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The Development of an Interpersonal-Developmental-Existential Assessment Inventory for Determining Therapeutic Focus

Charles A. Pap

THE DEVELOPMENT OF AN INTERPERSONAL-DEVELOPMENTAL-EXISTENTIAL ASSESSMENT INVENTORY FOR DETERMINING THERAPEUTIC FOCUS

by
Charles A. Pap
Bachelor of Science, University of Illinois-Champaign-Urbana, 1984
Master of Science, University of Wisconsin-Stout, 1989

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ABSTRACT

Increasingly, insurance companies, legislators, and funding agencies have examined the efficacy of psychotherapy and counseling, and have moved towards the briefer forms of therapy. Though some clinicians resist a move to greater accountability, the majority are concerned with providing an effective service to individuals, couples, and families experiencing biopsychosocial difficulties. This study involved the development of an instrument that will assist therapists in determining a therapeutic focus, which is seen as an important component in brief psychotherapy.

There were two distinct phases to this study. In Phase One, intake interviews at a large Midwestern university counseling center were audiotaped. Using a content analysis these interviews were examined using Budman and Gurman's (1986) Interpersonal-Developmental-Existential model as a coding strategy. Client statements were then translated into item form, using the client's actual statement with changes made to fit the item response options. In Phase Two, the test constructed, the 129 item IDE Assessment Inventory (IDEA), was given to 394 undergraduate psychology students. Items were analyzed using Principal Components Analysis, a correlation matrix of item to scale Pearson correlation coefficients, and a measure of scale homogeneity, the separation index. Estimates of scale reliability were made using Chronbach's coefficient alpha.

Results showed that the four scales were relatively homogeneous and reliable. Using the item analysis statistics, items were moved, deleted or retained. In the final obtained composition there were 16 items in the Interpersonal scale, 14 in the Developmental, 15 in Existential, and 20 in the Defense Style scale. Further research is needed in using the IDE Assessment Form with actual counseling clients, to determine its utility. Additionally, future studies will be aimed at establishing construct validity of the inventory.

CHAPTER ONE

Increasingly, insurance companies, legislators, and funding agencies have examined the efficacy of psychotherapy and counseling (Budman and Gurman, 1988). Though some clinicians resist a move to greater accountability, the majority are concerned with providing an effective service to individuals, couples, and families experiencing biopsychosocial difficulties. Brief psychotherapy, widely accepted as therapy lasting twenty five sessions or less (Garfield and Bergin, 1986), has increased in popularity and acceptance during the last decade. Once thought to be less effective than long-term therapy, it is now seen as a clinical reality. Most clients do not desire to be in long term therapy, but rather look for the alleviation of a relatively specific problem (Garfield and Bergin, 1986).

Psychoanalytic and psychodynamic thought have dominated the delivery of psychotherapeutic services for the majority of this century. In part, this has dictated that successful psychotherapy must be long term in nature. This view stems from the belief that since the personal difficulties of the client developed over a number of years, then a similarly long duration would be needed to provide significant improvement (Garfield, 1989). In recent times, with innovations in short term psychodynamic theory, and other forms of brief therapy, there has been increasing acceptance of the clinician who chooses to use a time-limited approach.

Upon seeing or hearing from a prospective client for the first time the most obvious question is: "Why now?", or of all the possible moments that this person could have understandably sought treatment, why did he or she do so at this particular

time? Budman and Gurman (1988) have proposed a theoretical structure to help conceptualize why most clients seek out psychotherapeutic services, when they do. Of primary importance, in their theory, are three focus domains: interpersonal, developmental, and existential. Some themes that are addressed under these domains are: (1) interpersonal: interpersonal conflict, attachment, major social support changes (improvement or deterioration), sexual relationships, "outside" pressure to change; (2) developmental: developmental dysychronies, approximate developmental stage, significant or recent anniversaries, use of alcohol and other drugs; (3) existential: losses, one's own mortality, finiteness and limitations, freedom and responsibility, individuation and separation (Budman & Gurman, 1988). These themes, under the broader domains, can be used to guide therapist decisions regarding the most appropriate focus for treatment.

Budman and Gurman stress that it is the brief therapist's responsibility to choose the most salient issue that the client brings to therapy, and, rather than "flying by the seat of your pants", maintain a therapeutic focus throughout the course of treatment. This approach assumes that the client will not be able to address all the possible issues in their lives at any given moment in time, but rather that they may return at some later point to work on a similar, or as yet unknown issue.

This rather simple question, "Why now?" has led me to study brief psychotherapy, and to propose development of an instrument that will facilitate the processes involved in the briefer forms of psychotherapy. This instrument may be especially useful with populations that are relatively free from pathology, or put in other terms; as an assessment instrument for the adjustment disorders. Although the use of such an instrument would not be ruled out for the more severe disorders. The traditional diagnostic guide, the Diagnostic and Statistical Manual III-R, offers a

rigorous description of abnormal behavior. However, for those individuals described more appropriately as suffering from an adjustment disorder, there is little guidance for the therapist upon which to base assessment, and subsequently, treatment.

If an individual is having relationship difficulties, is stuck at a developmental stage without much understanding of why growth is blocked, or is experiencing a lack of meaning in his/her life, there is little other than clinical intuition on which to base treatment. Given the mandate by legislatures, insurance companies, employment assistance programs, and agencies with limited resources to provide efficient and effective service in a relatively short period of time, there seems to be a gap in the structured format of assessment for life adjustment problems. In understanding the move toward more efficient and effective counseling and psychotherapeutic interventions, it becomes clearer that there are few empirically tested assessment and diagnostic tools for the populations most commonly seen at university counseling centers, employee assistance program, or many private practices.

There has been much attention paid to making psychotherapy more viable for a broader segment of the general population (Garfield, 1989). However, most of the discussion has revolved around the relative merits of one theoretical orientation over another. My intent in this study was to develop an assessment tool that encompassed many orientations, and might prove useful to a broad range of psychotherapists.

Through the review of literature, I will summarize the range of theory regarding brief psychotherapy. Including those from short term psychodynamic theory, Strupp and Binder (1984), Mann (1981), and Sifneos (1979), Interpersonal psychotherapy Klerman, Weissman, Rounsaville, and Chevron (1984), and cognitive therapy (Beck, Rush, and Shaw, 1979).

This study, then, examined how well the interpersonal-developmental-existential organization describes the most common foci presented by students seeking services at a university counseling center. The goal was to create and empirically test an intake instrument that will allow counselors and therapists to make clinically relevant inferences regarding the reasons an individual seeks help. Ideally, this instrument, when combined with the initial intake, will allow the therapist to move more rapidly from the assessment phase to the therapeutic phase of treatment.

CHAPTER TWO

The appropriate length for psychotherapy has been a matter of discussion for a number of years. With the popularity of psychoanalysis during the majority of this century, the ideal length of therapy tended to be long and intensive. It is interesting to note, however, that Freud initially identified the length of treatment to be about six months to a year, with the hope that as the method became perfected the time required might be shortened (Garfield, 1989).

Budman and Gurman (1988) assert that brief psychotherapy cannot be reliably or meaningfully defined in terms of number of visits or time elapsed since therapy was initiated. Brief therapy, rather, involves a set of limitations on service delivery system resources. The techniques of brief therapy are derived from these attitudinal and systemic limiting factors. Attitudinally, planned brief therapy requires that the therapist and the client agree and accept a set of values as to what therapy can and cannot do.

Practitioners of all the psychotherapies, according to Budman and Gurman, have spoken and unspoken values regarding the ideal manner in which their specific therapy is practiced. I will summarize the differences that Budman and Gurman identify between long and short term psychotherapists. The long-term psychoanalytically oriented therapist almost always seeks major character change, and may view such change as synonymous with cure. The long-term therapist is likely to endorse the assumption that only a significant and continuing therapeutic relationship with a trained therapist can begin to chip away at psychological

pathology. Personalities, tend to be seen by the long-term therapist, as largely static and immutable. Another common belief of long-term therapists is that the particular problem the patient presents as a reason for seeking help is only a representation of a larger, more deeply embedded pathology. Symptomatic improvements are seen as not genuine in and of themselves.

In long term therapy, the therapist and client are likely to experience an indefiniteness of time, a sense that the therapist will be there as long as it is necessary, or put another way, the work of treatment will expand to fill the time available for it. Additionally, the long term therapist almost always sees therapy as benign and useful. Finally, Budman and Gurman assert that long term therapists believe that therapy should be the most important part of a client's life.

The brief therapist, conversely, attempts to use the least radical procedure that is available. Therapy begins with the least costly, least complicated, and least invasive treatment first. The brief therapist holds parsimony of intervention as a core value.

The brief therapist views "cure" as impossible. The human condition is seen as pervaded by anxieties, doubts, losses, changes, and conflicts. Regardless of how long someone is in therapy they will not be transformed into someone who is always sensitive, assertive, insightful, responsible or in any way "finished" in their development. Brief therapists view people as constantly changing and developing. The therapist, then, may help in negotiating some of life's important tasks, and since it is understood that change is inevitable, to some degree, for everyone, and that the therapist's responsibility is to facilitate developmental growth.

The brief therapist takes the presenting problem seriously and hopes to make changes in some of the areas that the client specifies as important. For those

individuals who cannot give a specific focus of their distress the therapist and client must first define the problem collaboratively and then consensually determine a treatment plan.

The brief therapist realizes that significant change may occur after termination, and therefore the therapist may never see, or be recognized for change. The brief therapist sees therapy as "for better and for worse", or in other words not everyone who seeks treatment will necessarily benefit or even need such treatment. The short term therapist realizes that in some cases, such as "therapy addicts" or chronically dependent, the best course of action would be a minimal intervention that encourages change and action.

The brief therapist sees being in the world as more important than being in therapy. Most short term therapists are present-oriented, and tend to focus on current relationships, present-centered problems, and ongoing life situations.

Below is a summary of Budman and Gurman's (1988) comparison of values between long term and short term therapists:

Long term therapist	Short term therapist
1. Seeks change in basic character.	Prefers pragmatism, parsimony, and least radical intervention, and does not believe in the notion of "cure".
2. Believes that significant psychological change is unlikely in everyday life .	Maintains an adult developmental perspective from which significant psychological change is viewed as inevitable.
3. Sees presenting problem as reflecting more basic pathology.	Emphasizes patient's strengths and resources; presenting problems are taken seriously(although not necessarily at face value).
4. Wants to "be there" as patient makes significant changes .	Accepts that many changes will occur "after therapy" and will not be observable to the therapist.

5. Sees therapy as having a "timeless" quality and is and willing to wait for change.	Does not accept the timelessness of some models of therapy.
6. Unconsciously recognizes the fiscal convenience of maintaining long-term patients.	Fiscal issues often muted, either by the nature of the therapist's practice or by the organizational structure for reimbursement.
7. Views psychotherapy as almost always benign and useful.	Views psychotherapy as being sometimes useful and sometimes harmful.
8. Sees patient's being in therapy as the most important part of patient's life.	Sees patient's being in the world as more important than being in therapy.

Bolter, Levenson, and Alvarez (1990) empirically examined Budman and Gurman's theoretical proposals concerning major differences in the value systems of long- vs. short-term therapists. The subjects they used were 222 randomly selected, licensed psychologists who indicated their preferred approach (short- vs. long-term). Results provided support for Budman and Gurman's assertion that long-term vs. short-term therapists differ in their value systems. Overall, therapists who preferred a short term approach were more likely to endorse the short term values listed above, than the long term therapists. Short-term and long-term therapists differed most on their values regarding time. Long-term therapists valued a "timeless" quality in therapy, while short-term therapists valued an awareness of "limited time" in therapy. Additionally, long term therapists differed from short-term therapists in their conceptualization of how psychological change occurs. Long-term therapists tended to agree that an individual's personality was static and immutable, and that a long-term therapeutic relationship was necessary to overcome "inertia or resistance to change". Short-term therapists, on the other hand, were more likely to take an adult developmental perspective; if an individual was experiencing an obstacle to

developmental growth then only an intervention that would resume growth was necessary.

Koss and Butcher (1986) summarized several factors that account for the increased emphasis upon short-term treatment in clinical practice. They state that most patients, when they enter psychological treatment, do not anticipate that their program of treatment will be prolonged, but rather believe that their problems will require a few sessions at most. Additionally, most patients seek psychological treatment for a specific and focal problem, not for general personality changes. Additionally, brief therapy methods, once thought to be appropriate only for less severe problems, have actually been shown to be effective with severe and chronic problems, when treatment goals are kept reasonable (Budman & Gurman, 1988).

Koss and Butcher further indicate that brief treatment methods have generally the same success rates as longer term treatment programs, and most insurance companies or prepaid health programs recognize the benefits of brief therapy and now limit the payment to a number of sessions that would fall within a brief treatment modality.

Clearly there are differences in how psychotherapists view the course of therapy, and define the requirements for change. Budman and Gurman (1988) discuss some of the factors that affect the client upon their initial meeting with a psychotherapist. Clients' attitudes towards therapy, especially the expected time they plan to stay in treatment, are determined by their familiarity with mass media portrayals of therapy, which for the most part portray long term continuous treatment. In addition, a client's previous personal experience in therapy, and implicit view of psychological health, impact expectations regarding duration of treatment. Garfield

(1986) states that most clients expect to stay in treatment for about six to eight sessions, and in fact most clients actually stay in therapy for six to eight sessions.

Koss and Butcher (1986) provide a summary of common characteristics of brief therapies:

(1) Most brief therapists inform the patient of the time limitations in advance and expect that the focused and limited goals will be achieved in that time.

(2) Most therapists limit therapeutic goals within attainable reach, these goals include amelioration of the most disabling symptoms, re-establishment of a previous level of functioning, and development of some understanding of current disturbance and increased coping abilities.

(3) Most brief therapists view the development of a therapeutic relationship as an important element.

(4) Most brief therapy sessions are centered around concrete content and are focused on the "here and now" instead of early life events.

(5) Most therapists tend to be both active and directive in relating to the patient in order to maintain direction and organization of the sessions.

(6) Most brief therapists believe that effective brief therapy requires an experienced therapist who can keep therapeutic goals in sight and not get bogged down in content that is irrelevant to the agreed-on goals. It is necessary to have early, rapid assessment in brief therapy. This assessment must provide an understanding of the extent of the patients problem, the critical nature of the present situation, and the personal resources the patient might have that could be called into play to increase his/her coping skills.

(7) Most brief therapists consider flexibility in the therapist role important in abbreviating therapy.

(8) Most brief therapeutic approaches are aimed at prompt early intervention at the onset of symptoms or during an experienced crisis. Reaching clients with prompt assistance at an early point in their crisis can aid in resolving immediate problems and prevent more serious or chronic pathology which may require more lengthy treatment at a later time.

(9) Many therapists consider that selecting appropriate clients for brief treatment is important, while understanding that "brief therapy" is the treatment the great majority of clients receive. Regardless of symptom severity, clients who have a good ability to relate to others are considered to be better candidates for brief therapy.

MacKenzie (1988) noted that there appeared to be three suggestions for setting time limits in short-term therapy. The first is the "Procrustean" alternative, or "one size fits all." The therapist would set either the number of sessions or a specific date of termination. The second possibility that MacKenzie reports is what he calls the "sporting alternative", in which "the finish line is marked, but the pace varies." By this he refers to establishing the date of termination, but leaving the number of sessions open, usually allowing for more frequent sessions at the beginning of treatment with less frequent sessions towards the end. The third recommendation is called the "elastic alternative", in which neither the number of sessions or duration is set, but rather there is clear communication that therapy will be brief, and the pressure for rapid work will lead to termination without a forced termination date or limit on the number of sessions.

In addition to clear communication of the issue of time in therapy, the brief therapist also holds expectations in terms of their role and that of the client. In discussing brief group therapy, Yalom and Yalom (1990) suggest that as in any brief therapy the therapist must remain very active, especially in helping individuals

establish treatment goals. They suggest that goals should reflect desired changes regarding the client's interpersonal functioning, while understanding the realities, especially in terms of the time constraints the particular group is under. They conclude that goals tend to be more limited and circumscribed than would be in an on-going group.

As in brief individual therapy, once the initial goals are established, it is then the therapist's task to maintain the focus while the group progresses. Yalom and Yalom state, however, that it is also important for the patient to assume some responsibility regarding his/her stated or agreed upon goals. For example, if the patient states at the beginning that he would like to be able to share his feelings more openly, the therapist may ask "Would you like me or others in the group to point out to you when we see you holding back from expressing feelings in group?" This type of statement also serves to limit resistance or power struggles, and encourages the patient to revalidate the stated focus.

For some therapists there is less freedom available for determining exactly the optimal length of therapy. Instead, a crucial decision for some therapists concerns limiting the number of sessions allocated to any one client, especially in agencies that have limited service delivery resources. Howard, Kopta, Krause, and Orlinsky (1986) examined the expected benefits from specific varied "doses" of psychotherapy. In a meta-analysis, the authors combined 15 samples covering a period of more than 30 years, reporting data for 2,431 patients in individual outpatient psychotherapy. In general, the patients being treated were suffering from depressive or anxiety disorders, few were classified as psychotic or having a personality disorder. Therapists were from each of the major mental health professions, and their orientations were usually psychodynamic or interpersonal. Settings included private

practice, university counseling centers, and community mental health clinics. Results showed that 10 to 18% of patients reported improvement even before the first session of psychotherapy began, as the authors point out "simply as a function of initiating contact with the therapist or clinic." By the eighth session 48 to 58 % would expect to be measurably improved, whereas 75% should have shown measurable improvement by the end of six months of once weekly psychotherapy (26 weeks), and about 85% by the end of a year of once weekly treatment.

The authors conclude that the results of their meta-analysis suggest that after 26 sessions about 75% of patients have shown some improvement. Though maximal benefit will not have been reached, for those agencies confronted with treating an increasing demand on limited resources, 26 sessions might serve as a reasonable time limit, while still providing effective treatment. It is interesting to note that the median dose of treatment was higher for those studies examining time-limited therapy than it was for those studies examining time-unlimited therapy, suggesting that the lack of structure may lead to clients dropping out of therapy sooner.

Howard et al. state that a common criterion in deciding efficacy of treatment in pharmacological studies is the dosage at which 50% of patients show some response. From their study it may be concluded that six to eight sessions of psychotherapy would meet that criterion, since at eight sessions approximately 53% of patients showed some improvement. However, as mentioned above, for those agencies with limited resources, 26 sessions would seem to both provide an effective treatment, and limit the number of sessions allocated to any one patient. It is noteworthy that in this meta-analysis the majority of therapists' orientations were psychodynamic or interpersonal, none of the therapies were behavioral or psychopharmacological.

Perhaps results would be different should a more structured, be it behavioral or eclectic, approach be used.

