control, higher on the Surgency, and lower on the Anxiety subscales of the Sixteen Personality Factor Questionnaire. (See Table 19).
CHAPTER VI

DISCUSSION AND SUMMARY

Summary of Results

This study has two parts. The first part was the development of the GASP and the second was the preliminary evaluation of the GASP.

The Development of the GASP

The objective was to develop a standardized, group procedure for patients hospitalized for a short term. Literature relevant to this task came from three areas: brief psychotherapy, problem-solving therapy, and Goal Attainment Scaling. The analysis and synthesis of these areas showed that it was possible to develop a short-term group procedure. This process, the GASP, consists of the following general steps: communicating to the client that the task is to articulate goals that can be accomplished within two weeks; developing a list of events that preceded hospitalization; writing a list of the feelings the client experienced when the events happened; constructing a list of
the client's strengths that permit them to survive their emotional trauma; listing the problems the events and feelings create; listing goals that would solve the problems; listing what the person can do to make the problem worse and what can be done to alleviate the problem; reviewing the client's progress weekly. The first objective, the development of the GASP was achieved. It was possible to develop a standardized short-term multi-component therapeutic process for groups of clients.

The Preliminary Evaluation of the GASP

The subjects for the preliminary evaluation were 32 voluntarily hospitalized patients of the psychiatric unit of Valley General Hospital. They were divided into a non-equivalent control group and the GASP group. They were administered the Rotter Internal-External Locus of Control Scale, the Target Outcome Assessment Sheet, and the Sixteen Personality Factor Questionnaire upon admission, and again eight days after their initial interview.

The results of the preliminary evaluation were:

1. The environmental press was found not to be different six months before the study or during both phases of the evaluation. The empirical support for equivalent ward atmospheres (Hypothesis 1) meant that the environment of the psychiatric unit was essentially the same six months before the research began, and throughout the evaluation period. The three different groups of
clients saw the environment as having the same psychological press, whether or not the evaluation was present. Although different events occurred in January, June, and August, they were not sufficiently different to cause the environments in the hospital at those times to be seen as different.

2. Both groups were found not to be significantly different on their pretest scores. Both groups could be considered to have started at essentially the same point on their pretests.

3. Three independent raters rated the categories and the direction of the clients' goals. There was a 99.5 per cent inter-rater agreement. Ninety per cent of the clients' goals identified at admission stayed in the same categories during the GASP. Of this 90 per cent, goals were all in the same direction 100 per cent of the time. The conclusion here is that most people know what they have to work on, and never shift direction. The goals identified upon admission are the same as those identified during the GASP. The GASP does not assist the clients in selecting goals, but more finely defines levels of attainment. Although both groups achieved higher posttest scores on their level of goal attainment, neither was superior in helping clients to achieve all their goals for hospitalization. The results for Hypothesis 3 showed that there was no difference between the two groups in helping clients achieve their goals for hospitalization. Perhaps if
another step were added to the GASP to improve the specification of the levels of success during the GASP, goal attainment would be significantly higher. (Since subjects failed to differentiate their "most important goal", the "most important goal" hypothesis was dropped.)

4. At the posttest, the GASP group was significantly different on the internal locus of control when compared to the non-equivalent control group. The statistical support for Hypothesis 5 indicated that the GASP is better than the non-equivalent control group in inducing a more internal locus of control for this sample of clients. This increased sense of self control is in response both to the learning that takes place during the GASP, and the learning that the clients undergo as they actually put their goal attainment behaviors into practice. In other words, hospitalization with the GASP influences people to believe that they are responsible for what happens to themselves. The potential to learn how to understand the use of goals intellectually and to implement the procedure for their own goals may convince clients that they are more responsible for themselves and their condition.

5. At the posttest, both groups were not statistically different in increasing ego strength. There was no statistical support for stating that the GASP group was different than the non-equivalent control group on
Factor C, Ego Strength. The above finding is interesting. One would expect that psychiatric hospitalization should reduce the client's state of confusion. It was initially believed that an actual listing of events, feelings, strengths, problems, and goals enabled clients to have an even greater understanding of themselves, but hospitalization without the GASP also involves clients in affective and behavioral self-examination. The GASP could possibly be conducive to permitting greater personality integration if it were expanded. For example, the strengths list could be designed to include an exercise on positive self-statements.

6. At the posttest, both groups were not statistically different in increasing assertiveness. The data on Assertiveness, Factor E, pointed out that neither group was more assertive than the other. There are several possible explanations for this: assertiveness is more complex than merely exercising decisions and having self-control in a situation, and the increased assertiveness may have been a result of the clients' participation in other parts of the treatment program.

7. At the posttest, the GASP group was significantly different in Surgency when compared with the non-equivalent control group. For Surgency, Factor F, the data demonstrated that the members of the GASP were significantly more enthusiastic about themselves than were their counterparts. It is suggested that this
outcome is the result of the concrete focus the GASP provides. By proceeding in small sequential steps, the people's enthusiasm for both themselves and life in general rises as each step is attained. Psychotherapy should reverse the downward spiral that causes a person to seek therapy in the first place. It is speculated the even greater enthusiasm demonstrated with the GASP is a result of the sequential steps taken toward goals, and of positive feelings of self-worth that come from hearing others say what they like about a person.

8. At the posttest for Guilt, Factor 0, there was no difference between the GASP and the non-equivalent control group. Since both groups tested lower in the posttest, it appears that the other parts of the program worked to lower guilt.

9. At the posttest for Anxiety, Factor Q4, there was a statistically significant difference between the GASP and the non-equivalent control group. The GASP subjects' posttest mean for anxiety was lower than their pretest mean, while the non-equivalent control group subjects posttest mean for anxiety was actually higher than their pretest mean. This outcome appears to be a result of GASP subjects having a specific framework for how they came to seek treatment, what their problems are, and what they are specifically going to do to remedy the situation. As the clients engage their specific steps and progress toward goals, worry about "what to do" decreases. It is apparent
that without this type of concreteness, people's situations and problem-solving methods remain vague, and this vagueness may increase anxiety, instead of lowering it.

10. There was no statistically significant difference between the GASP and the non-equivalent control group for length of stay. The length of GASP hospitalization was reduced by 16.3 per cent. This difference, though not significant, could have fiscal implications for providing treatment. It would be interesting to examine this hypothesis for treatment periods different than eight days, and/or for a time of study longer than six weeks.

These preliminary results from the Locus of Control Scale, and some subscales of the Sixteen Personality Factor Questionnaire suggest that hospitalization with the GASP showed promise as a therapeutic procedure. The Goal Attainment Scale could be modified and incorporated into a psychotherapeutic procedure and integrated successfully into the treatment milieu of a short-term psychiatric unit for voluntarily hospitalized people.