Review of short-term psychodynamic therapies

Ursano and Hales (1986) reviewed some of the more common brief individual psychotherapies. They examined four dynamic psychotherapies, including focal (Malan, 1976), short-term anxiety provoking (Sifneos, 1981), time-limited (Mann, 1981), and broad-focus short-term dynamic psychotherapy (Davanloo, 1980). They also examined interpersonal psychotherapy and cognitive therapy.

Commonalities exist between the short-term psychodynamic therapies, most obvious is the strong reliance on traditional psychoanalytic principles. Transference is a key objective in these short-term dynamic therapies. The therapist attempts to have the patient deal in a healthy fashion, with issues associated to an important figure from their past. Transference having taken place, there will be an opportunity to see the central issue unfold regarding the attachment-separation ambivalence experienced earlier in the patient's life.

Malan (1976) has developed a brief form of psychoanalytic psychotherapy that aims to develop a "focal conflict." This focal conflict is then the basis for therapy in a brief period of time. This focal conflict is arrived at by attending to what the "patient offers." Malan suggests that determining a focus, at least in terms of the psychotherapeutic process, is as important as the formal diagnostic process. This focal conflict should be acceptable to the patient and not withheld until the outcome is decided.

Malan also identifies some characteristics that would make an individual a good candidate for brief therapy, which include: a capacity to think in feeling terms,

ability to demonstrate high motivation, and a good response to trial interpretations. Individuals that would not be good candidates would have had serious suicide attempts, drug addiction, long-term hospitalization, alcoholism, chronic phobic symptoms, or severe destructive acting out. Severe pathology alone, however, does not prevent an individual from benefiting from brief focal therapy. Malan sees the balance between identification of the focal conflict and motivation as the deciding factors in terms of acceptance into therapy.

Malan, in determining the focal conflict, seeks to identify early traumatic experiences, or patterns of behavior that point to an internal conflict that will be the focus of therapy. In dynamic terms, and according to Malan, the greater the chances that the focal conflict will manifest itself in transference, the greater the chances for a positive outcome.

Malan reports an average of about 20 sessions for his form of brief therapy. He feels that a specific date for termination is more productive than a set number of sessions. The set date for termination gives an identifiable life span to therapy, and decreases the chances that therapy will slowly become long-term work. Additionally, a time limit concentrates work, generates termination issues, and increases the chances that the focus identified at the outset will remain central.

Sifneos (1981) describes a short-term approach that aims at increasing the patient's anxiety rather than suppressing it, as he states most supportive forms of therapy do. He, like Malan, identifies characteristics a patient must possess to be a candidate for his short-term anxiety provoking therapy. The patient must have above average intelligence, had at least one meaningful relationship with another person in his/her lifetime, high motivation for change, and either present with a specific

complaint or be able to prioritize their complaints and be willing to work on the one with the highest priority.

Sifneos uses anxiety-provoking confrontations to clarify issues from the patient's early experiences, and offers interpretations as to how those experiences relate to present day difficulties. Therapy lasts on average 12 to 16 sessions, with an upper limit of about 20. The direct confrontation of the individual's defense mechanisms is the unique aspect of Sifneos' short-term anxiety-provoking therapy.

Mann (1973), like Malan, views time limitation as vitally important in short-term psychotherapy. The sense of limited time and termination are key in the therapeutic process. Mann limits the treatment to a total of 12 hours. The allotment of that time is determined by the patient, for example the patient might opt for hour long sessions for 12 weeks or half-hour sessions for 24 weeks.

The most important step in treatment, like in other brief forms of therapy, is the identification of a central issue. This central issue reoccurs over time, and pertains to the individual's development and adjustment to his/her environment. Mann usually describes his interpretation of the identified central issue to the patient. The language is clear and concise with little esoteric elaboration. The patient may add to or re-describe the central issue but most commonly it strikes a responsive cord as something accurate, but until stated, unknown.

Mann indicates that to prevent short-term therapy from becoming long-term, clarity of goals of treatment must be maintained, and the activity level of the therapist must remain high. Transference usually becomes the central feature of treatment. The client's present symptoms, painful experiences, unwanted behavior, and relationship problems for which assistance is requested, become more apparent through the therapeutic relationship. Once receiving this information the therapist offers an

understanding of what underlies the client's anxiety and problems, and subsequently this insight provides the motivation for change.

Davanloo (1980) describes a broad focused short-term dynamic psychotherapy. Confrontation is used to identify "true feelings" especially about transference issues and regarding events from the past. A strong relationship is needed because of the confrontation that is used in this brief approach. The therapist may expect hostile and angry feelings because of the confrontation of the patient's defenses. On average, Davanloo identifies his treatment needing 15 to 25 sessions, with a recommendation of an upper limit of about 40 sessions. Davanloo utilizes traditional psychoanalytic principles including interpretation of dreams, fantasies, and transference material.

Ursano and Hales (1986) see many similarities between these brief psychodynamic therapies. Goals for these therapies are seen as facilitating "health-seeking behaviors and mitigating obstacles to normal growth." These brief therapies focus on the development of the individual, and relate whatever conflict is presented to the specific context, be it the environment, interpersonal relationships, physical health, or impeded developmental growth. Brief dynamic psychotherapy has attainable goals, and discourages "therapeutic perfectionism".

Ursano and Hales point out that the selection criteria for many of the brief psychodynamic therapies are the same. To summarize patients should be able to engage with the therapist relatively quickly, terminate therapy in a short period of time, exhibit relatively high levels of ego strength, and motivation towards psychotherapy.

In addition to the patient characteristics listed above, brief dynamic therapies emphasize developing and maintaining a therapeutic focus. This focus is constructed

through evaluation sessions, and it is the therapist's responsibility to maintain that focus through the course of treatment and through tangential material.

There is agreement between Malan, Mann, Davanloo, and Sifneos regarding the duration of brief therapy. The range is between 5 and 40 sessions, although most indicate 10 to 20 sessions as the ideal.

Review of other brief therapies

Klerman, et al. (1984) have developed a short-term interpersonal psychotherapy. As with some of the dynamic brief therapies, interpersonal psychotherapy specifies a goal of about 12 to 16 weeks for treatment length. Therapy focuses on current interpersonal difficulties individuals might be facing. Patients with high levels of psychopathology or requiring substantial behavior change are not strong candidates for interpersonal psychotherapy.

Focus is on current difficulties, rather than past relationships. Attempts are made to classify the patient's presenting problem into one or more of four problem areas: grief reaction, interpersonal disputes, role transition, and interpersonal deficits. The middle stages of treatment focus on resolving specific problem areas. Examples of this would be: clarifying positive and negative feeling states, identifying past models for relationships, and guiding and encouraging the patient in the examination and choice of alternative courses of action. Interpersonal psychotherapy focuses on reassurance, clarification of feeling states, improvement in interpersonal communications, testing of perceptions, and interpersonal skills rather than personality reconstruction. In sum, interpersonal rather than intrapsychic or cognitive events are the focus of interpersonal psychotherapy.

Klerman et al. developed interpersonal therapy primarily for treatment of depression. Assessment plays an important role, and an understanding of the patient's history of depression and interpersonal problem areas is the initial step.

Beck, Rush, and Shaw (1979) developed a brief cognitive treatment for depression. Cognitive therapy identifies specific cognitions (thoughts or images) and schemata (silent assumptions) as causes for depressive symptoms. Treatment is directed at having the patient recognize and record cognitive distortions and then to learn how to develop new cognitions that will not lead to dysphoric affects. Some of the common distortions are personalization (giving personal meaning to a neutral event), selective attention (ignoring the positive aspects of a situation), overgeneralization, and magnification. In sum, individuals may form cognitions that reflect a negative view of themselves, the world, or the future.

The goals of cognitive therapy are to identify stereotyped views that patients bring to various situations, and to recognize and correct these views so as to conform with objective reality. Goals also include the identification of schemata, development of new cognitive responses to situations, and generation of new schemata and the application of them to anticipated and actual events. Cognitive therapy has also been used for treatment of anxiety, phobic disorders, obesity, drug and alcohol abuse, and chronic pain.

Seligman (1979) describes behavior therapy as a comprehensive short term approach. Behavior therapy is based on the assumption that human behavior is observable, measurable, and predictable. An individual can then be described by a combination of measurable behaviors across a wide variety of environments and contexts. It should be noted that behavior therapy does not assume that any one behavior is representative of the entire person. A second assumption of behavior

therapy, according to Seligman, is that normal and abnormal behavior are neither quantitatively nor qualitatively distinct. The difference between normal and abnormal begins with the "labeling" process. Behavior may be labeled abnormal or undesirable because of the particular society's custom, discomfort the behavior causes the individual, or the inefficiency of a particular behavior to achieve a specific goal. Behavior therapy has traditionally focused on conditioning processes to explain human learning. Behavior therapy has long been seen as working within a time limited framework, in which the therapist negotiates with the client to work on mutually agreed upon goals. Behavior therapy uses techniques such as systematic desensitization, in vivo desensitization, flooding and implosion, and positive reinforcement. Therapeutic goals are aimed at symptom reduction, rather than attempting to uncover underlying causes.

Beard, Marlowe, and Ryle (1990) describe a short term approach to the treatment of personality disorders, referred to as cognitive analytic therapy. Cognitive analytic therapy integrates cognitive behavioral therapy with the object relations school of psychoanalysis. Individual acts or roles are seen to be controlled by mental, behavioral, and environmental factors that are linked in sequence. Ryle (1979) describes intentional action as organized by "procedural sequences" which are revised by the addition of new experiences. Neurotic procedures are seen as not being open to such revision, because of "traps", "dilemmas", and "snags". Sequential diagrammatic reformulation (SDR) is a flow chart that is used to guide therapeutic interventions, and is also used as a means for patients self-monitoring. Clinical interview provides the main source of information for the SDR. Additional information is gained from the patients own self-monitoring, written assignments, and bibliotherapy. Through this process the therapist begins to identify a set of state

descriptions, of which one is the "core state" and represents the "long-term, unresolved psychic pain" of the patient. Individuals are sometimes aware of this central issue, but often times not, and tend to avoid it. Coping strategies are often limited and there is a tendency for unrewarding interpersonal strategies or somatic, behavioral, or psychological symptoms.

The SDR is used by the clinician as an assessment tool that identifies the core state, as well as a shift between various states. It provides visible evidence to the patient, of being understood, and subsequently reduces anxiety, and provides motivation for change. Structural diagrammatic reformulation is an attempt to bridge two relatively diverse theoretical orientations into a workable short-term therapy.

Eclecticism

Recent surveys have estimated that between 30% and 70% of psychotherapists identify themselves as eclectics (Norcross, Prochaska, & Galagher, 1989). However, the term often conveys an approach that does not appear to offer direction or a decision making process for problems occurring through the course of therapy. Lazarus, Beutler, and Norcross (1992), in a discussion of the future of technical eclecticism, point out that technical eclecticism was a term coined by Arnold Lazarus in response to the observation that amalgamated theories only breed confusion. The technical eclectic uses procedures drawn from different sources without necessarily subscribing to the theories that spawned them.

Technical eclecticism is seen as providing an effective treatment based on a systematic process of choosing interventions that have been empirically demonstrated to be successful with specific patients and problems. Technical eclecticism is predicted to be the "psychotherapeutic zeitgeist" of the 21st century, according to

Lazarus et al. With the prevalence of HMO' s and managed care providers favoring short-term treatment with identifiable outcomes, technical eclecticism will flexibly adapt a variety of psychotherapeutic interventions to meet the specific needs of the individual patient.

Lazarus, et al. also predict that the limitations of theoretical integration will be more fully realized in the coming years. Unlike technical eclectics, theoretical integrationists attempt to "meld disparate ideas into harmonious wholes by constructing a superordinate umbrella and by building a coherent framework from the best elements of connecting theories" (p. 30). Since there is no evidence that any one theory of psychotherapy is more effective than another, and since there is an uncertain relationship between theory and application, Lazarus, et al. warn clinicians about perpetuating psychotherapy through persuasive power rather than through empirically tested efficacy. London (1964) points out that: "However interesting, plausible, and appealing a theory may be, it is techniques, not theories, that are actually used on people. Study of the effects of psychotherapy, therefore, is always the study of the effectiveness of techniques" (p. 34).

Lazarus et al. (1992) further predict that there will be a treatment of choice for selected clinical disorders, and that psychotherapy will be increasingly matched to client variables beyond diagnosis. The authors state that current diagnosis is limited in terms of serving as a basis for psychosocial interventions. Psychosocial interventions impact the whole person, the whole system, they are not so specific as to say we may change only major depression, and not anxiety, or for that matter changing only one symptom without impacting interpersonal relationships, thought patterns, and other situational factors. For Lazarus, et al. the challenge to psychotherapy is to continue to evolve as a discipline, and in so doing to increase it's

ability to match different procedures to specific patient characteristics regardless of that individual's formal diagnosis. They state: "Even within any particular theoretical system like cognitive or psychodynamic therapy, selecting among a wide variety of specific interventions is never based upon formal clinical descriptions... the selection of specific procedures with psychotherapy systems rests on a set of poorly understood postulates about how the client will cope with and react to the therapist's words and actions (p. 32)." In response to the apparent discrepancy between treatment and diagnosis the authors suggest that assessment of the patient's objectives, coping behaviors, resistances, situational contexts, emotional experiences, and beliefs should be used in making decisions regarding the most appropriate interventions to use. Additionally, nonspecific factors, common to many forms of psychotherapy, will be better defined and included in the decision-making process regarding optimal treatment options. In other words, successful therapy in the future will consist of matching specific clinical procedures with particular relationship stances, that produce therapeutic commonalities that are effective with a specific individual or a problem (Paul, 1967).

Patterson (1989), conversely, argues that for eclecticism to be systematic it must be based on the core elements of the major theories. Three of these common elements are empathic understanding, respect or warmth, and therapeutic genuineness. Patterson believes that current eclectic proposals build on the differences in methods or techniques of the major theories. Effectiveness of certain theories are attributed to the unique elements, usually those not included in the relationship, rather than the commonalities. Frank (1982) points out that psychotherapists compete to show that their particular theory or method is better than any other theory or method, and that this inevitably emphasizes the differences

between any theoretical orientation. Garfield (1982) states that for progress in psychotherapeutic effectiveness to occur it will be necessary to delineate and operationalize some of the common variables that play an important role in the major psychotherapies. This will provide the basis for a clearer understanding of psychotherapeutic principles and procedures, and allow research to cross theoretical boundaries.

Patterson (1989) argues that the relationship between client and therapist is the most important common factor. He views the "therapeutic personality", as possessing characteristics such as perceiving and communicating empathy, showing warmth, respect, and concern for the client, and being genuine, honest, and authentic in the relationship. Patterson argues that some resistance to acknowledging these as common elements stems from their identification with client-centered therapy. He states however that every major theory either explicitly or implicitly incorporates at least the basic principles of empathic listening and understanding, respect, and genuineness. Patterson concludes that these elements define the therapeutic relationship, and are the necessary and sufficient therapist conditions for therapeutic change.

Eclecticism, as conceptualized by several authors, will provide the theoretical flexibility needed to match proven effective interventions to specific presenting problems, however, as Patterson argues, the essential elements of the therapeutic relationship will need to be incorporated regardless of type of treatment chosen.

Budman and Gurman (1988) have recently outlined an approach for the discovery and establishment of a therapeutic focus that is neither overly restrictive nor so vague as to lack clinical utility. The interpersonal-developmental-existential (IDE) paradigm is offered as an attempt to capture and understand the core interpersonal life

issues that lead a client to seek psychotherapy or counseling. The IDE approach is neither exclusively symptom-oriented, nor exclusively intrapsychic or interpersonal. It stems from a brief eclectic approach that seeks to combine individual, couple, and family counseling principles with existential theory, and theories of interpersonal relationships.

Budman and Gurman picture the IDE paradigm as a straight line. This line is seen as the course of our lives, with one end representing birth and the other representing death. At any time, each of us is somewhere along this line, which represents the developmental component. We are all interactional beings, and our difficulties, symptoms, joys, and sorrows can usually be understood in terms of how these interactions, or lack of any interaction, affect our daily lives. This is the interpersonal component. They go on to state that since we are mortal and our lives are finite, we cannot escape our own mortality and that of those around us. This awareness of finiteness and limitation carries with it the final component to the tripartite model of focus, the existential component.

The IDE paradigm is a frame of reference that attempts to help the therapist answer the central question, "Why now?" Or, of all the possible moments that this person could have understandably sought treatment, why did he/she chose to do so now? The answer to this question will provide the therapist at least a partial focus for treatment.

In seeking an IDE focus the therapist should be aware of the most commonly presented foci. These include the following: (1) losses, (2) developmental dysynchronies, (3) interpersonal conflicts, (4) symptomatic presentations, (5) personality disorders. Each of these areas should be understood within a developmental life span context, and related to a client's current interpersonal milieu.

The therapist seeking to locate an IDE focus should consider the following questions in particular:

1. What is the clients reason for seeking therapy at this time? This is a different question from only identifying the presenting symptoms or problems. The client may have some difficulty in identifying exactly why they have entered therapy. For some the problem will be of long standing duration, and for others it will be an easily identifiable event (loss of a loved one, job change, etc.) The therapist should pay attention to more subtle psychosocial changes that may have led the client to seek treatment.

2. What is the client's age? Date of birth? Approximate developmental stage? Many adults enter therapy in the months surrounding their birthdays. Often the birthday highlights a developmental milestone that carries with it certain expectations. For a single unattached young adult who is looking for a meaningful relationship, birthdays may highlight loneliness and frustration. Regardless of the significance of the client birthdays, their developmental stage is always central. Anxiety and depression have different meanings depending on that person's particular developmental stage.

I will elaborate on each of the three components in the IDE framework to provide a foundation for the relevance to doing brief psychotherapy.

The interpersonal component

The interpersonal approach as described by Sullivan (1956) and Klerman, et al. (1984) focuses on the processes between people rather than the mind, society, or the brain. Hence, the interpersonal approach examines the individual's closest relationships, including family of origin, family of procreation, as well as romantic,

work, friendship and community relationships. Subsequently, the roles of most concern to the interpersonal therapist are parent, child, sibling, spouse, friend, lover, supervisor, supervisee, peer, neighbor, and community member.

By examining the various roles the client occupies the therapist assesses the relationship between that individual and others, which is an indication of the position the individual holds within a social system. Disturbances in social roles are seen as an antecedent to psychopathology, and conversely mental illness may impair an individuals' capacity to perform in society.

Klerman, et al. (1984) outlined an interpersonal assessment process that includes the following components:

1. A complete inventory of current and past relationships with significant others especially in the families of origin and of procreation but also at school and work, in love relationships and friendships, and in community activities.
2. The quality and patterning of the interactions, which extended over time become the history of the individual's interpersonal relations, similar to the history of symptoms, illness, and treatment that is an essential part of medical and psychiatric assessments. These patterns include issues of relationship to authority; dominance and submission; dependency and autonomy; intimacy; trust and confiding; demonstration of affection; sexual feelings and activities; residential and household arrangements; division of labor and tasks within families and at workplace; financial arrangements; shared recreational, religious, and community activities; and responses to separations and losses.
3. The cognitions the individual and the significant others develop, hold, and change about themselves, each other, their reciprocal roles, and the history of their

relationship. Cognitions involve beliefs and attitudes about norms, expectations, and meaning ascribed to roles and role performance.

4. The associated emotions (also called moods, affects, feelings), including pleasure, joy, sadness, disappointment, anger, rage, hostility, trust, warmth, surprise, fear, guilt, envy, jealousy, shame.

Sullivan (1953) states that "a personality" can never be isolated from the complex of interpersonal relations in which the person lives and has his being. For Sullivan, the first eighteen months of life represent the initial place to examine interpersonal relationships. The most important relationship at this time is with the significant adult, usually the mother. This earliest relationship, the emotional attachment, begins to determine who and what we are. As the infant expands his or her personality through the exercise of power (usually by crying), the infant begins to develop the sense of how the parent reacts to meeting the infant's needs. Similarly, the infant learns about his power especially regarding the reaction of the parent in the satisfaction of his needs.

Mullahy (1953) outlined Sullivan's basic principles. Human behavior is seen as falling in one of two categories, either the pursuit of satisfaction or the pursuit of security. These goals or "end-states" are ultimately interpersonal processes. Furthermore, these needs represent why we cannot live and be human other than in "communal existence with others." To gain satisfaction and security is to have power in interpersonal relationships, not to do so is to be without power, or helpless. Subsequently, through, as Mullahy puts it, psychiatric inquiry the individual is seen not as an isolated or self-contained entity, but rather one involved in an interpersonal process between two people. Mullahy concludes that the best way to proceed with

this inquiry is by participant observation, or by the investigator becoming a constituent element of the situation.

According to Sullivan (1956), therapy works because the patient is able to better understand the significance of his or her past and the role it plays in their present behavior and perspective on life. The patient is able to achieve greater security by giving up a security-seeking process that was not satisfying, and ironically probably never led to a greater sense of security. In essence, Sullivan states that most patients have for years been acting out conflicts, substitutions, and compromises; "...the benefit of treatment comes in large part from their learning to notice what they are doing"(p. 223). Therapy aims to increase the awareness of the patient regarding his/her part in interpersonal relationships.

Klerman, Budman, Berwick, Weissman, and Damico-White (1987) studied the effects of Interpersonal Counseling (IPC) on stress levels of patients seeking primary care through a large health maintenance organization (HMO). IPC is a focused, psychosocial, brief intervention. Based on interpersonal psychotherapy (Klerman, et al., 1984) IPC was developed for administration by nurse practitioners working in a primary care setting. It is easily learned through a short training program of 8 to 12 hours. Briefly, IPC consists of an assessment phase in which symptoms are reviewed, chronologically in relation to recent life events and stress, including an interpersonal inventory. The symptoms are then "reformulated" into one of four problem areas: (1) unresolved grief, (2) role transitions, (3) role disputes, and (4) interpersonal deficits.

Treatment consists, usually, of six sessions during which the IPC encourages the patient's capacity for coping with the problem area. The IPC therapist aims to

facilitate independence, and patients who felt significantly improved were not necessarily urged to continue.

Results showed that when compared with an untreated group, those patients receiving IPC showed a greater reduction in symptom scores over an average interval of 3 months. This study provided evidence that early detection and outreach to individuals experiencing stress, followed by a brief treatment based on interpersonal psychotherapy could reduce symptoms of distress. Additionally, such intervention may result in a reduction in utilization of health care services.

Weissman and Klerman (1973) conducted 700 interviews with depressed patients who had undergone psychotherapy for eight months. They aimed to describe what patients discuss in psychotherapy, and to explore the relationship between reflection and concepts of insight, and their relevance to psychotherapeutic outcome. The psychotherapy offered was supportive and aimed at helping patients cope with life circumstances. Most of the patients in this study were from middle to lower class backgrounds, though at the time of this study few individuals from lower to middle class backgrounds, nationally, were seeking psychotherapy. Their results showed that this group of patients discussed immediate current life experiences such as practical problems, interpersonal relations with children, spouse, friends, and the patient's concern with her own current mental and physical symptoms. Discussion of family of origin occurred in only 26 percent of the interviews, and discussion of early experiences in only 6 percent of the interviews.

From these results Weissman and Klerman identified the basic interpersonal themes that represent the basis for their later interpersonal theory (1984). It is interesting to note that twenty years ago their conclusion was that therapists should not be disappointed when patients were unable to engage in insight oriented

psychotherapy. The authors point out that problems experienced before in working with patients from these backgrounds had less to do with presumed patient deficits, and more to do with therapists' expectations regarding what the patient should discuss. Out of 700 interviews, patients discussed concerns regarding their own children in 651, practical problems in 601, and interpersonal relationships in 566, making up the most frequent topics addressed in therapy. Then, as now, it makes most sense to adapt to the needs of the patient rather than adhering to prior expectations and conceptions that provide only limited effectiveness.

Horowitz and Vitkus (1986) examined the interpersonal basis of psychiatric symptoms, concluding that therapists tend to classify disorders in terms of symptoms, and classify the severity of disorders in terms of symptoms, while the actual work of treatment usually focuses on interpersonal events, conflicts, and goals. Horowitz and Vitkus developed an instrument that measures interpersonal problems that are typically described by people seeking psychotherapy. After viewing intake interviews, two observers recorded problems, and then coded phrases that began with "I find it hard to....", or "I can't", or "I can't stop". The majority of these statements were coded interpersonal by 13 of 14 judges. Fifty subjects then sorted the problem behaviors into categories that seemed to go together semantically. The multidimensional scaling procedure yielded three dimensions. The first was called a dimension of control, which described the subjects intention to influence, change, or control another person. The second dimension was called the nature of involvement, ranging from positive (friendly) to negative (hostile). The third dimension, psychological involvement, described the degree to which the subject was cognitively or emotionally involved with another person. From these, they assembled a

questionnaire that assessed the degree to which each item represented a problem for an individual, an example follows:

0=Not at all

1=A little

2=Moderately

3=Quite a bit

4=Extremely

It is hard for me to:

1. Trust other people	0	1	2	3	4
2. Be direct in expressing my feelings to other people	0	1	2	3	4
3. Socialize with other people	0	1	2	3	4
4. Let myself feel close to other people	0	1	2	3	4

Horowitz and Vitkus then used the Inventory of Interpersonal Problems to study the interpersonal elements of psychiatric symptoms. They state that prototypic depression or prototypic anxiety contains a large number of elements. Prototypic depression, for example, contains so many elements that people vary considerably in their experience of depression. Interpersonal problems associated with one subtype of depression can be very different from interpersonal problems associated with another subtype. Therefore depression cannot be linked with any one cluster of interpersonal problems. Horowitz, Weckler, and Doren (1983) studied two men suffering from depression, who were about equally depressed. Their responses on the Inventory of Interpersonal Problems showed a marked difference in interpersonal difficulties. One man experienced problems with closeness, while the other experienced problems with aggression. Subsequently, though they both were being

treated for depression, the goals of treatment were markedly different. This provides an example of the difficulty in relying on a traditional diagnosis to determine therapeutic focus or a individualized treatment plan. We cannot say that because two individuals carry a diagnosis of major depression, their psychotherapeutic treatment should be similar. What is needed is an assessment strategy that incorporates the "diagnosis" with what will eventually be done in psychotherapy.

The developmental component

Developmental theory may be traced back to Plato's Republic. Plato suggested that "reality" can be divided into the world of appearances (observable behaviors), and the intelligible world (the process of "thinking about thinking"). In the world of appearances there are two states, imagining and belief. Each is based on what can be observed, and what can be counted. In modern terms, this position is best illustrated by the school of behaviorism. Those who prefer the intelligible or thinking world believe that what people think is more important than what they actually see or believe they see. The ideas people have regarding the construction of reality are most important. Phenomenological, psychodynamic, and some cognitive approaches illustrate this process (Ivey and Goncalves, 1988).

Ivey and Goncalves (1988) outline a developmental therapy that examines client thinking structures that repeat themselves again and again at each developmental stage. Individuals are believed to construct world views and actions based on thoughts, feelings, and behaviors, that have been derived from the person-environment interaction. However, according to Ivey and Goncalves, developmental therapy does not follow the strict environmentalism of behaviorism. Additionally,

developmental therapy rejects the position of humanistic and some psychodynamic theory that posits the individual can construct almost anything from within the self.

Ivey and Goncalves draw comparisons between Plato's basic concepts and those of Piaget (1954). The Piagetian concepts of the sensori-motor preoperational and concrete operations, are seen related to the Plato's world of appearances, while the Piagetian concepts of formal and post-formal operations would fall under the Platonic "intelligible world."

Erickson (1950) outlined his conceptions of development in the eight stages of "man". These eight stages describe the development, in psychoanalytic terms, of the infant into adult. The child's sense of identity begins with the either trusting that their most basic needs will be met, or by an initial mistrust that their care taker will indeed assure their survival. Independence and autonomy are essential parts of Erickson's theory of development. The child, without the sense that he or she will not be overwhelmed, by the environment, may develop guilt or the pervasive feeling that they are exposed or being looked at. Basic to Erickson's model is the dichotomy between industry and inferiority. Healthy development leads the child to a sense that they will be productive members of the society, in which they will have an occupation that is satisfying with the opportunity for accomplishment. Through this sense of a role in society comes the individuals sense of identity, without it the child will have diffuse role, that may lead to a sense of inadequacy or a feeling that he/she has nothing of value to offer the world. Erickson also identifies the importance of developing the capacity for intimate interpersonal relationships, which include both sexual relationships and close friendships. The avoidance of these relationships may lead to a sense of isolation and self-absorption. In the later stages of development, according to Erickson, the individual shows interest in guiding and helping the next generation,

most frequently assumed by parental responsibility. The absence of this interest is often followed by mutual repulsion, individual stagnation, and interpersonal impoverishment. In Erickson's last stage of development the individual exhibits acceptance of their life and of the choices they made. Lack of this ego integration leads to a significant fear of death, or the feeling that the one and only life cycle is not accepted as the ultimate life. In other words, without the acceptance of one's life there follows a sense of despair that time is too short, without opportunity to start another life that will lead to integrity.

Erickson not only outlines a basic theory of development, but also includes the importance of interpersonal and existential issues, making his model an important addition to understanding the Interpersonal-Developmental-Existential paradigm outlined by Budman and Gurman. While Erickson's developmental theory makes no distinction between women and men, others have suggested development may be different between the sexes.

Levinson (1978) presented a view of adult development for men. The life cycle is broken down into "eras" which approximately follow this sequence: age 0-22 childhood-adolescence, 17-45 early adulthood, 40-65 middle adulthood, 60-? late adulthood. Between each era there is a transition point where the tasks of one era are getting under way as the tasks of the previous one are being terminated.

The individual life structure is considered in these terms: (1) it is the individual's sociocultural world as it impinges upon him has meaning and consequences, (2) some aspects of the self are lived out whereas others are inhibited or neglected, and (3) the man's participation in the world needs to be examined so as to provide a landscape, a cast of characters, a variety of resources and constraints out of which the man fashions his world.

Levinson describes the Early Adult Transition, which begins at age 17 and ends at 22. During this time the first task is to start moving out of the preadult world, and into one's own role. This is accomplished by taking preliminary steps into the adult world, to explore the various possibilities that exist. During this time the young man is seen on the boundary between adolescence and adulthood.

The next stage consists of Entering the Adult World, and extends from age 22 to 28. The main task during this stage is to form a provisional structure that serves as a link between the "valued self" and adult society. A variety of initial choices are carried out including occupation, love relationships, peer relationships, values, and life style. During this time the young man explores these various options, and attempts to maximize alternatives, put another way; strong commitments are avoided. Ironically, the other main task during this period is to create a stable life structure, which entails becoming more responsible and finding a way of making a living.

The next transition occurs around age thirty, between 28 and 33, and referred to as changing the first life structure. Here the young man works on the flaws and limitations of the first adult life structure. This can be a time of developmental crisis if the man finds his present life structure intolerable, yet seems unable to form a better one.

The next developmental stage called Settling Down, provides the structure for the culmination of early adulthood. A man seeks to invest himself in meaningful experiences such as work, family, friendships, leisure, community, while still attempting to accomplish his youthful ambitions. During this stage a man attempts to find his role in society, to develop competence in his world of work, and to advance in that system often referred to as "making it." Towards the end of this period, age 36

to 40, there is a greater expectation to be "one's own man", to have a measure of authority.

The Mid-life Transition, roughly age 40 to 45, provides a bridge into middle adulthood. During this time there occurs a careful evaluation of one's life, usually the question goes "What have I done with my life?" By age 45 the tasks of the Mid-life Transition must be given up, followed by reappraisal and exploration through which the man must make new choices. For some this shift results in a change in job or occupation, divorce or love affair, or a geographical move.

Between ages 50 and 55, known as the Age Fifty Transition a man may work further on the tasks of the Mid-life Transition, and may modify the life structure formulated in his mid-forties. This time may also result in some form of crisis, especially for men who changed little in the Mid-life transition. From age 55 to 60 there occurs a stable period devoted to building a second middle adult life structure. Especially for men who are able to rejuvenate themselves, this may be a period of great satisfaction. Finally, from about 60 to 65, the Late Adult Transition terminates middle adulthood, and begins late adulthood. The main tasks are preparing for retirement, leaving the world of work, and finding other satisfiers and other roles. It is a period of significant development and is a major turning point in the life cycle.

Levinson, in describing the male life cycle points out that the ages for each transition are normative, with individuals varying greatly. However, these periods do represent opportunities for developmental work, as a means of creating a life most suitable to the self.

Gilligan (1982) argues that the vast majority of developmental research and theory has been conducted about men by men. She asserts that there are significant

differences between men and women, and that research on adult development needs to include "in women's own terms the experience of their adult lives"(p. 173).

Gilligan points to the ethic of care, which is notably absent in mainstream developmental thought, and sees it as the tie between relationship and responsibility. She states, "While an ethic of justice proceeds from the premise of equality- that everyone should be treated the same-an ethic of care rests on the premise of nonviolence-that no one should be hurt. In the representation of maturity , both perspectives converge in the realization that just as inequality adversely affects both parties in an unequal relationship, so too violence is destructive for everyone involved (p. 174)." Gilligan feels that the discussion between justice and care contributes to the understanding of not only women's development, but also a more comprehensive understanding of adult work and family relationships.

Chickering (1969) in 'Education and Identity' outlined what he saw as seven key developmental tasks facing young adults. He referred to them as "vectors" of development because each has direction and magnitude. The seven major areas he identified are: competence, emotions, autonomy, interpersonal relationships, purpose, identity, and integrity.

Chickering identifies three components to competence. The first is the development of intellectual competence. Most educational institutions, he states, are devoted to fostering or forcing this kind of development. Development of physical or manual skills competence is a concern for many non-college young persons. The third component, and most important for young adults, is social and interpersonal competence. This is related to the ability to make friendships that are healthy and satisfying.

The second developmental task that Chickering identifies is the ability to manage emotions. There are basically two major impulses to manage: aggression and sex. The young adult attempts to develop legitimate ways of expressing anger and hate. Maturity involves developing socially acceptable ways of dealing with provocations or new conditions in living. Sexual impulses are more insistent than before and require more widespread adjustment. Pressure from family and from peers are great, and there may be contradictory signals being sent. Increased awareness and developing more useful and effective modes of expression go together through the larger process of development.

Autonomy refers to the independence of maturity, which is stable and secure. Coping behaviors are well coordinated with personal and social needs. Chickering states that to be emotionally independent is to be free of continual and pressing need for reassurance, affection, or approval. It begins with disengagement from parents. However, he adds that recognition and acceptance of interdependence is the capstone of autonomy. In essence we need others, and each of us cannot receive the benefits of a social structure without contributing to it: loving and being loved are necessarily complementary.

Chickering states that development of identity is the process of discovering with what kinds of experience, at what levels of intensity and frequency, we resonate in satisfying our inner self, in a safe, or in a self-destructive fashion. Development of identity also involves clarification of conceptions concerning physical needs, characteristics, personal appearance, sexual orientation, and appropriate roles and behaviors. Once achieved a solid sense of identity fosters change in other major vectors of development.

Chickering observes that a sense of identity frees interpersonal relationships. A major developmental task for young adults is to learn how to manage oneself and others to accomplish tasks requiring joint effort. Additionally, he adds that with greater autonomy and a firmer sense of identity, relationships shift toward greater trust, independence, and individuality. Freeing interpersonal relationships survive episodes of disagreement, and persist through separation and even non-communication.

The sixth vector on Chickering's developmental wheel is that of clarifying purpose. Development of purpose occurs as questions such as "Who am I ?", "Who am I going to be?", and "Where I am going?" Development of purpose requires making plans and priorities that integrate avocational and recreational interests, vocational interests, and life-style considerations. With such integration life flows with direction and meaning.

The last developmental hurdle Chickering identifies is that of developing integrity. Integrity is defined as a clarification of a personally valid set of beliefs that provide a guide for behavior. During childhood the individual internalizes his/hers parent's values. Integrity occurs as the individual begins to personalize values and is analogous to selecting a wardrobe where items are tried on, some are discarded, and others are set aside for the new wardrobe. This "personalizing" of values leads to congruence, or the achievement of behavior that is consistent with that which is most meaningful and important for each individual.

The developmental component is of special interest when working with the college age population, since many are at a developmental transition point, in which their identity is in the process of forming. For many others this is a time of struggle,

where a career choice is not immediately apparent, and social relationships are quite difficult.

The existential component

The existential component in this tripartite model refers to issues concerning meaning. What is meaningful to an individual?, What is life all about? How do we deal with the inevitable ending of life? These are the questions that bring many people to psychotherapy, and subsequently existential issues are important in determining an appropriate focus for psychotherapy.

Yalom (1980) outlines four themes that his existential psychotherapy is concerned with: death, freedom, isolation, and meaningless. Death is the most obvious concern associated with existential thought. Yalom states that a core existential conflict is the tension between the awareness of the inevitability of death and the wish to continue to be. We exist now, but all must inevitably die.

Freedom is another ultimate concern, and refers to the absence of external structure. The individual is entirely responsible for his or her own world, life design, choices, and actions. Freedom is described as a void, an abyss. A key existential dynamic is the clash between our confrontation with groundlessness and our wish for ground and structure.