Limitations of the Study

The discussion of limitations of this study is divided into two parts: the limitations of the development of the GASP, and limitations of the preliminary evaluation.
The development of the GASP has an inherent shortcoming, the myth of objectivity. The developer was required to make decisions and choices about which literature to include, and which to exclude. These judgments were based on empirical data whenever possible. However, personal biases could not be avoided. For example, the benefits of the psychoanalytic approach to psychotherapy might have been more fully explored and incorporated into the GASP. Although such psychotherapy may be effective, the process is time-consuming and consequently is accessible to fewer clients. The GASP could be enhanced by the critical appraisal and use by clinicians with different theoretical orientations.

With respect to the preliminary evaluation, there are limitations which should be recognized in evaluating the results. First, true random sampling was not possible in selecting the psychiatric clients. Consequently, the conclusions may be generalized only to clients of Seattle who would desire psychiatric treatment at Valley General Hospital.

Second, the reader should be reminded that this evaluation was conducted with voluntarily hospitalized clients, and that there were twice as many neurotics as psychotics in the population. It is conceivable that the results of this evaluation could only be reconfirmed if a similar population were used in future studies. Perhaps the concrete nature of the GASP is applicable only for those who
are sufficiently disturbed or confused as to request hospitalization.

Third, although there is research to indicate that brief psychotherapy is important, follow-up research would have enabled the researcher to assess how long-lasting the results were. Research could possibly be bolstered by data on recidivism or rate of return to therapy. Both of these questions were initially addressed; lack of client participation led to inconclusive results.

Fourth, there is no input from clients as to how they differentially perceived the effects of their hospitalization (See Appendices K and L for potential client satisfaction questionnaires).

Fifth, the group was conducted as an open entry, open exit group where membership was not restricted. The results might be different with a contained, time-limited group.

Sixth, the sample size was small. Different results might be achieved with a larger sample of comparable psychiatric hospitals.

Recommendations for Further Research

1. As mentioned above, the present results do not address the long-term effectiveness of treatment employing the GASP. By gaining the cooperation of the clients over some time, it would be of interest to assess the long-term effectiveness of the GASP. Further, it would also
be interesting to know under which conditions clients are more satisfied with their hospitalization.

2. The preliminary findings suggest hospitalization with the GASP does have an impact on people in crisis. It offers them a plan to help them problem-solve. As such, the application of the GASP to other areas of psychology seems to be a potentially fruitful venture. It is entirely possible that the GASP could be offered as part of life-planning workshops, career-planning workshops, marital intervention procedures, and family therapy, to name but a few areas of application.

3. In light of the previous recommendation it would be helpful to conduct evaluations with larger samples and different populations such as non-hospitalized populations, more psychotic populations, or involuntarily hospitalized populations.

4. While the area of assessing psychotherapeutic properties of a process is not new, such research does challenge researchers to look at better articulation of the content of the process. Further evaluations could be conducted to see if there is any merit in such refinement. Along this line of refinement, it might be beneficial to identify the more potent parts of the GASP, as well as those steps that are impotent by sequentially deleting steps in the GASP. Thus one could employ the various steps of the GASP, excluding some, and see if the results are similar.
5. In this evaluation the GASP was an integral part of a total treatment program. It would be interesting to examine the GASP on its own, independent of any program and see if it has the same psychiatric impact.

Conclusion

It may be concluded that the Goal Attainment Scale can be adapted and incorporated into a group process that assists clients in a goal-oriented problem-solving approach to brief therapy. This process integrated all the important components from the brief psychotherapy, problem-solving therapy, and the Goal Attainment Scaling literature such as: limited goals, short time duration, focused interviewing, present centeredness, therapeutic flexibility, ventilation, and the teaching of broad coping skills. The results of the exploratory evaluation suggest this integration, the GASP, does differentially affect some aspects of the client's hospitalization. Hospitalization with the GASP holds promise as an effective group process for hospitalized psychiatric clients.
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APPENDIX A

EXAMPLE OF ONE CLIENT'S COMPLETED GASP
EVENTS
Married shortly after she entered nursing school. 
She started work after completion of schooling. 
Separated. 
Counseling to save marriage. 
Saw each other one/twice per week. 
Slept together. 
She said she wanted me to find someone else. 
She filed for divorce to save me the pain of goodbye. 
I had a date with a girl. 
Thought of wife. 
Got nervous/tense. 
Called friends -- no answer. 
Called wife -- she refused to see me. 
Talked on front lawn with wife. 
Said I wanted one more chance -- she said no. 
I turned by back and slashed my wrist. 
Wife stopped my bleeding. 
Ambulance came. 
I came to psychiatric unit. 
I decided to stay for help.

FEELINGS
Hate myself, alone. 
Insecure, afraid. 
Lost, guilty, dirty. 
Empty, angry, tired. 
Cold, lonely, used. 
Jealous, set-up, trapped. 
Desperate, confused, sad. 
Helpless, disappointed.

STRENGTHS
Gentle, empathic. 
*Determined. 
Affectionate. 
*Plan ahead. 
Curious. 
Insight. 
Intelligent. 
Industrious. 
*Controlled. 
Good listener. 
Handsome. 
Trusting. 
Helpful. 
Dependable. 
Caring. 
Straightforward. 
Sexy. 
*Physically powerful. 
*High moral standard. 
Like to help others.
* = also causes problems.

PROBLEMS
Hard to make friends. IV 
Stifle anger - back pain. 
Hate myself. II 
Still love wife. III/IV 
Division of property. II/III/IV 
Easily distracted. I 
Job dissatisfaction. 
Bad temper. 

(Number after Problem refers to Goal # that addresses this problem)

GOALS
I. Finish projects I start. 
II. Feel good about myself. 
III. Face divorce. 
IV. Communication skills. 
V. Establish a new home for myself.
APPENDIX B

EXAMPLE OF COMPLETED
TARGET OUTCOME ASSESSMENT SHEET
<table>
<thead>
<tr>
<th>GOAL LEVELS</th>
<th>GOAL 1</th>
<th>GOAL 2</th>
<th>GOAL 3</th>
<th>GOAL 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increase Verbal Communication</td>
<td>Decrease Suicide Behavior</td>
<td>Increase interpersonal Relations</td>
<td>Express Angry Feelings</td>
</tr>
<tr>
<td>Most Unfavorable</td>
<td>Most Unfavorable</td>
<td>Effect Suicide</td>
<td>Can name no one except wife</td>
<td>Never express anger</td>
</tr>
<tr>
<td>(-2)</td>
<td>Spontaneously speak to no more</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>than one person per day</td>
<td></td>
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<tr>
<td>Less than Expected</td>
<td>Less than Expected</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(-1)</td>
<td>Spontaneously speak to no more</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>than 2 to 4 people per day</td>
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<td>Expected level</td>
<td>Expected level of Success</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>of Success</td>
<td>(0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spontaneously speak to 5 to 6</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>people per day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than Expected</td>
<td>More than Expected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(+1)</td>
<td>Spontaneously speak to 7 to 9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>people per day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most Favorable</td>
<td>Most Favorable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(+2)</td>
<td>Spontaneously speak to more</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>than 9 people per day</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When I feel angry, list event, circumstances, and action taken
Share list with community
Have a meeting to share list with my family
APPENDIX C

TRAINING AGENDA
Session 1: Introduction of uniformity

In this session the 14 points were presented. The focus of the session was to underline the necessity for consistency and uniformity of presentation. Although each client's content would be different, the form of the process must stay the same. The session was spent defining what the GASP process must include.