Existential isolation, which differs from interpersonal isolation (isolation from others, or loneliness), and intrapersonal isolation (isolation from parts of ourselves), is an isolation both from creatures and from the world that cuts beneath other isolation. No matter how close each of us becomes to others, we enter the world alone and must inevitably leave it alone. The conflict here is the tension between our awareness of our absolute isolation and our wish for contact, for protection.

The fourth concern that Yalom describes is meaninglessness. If we must die, if we constitute our own world, if each is ultimately alone in an indifferent universe, then what meaning does life hold?. If there is no preordained design for us, then each of us must construct our own meaning in life. The existential conflict stems from us as individuals seeking meaning, being thrown into a universe that has no meaning.

Bugental and Bracke (1992), in their discussion of the future of existential-humanistic psychotherapy, see an increasing need to address feelings of emptiness and lack of personal meaning in our society. The authors feel that these issues call for more thorough therapeutic aids, and that many short-term therapies have limitations, and are "incompletely satisfying".

Lasch (1978) and Cushman (1990) have described how various forces, social, political and economic have created an environment where being oneself with clear boundaries and a sense of self-efficacy is difficult for many of us. They argue that we are looking to fulfill ourselves, looking for meaning and direction, by seeking more things. Cushman points out that advertisers capitalize on our lack of meaning, by convincing the public that a certain product is indispensable, or by stimulating a particular fear and anxiety, then presenting a product as the cure for that fear or anxiety . The public believe that reassurance, attractiveness, or personal meaning is available over the counter. Lasch sees a narcissistic society that may be liberated, but doubting the reality of personal existence, fiercely competitive for approval, and superficially cooperative while hiding a deep resentment. In short, too many individuals are looking for immediate gratification while feeling unsatisfied, allowing themselves to be seduced by the next product or fashionable trend.

Cushman (1990) sees psychology as the social science devoted to treating these feelings of emptiness, yet paradoxically, as also creating the problems that it

seeks to cure. Like many other industries, the self-improvement industry (of which mainstream psychology, pop psychology, and pop religion are a part) is seen as offering the "life-style solution." Cushman (1990) states " ... psychotherapy appears to be less a "scientific" cure and more a covert vehicle for cultural guidance and transmission. Individuals in the postmodern era, without a cohesive community, are struggling to find sense and meaning in a confusing world. There is little to guide them, and they stumble and feel despair.... without the therapist being aware of it, practice deviates from normative discourse by allowing the therapist to function as a model for the patient, by providing corrective emotional experiences of care, respect, and understanding, and by allowing the patient to 'take in' the therapist's ideas, values, and personal style" (p. 606). Though somewhat extreme, Cushman reminds us that it is important to help clients find meaning in their lives, rather than assuming that what is meaningful to one person will not necessarily apply to another person, who has unique experiences and aspirations.

Bugental and Bracke (1992) believe that the existential-humanistic orientation can provide help to those individuals that experience meaninglessness and emptiness in their lives. The authors feel that "the experience of emptiness comes not from being truly empty but rather emerges as a defense against the fear that we are powerless to change and direct our lives. The absence of meaning derives from living lives directed by others" (p. 30). Cushman (1990) argues that psychotherapists are as much to blame as advertisers for promoting the "life-style solution." He states that " most psychotherapy discourse uses the dominant ideology of its era (the value of individualism and the transhistorical nature of the bounded, masterful, fully-individuated self) even though the patient's suffering is caused in large apart by that particular formulation and by the political and economic arrangements that constructed

it" (p. 607). According to Cushman the "life-style solution" suggests that if individuals think and behave more like their therapist, they will solve their problems and feel better. For the therapist has presumably learned the most effective means of living; Cushman argues that this idea carries out a subversive message.

The "life-style solution" compensates for cultural deficiencies through teaching and modeling, but denies the individual's self, especially when that person may deviate from the status quo. Cushman believes that by accepting society's expectations and psychology's
normative discourse, the "life-style solution" cooperates in further constructing the empty self.

Bugental and Bracke (1992) take Cushman's argument as support for an existential-humanistic approach. They state that "psychotherapies founded on mechanistic models and the dominant objectivist ideology of our era will be of little help in treating emptiness and loss of meaning" (p. 33). They further provide postulates of the existential-humanistic perspective: (1) The only and ultimate site of significant life change is in the subjectivity of the client, (2) as full presence and commitment to therapy, as possible, are required of both client and therapist, (3) the chief task of therapy is to help clients disclose to themselves through inner "searching" the ways in which they constrict their awareness and, thus, their lives.

Bugental and Bracke warn against the emerging trend toward managed behavioral care that aims to reduce specific symptoms in a relatively short period of time. They acknowledge that managed care will open psychotherapy to many people who would otherwise not receive these services, however, they point to the important contribution that adherence to existential-humanistic principles will have in increasing and enriching the life experience of those seeking psychotherapy.

Norcross (1987) performed a content analysis on over 80 publications related to existential psychotherapy. Through that analysis he was able to identify eight consistent themes: ontology, intentionality, freedom, choice/responsibility, phenomenology, individuality, authenticity, and potentiality. These eight themes provide a good overview to the existential component of this study, so I will describe each in slightly greater detail.

Ontology, or the study of being, is a theme that is universal for existentialists. In looking at psychodynamics the existential psychotherapist must recognize the conflicts that arise from the individual's confrontations with existence, namely death, freedom, meaning, and as Yalom (1980) points out, existential isolation. From this perspective the central task of the psychotherapist is to understand the patient as a being in this world. This "being in the world" is contrasted by non-bearing or nothingness. As people become alienated from their source of being they experience anxiety, pain, or guilt. Norcross (1987) states that only through the pain of living and experiencing the dread of nothingness can we as human beings begin to arrive at our unique selves. Yalom (1980) observes that the physicality of death destroys us, but the idea of death saves us.

Intentionality refers to the questioning of existence and the creation of meaning. As Sartre (1967) states, man is nothing else but what he makes of himself. This is a central tenet of the existential perspective, that individuals create their own meaning in an otherwise meaningless world. The meaninglessness of life may be presented as depression, anxiety, feelings of emptiness and boredom. The therapist, as a means for intervention, seeks to help the client understand the greater sense of mastery that comes with determining their own attitudes toward external circumstances.

Freedom, as Norcross (1987) describes, is that quality of action of the centered self, not of the will or ego, but of the totality of the individual. Human beings are seen as free but continually facing a variety of restrictions including instincts, inherited dispositions, and the environment. May (1981) defines freedom as possibility, which entails being able to simultaneously maintain different possibilities in one's mind, while not knowing in which direction to act. External circumstances are seen as limiting, but not determining. Subsequently, one of the goals for existential psychotherapy is to help clients to choose freedom, rather than accepting their situation as predetermined.

Choice and responsibility are central to existentialism. Norcross (1987) sees the anguish over freedom to be anguish over choice. Subsequently, choice involves responsibility; or in other words choosing between options means that something will be lost and other options will be eliminated. Existential psychotherapy seeks to restore the client's responsibility, and to help the individual become aware of the choices available to him or her.

Existential psychotherapy seeks to comprehend existence directly, and hence its method is phenomenological. The individual is understood within his or her own context, on his or her terms, and not comprehended in the "artificial realm of theory." The existential psychotherapist sees the client as an individual and not as an object, case, or problem. Subsequently, traditional diagnostic categories have limited utility for the existential psychotherapist, since to use such nomenclature negates the uniqueness of the responsible person. The phenomenological approach also considers both time and space. In speaking about growth and change the therapist must consider that each one of us can look back into the past, experience the present, and project ourselves into the future.

The sixth basic theme identified by Norcross is the uniqueness of the individual. Each individual is unique and cannot be understood by arbitrary reductions or compartmentalization of experience. This is not to say that the individual is an island, but rather that the individual is connected to the world and to other people, while remaining singular in their experience.

Authenticity is an attribute of an individual who evaluates and affirms his/her own unique sequence of possibilities, and does not accept prescribed routine uncritically. Bugental (1976) sees "authenticity" as a central aspect of psychotherapy. To be authentic is to be aware of ourselves as persons, to be aware of our relationships, and the world. Furthermore, authentic people take responsibility for their choices, and accept the full consequences of those decisions.

Potentiality is the final theme identified by Norcross, and refers to the concept that each individual has the capacity to grow and reach his/her unique potential. This is accomplished by being authentic, throwing off "the burden of the past" and transcending the former self. Transcendence is defined as that rare experience of transcending the subject-object, body-mind, causal-teleological, and temporal-spatial dichotomies.

Existential issues are difficult to identify, and often pose difficulties for the therapist working out of a short-term model. How can a "meaning of life question" be resolved in a time-limited way? It is important to remember that each individual strives for meaning, it may be masked by a number of defenses, but it is there. The therapist needs to understand what is really meaningful in a person's life, before decisions regarding therapeutic focus can be made.

Focus selection

The decision to do psychotherapy from a brief model necessitates forming a focus. Without a clear idea of the most salient issue, the therapist may find him/herself slowly moving into long-term work, or having clients prematurely leaving therapy. Since the need for determining a focus is most obvious for the brief therapist, let me review the processes some have developed in response to increased demand on counseling services.

Gage and Gyorky (1990) outlined how decisions about client assignment were made at a university counseling center. Staff members at a university were surveyed on what types of individuals would fit various disposition categories: (1) hospitalize, (2) refer out for open-ended therapy, and (3) recommend as appropriate for assignment within the center. There was a high degree of consensus regarding which clients were appropriate for hospitalization, which included those with signs of suicidal or homicidal potential, or the inability to function autonomously. In the "refer out" category, responses were related to chronicity, including having had previous long-term therapy, having had multiple therapy experiences, and evidence of chronic untreated disturbance.

Responses for the "appropriate for time-limited" category included developmental tasks, and specific well-defined areas of difficulty (e.g. academic concerns, relationship problems, career choice, and loneliness). Client descriptors for this group included good ego strength, ability to focus on goals, and mild disturbance.

An analysis of actual caseloads of the respondents showed that the majority of persons seen in this time-limited setting were experiencing adjustment problems, academic troubles, and identity and self-esteem issues. The next most frequent group

of clients included those with eating disorders, personality disorders, severe depression, and concerns involving adult children of alcoholics.

Also of note was the discrepancy between current caseload and responses for appropriate disposition. It seemed that if a client was in crisis or had a more serious diagnosis, then that person might be accepted for treatment despite similarity to the "refer out" category. The authors conclude that this may be the result of the difficulty of making decisions in the initial interview about a client's suitability for time-limited therapy.

Dworkin and Lyddon (1991) describe the development of a time-limited and managed-care treatment policy at Colorado State University's Counseling Center. As with a number of similar facilities, the authors' counseling center was faced with increasing demand while experiencing a series of financial cutbacks and limited resources. After attempting a variety of policies, including session limits and charging a 15 dollar fee for every session past the five allotted to each student per semester, they began a process of redefining their role as a university counseling center. The principles they outlined are summarized below:

1. Universities have a significant role to play in the psychological development and well-being of their students, and counseling centers should be one of the critical elements in fulfilling this role.

2. The mission of a counseling center is varied and includes: brief remedial services to students, training of future professionals, consultation to campus agencies, outreach in the form of education to the campus community, and crisis intervention.

3. It is not the role of counseling centers to offer long-term individual therapy to every student who wants and/or needs it.

With this role in mind they moved to a time-limited managed-care model for providing services. The move was made to conducting effective assessment during the initial intake, providing 24-hour crisis intervention (which included a day-time walk in program), and providing a range of psychotherapy and counseling services listed below. Each staff member was allowed 20% of their caseload for individuals that needed longer-term work. Types of treatment were divided into four categories. short-term (5 sessions or fewer within a semester), intermediate (up to 10 individual sessions per semester); extended (individual treatment over several semesters, offered primarily for training purposes); and group work. To determine which service to provide an individual, the following variables were considered:

1. Motivation for change
2. Ability to clearly identify a focal conflict
3. Desire for symptomatic relief
4. Evidence of previous coping ability
5. Ability to introspect, self-monitor, and experience feelings
6. Capacity for self-responsibility
7. Ability to develop trust, be open, and relate to others
8. Presence of a situational problem
9. Positive use of prior therapy

Using a pre-intake questionnaire that assesses relationships, alcohol use, and existence of sexual problems, the staff made decisions about appropriate dispositions. Dworkin and Lyddon (1991) conclude that while a time-limited managed care model may not fit for every agency or for every staff member, they have developed an effective way to cope with increasing demand on a university counseling center.

Robbins and Zinni (1988) discussed various facets of implementing a time-limited approach in a university counseling center. Three primary facets were identified, which they labeled as (1) motivational factors, (2) technical treatment issues, and (3) evaluation and planning mechanisms.

DeLacour (1986) describes a collaborative approach to finding a therapeutic focus within a brief psychodynamic framework. In their approach questions are aimed at the precipitating events that brought the client to seek services. Additionally, a chronological view of the client's developmental, familial, and relational experience is formed. The nature of relationships with parents, siblings, people in positions of authority, and peers are examined. Within the analysis of the clients significant relationships the experiences of loss, disappointment, rejection, and general coping style are considered.

DeLacour suggests that when an individual seeks assistance with a problem, the situation has become too much to cope with, or their customary coping strategy and defense mechanisms are either no longer functional or have been exhausted. The therapist aims, in the first meeting, to identify what has come into the forefront, and then to bring that into the client's awareness, often for the first time.

The gathering of information includes not only history taking, but also the vital information received from observing the client's approach to the relationship with the therapist. The brief therapist examines this relationship behavior in hopes of establishing a theme, describing how the individual relates in interpersonal relationships, as well as looking for transference issues. The initial clues regarding the relationship are compared to the information received during the assessment and history-taking phase. The focal issue, according to DeLacour, is arrived at over 2-4 sessions, though the decision of what the focal issue will be should not be made until

sufficient evidence exists, so that the therapist is not leaping into a rigid conclusion. The client's assistance and insight are helpful in the exploration of the focal issue, and the process is seen as a collaborative one.

Once a focus is conceived an agreement is made between the therapist and client about what direction will be followed. The therapist communicates the central issue clearly but briefly, so that the client understands what the therapist has identified as the central focus, and may either agree or disagree with it. It is obviously important to avoid leading the client to a focus with which they do not fully agree, or agree with simply as an attempt to please the therapist.

Ryle (1979) describes a process of forming the therapeutic focus by redefining the presenting problem in terms of either dilemmas, traps, or snags. Ryle defines common dilemmas, traps, and snags that clients present. A dilemma is expressed in the form of "either/or", defined as false dichotomies that restrict the range of choice, or "if/then", which are false assumptions of causality. A typical statement would be "In relationships, I am either close to someone and feel smothered, or I am cut off and feel lonely."

Traps are described, as being caught in two complementary dilemmas. An example would be, "I am not assertive enough, because of this I am often taken advantage of. If I am taken advantage of, I become angry. When I become angry I afterwards feel guilty, as a result I become unduly accommodating to others." The therapist helps the patient identify dysfunctional cognitions, and then helps generate and implement more adaptive thought.

A "snag" is seen as change being blocked by the anticipated consequences. These consequences may be the actual responses of others, or the expectation of such responses. Ryle also believes that the feared consequence may be deduced by the

therapist, but not known to the client. From a dynamic perspective an example of a "snag" would be the common Oedipal fear of a young adult, who limits assertion or success 'as if' these would be damaging to, or provoke revenge from the parents.

Once identified, the resolution of the client dilemmas, traps, and snags becomes the main focus of therapy. Like Beck, et al. (1979), exploration or identification of dilemmas, traps, and snags illuminates the person's beliefs, assumptions and modes of construing. Ryle's (1979) therapy attempts to revise the recurring difficulties in living, to more adaptive thoughts and behavior.

Ultimately, the process of determining a therapeutic focus is the same as the diagnostic process. Auerbach and Childress (1987) examined the utility of the DSM-III for psychotherapy. Addressing criticism that the DSM-III groups individuals together whose symptoms are similar, but who may have more fundamental differences, the authors reviewed the records of 30 patients whose main modality of treatment was psychotherapy. The authors found that a relatively wide range of DSM-III diagnoses were represented by their outpatient sample. About 80% of the patients fit well or moderately well in a DSM-III category. Of the 20% who did not fit well, most represented "problems in living", though the authors state that this did not mean the issues weren't taken as significant by the individual. Additionally, even when the diagnosis did fit the patient well, it did not express the essence of the problem for which the individual had sought treatment.

The V codes in particular were seen by the authors as not providing much clinically relevant information. Individuals could be "forced" into a diagnostic category, but this procedure is seen as questionable from both a scientific as well as an ethical point of view.

Another problem with the DSM-III, described by Auerbach and Childress, is that it does not account for the uniqueness of the individual. It is a classification of disorders, and not of people, and since much of what happens in psychotherapy has to do with the patient's personality, they cite this as problematic for psychotherapy. Arbitrary assignment is more likely to occur for the patients who present with problems of living than with those who present with more definite mental disorders. However, the percentage of individuals with problems in living is substantial among those seeking outpatient psychotherapy, and it could be argued that this group may be most helped by psychotherapy. The authors conclude that the criticisms of DSM-III point to the need for elaboration and continued revision.

Piper, DeCarufel, and Szkrumelak (1985) examined 21 psychiatric outpatients treated with short-term psychoanalytically oriented, individual psychotherapy. Outcome ratings were obtained from the patient, psychotherapist, and an independent rater. Two factors emerged as good predictors of both process and outcome variables. The first was the patient's predominant defensive style, and the second was the object choice of the patient.

Defensive style was defined as an unconscious habitual mental process through which individuals attempt to deal with conflict among impulses, internal prohibitions, and external reality. Object choice was a comparison of the patient's current important relationships with the quality of previous important relationships and of the current relationship with the therapist. Presented below are Piper et al.'s (1985) description of the developmental continuum between object relationship and defensive style.

Rating Scales for Defensive Style and Object Choice (Piper, et al., 1985)

Anchor points	Defensive style	Object Choice
7(Excellent)	Sublimation, suppression, anticipation humor, altruism	Genital. Stable relationships with valued external objects; autonomy, differences, and inevitable disappointments tolerated
5(Good)	Reaction formation, intellectualization repression, isolation, undoing, regression	Oedipal. Basically stable relationships with valued external objects whom the patient experience conflictual feelings; triangulation is evident; chronic apprehension about loss of the opposite-sex object who is viewed as unconsciously belonging to a previously internalized object.
3(Fair)	Projection, denial through fantasy, introjection, passive aggression	Obsessive. Somewhat unstable relationships with acting out, turning against oneself, ambivalently valued objects, predominance of resentment; autonomy denied through coercion and devaluation; constant fear and unconscious expectation of object loss; gratification through possessive control and submission of objects.
1(Poor)	Splitting projection, massive denial massive distortion, depersonalization	Depressive. Basically unstable relationships with minimally valued objects; value is attached only to a lost, previously internalized object (typically a maternal figure);helpless feelings concerning autonomy of objects; continual preoccupation and dejection about object loss; prevailing self-devaluation, sadness. and emptiness.