Session 2: Timing -- brevity of goals

As the notion of GASP uniformity had been emphasized initially, the group was now ready to identify a means of controlling the time factor of the process. This was to be accomplished by emphasizing that client goals should be such as to be achieved within two weeks. The content of the group was concerned with emphasizing this point to clients. Their goals should be able to be achieved within two weeks, not two months or one year. The staff role-played examples of clients with too expansive goals.

Session 3: Timing -- brevity of process

The group was instructed how to keep the GASP under sixty minutes. Thus if a client identified "feelings" they should be instantly noted on the board rather than waiting for the "Feeling" aspect of the process. This is a process that develops the lists, rather than a process that needs to have every aspect of the client emphasized. The staff was instructed to have clients keep their comments brief and then to move to the next point.

Session 4: How to elicit answers

The group's task was to brainstorm questions that would assist the client in the process. The group developed, and agreed upon, questions that were incorporated into the process as suggested questions.

Session 5: Identifying behavioral goals
Session 6: Identifying behavioral goals

Behavior criteria for goals was emphasized. It was explained to the group how to turn any goal into observable behavior. For example, if the goal was "to feel better" the staff
was instructed to ask the client what s/he would be doing if s/he felt better. Within both sessions, the staff was to identify any goal and re-define that goal into observable behavior. The group's task was to identify typical client goals and to come to an agreement as to whether or not they referred to observable behavior.

Session 7: Forcing goals

As some clients are resistant or find it difficult to articulate goals, the staff explained the problem of articulating goals for them -- or forcing goals upon the client. If, after exploring all potential alternatives, the client has not defined a goal the therapist identified, it was agreed to let the client have his/her way.

Session 8: Memory cues, feelings, and conclusion

The staff shared methods they had developed to remember the GASP. It appears that individuals use unique methods that only they or like thinking people employ. Secondly, the staff's feelings about the GASP were explored as well as their feelings about this research. Finally, the GASP procedure was re-articulated in the 14 steps to ensure uniformity.

The 8 one-hour weekly sessions were a part of the regular work day. Staff that worked afternoon and evening shifts were paid over-time to attend.

In addition to having a focusing theme these were problem-solving sessions where staff was critiqued on their performances of the past week. These sessions were used to generate solutions to perceived problems. The typical problems are listed in the themes of the weekly sessions.

The general tone of the meetings was one of excitement and curiosity, generated by the staff's notion that they were involved in a learning experience that was of value to them and the patients.
APPENDIX D

THE WARD ATMOSPHERE SCALE
WAS Subscale Definitions

1. INVOLVEMENT measures how active and energetic patients are in the day-to-day social functioning of the ward, both as members of the ward as a unit and as individuals interacting with other patients. Patient attitudes such as pride in the ward, feelings of group spirit, and general enthusiasm are also assessed.

2. SUPPORT measures how helpful and supportive patients are towards other patients, how well the staff understand patient needs and are willing to help and encourage patients, and how encouraging and considerate doctors are towards patients.

3. SPONTANEITY measures the extent to which the environment encourages patients to act openly and to freely express their feelings towards other patients and the staff.

4. AUTONOMY assesses how self-sufficient and independent patients are encouraged to be in their personal affairs and in their relationships with staff; how much responsibility and self-direction patients are encouraged to exercise; and to what extent the staff is influenced by patient suggestions, criticism and other initiatives.

5. PRACTICAL ORIENTATION assesses the extent to which the patient's environment orients him/her towards preparing himself for release from the hospital and for the future. Such things as training for new kinds of jobs, looking to the future and setting and working toward practical goals are considered.

6. PERSONAL PROBLEM ORIENTATION measures the extent to which patients are encouraged to be concerned with their feelings and problems, and to seek to understand them through openly talking to other patients and staff about themselves and their past.

7. ANGER AND AGGRESSION measures the extent to which a patient is allowed and encouraged to argue with patients and staff, to become openly angry and to display other expressions of anger.
8. ORDER AND ORGANIZATION measures how important order is on the ward, in terms of patients (how they look), staff (what they do to encourage order) and the ward itself (how well it is kept); also measures organization, again in terms of patients (do they follow a regular schedule, do they have carefully planned activities) and staff (do they keep appointments, do they help patients follow schedules).

9. PROGRAM CLARITY measures the extent to which the patient knows what to expect in the day-to-day routine of his ward and how explicit the ward rules and procedures are.

10. STAFF CONTROL measures the extent to which it is necessary for the staff to restrict patient, i.e., in the strictness of rules and schedules, in the relationships between patient and staff, and in measures taken to keep patients under effective controls.
The Ward Atmosphere Scales

<table>
<thead>
<tr>
<th>Scale</th>
<th>Representative Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Involvement</td>
<td>This is a lively ward.</td>
</tr>
<tr>
<td>2. Support</td>
<td>Staff go out of their way to help patients.</td>
</tr>
<tr>
<td>3. Spontaneity</td>
<td>Patients are encouraged to show their feelings.</td>
</tr>
<tr>
<td>5. Practical orientation</td>
<td>Patients are encouraged to learn new ways of doing things.</td>
</tr>
<tr>
<td>6. Personal problem orientation</td>
<td>Personal problems are openly talked about.</td>
</tr>
<tr>
<td>7. Anger</td>
<td>Patients often gripe.</td>
</tr>
<tr>
<td>8. Order</td>
<td>Most patients follow a regular schedule each day.</td>
</tr>
<tr>
<td>9. Program clarity</td>
<td>Ward rules are clearly understood by the patients.</td>
</tr>
<tr>
<td>10. Staff control</td>
<td>Patients who break rules are punished for it.</td>
</tr>
</tbody>
</table>
WARD ATMOSPHERE SCALE QUESTIONS

Directions: This is an inventory. There are no right or wrong answers. Please answer True or False to each question as it applies to you.

1. Patients can leave the ward whenever they want to.
2. Doctors spend more time with some patients than with others.
3. There is very little emphasis on making plans for getting out of the hospital.
4. Staff don't order the patients around.
5. It's hard to get a group together for card games or other activities.
6. Most patients follow a regular schedule each day.
7. Patients talk very little about their pasts.
8. Patients put a lot of energy into what they do around here.
9. Patients sometimes play practical jokes on each other.
10. This is a lively ward.
11. Patients never know when a doctor will ask to see them.
12. Patients can wear what they want.
13. Patients tend to hide their feelings from one another.
14. The healthier patients on this ward help take care of the less healthy ones.
15. This ward emphasizes training for new kinds of jobs.
16. Once a schedule is arranged for a patient, the patient must follow it.
17. Many patients look messy.
18. Patients tell each other about their personal problems.
19. A lot of patients just seem to be passing time on the ward.
20. It's hard to get people to argue around here.
21. The patients know when doctors will be on the ward.
22. There is no patient government on this ward.
23. Patients set up their own activities without being prodded by the staff.
24. Doctors have very little time to encourage patients.
25. Most patients are more concerned with the past than with the future.
26. The staff very rarely punishes patients by restricting them.
27. The ward has very few social activities.
28. Patients' activities are carefully planned.
29. Patients hardly every discuss their sexual lives.
30. The patients are proud of this ward.
31. Patients often gripe.
32. New treatment approaches are often tried on this ward.
33. Things are sometimes very disorganized around here.
34. The staff act on patient suggestions.
35. When patients disagree with each other, they keep it to themselves.
36. The staff know what the patients want.
37. On this ward everyone knows who's in charge.
38. Personal problems are openly talked about.
39. Very few things around here ever get people excited.
40. Staff never start arguments in group meetings.
41. If a patient breaks a rule, he knows what will happen to him.
42. Very few patients have any responsibility on the ward.
43. Patients say anything they want to the doctors.
44. Patients rarely help each other.

45. There is very little emphasis on making patients more practical.

46. Patients can call nursing staff by their first names.

47. This is a very well organized ward.

48. Patients are rarely asked personal questions by the staff.

49. Discussions are pretty interesting on this ward.

50. Patients often criticize or joke about the ward staff.

51. People are always changing their minds here.

52. Patients can leave the ward without saying where they are going.

53. It is hard to tell how patients are feeling on this ward.

54. Staff are interested in following up patients once they leave the hospital.

55. Patients are encouraged to plan for the future.

56. Patients who break the ward rules are punished for it.

57. Patients often do things together on the week-ends.

58. The ward sometimes gets very messy.

59. Staff are mainly interested in learning about patients' feelings.

60. Nobody ever volunteers around here.

61. Patients on this ward rarely argue.

62. If a patient's medicine is changed, a nurse or doctor always tells him why.

63. Staff rarely give in to patient pressure.

64. It's OK to act crazy around here.

65. Doctors sometimes don't show up for their appointments.

66. There is very little emphasis on what patients will be doing after they leave.
67. Patients may interrupt a doctor when he is talking.

68. The staff make sure that the ward is always neat.

69. The patients rarely talk about their personal problems with other patients.

70. Patients are pretty busy all of the time.

71. On this ward staff think it is a healthy thing to argue.

72. Patients never know when they will be transferred from this ward.

73. Patients are expected to take leadership on the ward.

74. Patients tend to hide their feelings from the staff.

75. Patients are encouraged to learn new ways of doing things.

76. Patients will be transferred from this ward if they don't obey the rules.

77. The ward staff help new patients get acquainted on the ward.

78. The day room is often messy.

79. Patients are expected to share their personal problems with each other.

80. Patients here rarely become angry.

81. Staff tell patients when they are getting better.

82. Patients are encouraged to show their feelings.

83. Nurses have very little time to encourage patients.

84. Staff care more about how patients feel than about their practical problems.

85. Patients are rarely kept waiting when they have appointments with staff.

86. The staff set an example for neatness and orderliness.

87. It's not safe for patients to discuss their personal problems around here.

88. Staff sometimes argue with each other.
89. Doctors don't explain what treatment is about to patients.

90. Patients here are encouraged to be independent.

91. Patients are careful about what they say when staff are around.

92. Staff go out of their way to help patients.

93. Patients must make plans before leaving the hospital.

94. It's a good idea to let the doctor know that he is boss.

95. Staff strongly encourage patients to talk about their pasts.

96. There is very little group spirit on this ward.

97. If a patient argues with another patient, he will get into trouble with the staff.

98. Ward rules are clearly understood by the patients.

99. The staff discourages criticism.
APPENDIX E

THE TARGET OUTCOME ASSESSMENT SHEET
<table>
<thead>
<tr>
<th>PROGRAM EVALUATION PROJECT</th>
<th>GOAL 1</th>
<th>GOAL 2</th>
<th>GOAL 3</th>
<th>GOAL 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LEVELS—WHERE ARE YOU ON THE SCALE?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUCH WORSE THAN EXPECTED</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOMEWHAT LESS THAN EXPECTED</td>
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<td></td>
</tr>
<tr>
<td>EXPECTED OR MOST LIKELY RESULT</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>SOMEWHAT BETTER THAN EXPECTED</td>
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<td></td>
</tr>
<tr>
<td>MUCH BETTER THAN EXPECTED</td>
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</tbody>
</table>
APPENDIX F

THE ROTTER INTERNAL-EXTERNAL LOCUS OF CONTROL SCALE
(Social Reaction Inventory)
SOCIAL REACTION INVENTORY

This is a questionnaire to find out the way in which certain important events in our society affect different people. Each item consists of a pair of alternatives lettered a or b. Please select the one statement of each pair (and only one) which you more strongly believe to be the case as far as you're concerned. Be sure to select the one you actually believe to be more true rather than the one you think you should choose or the one you would like to be true. This a measure of personal belief; obviously there are no right or wrong answers.

Please answer those items carefully but do not spend too much time on any one item. Be sure to find an answer for every choice. For each numbered question make an X on the line beside either the a or the b, whichever you choose as the statement most true.

In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the one you more strongly believe to be the case as far as you're concerned. Also try to respond to each item independently when making your choice: do not be influenced by your previous choice.

REMEMBER

Select that alternative which you personally believe to be more true.
1. a. Children get into trouble because their parents punish them too much.
   b. The trouble with most children nowadays is that their parents are too easy with them.

2. a. Many of the unhappy things in people's lives are partly due to bad luck.
   b. People's misfortunes result from the mistakes they make.

3. a. One of the major reasons why we have wars is because people don't take enough interest in politics.
   b. There will always be wars, no matter how hard people try to prevent them.

4. a. In the long run, people get the respect they deserve in this world.
   b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. a. The idea that teachers are unfair to students is nonsense.
   b. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. a. Without the right breaks one cannot be an effective leader.
   b. Capable people who fail to become leaders have not taken advantage of their opportunities.

7. a. No matter how hard you try, some people just don't like you.
   b. People who can't get others to like them don't understand how to get along with others.

8. a. Heredity plays the major role in determining one's personality.
   b. It is one's experiences in life which determine what they're like.
9. a. I have often found that what is going to happen will happen.
   b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10. a. In the case of the well prepared student there is rarely, if ever, such a thing as an unfair test.
    b. Many times exam questions tend to be so unrelated to course work, that studying is really useless.

11. a. Becoming a success is a matter of hard work; luck has little or nothing to do with it.
    b. Getting a good job depends mainly on being in the right place at the right time.