Piper, et al. (1985) examined moderately disturbed patients and found that defensive style and object choice are two independent predictors of favorable process and outcome. As such, assessment of defensive style and object choice would be an important addition when determining the focus for treatment. In order to do short-term

therapy an understanding of which defensive mechanisms are at work would save time, otherwise spent in a frustrating struggle with those same defense mechanisms.

Bond, Gardner, Christian, and Sigal (1983) set out to construct a questionnaire that would assess a person's perception of his or her defensive style. They hypothesized that defensive styles might identify aspects of a person's stage of development. The questionnaire was designed to identify an individual's characteristic style of dealing with conflict, either consciously or unconsciously. Statements were written to reflect behavior that would suggest a particular defense mechanism, including: acting out, pseudoaltruism, as-if behavior, clinging, humor, passive-aggressive behavior, regression, splitting, somatization, suppression, withdrawal, dissociation and others. Examples of the statements are as follows: "There is no such thing as finding a little good in everyone. If you're bad, you're all bad" (Splitting) or "If my boss insulted me, I might make a mistake in my work or work more slowly so as to get back at him" (Passive-aggressive).

Respondents were asked to indicate agreement or disagreement, with each statement, along a nine-point Likert-type scale. Four factors were derived that showed clusters of defenses:

Style 1- Defensive mechanisms seen as immature; withdrawal, regression, acting out, inhibition, passive-aggression, and projection

Style 2- Defense mechanisms related to omnipotence, splitting, and primitive idealization.

Style 3- Two defense mechanisms; reaction formation and pseudoaltruism

Style 4- Derivatives of more mature defensive mechanisms; suppression, sublimation, and humor.

In terms of assessment, Bond, et al. (1983) state that a questionnaire has some important advantages over the clinical interview, in their case, for assessment of defensive functioning. It saves time; it does not require highly trained professionals to administer it; it eliminates problems of inter-rater reliability; it can provide a measure of the degree to which defenses are present on a standardized continuum; and it provides an opportunity to gather normative data. Many of these same points would apply to a standardized instrument for determining therapeutic focus.

The need for assessment of therapeutic focus

The need for establishing a therapeutic focus has been approached from a variety of positions, ranging from use of clinical intuition to more systematic approaches. Hatcher, Huebner, and Zafkin (1986) state that there appears to be a general consensus in the brief therapy literature that it is important to establish a therapeutic focus. However, there has been little empirical research on the exact nature of that focus, on what constitutes a focus, how it is established, and to what extent focus changes during the course of treatment. Hatcher, et al. studied clients seeking help at a university counseling center. A statement of focus was gathered at three points in time: the intake, consultation, and termination, to determine how the focus changed over the course of brief therapy. The initial focus was derived by taking a history of the client's developmental and family background, current functioning, and the presenting complaint. The therapist then discussed the proposed focus with agency staff, consulting therapist and his/her supervisor. Following this consultation, the final focus was agreed upon, and included in a summary that went in the client's chart. From those summaries 13 thematic categories were compiled:

1. Loosening defenses and/or becoming aware of affect
2. Self-esteem issues
3. Evaluation and/or preparation for long-term therapy
4. Childhood trauma(death, divorce, hospitalization, etc.)
5. Late adolescent identity issues (career, relationships, separation-individuation
6. Accepting ambivalence
7. Crisis intervention (current)
8. Counterdependent issues (i.e. patient lets self "be helped")
9. Symptom relief (i.e. anxiety attacks, eating disorder)
10. Superego issues (including masochistic issues)
11. Academic difficulties (work block)
12. Impulse control
13. No focus

Blind raters were able to achieve high reliability (mean phi> .82) with 10 out of the 13 foci, and fair reliability (mean phi> .71) with three categories (self-esteem issues, accepting ambivalence, and counterdependent issues). Results showed that the presenting complaint was not the same as the consultation focus or the termination focus. The therapist was able to approximate, but not exactly match, the eventual focus for the therapy. Over the course of therapy the focus was shaped, defined, and sometimes entirely changed as new material emerged.

The most frequent termination foci were "adolescent identity issues" and "loosening defenses". The most frequent change was from a client's presenting complaint, usually for symptom relief, to one of the other foci. In only a few cases did therapists take the presenting complaint at face value. In many instances, clients

would present a vague complaint, such as "I'm just not happy", leaving little information for the therapist to go on.

In concluding, the authors state that there should not be a rigid, inflexible adherence to a focus, but rather a careful charting of the proposed focus. The therapist should continually ask: "Does the stated focus still seem to be related to the patient's core conflict?", and "Is this the focus which is maximally useful to the patient?"

Hall, Arnold, and Crosby (1990) report that while teaching a didactic course on brief, insight-oriented psychotherapy to psychiatric residents, the most persistent questions that arose were about establishing the therapeutic focus. Students expressed concern about how best to choose a focus, whether the identified focus was the "correct one," and how to go about maintaining the focus over the course of treatment. After reading several chapters on focus selection the residents found Budman and Gurman's (1988) discussion of the five most common foci in brief therapy to be "clear, helpful, and immediately applicable to clinical material" they were seeing . Hall et al. see Budman and Gurman's model as a general systems theory and describes clinical symptomatology to be the result of a "complex hierarchical interlocking of biopsychosocial relationships". Each piece, whether it is biochemical and physiological, intrapsychic, interpersonal, societal, and cultural, is believed to exist not as a separate piece but rather as an indispensable piece of the whole. Commenting on Budman and Gurman's central question, "Why now?", they see the answer to the question as a pass key into the system with the therapeutic focus as a critical variable. Even more critical is the therapist's belief that resolution of the chosen focus will be dependent on a positive influence on the multiple interrelated systems that were not selected. In essence, the therapeutic focus is determined by that area which is most accessible or amenable to therapeutic exploration. As well,

the central question of "Why now?" stimulates the patient to examine what in their lives is most problematic and which carries the most affect. Hall, et al. conclude that a system in flux is more readily prompted towards change than a system in homeostasis. Further, the pursuit of this central question will often result in an identification of a focus that is different from the patient's presenting complaint.

Horowitz, Marmar, Weiss, DeWitt, and Rosenbaum (1984) studied 52 bereaved patients who were given 12-sessions of time-limited, once a week dynamic psychotherapy. They sought to test various hypotheses linking process to outcome. Results showed that on average, patient characteristics were not predictive of outcome. One out of ten partial correlations was significant, in which patients who were rated as having a more stable and coherent self-concept (developmental level) before treatment showed a moderately better outcome in work and interpersonal functioning. The authors concluded that patients with higher levels of psychological organization may only be experiencing a transitory disruption of interpersonal functioning as a consequence of bereavement. Treatment may provide symptomatic relief which in turn allows the patient to return to their normal lives, and to their level of functioning before the experience of significant loss. While patients with pre-bereavement interpersonal inadequacies may experience symptom relief they will not experience significant improvement in interpersonal functioning. As with other forms of brief therapy, focus selection is vitally important, and maintenance of realistic therapeutic goals a necessity in terms of defining successful outcome.

Strupp and Binder (1984) outline a method for establishing a focus in their time limited dynamic psychotherapy(TLDP). That focus is grounded on two principles:
1. For the kinds of psychological problems treated by TLDP, the primary arena for construing life experience is interpersonal.

2. The primary psychological mode of construing life experience, for the therapeutic operations central to TLDP, is narration; the telling of story to oneself and others.

The TLDP focus considers the interpersonal roles in which patients "unconsciously cast themselves, the complementary roles in which they cast others, and the maladaptive interaction sequences, self-defeating expectations, and negative self-appraisals that result" (p. 68). By establishing a focus the therapist is able to conceptualize these problematic behaviors, and this allows the therapist to refer back to the focus for therapeutically relevant material.

The "focal narrative" describes human actions, which means that the focus is constructed of actions, and is not simply a collection of traits or other static features. These human actions are embedded in a context of interpersonal transactions, and organized in cyclical psychodynamic patterns. These patterns are seen to be a recurrent source of problems in living, and represent the patient's current problem for which they are seeking therapy.

Strupp and Binder state that the TLDP focus contains four structural elements which describe the patients interpersonal actions. These four action categories are:

1. Acts of self. These include all domains of human action, including both private and public actions. For example feeling affectionate as well as displaying affection.
2. Expectations about others' reactions. These are the imagined reactions of others reactions which may exist on a conscious, preconscious, or unconscious level. An example would be, "If I ask her out she will just laugh at me".
3. Acts of others toward self. These are observed acts of others that are viewed as occurring in specific relation to the acts of self. In other words, the actions of others appear, or are assumed, to be caused by the patient's own actions.

4. Acts of self toward self (introject). This category of actions refers to how one treats oneself; for example self-controlling, self-punishing, self-effacing.

The following examples are given:

Presenting problem: The patient complains of depression and marital difficulties.

Acts of self. Frances assumes a passive interpersonal position in which she refrains from disclosing her inner self, avoids social contact by withdrawal or procrastination, defers and submits to others' wishes, and spends much time in private thinking and wondering rather than in active communication.

Expectations of others' reactions: Frances expects that other people will ignore or reject her. She validates this expectation with recollections of being ignored or rejected by her mother and by various significant others.

Observed reactions of others: Others find Frances's passivity unappealing and do not spontaneously recognize her distress and come to her aid. However, Frances does not see this as an understandable reaction to her passivity, but instead interprets this as evidence that others are actively rejecting her and ignoring her.

Introject (how patient treats herself): Frances views herself as helpless in a hopeless situation. Rather than endure the imagined negative reactions of others, she inhibits and controls herself and refrains form asserting her desires or complaints (hoping that this interpersonal passivity will make her presence more palatable to others).

Strupp and Binder suggest waiting for two or three sessions before attempting to identify a TLDP focus. This allows the therapist an opportunity to examine the "ordinary complexity of the patient's narrative themes." As material is brought up and discussed the therapist may assess the patient's responses to various affectively

laden material. Often the patient may respond with loose or disorganized thinking, with seemingly inappropriate affects, attempts to control impulses, or with defense mechanisms aimed at maintaining psychic or interpersonal equilibrium. By allowing two or three sessions, according to Strupp and Binder, the therapist gathers information about recurrent patterns of interpersonal behavior.

Though the TLDP focus may be decided upon after the second or third session, there are guidelines for conducting the initial assessment. In the initial intake, it is important that the therapist (1) ask specific questions to clarify the patient's interpersonal behavior and subjective experiences, which is done by (2) asking open-ended questions, and (3) offer clarifying and interpretive comments, including parallels between instances of maladaptive behavior in seemingly diverse relationships or interactions. An outline for conducting the initial assessment follows:

I. PRESENTING PROBLEM:

1. What is the nature of the presenting problem? ("What brings in the patient now?")

2. Can the patient view the problem in interpersonal terms? Who are the significant persons involved?

3. Is there an immediately identifiable trauma or precipitant? If not, can one be found?

4. Does the presenting problem appear to occur for the first time in the patient's life? How long has the patient been aware of it? Have there been previous episodes? If so, when and under what circumstances did they occur? How did the patient handle any previous episodes?

5. How did the patient decide to seek therapy now? (Examining this question might involve having the patient review his or her thinking even minutes before having made the decision to contact the therapist).

II. RELATIONSHIPS

1. Social relationships

2. School and/or work relationships

3. Intimate and/or sexual relationships (including the patient's spouse and children)

4. Family of origin (parents, parental surrogates, siblings, relatives)

5. Leisure/recreational activities and interests

III. SIGNIFICANT LOSSES (EMOTIONAL AND/OR ACTUAL):

1. Separations and/or losses occurring in (1) childhood; (2) adolescence; (3) adulthood; including (a) parental separation or divorce; (b) death of parent; (c) birth of siblings; (d) frequent moves; (e) patient own separation or divorce from a spouse; (f) death of a spouse or other loved one.

IV. OTHER SIGNIFICANT LIFE DISRUPTIONS:

1. Serious injury or illness to self or significant other, job or career disruptions, and so on.

Strupp and Binder stress the importance of using the therapist-patient relationship as a means of assessing the patient's interpersonal functioning. From this information the TLDP focus will emerge, and point the therapist to the most salient feature of the patient's personality that is causing reoccurring problems.

In summary, there appears to be wide agreement that within the context of brief therapy it is important for the therapist to work towards identifying a therapeutic focus, and further it is the therapist's responsibility to maintain that focus through the

course of therapy. Certainly some flexibility should be allowed, however with too much flexibility there is the risk of the therapy turning into a more diffuse long-term process. Budman and Gurman (1988) have provided a theoretical structure for doing brief psychotherapy. Their central question is "Why now?" The proposed study will constitute an attempt to respond to that question, and further to develop an instrument that will aid the clinician in determining an appropriate therapeutic focus.

Qualitative analysis

Bogdan and Biklen (1982) provide a reference for doing qualitative research. Qualitative research has the natural setting as the direct source of data and the researcher is the key instrument, further the qualitative researcher is concerned with process rather than simply outcome. Subsequently, qualitative research is descriptive, and data is analyzed inductively. Context and "meaning" are a central concern to the qualitative approach; researchers are interested in how different people make sense out of their experiences.

When contemplating a case study they suggest that particular attention be paid to sampling procedures. What is the "typical" situation you are attempting to study? Objects, people, situations, and events do not possess their own meaning, but rather meaning is conferred upon them. The meaning that people give to their experiences and their process of interpretation is the essential component in understanding the whole process.

Jones and Windholz (1990) used audiotapes of psychoanalytic psychotherapy to study the therapy process. The treatment hours of a six year analysis were audiotaped and transcribed. Transcripts of these hours were then rated by clinical judges. This technique provided a standard language for the description and

classification of the analytic process. Through this process certain items emerged a clearly more important descriptor of the analytic process. During the middle of the analysis of the case being studied a heightening of certain defenses became evident. The client showed an increase in defiance, guilt, and hostility towards the therapist. The present study aims at using a similar method, systematic analysis of therapy sessions, to develop among others a Defensive Style scale to assess the level of defensiveness, as described by Jones and Windholz (1990).

Test construction

Crocker and Algina (1986) note that the goal of most measurement in education and the social sciences is the location of individuals on a quantitative continuum with respect to a particular psychological construct. They describe a systematic approach to test construction that includes ten steps. Those ten steps are as follows: "1.) Identify the primary purpose(s) for which the test scores will be used, 2) Identify behaviors that represent the construct or define the domain, 3) Prepare a set of test specifications, delineating the proportion of items that should focus on each type of behavior identified in step 2, 4) Construct an initial pool of items, 5) Have the items reviewed (and revise as necessary), 6) Hold preliminary item tryouts (and revise as necessary), 7) Field-test the items on a large sample representative of the population for whom the test is intended, 8) Determine statistical properties of item scores and, when appropriate, eliminate items that do not meet pre-established criteria, 9) Design and conduct reliability and validity studies for the final form of the test, and 10) Develop guidelines for administration, scoring, and interpretation of the test scores (e.g., prepare norm tables, suggest recommended cutting scores or

standards for performances, etc.)" (p.66). The present study, for the most part, will attempt to follow the process outlined by Crocker and Algina.

Crocker and Algina (1986) indicate that typically test developers will conceptualize one or more types of behavior which are believed to manifest the construct and then simply try to "think up" items. The risk in taking this approach is the omission of important areas of behavior or inclusion or areas that are relevant to the construct only in the mind of the particular test developer. A number of alternatives are described by Crocker and Algina, among them are content analysis and direct observation. In content analysis, according to the authors, open-ended questions are posed to subjects about the construct of interest, and their responses are sorted into topical categories. Those topics that occur most frequently are sorted into topical categories. In direct observation, the test developer identifies the behaviors through direct observation. An example given, would be a vocational counselor interested in developing an inventory to assess stress in high-risk occupations. Direct observation of the work environment would help the test developer identify potential sources of stress.

Jackson and Lay (1968) outline a methodology for development of homogenous scales within a personality test. Correlational and factor analytic results yielded consistent evidence that content dimensions could be defined clearly and uniquely regardless of direction or wording effects. Content dimensions were uncorrelated with the factors such as acquiescence and desirability, as related to response style.

In the Manual for the Personality Research Form (PRF), Jackson (1967) describes four important principles he used in construction of the PRF. They are: (a) An explicit, theoretically-based definition of a particular trait is essential prior to attempts at measurement;

(b) Careful empirical selection of items for homogeneity contribute substantially to refined measurement.;

(c) Suppression of response bias such as desirability is best undertaken at the level of item selection and scale development; and

(d) Both convergent and discriminant components of validity must be considered at every stage of scale development if the final scales are to possess these properties.

Neill and Jackson (1970) describe a variety of item selection strategies ranging from traditional biserial and item-total correlations, to a variety of techniques aimed at suppressing desirability variance or maximizing item variance. These techniques included differential item variance functions and factor analysis. They state that an item selection strategy should be based on the effect choosing an item will have on replicability, convergent and discriminant validity, scale homogeneity, and freedom from desirability bias.

Koteskey, Walker, and Johnson (1990) developed a measurement of identity that spanned adolescence through adulthood. They defined identity not in terms of individuality, but in terms of relationships with others. They stress that people know who they are on the basis of their relationship with others in their culture, community, religion, and family. In three experiments they revised their instrument, yielding four reliable scales that give information regarding a person's sense of family, religious, community, and cultural identity. They conclude that identity may be defined and reliably measured in terms of relationships.

In a discussion of developing instruments for use in counseling Osipow (1991) states that factor analysis can help sharpen scale items and clusters, but the resulting scale is more adequate if it starts with a theoretical context rather than simply factor analyzing a set of items already developed. He goes on to state "I have been

impressed with the importance of using ideas from practice to stimulate the development of scales. Important questions arise from experience for which there are no adequate instruments to use to study. Thus, it becomes important to be willing to study the phenomena. No amount of sophisticated data analysis skill, or experimental design will improve findings based on sloppy measures" (p. 70).

In summary, this study drew on the theoretical foundations of brief psychotherapists, including Strupp and Binder (1984), Mann (1981), Sifneos (1979), Beck (1979), and especially Budman and Gurman (1988). The following chapters will present the method, results, and a discussion of the development of the IDE Assessment Inventory.

CHAPTER THREE

This study was conducted in two separate phases. In Phase One a content analysis of intake interviews was performed as a means for generating items for the IDE Assessment Form. In Phase Two the instrument was administered to a large sample of undergraduate students, and then quantitatively analyzed to determine the reliability and homogeneity of the four theoretical scales that were proposed.

Phase one

Participants

Students seeking counseling, at a Student Counseling Center of a large public Midwestern university, signed a consent form to have their intake session audiotaped. A total of thirteen audiotapes were made. For those thirteen intake sessions the mean age of the clients was 20.46 , in terms of ethnicity 12 identified themselves as White and 1 as Asian. Two of the clients were First Year Students, five Juniors, and six Seniors. Ten of the clients stated that they had seen a counselor before, three had not.