12. a. The average citizen can have an influence in government decisions.
    b. This world is run by the few people in power, and there is not much the little guy can do about it.

13. a. When I make plans, I am almost certain that I can make them work.
    b. It is not always wise to plan too far ahead because many times things turn out to be a matter of good or bad fortune anyhow.

14. a. There are certain people who are just no good.
    b. There is some good in everybody.

15. a. In my case getting what I want has little or nothing to do with luck.
    b. Many times we might just as well decide what to do by flipping a coin.

16. a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
    b. Getting people to do the right thing depends upon ability; luck as little or nothing to do with it.

17. a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.
    b. By taking an active part in political and social affairs, the people can control world events.
18. a. Most people can't realize the extent to which their lives are controlled by accidental happenings.
   
   b. There really is no such thing as "luck".

19. a. One should always be willing to admit his mistakes.
   
   b. It is usually best to cover up one's mistakes.

20. a. It is hard to know whether or not a person really likes you.
   
   b. How many friends you have depends upon how nice a person you are.

21. a. In the long run, the bad things that happen to us are balanced by the good ones.
   
   b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. a. With enough effort we can wipe out political corruption.
   
   b. It is difficult for people to have much control over the things politicians do in office.

23. a. Sometimes I can't understand how teachers arrive at the grades they give.
   
   b. There is a direct connection between how hard I study and the grades I get.

24. a. A good leader expects people to decide for themselves what they should do.
   
   b. A good leader makes it clear to everybody what their jobs are.

25. a. Many times I feel that I have little influence over the things that happen to me.
   
   b. It is impossible for me to believe that chance or luck plays an important role in my life.

26. a. People are lonely because they don't try to be friendly.
   
   b. There's not much use trying too hard to please people; if they like you, they like you.
27. a. There is too much emphasis on athletics in high school.

       b. Team sports are an excellent way to build character.

28. a. What happens to me is my own doing.

       b. Sometimes I feel that I don't have much control over the direction my life is taking.

29. a. Most of the time I can't understand why politicians behave the way they do.

       b. In the long run the people are responsible for bad government on a national as well as on a local level.
APPENDIX G

THE SIXTEEN PERSONALITY FACTOR QUESTIONNAIRE

(16 PF)
Directions: This is an inventory. There are no correct or incorrect answers. Please circle the answer to each question as they apply to you. Answer each question with your first impression.

1. I think my memory is better than it ever was.
   a. yes,       b. in between,   c. no.

2. I can easily go a whole morning without wanting to speak to anyone.
   a. often,     b. sometimes,    c. never.

3. If I say that water is "dry" and the sun is "cold", I would say that "found" means the same as:
   a. gone,      b. lost,        c. unknown.

4. I generally go to bed at night feeling that I've had a satisfying day.
   a. true,      b. in between,  c. false.

5. If I had plenty of money, I would:
   a. be careful not to make other people envious,
      b. uncertain
      c. show people how to live well.

6. The worst punishment for me would be:
   a. hard labour,
      b. uncertain,
      c. to be shut up alone.

7. If my income were more than enough for ordinary daily needs, I would feel I should give the rest to a church or other worthwhile cause.
   a. yes,      b. uncertain,   c. no.

8. I'm the one who takes the first step in making new friendships.
   a. usually,  b. sometimes,   c. never.

9. On a free evening, I would prefer to read about:
   a. how to talk to people from abroad,
      b. uncertain,
      c. military defense against the enemy.
10. Most people "go lazy" on a job if they can get away with it.
   a. yes.   b. uncertain,   c. no.

11. When I was a child, I more often spent free time:
   a. building something,
   b. in between,
   c. reading.

12. I am much more fortunate than most people in being able to do the things I like.
   a. yes,   b. uncertain,   c. no.

13. I can always forget trivial, unimportant things that I have done wrong.
   a. yes,   b. in between,   c. no.

14. If I had a lot of money to give to charity, I would give it:
   a. all to scientific research,
   b. half to each,
   c. all to churches.

15. A seaside beach would be more appealing to me if there were:
   a. no people around,
   b. in between,
   c. lots of families at play.

16. If I were to mix alcoholic drinks at a party, I'd probably:
   a. try to make them exactly as people want them,
   b. uncertain,
   c. surprise people by making them strong.

17. I often jump to conclusions.
   a. yes,   b. in between,   c. no.

18. I have sometimes, even if briefly, had hateful feelings toward my parents.
   a. yes,   b. in between,   c. no.
19. I would prefer to be:
   a. a business executive who attends one meeting after another,
   b. uncertain,
   c. a research scientist.

20. I think the opposite of "right" is the opposite of:
   a. left,       b. wrong,       c. correct.

21. I feel that my emotions are:
   a. well satisfied,
   b. only partly satisfied,
   c. very little satisfied.

22. I admire more the person, who, when asked his opinion:
   a. wants to be sure of the details before deciding,
   b. in between,
   c. speaks right up, and shows where he stands.

23. I love to make people laugh with funny stories.
   a. yes,       b. in between,   c. no.

24. I think most people take life:
   a. too seriously,
   b. in between,
   c. not seriously enough.

25. During an interview, whether it's important or not, I:
   a. feel "on edge" and ill at ease,
   b. in between,
   c. feel confident and composed.

26. My friends are more likely:
   a. to ask me for advice,
   b. in between,
   c. to give me advise.

27. I think most people take their duties to the community seriously enough.
   a. true,      b. in between,   c. false.
28. There are some areas of knowledge that are better left alone.
   a. true, b. in between, c. false.

29. If I feel like telling someone just what I think of him, I:
   a. go right ahead and speak the truth,
   b. in between,
   c. first consider the consequences of my doing so.

30. I have more ups and downs in mood than most people I know.
   a. yes, b. in between, c. no.

31. Today we need more logical, cool thinking in social matters and less attachment to older ideas and loyalties.
   a. yes, b. in between, c. no.

32. I prefer to eat lunch:
   a. with lots of other people,
   b. in between,
   c. by myself.

33. I'm careful and practical about things so that I have fewer accidents than most people.
   a. yes, b. in between, c. no.

34. When something unexpected happens, I:
   a. remain very composed or calm,
   b. in between,
   c. become extremely nervous or tense.

35. It's hard for me to admit it when I'm wrong.
   a. yes, b. sometimes, c. no.

36. Which word does not belong with the other two?
   a. by, b. after, c. near.

38. I have some special fears, for example, of certain animals, or being shut in, or crossing wide streets, or being alone in the dark, and so on.
   a. yes, b. in between, c. no.
39. I really can't blame people for trying to grab what they can.
   a. true,   b. in between,   c. false.

40. If I had to choose one, I'd prefer a vacation which was:
   a. relaxing,
   b. in between,
   c. filled with activities.

41. I value good manners and respect for rules, more than easy living.
   a. true,   b. in between,   c. false.

42. When I'm in a group of strangers, I'm usually one of the last to express my opinion publicly.
   a. yes,   b. in between,   c. no.

43. I enjoy learning to work new gadgets in everyday things, from can openers to cars.
   a. yes,   b. in between,   c. no.

44. When people secretly say bad things about me, I:
   a. forget it,
   b. in between,
   c. try to catch them at it.

45. In intellectual interests, my parents are (were):
   a. above average,
   b. average,
   c. a bit below average.

46. Many popular magazines are concerned with writing what most people want to read rather than with the truth.
   a. yes,   b. in between,   c. no.

47. I never let myself get depressed over trifles.
   a. true,   b. in between,   c. false.

49. There are times, every day, when I want to enjoy my own thoughts, uninterrupted by other people.
   a. yes,   b. in between,   c. no.
50. When I'm talking to people, outside noises, passersby, etc., don't draw my attention away from what I'm doing.

a. true,  b. in between,  c. false.

52. When I know I'm doing the right thing, I find my task easy.

a. always,  b. sometimes,  c. seldom.

53. I'd prefer a job which requires lots of decisions in dealing with people.

a. true,  b. uncertain,  c. false.

54. "Hot" is to "warm" as "mountain" is to:

a. slope,  b. plain,  c. hill.

55. I get over disappointments:

a. quickly,  b. in between,  c. slowly.

56. If I don't get my way with a clerk in a large company, I don't hesitate to go to her superior.

a. true,  b. in between,  c. false.

57. I take it on myself to liven up a dull party.

a. often,  b. sometimes,  c. never.

58. When I need immediately the use of something belonging to a friend but he's out, I think it's all right to borrow it without his permission.

a. yes,  b. in between,  c. no.

59. I can easily start to talk with a group of strangers in a bus or waiting room.

a. yes,  b. in between,  c. no.

60. As a job, I would prefer:

a. writing or editing children's books,  
b. uncertain,  
c. repairing electrical machines.

61. Even in an important game, I am more concerned with enjoying it than with who wins.

a. always,  b. generally,  c. occasionally.
62. I would rather think about my ideas than take part in athletic games.
   a. yes,       b. in between,    c. no.
63. I think it is wiser to keep the nation's military forces strong than just to depend on international goodwill.
   a. yes,       b. in between,    c. no.
64. I'm more easily upset by bad news than most people I know.
   a. true,      b. uncertain,     c. false.
65. When I'm with a group of people, I agree with their ideas so that no arguments will arise.
   a. usually,   b. in between,    c. I often disagree.
66. I would rather spend a free evening:
   a. with a good book,
   b. uncertain,
   c. working on a hobby with friends.
67. I like to find excuses to put off work and have fun instead.
   a. often,     b. sometimes,     c. rarely.
68. When I'm criticized, it disturbs me badly.
   a. yes,       b. in between,    c. no.
69. My mind doesn't work so clearly at some times as it does at others.
   a. true,      b. in between,    c. false.
70. I talk to people:
    a. to make them feel comfortable,
    b. in between,
    c. only when I have something to say.
71. I think the proper number to carry on the series 1, 3, 2, 4, 3, 5, is:
   a. 4,         b. 6,            c. 8.
72. I have the feeling that my blood pressure goes up very quickly when someone annoys me.
   a. yes,    b. in between,    c. no.

73. If I had to tell a person a deliberate lie, I'd have to look away, being ashamed to look him in the eye.
   a. true,    b. uncertain,    c. false.

74. I would rate myself as a relatively casual and lighthearted person.
   a. yes,    b. in between,    c. no.

75. The sight of littered, untidy streets makes me cross.
   a. true,    b. in between,    c. false.

76. I would like a job where I:
   a. have a lot of responsibility and can show my competence.
   b. in between,
   c. would be given definite tasks so that I always know what I'm supposed to do.

77. I would prefer to have:
   a. more money,
   b. uncertain,
   c. more time for thinking about life.

78. If anyone betrays my trust, I:
   a. get very angry with him,
   b. in between,
   c. soon forgive him.

79. Newspaper accounts of everyday dangers and accidents:
   a. make rather dull, trivial reading,
   b. in between,
   c. hold my attention.

80. I can do hard physical work without feeling worn out as quickly as most people do.
   a. yes,    b. sometimes,    c. no.
81. I don't feel guilty if I'm scolded for something I didn't do.
   a. true,       b. uncertain,       c. false.

82. I would rather be known for:
   a. relying or depending on well-tried methods,
   b. in between,
   c. always trying new ideas.

83. I like to keep track, at least roughly, of where money is spent.
   a. yes,       b. sometimes,       c. no.

84. When I have to face a hard day of work, I:
   a. wish it would never come,
   b. in between,
   c. look on it as a challenge.

85. If I can't seem to solve a problem, I:
   a. try harder,
   b. in between,
   c. feel the problem is too hard for me.

86. I may be less considerate of other people than they are of me.
   a. true,       b. sometimes,       c. false.

87. In my spare time I would rather join:
   a. a hiking and exploring club,
   b. uncertain,
   c. a community service organization.

88. I have pots numbered 1, 2, 3, and 4. Each holds twice as much as the next lower number. After I pour from a full 4 into an empty 3, how many half-full 1's can I still fill from 4?
   a. 2,       b. 4,       c. 8.

89. When I get up in the morning, I feel I can hardly face the day.
   a. often,       b. sometimes,       c. never.
90. If we are lost in a city and my companions disagree with me on the best way, I:
   a. happily go my own way,
   b. in between,
   c. make a fuss, and follow them.

91. I would rather listen to music:
   a. alone at home,
   b. uncertain,
   c. with an audience in a large auditorium.

92. When I'm in bed with the flu or a bad cold:
   a. I enjoy it as a sort of vacation,
   b. uncertain,
   c. I feel worried and concerned about not working.

93. I feel I would have a great deal of difficulty giving a speech before an audience of strangers.
   a. true,       b. uncertain,       c. false.

94. Some of the things I enjoy involve the the thrill of danger.
   a. yes,       b. in between,       c. no.

95. Most people get too upset over things of no importance.
   a. true,       b. uncertain,       c. false.

96. I'd prefer:
   a. to go camping,
   b. in between,
   c. to attend an outdoor musical performance.

97. When I have to tell a friend something he won't like, I:
   a. get it done at the first opportunity,
   b. in between,
   c. put it off as long as possible.

98. I sometimes feel sorry for all the people in the world.
   a. yes,       b. in between,       c. no.
99. I most enjoy a meal if it consists of:
   a. unusual, exotic foods,
   b. uncertain,
   c. standard, regular foods.

100. I enjoy being considered part of the group when my neighbours do anything.
   a. true,       b. in between,   c. false.

101. At times I feel like smashing things.
   a. true,       b. in between,   c. false.

102. Before a test or examination, I:
   a. get tense and wrapped up in what's coming,
   b. in between,
   c. keep quite calm.