The counselors for this study were four Pre-Doctoral Psychology Interns, at a APA-approved internship within a university counseling center. Their mean age was 36.9, two were male and two were female, and all identified their ethnicity as White. The mean number of years of counseling experience was 5.75. Two of the counselors identified their theoretical orientation as "Eclectic", and the other two identified themselves as "Cognitive-Behavioral" in orientation.

Procedure

The director of training at the counseling center was approached and agreed to allow intakes, performed by interns, to be audiotaped with the client's permission. Copies of the consent form and brief demographic information form (see Appendix B) were approved as well. Four Pre-Doctoral interns agreed to participate in the first part of the study. Clients being seen for the first time at the center were asked if they would be willing to participate in a study examining themes that clients bring to a university counseling center. Clients who were interested were then asked to read and sign the consent form describing the study and the purpose for which the audiotapes would be used. Clients were informed that they had the right to not participate, and that their decision to participate or not would in no way effect the type of services they would receive at the counseling center. In the consent form, participants were informed that only their first session, the intake session, would be audiotaped for this research project. Additionally, they were informed that the intake session would be transcribed and then analyzed by this researcher. Furthermore, they were informed that the audiotapes and transcribed copy would be kept confidential, and destroyed at the completion of the study.

Counselors were asked to conduct the intake as they would normally, that is to ask the same questions as they would in any other intake session. Furthermore, they were instructed that this study would focus on client statements, and their performance doing an intake would not be judged in terms of thoroughness or issues of style. Additionally, the counselors were informed that if they wished, a copy of the results would be sent to them.

From the thirteen audiotaped intake sessions, eight were randomly chosen to be transcribed and analyzed. It was decided that should the audio quality of any one

of the tapes should be unintelligible or inaudible, another session would be randomly chosen. There were small sections (a sentence or two) in several tapes that were inaudible. It was decided that the pieces that could not be understood were not sufficient to disqualify the entire tape from analysis. Therefore, all eight sessions that were initially chosen were transcribed.

Analysis

Only client statements, and not counselor statements, were analyzed. A client statement was separated into a "unit" of speech. Each unit consisted of enough words for the researcher to satisfactorily code it into one of the categories listed below. Therefore a "unit" may have been two words or two paragraphs, with the average being between 6-10 words. Each unit started with the client responding to the therapist, and ended when the theme of the unit changed (even if this involved no additional counselor response).

The following categories were used to code client theme units:

1= Interpersonal domain

a- intimate relationships (involving romantic relationships e.g. boyfriend, girlfriend, lover, etc.)

b- family of origin relationships

c- friendships

d- lack of relationships (loneliness)

e- losses

f- miscellaneous interpersonal issues

2= Developmental domain

a-developmental dysyncronies (young adult being unsuccessful separating from parents, young adult being unable to form a significant romantic relationship, etc.)

b-developmental transitions (graduation form high school or college, first job on career path, marriage, first child, etc.)

c-career development (choosing major and/or career)

d-misc. developmental issues

3= Existential domain

a-existential isolation (being alone in the world)

b-meaning (purpose in life, fulfillment)

c-freedom and responsibility

d-identity issues

e-mortality/death

f-misc. existential issues

4= Defensive style

a-ambivalence

b-avoidance/withdrawal

c-passive-aggression

d-negativistic/pessimistic/self-critical

e-unresolved anger

f-misc. defensive statements

5= Misc. client statements (Otherwise uncodable).

"Healthy" or functional statements

Item construction

Once all statements had been coded they were sorted into four scale categories. A summary of the number of statements coded in each category is presented in the Results section. The statements were then reformulated into survey items. Every effort was made to retain the literal meaning of the actual client statement, while making changes to fit the item response options.

Item responses were 1= Very true 2= Mostly true 3= Somewhat true 4= Not at all true. It was decided to code the responses so that a high score would indicate a problem in that area. Therefore, all items were recoded so that (1=4) (2=3) (3=2) (4=1), except for the following items which remained coded in the original format: INTERPERSONAL: I13 I17 I11 I25 I65 I98 I106 I108 I112 I116 DEVELOPMENTAL I42 EXISTENTIAL I47 I55 I91 I94 DEFENSIVE STYLE: I28 I60 I33 I128. Therefore, higher scores would reflect a problem in a specific domain, while lower scores would reflect a relative absence of problems in a particular area.

Phase two

Participants

The participants for Phase Two were students in introductory psychology courses at a large Midwestern university. The departmental committee reviewed a proposal for data collection and allowed access to their general research pool of subjects. There were 394 subjects that participated in completing the IDE Assessment Inventory. Of those who took the instrument, 203 (51.5%) were women and 191 (48.5%) were men. The mean age was 19.8 with a range of 18 to 37. First Year Students made up 60.4 % of the sample, Sophomores 17.8%, Juniors 12.7%, and Seniors 4.3%. In terms of ethnicity, 81.2% identified themselves as White, 4.8% as

African-American, 2.8% as Asian-American, 1.8% as Hispanic, and 9.1% as International (Non US citizen). In response to the following questions: "Have you ever seen a counselor, social worker, psychologist, or psychiatrist?", 70.8% said No, and 28.7% said Yes.

Procedure

Upon receiving departmental approval, sign-up sheets for this study were placed in the psychology department. Dates and times were posted and prospective subjects were informed that they would receive one hour of research extra credit for their participation.

Subjects were informed that this project was a study aimed at examining common themes with which individuals present at university counseling center. Subjects were asked to answer the questionnaire items as openly and honestly as possible, and that their participation should take from thirty to forty-five minutes. Furthermore, they were advised that their participation was voluntary, and that they could stop their participation at any point without losing the research extra credit. They were also informed that all responses would be kept confidential. A consent form and demographic sheet was given to each participant (see Appendix C). No identifying information, such as name or social security number, was associated with the subject's responses. Subject's responses were coded on standard Opti-Scan sheets. Items were reversed scored with the exception of the following items: 13, 17, 11, 25, 28, 33, 42, 47, 55, 60, 65, 91, 94, 98, 106, 108, 112, 116, and 128. Therefore, higher scores would reflect a problem in a specific domain.

Analysis

The analysis began with computing scores on each scale. The theoretical item composition scales were summed to create a total score for each of the four scales. Item analysis for Phase Two consisted of generating a correlation matrix containing the Pearson correlation coefficients of each item with each of the four theoretically composed scales. Internal consistency reliability analysis was conducted on each of the four scales, with coefficient Alpha derived for each scale. Each item was analyzed in terms of its contribution to overall Alpha, by examining the 'Alpha if item is deleted." A Factor analysis was done on each of the four scales, using Principal Components Analysis (PCA), unrotated. The goal of PCA is to summarize patterns of correlations among observed variables, to reduce a large number of observed variables to a smaller number of factors, to provide an operational definition (a regression equation) for an underlying process by using observed variables, or to test a theory about the nature of underlying processes (Tabachnick & Fidell, 1989). An attempt was made to maximize the homogeneity of each of the four scales, therefore the eigenvalues on the first factor were examined. It was desirable to have that first factor eigenvalue to be substantially larger than the subsequent factors, this would provide evidence of a predominant factor within each domain. In addition, the factor loading, for each individual item, on only the first factor was considered. An item with a large factor loading on the first factor was seen as contributing to the overall theme of the specific scale.

A "Separation Index" was calculated for each item, to determine how well it separated from the other three scales, it was calculated by the following formula:

$$r_{sep(i)} = r^2_{ia} [(r^2_{ib} + r^2_{ic} + r^2_{id}) / 3]$$

$r_{sep(i)}$ = separation index for an item "i"

ia = item to own scale

ib, ic, id = other three scales

The separation index therefore is the difference between the correlation of an item with its own scale and the average of the correlations with the other scales. It provides an indication of an item's convergence with its own scale, and a measure of its divergence from the other three scales.

The goal of this analysis was to determine if the theoretical structure predicted was confirmed with the data set obtained. The instrument was revised following this step to retain items which adequately represented the interpersonal, developmental, existential, and defensive style domains proposed above while deleting items that represented idiosyncratic themes.

CHAPTER FOUR

Results

Since a content analysis was used for the first phase, a sample of the transcribed intakes will be presented in the results section, to illustrate the process that was followed. The items generated from this first phase will then be presented . Results of the second phase will consist of the item analysis for the original scale composition, the final scale composition, and the cross-replication.

Phase one

A total of eight intake sessions were transcribed and analyzed. The procedure has been described above. However, to further explain the process used, three excerpts have been included with highlighted statements representing a coded client "unit" of speech. Counselor statements are followed by Co: and client statements follow Cl:. Asterisks will be used to symbolize names or places that might identify a client.

From Transcript 13

Co: Uh-mm as for this session... enough of the formalities uh-mm. I would like to get to know a little of what you've done and what made you decide to come into the Counseling Service today, and what I can help you with. Feel free to start wherever...

Cl: (nervous laughter)

Co: is comfortable.

Cl: Ok.uh-mm. It is.. I came for the first time last January for counseling cause *I was sexually abused when I was like six or so*, I'm not sure of the age exactly. But

uh-mm, that was.. I knew all my life... I should come... ***I should get counseling.*** But uh-mm ***I always thought I'm fine***... and I finally... finally did it, and it was.. it was like when I think of what I am most proud of in my life.. that that's what it is. That I finally took that step to get in for counseling.

Co: Takes a lot of strength to...

Cl: Yeah.

Co: realize that you can help yourself.

Cl: Yeah. I didn't have anything all summer... I was going to read and try to do things and write, and I didn't (nervous laughter). I, I just want to be able, to go past, get past, well I don't know what you do, but ***I just want to... be better...***

Co: Uh-uhmm...(inaudible).

Cl: I mean I can really see in so many ways how it has affected every part of my life.

Co: Uh-uhmm.

Cl: And this summer... ***I had trouble***.. OK.. the person who abused me was only a few years older than me, and he was my neighbor and the thing... all this time I never called it actual abuse... it was just this thing that happened when I was little...

Co: Uh-hmm

Cl: and actually his brother did too ... it just wasn't as severe so I never considered it that way... and I basically did it willingly I didn't know what I was doing at all.

Co: You were young... you didn't know.

Cl: Yeah, but I never even considered it sexual abuse until maybe a year a ago, a year and half ago, and this summer well ***I'm finding out more and more of my friends were abused.*** One of my best friends, a girl I spent basically the whole summer with,

we saw each other every day, she just found out well she is just learning since last November, cause she was sexually abused and ***she has had like flashbacks, and she didn't remember, and I always knew...***

Co: You've always remembered.

Cl: Yeah I don't remember details but was years ago.

Co: Sure.

Cl: But uhmm, she is pretty sure it was her Dad, and uhmm her other sisters were abused too. And she is dealing... she just figured out it was her Dad... she is not exactly sure yet but.. we are pretty sure, we have talked about it a lot. And if.. I guess I'm having... and then my other best friend was sexually abused too but she hasn't figured out who yet. And ... so ***I keep comparing my situation to theirs*** and to me ***I feel I [illegible]e shouldn't.. uhmm my problems are nothing*** .. I mean I look how I've always known...

Co: Uhmm

Cl: and how they are just figuring it out, and I see that as mine isn't that bad... ***but it really isn't that bad. I 'm having a lot trouble with that lately.***

Co: OK, so what you are doing is minimizing the painful experience just because you didn't block it out...

Cl: Yeah.

Co: like other people did.

Cl: Yeah. He was only a few years older than me, so.... he didn't completely know what he was doing.

Co: What was the neighbor boys name? that abused you.

Cl: ***** (deep breath).

Co: ***** OK. How do spell his name?

Cl: *****.

Co: uh-mm.

From Transcript 4

Co: OK it says here you would like to be able to discuss personal problems with someone who is not already emotionally involved ... Right ... sounds like there has been some feelings going on here.

Cl: ***It is hard talking to people who you know already have their minds made up what they want you to do***

Co: Uh-huh... yeah what's the deal ****.

Cl: Well, uhmm ***I found out that I am pregnant*** ..

Co: You did...

Cl: Right , this past weekend and ... I am here on an ****** *******so...

Co: It complicates things

Cl: from *******... I live in ********. so I had told the ******, and they wanted me to figure out all my options and what I can do with it, and they kinda want me to stay ... but ***I don't really know if that is what I want to do*** ...

Co: Uh-uhmm, what would staying involve?

Cl: Abortion

Co: Abortion

Cl: basically ***that is what everyone wants me to do*** ..

Co: Do they?.. who is everyone?

Cl: My parents and the *****.... I mean they haven't came out and said that but it seems that is what they would rather me do that..

Co: Uh-huh

Cl: I never believed in that ...

Co: Uh-huh it seems to go against your values system ... have you talked with your ***parents*** ?

Cl: Yeah I have ... ***they would rather me do that just to finish my education*** but they are not saying they won't help me if I decide to come back ...

Co: That would be their preference..

Cl: Right.

Co: But they would understand and support you if you ..

Cl: ***They do not want to make the decision for me they said..***

Co: OK , its a tough one, a tough spot to be in . Where are you with it ****?

Cl: I think now.. ***I think I am going to go back home...***

Co: Are you?

Cl: yeah, I think that will be best for right now ...

Co: And plan to have the baby ?

Cl: Probably, yes .

Co: OK...

Cl: I mean I was glad I went to the doctor yesterday I heard his heartbeat.. ***its hard to do something like that after...***

Co: You are about what...

Cl: 2 1/2 months

Co: 2 1/2 months

Cl: Yeah...

Co: You can cry if you want to

Cl: I have done a lot..

Co: I bet you have (chuckle) ... on the one hand it must be such a neat thing to be pregnant, huh, to know that that little baby is in there .. a life is growing...

Cl: It wasn't at first ...

Co: It wasn't... Ok

From Transcript 9

.....

Co: What was it like coming off to college?

Cl: Ah...

Co: What, what's your experience after high school been like. I noticed that you are a senior.

Cl: Yes (chuckling) Um, actually I was ready to get out. ***I was ready to leave. I was sick of....***that's why I graduated early. I got to get out early so, so I could come out here. Ah, I got sick of it back there, my folks were really starting to (pause) ... lets see yeah, yeah... I didn't, ***I didn't feel like I had enough freedom***, enough (inaudible) ***I was really getting ah, sick of my job.***

Co: What were you doing?

Cl: I was working in a grocery store back home. I, it wasn't the job, it was my boss, he was an idiot, that's what it was. I still say that.

Co: I have had a boss or two like that.....

Cl: I, I was of ... ***I was sick of him.*** A lot of things at school with the teachers, some of the teachers and the principle and stuff like that. Such a sports oriented school. Academics..... ***I didn't think much of High School.. things could have been a lot better.***

Co: So what is your major here?

Cl: Computer Engineering

BREAK....

Co: Since you've been in college ..... ah, how about going back to your Freshman year . what was that like?

Cl: Ah, the first semester when I came up here from ****** right out of high school. Um, ***I didn't do much for the first few weeks*** but then after a while I started hanging around the guys from my floor.

Co: Where did you live?

Cl: When I first came. I lived in ****** Hall.

Co: What group is that in? ***

Cl: Yeah, old ***.

Co: **** Yeah.

Cl: I started hanging around with them and had some fun, occasionally, around the middle of the semester (sigh) and then ***I started to shy away and didn't do much.*** Then ***I went home*** for the summer, ***and that was miserable*** (kind of laughing) as I remember. I didn't remember why but I just remember it was.... (pause) then I came back next fall , ah during Marching Band and hung around with some of the Marching Band people, seemed like.....

Co: I used to be with that... Tenor Sax.

Cl: Tenor Sax

Co: So did you make any lasting friends from Band?

Cl: Oh yeah I'm in Band this year.

Co: Oh, so you're still in ....

Cl: Yeah, its my third year in Band . So there are still some people that's still there so... and a lot of my friends are from Band right now. And, and then the next

semester ***I didn't do much of anything. I can't remember what I did...*** i, I didn't , ***I didn't do anything social that year*** besides Band in the Fall and then... (long pause) (tapping something) .. that's it.

Transcripts were analyzed, and statements that fit one of the four domains were marked and then translate into items. Where possible the client's exact words were used, changes were made for some items to make the item more understandable, or to fit with the response options indicated above. A total of 202 items were generated in this manner. A summary of the number of statements coded in each category is presented below:

1= Interpersonal domain

- a- intimate relationships 10
- b- family of origin relationships 22
- c- friendships 16
- d- lack of relationships (loneliness) 7
- e- losses 1
- f- miscellaneous interpersonal issues 9

2= Developmental domain

- a-developmental dysyncronies 6
- b-developmental transitions 4
- c-career development 5
- d-misc. developmental issues 4

3= Existential domain

- a-existential isolation 2
- b-search for meaning 11
- c-freedom and responsibility 9

d-identity issues 8

e-mortality/death 0

f-misc. existential issues 7

4= Defensive style

a-ambivalence 4

b-avoidance/withdrawal 9

c-passive-aggression 5

d-negativistic/pessimistic/self-critical 15

e-unresolved anger 9

f-misc. defensive statements 7

5= Misc. client statements (Otherwise uncodable).

"Healthy" or functional statements 6

Presented below are examples, taken from the excerpts presented above, to illustrate how client statements were translated into item form.

Transcript 15	Item
I was sexually abused when I was like six	***I have been abused***
I should get counseling	***I should get counseling***
she has had like flashbacks	***I have had flashbacks***
Transcript 4	
It is hard talking to people who you know already have their minds made up what they want you to do	***It is hard for me to talk with other people about my problems.***
I don't really know if that is what I want to do	***I don't really know what I want to do***
I think I am going to go back home...	***I think that I am going to drop out of school and go back home***

Transcript 9

I didn't feel like I had enough freedom,	*I don't feel like I have enough freedom*
I didn't think much of High School.	*I didn't think much of High School.*
I didn't do anything social that year	*I don't socialize much*

Items that were confusing or redundant were eliminated, leaving 129 items in the IDE Assessment Form (see Appendix C). Of the 129 items 39 were hypothesized, based on content, prior to administering the test, as belonging in the Interpersonal scale, 20 in the Developmental scale, 25 in the Existential scale, and 45 in the Defensiveness scale.