103. I may deceive people by being friendly when I really dislike them.
   a. yes,        b. sometimes,   c. no.

104. Which word does not belong with the other two?
   a. lead,       b. win,         c. succeed.

105. If Susan's mother's sister is Judy's great aunt, what relation is Judy's great aunt to Susan?
   a. grandma,    b. aunt,        c. mother.
List of Questions for
Factors C, E, F, O, Q₄

C  1. I generally go to bed at night feeling that I've had a satisfying day.
   a. true,    b. in between,    c. false.

E  2. If I had plenty of money, I would:
   a. be careful not to make other people envious,
   b. uncertain
   c. show people how to live well.

F  3. The worst punishment for me would be:
   a. hard labour,
   b. uncertain,
   c. to be shut up alone.

O  4. I can always forget trivial, unimportant things that I have done wrong.
   a. yes,    b. in between,    c. no.

Q₄  5. I often jump to conclusions.
    a. yes,    b. in between,    c. no.

C  6. I feel that my emotions are:
    a. well satisfied,
    b. only partly satisfied,
    c. very little satisfied.

E  7. I admire more the person, who, when asked his opinion:
    a. wants to be sure of the details before deciding,
    b. in between,
    c. speaks right up, and shows where he stands.

F  8. I love to make people laugh with funny stories.
    a. yes,    b. in between,    c. no.

O  9. I have more ups and downs in mood than most people I know.
    a. yes,    b. in between,    c. no.
Q4 10. When something unexpected happens, I:
   a. remain very composed or calm,
   b. in between,
   c. become extremely nervous or tense.

C 11. I have some special fears, for example, of certain animals, or being shut in, or crossing wide streets, or being alone in the dark, and so on.
   a. yes,       b. in between,    c. no.

E 12. I really can't blame people for trying to grab what they can.
   a. true,      b. in between,    c. false.

F 13. If I had to choose one, I'd prefer a vacation which was:
   a. relaxing,
   b. in between,
   c. filled with activities.

   a. true,      b. in between,    c. false.

Q4 15. When I'm talking to people, outside noises, passersby, etc., don't draw my attention away from what I'm doing.
   a. true,      b. in between,    c. false.

C 16. I get over disappointments:
   a. quickly,    b. in between,    c. slowly.

E 17. If I don't get my way with a clerk in a large company, I don't hesitate to go to her superior.
   a. true,      b. in between,    c. false.

F 18. I take it on myself to liven up a dull party.
   a. often,      b. sometimes,    c. never.

O 19. I'm more easily upset by bad news than most people I know.
   a. true,      b. uncertain,     c. false.
20. When I'm criticized, it disturbs me badly.
   a. yes,    b. in between,    c. no.

21. I have the feeling that my blood pressure goes up very quickly when someone annoys me.
   a. yes,    b. in between,    c. no.

22. If I had to tell a person a deliberate lie, I'd have to look away, being ashamed to look him in the eye.
   a. true,    b. uncertain,    c. false.

23. I would rate myself as a relatively casual and lighthearted person.
   a. yes,    b. in between,    c. no.

24. I don't feel guilty if I'm scolded for something I didn't do.
   a. true,    b. uncertain,    c. false.

25. If I can't seem to solve a problem, I:
   a. try harder,
   b. in between,
   c. feel the problem is too hard for me.

26. When I get up in the morning, I feel I can hardly face the day.
   a. often,    b. sometimes,    c. never.

27. If we are lost in a city and my companions disagree with me on the best way, I:
   a. happily go my own way,
   b. in between,
   c. make a fuss, and follow them.

28. I would rather listen to music:
   a. alone at home,
   b. uncertain,
   c. with an audience in a large auditorium.

29. I sometimes feel sorry for all the people in the world.
   a. yes,    b. in between,    c. no.
Q4 30. Before a test or examination, I:
   a. get tense and wrapped up in what's coming,
   b. in between,
   c. keep quite calm.
APPENDIX H

INFORMED CONSENT LETTER
Currently we are evaluating the effectiveness of the treatment on our unit in an effort to up-grade our services. We are asking that you help us with this effort by completing three brief groups of information surveys. We wish to collect information at the beginning of treatment, later during your treatment, and once after you leave. The information gathered is confidential and your identity will remain anonymous. Participation in these surveys is voluntary. If you want to refuse to participate, you need only say so. You may stop completing the requested information whenever you choose, and there will be no repercussions. Such information will help us to offer a more effective and efficient service to our clients.

Your signature below indicates that you have read this letter, understand its contents, and agree to participate in this effort.

__________________________
patient's signature
APPENDIX I

CHRONOLOGY OF EVENTS FOR THE GASP
An Estimate of Chronology of Events
for One Patient in the GASP

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Enter hospital, sign informed consent letter to participate in research.</td>
<td>4/15</td>
</tr>
<tr>
<td>2) Intake interview.</td>
<td>4/15</td>
</tr>
<tr>
<td>3) Pre-test 16 PF and I-E Scale (Social Reaction Inventory)</td>
<td>4/15</td>
</tr>
<tr>
<td>4) Initial Treatment Conference.</td>
<td>4/16</td>
</tr>
<tr>
<td>5) Problems and levels determined on Target Outcome Assessment Sheets</td>
<td>4/18</td>
</tr>
<tr>
<td>6) Problems categorized according to: Self, family, peer, and work.</td>
<td>4/18</td>
</tr>
<tr>
<td>7) Eight days following identification of client's problems and levels: (a) client completes Target Outcome Assessment Sheet, 16 PF and I-E Scale (Social Reaction Inventory); (b) check made on percentage of agreement between client problems upon admission and goals identified via GASP; (c) determination made of percentage of agreement in direction of goal/problem.</td>
<td>4/26</td>
</tr>
</tbody>
</table>
APPENDIX J

CHRONOLOGY OF EVENTS FOR THE NON-EQUIVALENT CONTROL GROUP
An Estimate of Chronology of Events for One Patient
In The Non-Equivalent Control Group

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Enter hospital, sign informed consent letter to participate in research.</td>
<td>5/1</td>
</tr>
<tr>
<td>2) Intake interview.</td>
<td>5/1</td>
</tr>
<tr>
<td>3) Pre-test 16 PF and I-E Scale.</td>
<td>5/1</td>
</tr>
<tr>
<td>4) Initial Treatment Conference</td>
<td>5/2</td>
</tr>
<tr>
<td>5) Problems and levels determined on Target Outcome Assessment Sheet</td>
<td>5/3</td>
</tr>
<tr>
<td>6) Eight days following identification of client's problems and levels: (a) client completes Target Outcome Assessment Sheet, 16 PF and I-E Scale</td>
<td>5/11</td>
</tr>
</tbody>
</table>
APPENDIX K