The result, then, of the first phase of this study was the generation of the items that make up the IDE Assessment Inventory. Presented below are the items in the inventory organized by domain:

INTERPERSONAL

1. My parents often would criticize me
2. My parents have made me feel badly about things that I have done
3. Ours is not a close family
4. In our family we often hug each other
5. In my family we say "I love you" to each other
6. I am not very close to my parents
7. I feel very close to my parents
8. I have feared that my father would abuse me
9. I remember one of my parents being gone a long time when I was younger
10. When I am upset I usually try talking with a friend about it
11. My friends and I have talked about sex
12. The thought of being in a relationship really scares me
13. I have never been able to develop a dating relationship.
14. The person I care about is not ready for a real commitment
15. I get irritated when I am in a relationship too long
16. I don't expect anything from my parents
17. I like to help people
18. I don't particularly make an effort to see my family
19. I have not had a significant relationship in my life
20. I tend to put responsibility for relationships on other people
21. I am dealing with a lot of shyness right now
22. I get nervous in larger groups
23. I get nervous in sexual situations

24. I get nervous when I go to parties
25. I'm reluctant to go up and talk to people
26. When I am around other people who are having fun, I don't know what to do
27. I have a lot of people that are willing to help me
28. There is a lack of communication between the people I am close to
29. I'd like to have an intimate relationship
30. I want to learn how to have better relationships
31. I like to talk to people
32. I have a lot of friends
33. I am trying to be more open with my friends
34. My friends care for me
35. It is very important to my family that I am a success
36. I am a very sensitive person
37. I tend to care more for other people than I do for myself
38. The people that I date are emotionally unstable
39. There is a lot of conflict in my life

DEVELOPMENTAL

1. I have been abused
2. There were painful events in my childhood
3. I am worried about getting a good job
4. I have ended up not very happy in my life
5. I am not the person I once was
6. I don't allow myself to make mistakes
7. I have made a great deal of improvement in my life
8. I don't think that anyone will ever marry me
9. I consider myself a virgin
10. When I was young, I took care of the family
11. There are so many things that interest me
12. The idea of marriage sounds silly to me
13. I'm from a small town
14. My parents had problems raising me
15. There are things in my life that are basically unresolved
16. I don't know how to act around people I am attracted to
17. I have never had a real date in my life
18. I need to develop my social skills
19. I am undecided about my major
21. I have a lot of high expectations to meet

EXISTENTIAL

1. I am really lost
2. I don't know what I should do in my life
3. I take on a lot of responsibility
4. I am afraid that my friends would not like who I really am

5. I have recently ended a very meaningful relationship
6. I feel bad making decisions that will affect other people's lives
7. I would feel guilty if I did something I knew was wrong
8. I think that life will be easier once I make an important decision
9. I have a lot of free time
10. I'm caught in the middle on a lot of things
11. I don't know how I feel
12. I want others to realize that they have to accept me the way I am
13. I am the "black sheep" of my family
14. My family knows that I am there for them, if they need me
15. I don't know what my identity is
16. My friends don't actually know me
17. I have become what people think I am, not who I really am
18. I am a creation of what people think I should be
19. I will be alone for the rest of my life
20. I don't feel like I have enough freedom
21. I am struggling with an important decision right now
22. I am confused about how to deal with a problem I am having
23. I think that I am going to drop out of school and go back home
24. Religion gives you a model on how to live a good life
25. I have so much to live for

DEFENSIVE STYLE

1. I am dealing with a lot of stress right now
2. Most of the socializing that other people do is very superficial
3. I have had strange experiences in my life
4. I have experienced a lot of pain in my life
5. I am not a good person
6. I have thought that I deserve only pain
7. I deserve the good things in life
8. I have low self-esteem
9. Someone in my immediate family has had a nervous breakdown
10. I cry often
11. I don't like myself
12. I have had terrifying nightmares
13. I have had friends that were in the mental hospital
14. I just try to bury my bad feelings
15. I can usually open up pretty easily
16. It is really hard for me to talk about my feelings
17. Sometimes I wish that I had never been born
18. I don't express things well
19. I have a lot of repressed anger
20. I have a lot of guilty feelings
21. Little things are just overwhelming me
22. I really don't care much about anything
23. When I get mad, I don't know the right way to express it

24. I am a very closed person
25. I look to other people to make decisions for me
26. I need to talk more about my problems
27. I keep changing my mind on important decisions
28. I've always had insomnia
29. I go along with the things that are required of me
30. I often offer suggestions to my friends about their problems
31. I never think I am good enough
32. I am a perfectionist
33. I am comfortable with who I am
34. I always do what other people want me to do
35. I can fool most people on how I really feel
36. I am afraid to burden other people with my problems
37. I feel that I am being fake with some people
38. I keep having negative thoughts
39. I think about my eating habits a lot
40. I need to be in control
41. I am nervous and tense frequently
42. Sometimes I feel really depressed
43. I like to get drunk
44. I don't think that I could ever attempt suicide
45. Drinking lets my true emotions come out

The items were randomly ordered and assembled into the 129 item IDE Assessment Inventory (see Appendix C). Response options were 1= Very true, 2= Mostly true, 3= Somewhat true, 4= Not at all true. Reponses were coded on Opti-scan sheets, along with the demographic information.

Phase Two

The first analysis step in Phase Two was to split the original sample into two samples, so that a cross-replication of the final obtained item groupings could be done. The original sample of 394 was split into two random samples. Using the SAMPLE command in the Statistical Package for the Social Sciences Release 4.0 (SPSS) (1991), a sample with 80 % and a sample with the other 20% were created. All statistical analyses were done using SPSS Release 4.0. Analyses for the original

item composition and the final obtained grouping were done using the 80% sample (N=321), the 20% sample (N= 73) was used for the cross-replication.

A correlation matrix containing Pearson correlation coefficients was computed for each item with each score on the four scales listed in Phase 1. A "Separation Index" was calculated by the formula calculated earlier. The separation index is the difference between the correlation of an item with its own scale and average of the correlations with the other scales. Higher separation index values reflect an item's contribution to its own scale independent of the other scales. Low or negative separation index values reflect items that do not contribute to its own scale, and/or converge with one or more of the other scales. Internal consistency reliability was estimated using Cronbach's Alpha. Additionally, a Principle Components Analysis was conducted to determine the basic structure of the four scales.

Table 1 contains the means, standard deviations, and range of the four scales, for the original scale composition, final obtained scale composition, and the cross-replication.

Table 1 presents the means, standard deviations, minimum scores, and maximum scores for the four scales through the original scale composition, final obtained scale composition, and the cross-replication. For the original item composition the Defensive Style scale had the highest mean, as might be expected since it also had the most items (45) of the four scales. None of the scales had the actual lowest or highest possible score. The final obtained scale composition reflects scales with more similar size. However, the Defensive Style scale still had the most items (20) and had the highest mean, standard deviation, and the greatest range. All four of the scales did have minimum scores that were the lowest score possible, a

Table 1

Means, Standard Deviations, and Range of Interpersonal, Developmental, Existential, and Defensive Style scales.

	Mean	Standard Deviation	Minimum Score	Maximum Score
Original scale composition				
Interpersonal (39 items)	74.19	11.21	52	112
Developmental (20 items)	37.10	6.92	23	57
Existential (25 items)	45.15	9.07	30	76
Defensive Style (45 items)	86.91	17.88	57	161
Final Obtained Scale Composition				
Interpersonal (16 items)	28.80	7.50	16	57
Developmental (14 items)	24.72	6.29	14	46
Existential (15 items)	24.50	7.25	15	51
Defensive Style (20 items)	35.27	10.47	20	77
Cross-Replication				
Interpersonal (16 items)	28.91	7.17	18	50
Developmental (14 items)	25.41	5.60	15	44
Existential (15 items)	25.49	7.06	15	48
Defensive Style (20 items)	36.41	10.48	22	68

score of 16 with 16 items, 14 with 14 items. and 15 with 15 items, and 20 with 20 items, respectively. Upon cross-replication all four scales showed stability in terms of their means, standard deviations, and ranges. All four scales had the mean scores increase slightly, around one point, standard deviations were also within one point of those found for the final obtained scale composition. Standard deviations stayed within one point of those found for the final obtained scale composition. There were differences in the maximum scores, with all four scales having lower maximum scores on cross-replications than on the final obtained scale composition. Minimum scores remained stable, only the Existential scale had the lowest score possible for minimum score on cross-replication.

A Principal Components Analysis (PCA), unrotated, was conducted. PCA extracts factors with eigenvalues greater than one. For the Interpersonal scale, PC extracted 11 factors with the following eigenvalues, (in the parenthesis is the number of items, taking each item's highest loading, that load on that factor and percent of variance accounted for by that factor): 6.50 (24, 16.7%), 3.50 (5, 9.0%), 3.21 (3, 8.2%), 1.78 (3, 4.6%), 1.55 (0, 4.0%), 1.44 (1, 3.7%), 1.36 (0, 3.5%), .1.27 (2, 3.3%), 1.17 (1, 3.0), 1.13 (0, 2.9%), and 1.02 (0, 2.6%). For the Developmental scale PC extracted five factors with eigenvalues of 3.7 (12, 18.5%), 2.34 (2, 11.7%), 1.50 (3, 7.5%), 1.32 (1, 6.6%), and 1.12 (1, 5.6%). For the Existential scale PC extracted seven factors with eigenvalues of 5.9(14, 23.7%), 1.80 (3, 7.2%), 1.59 (2, 6.4%), 1.29 (1, 5.2%), 1.21 (2, 4.9%), 1.14 (1, 4.6%), and 1.03 (1, 4.1%). For the Defensive Style scale PC extracted twelve factors with eigenvalues of 11.04 (32, 24.5%), 2.48 (2, 5.5%), 2.28 (4, 5.1%), 1.79 (2, 4.0%), 1.67 (0, 3.7%), 1.45 (0, 3.2%), 1.30 (1, 2.9%), 1.24 (2, 2.8%) 1.14 (0, 2.5%), 1.03 (1, 2.3%), 1.02 (0, 2.3%), and 1.01 (1, 2.3%). The complete

correlation matrix of the all the items in the original item composition is presented in Appendix A.

Tables 2, 3, 4, and 5 display item analysis statistics for the Interpersonal, Developmental, Existential, and Defensive Style scales for the original scale composition. Items are rank-ordered in terms of the item's correlation with its own scale, on the same line is the Alpha if item is deleted, first factor loading, and its separation index score. The content of each item has been included for reference.

Table 2 presents results for the original Interpersonal scale composition. There were 39 items in the Interpersonal scale, with a standardized item Alpha of .8253. The strongest item to scale correlation was for Item 122 ("There is a lot of conflict in my life"), however it had a negative separation index score of -.0032. The lowest item to scale correlation was for Item 37 ("When I am upset I usually try talking with a friend about it"), the correlation coefficient being -.1585. There were 20 items that had a .40 or better correlation with the Interpersonal scale. Alpha if item is deleted provides an indication of an item's contribution to the internal consistency of the scale. An item would be considered as not adding to the scales reliability if Alpha increases when an item is deleted, and subsequently an item would add to the scale's reliability if Alpha decreased when the item was deleted. Item 37 had the highest Alpha if item is deleted, while item 122 had the lowest. As described earlier, a principal components analysis was conducted to examine the basic structure of the four scales.

A large factor loading on the first factor identified an item as representing the general theme of the scale. Once again, item 122 had the largest loading on the first factor (.65494), and item 37 had the lowest (-.26147). Twenty items had first factor loadings of .40 or greater. Item 25 had the highest separation index score (.2331),

Table 2

Item analysis results for original item composition: Interpersonal Scale

Standardized item Alpha= .8253

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
122	There is a lot of conflict in my life	.6419	.8074	.65494	-.0032
25	I feel very close to my parents	.5834	.8088	.58510	.2331
21	I am not very close to my parents	.5822	.8100	.58171	.2153
100	There is a lack of communication between the people I am close to	.5677	.8098	.57740	.1962
9	Ours is not a close family	.5538	.8112	.55988	.2154
81	I am dealing with a lot of shyness right now	.5207	.8117	.52699	.1001
96	When I am around other people who are having fun, I don't know what to do	.5083	.8132	.53548	.0673
69	I don't particularly make an effort to see my family	.4985	.8130	.49979	.1322
77	I tend to put responsibility for relationships on other people	.4890	.8133	.50533	.0542
87	I get nervous in sexual situations	.4784	.8129	.49260	.0563

Table 2 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
49	I have never been able to develop a dating relationship	.4644	.8136	.45965	.0875
112	My friends care for me	.4589	.8142	.51111	.1024
93	I'm reluctant to go up and talk to people	.4579	.8137	.47558	.0725
84	I get nervous in larger groups	.4335	.8145	.43031	.0582
45	The thought of being in a relationship really scares me	.4326	.8146	.43126	.0135
1	My parents often would criticize me	.4301	.8147	.42104	.0802
17	In my family we say "I love you" to each other	.4290	.8151	.42914	.1631
90	I get nervous when I go to parties	.4231	.8150	.45913	.0963
5	My parents have made me feel badly about things that I have done	.4118	.8154	.42658	.0282
13	In our family we often hug each other	.4117	.8156	.40438	.1515
53	The person I care about is not ready for a real commitment	.3956	.8161	.37006	.2331

Table 2 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
104	I want to learn how to have better relationships	.3900	.8161	.35533	.0271
120	The people that I date are emotionally unstable	.3708	.8165	.37341	.0383
73	I have not had a significant relationship in my life	.3627	.8170	.34998	.0472
108	I have a lot of friends	.3575	.8189	.40056	.0782
98	I have a lot of people that are willing to help me	.3441	.8176	.36495	.0695
106	I like to talk to people	.3223	.8179	.34846	.0782
57	I get irritated when I am in a relationship too long	.3059	.8184	.30295	.0244
118	I tend to care more for other people, than I do for myself	.2954	.8184	.27091	-.0552
29	I have feared that my father would abuse me	.2889	.8186	.26604	.0011
33	I remember one of my parents being gone a long time when I was younger	.2801	.8198	.26427	.0103
61	I don't know how to act around people I am attracted to	.2358	.8209	.19987	.0272
65	I like to help people	.2131	.8207	.23745	.0443

Table 2 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
41	My friends and I have talked about sex	.1591	.8225	.16923	.0254
114	It is very important to my family that I am a success	.1122	.8253	.04667	.0000
110	I am trying to be more open with my friends	.0439	.8260	-.05000	-.0052
102	I'd like to have an intimate relationship	.0000	.8275	-.07958	-.0033
116	I am a very sensitive person	-.0043	.8278	-.02860	.0000
37	When I am upset I usually try talking with a friend about it	-.1585	.8335	-.26147	.0382

indicating that it converged with the Interpersonal scale and diverged from the other three. Item 119 ("I am trying to be more open with my friends") had the lowest separation index score (-.0052), which indicates that it correlates with one or more of the other scales. The Interpersonal scale, as a whole, correlates .7353 with the Developmental scale, .7450 with the Existential scale, and .7452 with the Defensive Style scale.

Table 3. provides the item analysis results for original Developmental scale composition. Standardized item Alpha for the scale was .7114. Nine items had correlations with scale of .40 or greater. Item 58 ("There are things in my life that are basically unresolved") had the highest correlation (.6387), while item 26 (" I have made a great deal of improvement in my life") had the lowest (.0965). Item 50 ("I am from a small town") had the largest Alpha if item is deleted (.7124), and item 58 had the lowest (.6491). Item 58 also had the highest first factor loading of .70550, while item 26 had the lowest (-.05298). Item 62 ("I don't know how to act around people that I am attracted to") had the highest separation index score (.1340), while item 14 ("I have ended up not very happy in my life") had the lowest (-.0287). The Developmental scale correlates .7353 with the Interpersonal scale, .6998 with the Existential scale, and .7140 with the Defensive Style scale.

Table 4 provides the item analysis results for the original Existentiai scale composition. Standardized item Alpha for the scale was .8293. The largest item to scale correlation was for item 59 ("I don't know what my identity is") at .7161, the lowest was for item 27 ("I would feel guilty if I did something I knew was wrong"), with .0906. There were 14 items with item to scale correlations of .40 or greater. Item 43 had the lowest Alpha if item deleted score (.7961), while items 47 ("I want others

Table 3

Item analysis results for original item composition: Developmental scale.

Standardized item Alpha = .7114

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
58	There are things in my life that are basically unresolved	.6387	.6491	.70550	.0591
18	I am not the person I once was	.5648	.6586	.61604	.1018
62	I don't know how to act around people I am attracted to	.5571	.6599	.52102	.1340
70	I need to develop my social skills	.5448	.6615	.53425	.0479
6	There were painful events in my childhood	.5000	.6672	.57654	.0990
14	I have ended up not very happy in my life	.5091	.6695	.62604	-.0287
30	I don't think that anyone will ever marry me	.4893	.670[illegible]	.53298	.0573
39	When I was young, I took care of the family	.4392	.6737	.51577	.0745
10	I am worried about getting a good job	.4339	.6749	.40923	.0412
74	I am undecided about my major	.3974	.6822	.34530	.0566
54	My parents had problems raising me	.3575	.6807	.39486	.0729
78	I have a lot of high expectations to meet	.3392	.6850	.29642	.0757

Table 3 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
2	I have been abused	.3282	.6828	.57654	.0529
66	I have never had a real date in my life	.3194	.6835	.30317	.0363
22	I don't allow myself to make mistakes	.3169	.6857	.26891	.0643
34	I consider myself a virgin	.3148	.6991	.17523	.0913
46	The idea of marriage sounds silly to me	.3017	.6850	.32636	.0087
50	I'm from a small town	.2407	.7124	.04750	.0568
42	There are so many things that interest me	.0978	.7024	.04944	-.0129
26	I have made a great deal of improvement in my life	.0965	.7078	-.05298	-.0189

Table 4

Item analysis results for original item composition: Existential scale.

Standardized item Alpha = .8293

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
59	I don't know what my identity is	.7161	.7964	.76809	.1687
43	I don't know how I feel	.7125	.7961	.76925	.1552
85	I am confused about how to deal with a problem I am having	.6825	.7972	.70312	.1617
7	I don't know what I should do in my life	.6340	.8008	.67694	.1677
3	I am really lost	.6084	.8042	.67675	.1584
82	I am struggling with an important decision right now	.5905	.8026	.58163	.1503
38	I'm caught in the middle on a lot of things	.5810	.8033	.59195	.0787
67	I have become what people think I am, not who I really am	.5661	.8048	.58661	.1307
71	I am a creation of what people think I should be	.5245	.8065	.52658	.1219
15	I am afraid that my friends would not like who I really am	.5121	.8080	.54216	.0613

Table 4 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
79	I don't feel like I have enough freedom	.5056	.8072	.49547	.0911
63	My friends don't actually know me	.4967	.8078	.53156	.0382
75	I will be alone for the rest of my life	.4961	.8090	.54836	.0751
94	I have so much to live for	.4814	.8083	.46236	.1186
88	I think that I am going to drop out of school and go back home	.3763	.8132	.41182	.0522
19	I have recently ended a very meaningful relationship	.3627	.8191	.29857	.0679
31	I think that life will be easier once I make an important decision	.3527	.8154	.31716	.0762
51	I am the "black sheep" of my family	.3478	.8142	.32472	.0548
23	I feel bad making decisions that will affect other people's lives	.3430	.8153	.30352	.0424

Table 4 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
91	Religion gives you a model on how to live a good life	.2671	.8209	.17510	.0606
55	My family knows that I am there for them, if they need me	.2667	.8184	.20916	.0261
12	I take on a lot of responsibility	.2392	.8200	.19869	.0098
35	I have a lot of free time	.1606	.8230	.10251	.0061
47	I want others to realize that they have to accept me the way I am	.1240	.8261	.02781	.0148
27	I would feel guilty if I did something I knew was wrong	.0906	.8261	.04282	.0024

to realize that they have to accept me the way I am") and item 27 had the highest with .8261. Item 59 also had the highest first factor loading (.76809), while item 47 had the lowest (.02781). Item 59 had the highest separation index score (.1687), while item 27 had the lowest (.0024). There were nine items with separation index scores above .10. The Existential scale correlates .7450 with the Interpersonal scale, .6998 with the Developmental scale and .8351 with the Defensive style scale.