THE CLIENT SATISFACTION QUESTIONNAIRE

FOR THE GASP
Client Satisfaction Questionnaire

1. Now that you have left the hospital, how do you feel in relation to your problem(s)?
   1. ___ Much better
   2. ___ Somewhat better
   3. ___ No improvement
   4. ___ Slightly worse
   5. ___ Much worse

2. If family or friends were involved in your treatment, how helpful did you find this experience?
   1. ___ Very helpful
   2. ___ Somewhat helpful
   3. ___ Not helpful at all
   4. ___ Made things worse

Comments ________________________________________

3. During your hospital stay, did you generally receive the hopeful feeling, from people you were involved with, that your problem(s) could be resolved?
   1. ___ Yes
   2. ___ Conflicting, yes and no
   3. ___ No
4. During your hospital stay, how did you feel in respect to the amount of time that was spent with you by your therapist and other staff members?
   1. ____ More than enough time was spent with me
   2. ____ Sufficient time was spent with me
   3. ____ Not enough time was spent with me

Please evaluate the following ward program activities by placing an "X" beside the appropriate response:

5. **Morning Community Meeting** (Large meeting where all patients and staff talk about concerns on the ward)
   1. ____ Very helpful
   2. ____ Moderately helpful
   3. ____ Not helpful
   4. ____ Made things worse
   5. ____ Did not participate

Comments or suggestions_________________________________________

6. **Goals Group** (Patients meet with therapists and other staff to discuss only goals)
   1. ____ Very helpful
   2. ____ Moderately helpful
   3. ____ Not helpful
   4. ____ Made things worse
   5. ____ Did not participate

Comments or suggestions_________________________________________
7. **Evening Group**
   1. _____ Very helpful
   2. _____ Moderately helpful
   3. _____ Not helpful
   4. _____ Made things worse
   5. _____ Did not participate
   Comments or suggestions_________________________________

8. **Chart Group**
   1. _____ Very helpful
   2. _____ Moderately helpful
   3. _____ Not helpful
   4. _____ Made things worse
   5. _____ Did not participate
   Comments or suggestions_________________________________

9. **Did you participate in family conferences?**
   1. _____ Yes
   2. _____ No
   If yes, how were family conferences?
   1. _____ Very helpful
   2. _____ Moderately helpful
   3. _____ Not helpful
   4. _____ Made things worse
   5. _____ Did not participate
   Comments or suggestions_________________________________
10. **Occupational Therapy**

1. _____ Very helpful
2. _____ Moderately helpful
3. _____ Not helpful
4. _____ Made things worse
5. _____ Did not participate

Comments or suggestions

---

11. **Individual talks with your psychiatrist and other staff members**

1. _____ Very helpful
2. _____ Moderately helpful
3. _____ Not helpful
4. _____ Made things worse
5. _____ Did not participate

Comments or suggestions

---

12. **Informal discussions with other patients**

1. _____ Very helpful
2. _____ Moderately helpful
3. _____ Not helpful
4. _____ Made things worse
5. _____ Did not participate

Comments
13. **Free Leisure Time**

1. ___ Very helpful
2. ___ Moderately helpful
3. ___ Not helpful
4. ___ Made things worse
5. ___ Did not participate

Comments or suggestions

14. **Other (Please specify)**

Comments or suggestions

1. ___ Very helpful
2. ___ Moderately helpful
3. ___ Not helpful
4. ___ Made things worse
5. ___ Did not participate

15. Thinking back over your hospital stay, what do you think were the three most helpful activities you participated in?

Comments or suggestions

16. Do you have any general comments or suggestions as to how we could have helped you more?

Comments or suggestions
APPENDIX L

THE CLIENT SATISFACTION QUESTIONNAIRE FOR
THE NON-EQUIVALENT CONTROL GROUP
Client Satisfaction Questionnaire

1. Now that you have left the hospital, how do you feel in relation to your problem(s)?
   1. _____ Much better
   2. _____ Somewhat better
   3. _____ No improvement
   4. _____ Slightly worse
   5. _____ Much worse

2. If family or friends were involved in your treatment, how helpful did you find this experience?
   1. _____ Very helpful
   2. _____ Somewhat helpful
   3. _____ Not helpful at all
   4. _____ Made things worse

   Comments

3. During your hospital stay, did you generally receive the hopeful feeling, from people you were involved with, that your problem(s) could be resolved?
   1. _____ Yes
   2. _____ Conflicting, yes and no
   3. _____ No
4. During your hospital stay, how did you feel in respect to the amount of time that was spent with you by your therapist and other staff members?
   1. ___ More than enough time was spent with me
   2. ___ Sufficient time was spent with me
   3. ___ Not enough time was spent with me

Please evaluate the following ward program activities by placing an "X" beside the appropriate response:

5. Morning Community Meeting (Large meeting where all patients and staff talk about concerns on the ward)
   1. ___ Very helpful
   2. ___ Moderately helpful
   3. ___ Not helpful
   4. ___ Made things worse
   5. ___ Did not participate

Comments or suggestions________________________________________

6. Did you meet with patients and staff to discuss only goals?
   1. ___ Yes
   2. ___ No

7. Evening Group
   1. ___ Very helpful
   2. ___ Moderately helpful
   3. ___ Not helpful
   4. ___ Made things worse
   5. ___ Did not participate

Comments or suggestions________________________________________
8. Chart Group
   1. _____ Very helpful
   2. _____ Moderately helpful
   3. _____ Not helpful
   4. _____ Made things worse
   5. _____ Did not participate
   Comments or suggestions________________________________________________

9. Did you participate in family conferences?
   1. _____ Yes
   2. _____ No
   If yes, how were family conferences?
   1. _____ Very helpful
   2. _____ Moderately helpful
   3. _____ Not helpful
   4. _____ Made things worse
   5. _____ Did not participate
   Comments or suggestions________________________________________________

10. Occupational Therapy
    1. _____ Very helpful
    2. _____ Moderately helpful
    3. _____ Not helpful
    4. _____ Made things worse
    5. _____ Did not participate
    Comments or suggestions________________________________________________
11. Individual talks with your psychiatrist and other staff members

1. _____ Very helpful
2. _____ Moderately helpful
3. _____ Not helpful
4. _____ Made things worse
5. _____ Did not participate
Comments or suggestions

12. Informal discussions with other patients

1. _____ Very helpful
2. _____ Moderately helpful
3. _____ Not helpful
4. _____ Made things worse
5. _____ Did not participate
Comments

13. Free Leisure Time

1. _____ Very helpful
2. _____ Moderately helpful
3. _____ Not helpful
4. _____ Made things worse
5. _____ Did not participate
Comments or suggestions
14. Other (Please specify)

________________________________________________________________________

1. ___ Very helpful
2. ___ Moderately helpful
3. ___ Not helpful
4. ___ Made things worse
5. ___ Did not participate

15. Thinking back over your hospital stay, what do you think were the three most helpful activities you participated in?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

16. Do you have any general comments or suggestions as to how we could have helped you more?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________