Table 5 presents item analysis results for the original Defensive style scale composition. Standardized item Alpha, for the scale, was .9127. Item 12 ("I keep having negative thoughts") had the largest item to scale correlation coefficient (.7350), while item 113 ("I always do what other people want me to do") had the lowest (-.3250). Thirty items had item to scale correlation coefficients of .40 or greater. Item 12 had the lowest Alpha if item is deleted (.9041), while item 113 had the highest (.9158). Item 12 also had the largest first factor loading (.75226), item 113 had the lowest (-.38568). Twenty-three items had first factor loadings of .40 or greater. Item 12 and item 26 ("Sometime I feel really depressed") had the highest separation index scores (.2243), while item 105 ("I often offer suggestions to my friends about their problems") had the lowest (.0025). Nineteen items had separation index scores over .10. The Defensive Style scale correlates .7452 with the Interpersonal scale, .7140 with the Developmental scale, and .8351 with the Existential scale.

In summary, the Defensive style scale had the largest Alpha (.9127), while the Developmental scale had the smallest (.7114). In each of the scales there were items that performed better than others in terms of their convergence with their scale, and divergence from the other scales. The next step in this study was to begin the

Table 5

Item analysis results for original item composition: Defensive Style scale

Standardized Alpha = .9127

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
12	I keep having negative thoughts	.7350	.9041	.75226	.2243
126	Sometimes I feel really depressed	.7282	.9039	.74176	.2243
44	I don't like myself	.6805	.9058	.71873	.1837
76	I have a lot of repressed anger	.6525	.9053	.66803	.1295
125	I am nervous and tense frequently	.6425	.9051	.63935	.1850
80	I have a lot of guilty feelings	.6395	.9055	.65409	.1364
111	I am comfortable with who I am	.6123	.9057	.64759	.1193
32	I have low self-esteem	.6042	.9104	.63424	.1377
56	I just try to bury my bad feelings	.5974	.9058	.60119	.1262
89	When I get mad, I don't know the right way to express it	.5962	.9058	.61539	.1277
68	Sometimes I wish that I had never been born	.5909	.9063	.60990	.1308
97	I need to talk more about my problems	.5796	.9060	.58315	.1004

Table 5 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
16	I have experienced a lot of pain in my life	.5728	.9061	.55676	.1162
4	I am dealing with a lot of stress right now	.5662	.9063	.56154	.1454
83	Little things are just overwhelming me	.5467	.9065	.56190	.1184
119	I feel that I am being fake with some people	.5435	.9065	.53452	.1085
107	I never think I am good enough	.5353	.9066	.54616	.1143
92	I am a very closed person	.5352	.9066	.53479	.0838
115	I can fool most people on how I really feel	.5321	.9066	.50634	.1460
11	I have had strange experiences in my life	.5246	.9068	.50610	.0925
72	I don't express things well	.5236	.9068	.54637	.0704
64	It is really hard for me to talk about my feelings	.5045	.9070	.48844	.0737
20	I am not a good person	.4748	.9079	.50871	.0884
86	I really don't care much about anything	.4526	.9078	.47570	.0140
95	I look to other people to make decisions for me	.4421	.9077	.47837	.0577
24	I have thought that I deserve only pain	.4321	.9079	.43909	.0772

Table 5 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
99	I keep changing my mind on important decisions	.4286	.9080	.44360	.0066
117	I am afraid to burden other people with my problems	.4270	.9080	.42131	.0640
124	I need to be in control	.4180	.9082	.38309	.1020
101	I've always had insomnia	.4140	.9081	.41127	.0667
129	Drinking lets my true emotions come out	.4054	.9082	.40264	.0934
48	I have had terrifying nightmares	.3839	.9086	.35506	.0798
52	I have had friends that were in the mental hospital	.3745	.9085	.34985	.0684
128	I don't think that I could ever attempt suicide	.3669	.9089	.36222	.0629
123	I think about my eating habits a lot	.3648	.9094	.31977	.0881
40	I cry often	.3439	.9058	.34573	.0820
8	I believe that the socializing other people do is very superficial	.3400	.9088	.33104	.0085
127	I like to get drunk	.3317	.9097	.31260	.0683

Table 5 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
36	Someone in my immediate family has had a nervous breakdown	.3275	.9090	.30356	.0352
60	I can usually open up pretty easily	.2850	.9100	.27627	.0229
103	I go along with the things that are required of me	.2648	.9099	.23697	.0496
28	I deserve the good things in life	.1911	.9059	.19059	.0101
109	I am a perfectionist	.1731	.9115	.11335	.0219
105	I often offer suggestions to my friends about their problems	.0657	.9118	.01769	.0025
113	I always do what other people want me to do	-.3250	.9158	-.38568	.0403

iterative process that would delete, move, or retain items for the final obtained scale composition.

Scale refinement

The next step of this study involved a process in which items were deleted, moved or retained. This process was based on the psychometric properties of the items in the original scale composition. In deciding which items would remain in each scale a variety of factors were considered. Decisions for item inclusion were based on the item's correlation with its own theoretically identified scale, alpha if item deleted, the factor loading on the first factor, the separation index (or the degree to which the item separated from the other three scales), and finally the content area the item was seen as tapping. For each scale a number of iterations were performed with items being deleted, items being moved from one scale to another, or items being included in the final groupings.

On the first iteration 23 items were deleted from the Interpersonal scale, 9 from the Developmental, 8 from Existential, and 24 from the Defensive Style scale. Four additional iterations occurred where items were added, switched, or deleted. Standardized item alpha was maximized without deleting an entire content area from a scale. Therefore, item 122 was included on the Interpersonal scale despite having a separation index score of -.0865, which indicated high correlations with the other three scales; in this case a high correlation with the Defensive Style scale. However, that item (122 "There is a lot of conflict in my life") was believed to represent a critical content area designated for the Interpersonal scale, namely that of interpersonal conflict. Item 129 ("Drinking lets my true emotions come out") was included on the Developmental scale, with a first factor loading of only .16455 because it represented

the only item that addressed use of alcohol as a means of expressing emotions. Over reliance on alcohol in the management of affect was felt to represent the potential for problems in developmental growth.

A number of items were switched to other scales on the basis of the their correlation with that scale. For example, Item 55 ("My family knows that I am there for them, if they need me") was originally on the Existential scale, where it was seen as representing level of responsibility towards family. It was included on the Interpersonal scale as a measure of commitment to family relationships. Item 60 ("I can usually open up pretty easily"), was originally coded on the Defense Style scale, but it had a higher correlation and increased the reliability of the Interpersonal scale, and therefore it was switched. Item 57 ("I get irritated when I am in a relationship too long") was moved from the Interpersonal to Developmental scale because it improved its reliability when included. Item 29 ("I have feared that my father would abuse me") was also switched from the Interpersonal to Developmental scale, with abuse felt to be a significant barrier to normal developmental growth. Item 86 (" I really don't care about anything") was moved from Defensive Style to Existential scale, because it had a higher correlation, with, and added to the Existential scale's reliability. Item 15 ("I am afraid that my friends would not like who I really am") was moved from the Existential to Defensive Style scale, and maybe more an indication of maintaining an internal sense of self that is different from what is shared with friends; seemingly a defensive style issue rather than an identity confusion issue. Item 45 ("The thought of being in a relationship really scares me") was moved from the Interpersonal to Developmental scale, and seems to relate more to making the developmental transition into a "relationship", rather than an interpersonal issue.

A Principal Components Analysis (PCA) was done on the final obtained scale compositions, with an unrotated solution. For the Interpersonal scale PCA extracted three factors with eigenvalues over 1.0, in the parenthesis are the number of items that load on each factor and the percentage of variance accounted for by that factor: 4.6 (17, 27.6%), 2.59 (0, 15.3%), and 1.22 (0, 7.2%). For the Developmental scale PCA extracted three factors with eigenvalues of 3.70 (11, 26.5%), 2.11 (2, 15.1%), and 1.04 (1, 7.5%). For the Existential scale PC extracted three factors with eigenvalues of 5.64 (14, 37.6%), 1.34 (1, 8.9%), and 1.06 (0, 7.1%). For the Defensive Style scale PCA extracted four factors with eigenvalues of 7.95 (20, 39.8%)), 1.27 (0, 6.4%), 1.15 (0, 5.8%), and 1.03 (0, 5.2%).

In summary, there were six iterations, with the first accounting for the majority of items deleted from the four scales. The other five iterations, resulted in "fine tuning" the scales, with maximizing the Standardized item Alpha as the first criteria, followed by item to scale correlation, separation index score, and loading on the first factor. Items that were seen as representing a specific content domain were included in the final obtained scale compositions, even if the psychometric properties were marginal..

Tables 6-9 include the item analysis results for the final obtained scale compositions for the Interpersonal, Developmental, Existential, and Defensive Style scales. A summary of the results will follow. The complete correlation matrix for the items in the final obtained composition appears in Appendix A.

Table 6 presents results for the final obtained Interpersonal scale composition. The standardized item Alpha was .8330, representing an improvement over the original composition which had Alpha of .8253, while going form 39 items to 17 items. All seventeen items had item to scale correlation coefficients over .40 . Item 25 ("I

Table 6

Item analysis results for the final obtained groupings: Interpersonal Scale

Standardized Item Alpha= .8330

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
25	I feel very close to my parents	.6084	.8149	.58729	.2670
21	I am not very close to my parents	.6073	.8146	.60397	.2270
122	There is a lot of conflict in my life	.6010	.8135	.63733	-.0816
9	Ours is not a close family	.5806	.8161	.58350	.2362
81	I am dealing with a lot of shyness right now	.5563	.8166	.56472	.1490
100	There is a lack of communication between the people I am close to	.5310	.8186	.54340	.0504
93	I'm reluctant to go up and talk to people	.5252	.8188	.52578	.1500
87	I get nervous in sexual situations	.5169	.8197	.53220	.0979
69	I don't particularly make an effort to see my family	.5015	.8204	.50815	.1333
17	In my family we say "I love you" to each other	.4947	.8249	.43613	.2263
84	I get nervous in larger groups	.4933	.8208	.48769	.1149

Table 6 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
77	I tend to put responsibility for relationships on other people	.4857	.8202	.51083	.0468
90	I get nervous when I go to parties	.4802	.8202	.50623	.1382
49	I have never been able to develop a dating relationship.	.4762	.8217	.46825	.1152
55	My family knows that I am there for them, if they need me	.4690	.8227	.43838	.1839
96	When I am around other people who are having fun, I don't know what to do	.4629	.8186	.55668	.0136
60	I can usually open up pretty easily	.4244	.8272	.36668	.1363

feel very close to my parents") had the highest correlation (.6084), while item 60 ("I can usually open up pretty easily") had a item to scale correlation coefficient of .4244. Item 122("There is a lot of conflict in my life") had the lowest Alpha if item is deleted, while item 60 had the highest at .8272. All items loaded on the first factor above .36. Item 122 had the highest first factor loading of .63733, item 60's loading on the first factor was .36668. Item 25 had the largest separation index score (.2670), while item 122 had the lowest at -.0816. The final obtained Interpersonal scale correlated with the Developmental scale .6629, with the Existential scale .6829, and with the Defensive Style scale .6769.

Table 7 presents item analysis results for the final obtained Developmental scale composition. Standardized item Alpha was .7773, an improvement from Alpha of .7114 in the original scale composition, there are 14 items in the final obtained composition, 20 in the original. Item 58 ("There are things in my life that are basically unresolved") had the largest item to scale correlation coefficient of .6843, while item 2 ("I have been abused") had the lowest (.3634). Item 58 had the lowest Alpha if item is deleted, item 74 ("I am undecided about my major") had the highest (.7772). Item 58 also had the largest factor loading (.70526), with item 129 ("Drinking lets my true emotions come out") having the smallest (.35923). Item 18 had the largest separation index score (.1912), while item 70 (" I need to develop my social skills") had the smallest at .0323. The final obtained Developmental scale correlates .6629 with the Interpersonal scale, .7542 with the Existential scale, and .7567 with the Defensive Style scale.

Table 8 presents item analysis results for the final obtained Existential scale composition. Standardized item Alpha was .8776, changed form the original Alpha of .8293. The final obtained scale composition includes 15 items. Item 43 (" I don't know

Table 7

Item analysis results for the final obtained groupings: Developmental Scale.

Standardized item Alpha=.7773

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
58	There are things in my life that are basically unresolved	.6843	.7410	.70526	.1554
18	I am not the person I once was	.6099	.7510	.62366	.1912
45	The thought of being in a relationship really scares me	.5617	.7554	.59110	.1700
6	There were painful events in my childhood	.5432	.7587	.56253	.1586
62	I don't know how to act around people I am attracted to	.5428	.7586	.53071	.1124
70	I need to develop my social skills	.5324	.7594	.51244	.0323
30	I don't think that anyone will ever marry me	.5048	.7607	.52689	.0809
39	When I was young, I took care of the family	.5034	.7606	.54212	.1605
10	I am worried about getting a good job	.4997	.7632	.45706	.0977
57	I get irritated when I am in a relationship too long	.4944	.7617	.50806	.1811
74	I am undecided about my major	.4174	.7772	.33784	.0708
29	I have feared that my father would abuse me	.4158	.7679	.42221	.1239

Table 7 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
129	Drinking lets my true emotions come out	.4000	.7722	.35923	.0703
2	I have been abused	.3634	.7708	.38667	.0872

Table 8

Item analysis results for the final obtained groupings:Existential scale

Standardized item Alpha=.8776

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
43	I don't know how I feel	.7724	.8567	.78078	.2407
59	I don't know what my identity is	.7719	.8569	.79074	.2370
7	I don't know what I should do in my life	.6680	.8632	.67423	.1920
85	I am confused about how to deal with a problem I am having	.6971	.8620	.67796	.1867
3	I am really lost	.6633	.8641	.69290	.2197
38	I'm caught in the middle on a lot of things	.6069	.8672	.58998	.1126
67	I have become what people think I am, not who I really am	.5970	.8667	.59920	.1672
82	I am struggling with an important decision right now	.5899	.8703	.55386	.1502
86	I really don't care much about anything	.5611	.8683	.58155	.1311
15	I am afraid that my friends would not like who I really am	.5489	.8688	.56235	.0974

Table 8 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation index
63	My friends don't actually know me	.5415	.8693	.54859	.1001
71	I am a creation of what people think I should be	.5325	.8700	.53140	.1386
75	I will be alone for the rest of my life	.5313	.8696	.55355	.1242
79	I don't feel like I have enough freedom	.5186	.8720	.48956	.1038
94	I have so much to live for	.4821	.8730	.46614	.1012

how I feel") had the largest item to scale correlation (.7724), item 94 (" I have so much to live for") had the smallest, .4821. Item 43 had the lowest Alpha if item is deleted (.8567), item 94 had the highest (.8730). All first factor loadings were greater than .46. Item 59 (" I don't know what my identity is") had the largest with .79074, item 94 the smallest at .46614. Item 43 had the largest separation index score, .2407. item 15 (" I am afraid that my friends would not like who I really am") had the smallest, .0974. The final obtained Existential scale correlates .6829 with the Interpersonal scale, .7542 with the Developmental scale, and .8442 with the Defensive Style scale.

Table 9 presents item analysis results for the final obtained Defensive Style composition. With 20 items in the final grouping standardized item Alpha was .9186, Alpha was .9127 in the original 45 item composition. Item 126 ("Sometimes I feel really depressed") had the highest item to own scale correlation, .7599, item 20 (" I am not a good person") had the lowest correlation, .5505. Item 126 also had the lowest Alpha if deleted, .9073, item 20 the highest, .9139. Item 126 had the largest first factor loading, .75554, while item 92 (" I am a very closed person") the lowest, .51631. Item 126 had a separation index score of .2863, while the lowest score came from item 92, .0907. The final obtained Defensive Style scale correlates .6769 with the Interpersonal scale, .7567 with the Developmental scale, and .8442 with the Existential scale.

In summary, all the scales increased their internal consistency while decreasing the number of items in each scale. The Defensive Style scale again had the largest Alpha, .9186, and the Developmental scale, had the smallest, 7773.

Table 9

Item analysis results for the final obtained groupings: Defensive Style scale

Standardized item Alpha= .9186

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
126	Sometimes I feel really depressed	.7599	.9073	.75554	.2863
121	I keep having negative thoughts	.7451	.9078	.75080	.2552
44	I don't like myself	.7152	.9097	.74539	.2213
76	I have a lot of repressed anger	.7005	.9091	.70149	.2002
80	I have a lot of guilty feelings	.6706	.9099	.67938	.1692
111	I am comfortable with who I am	.6640	.9101	.67714	.1677
125	I am nervous and tense frequently	.6426	.9109	.62781	.1858
32	I have low self-esteem	.6351	.9108	.64928	.1725
89	When I get mad, I don't know the right way to express it	.6316	.9111	.62091	.1768
68	Sometimes I wish that I had never been born	.6216	.9112	.63823	.1695
14	I have ended up not very happy in my life	.6214	.9114	.64504	.1421

Table 9 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
97	I need to talk more about my problems	.6123	.9118	.58742	.1462
56	I just try to bury my bad feelings	.6047	.9120	.58534	.1342
4	I am dealing with a lot of stress right now	.6043	.9117	.59220	.1815
16	I have experienced a lot of pain in my life	.5782	.9128	.56502	.1305
15	I am afraid that my friends would not like who I really am	.5625	.9126	.58523	.1175
83	Little things are just overwhelming me	.5505	.9130	.54241	.1131
119	I feel that I am being fake with some people	.5467	.9136	.52524	.1121
92	I am a very closed person	.5378	.9135	.51631	.0907
20	I am not a good person	.5019	.9139	.53564	.1142

Cross-replication analyses

To determine how stable the final obtained scale compositions were, the item analyses for each scale were then cross-replicated using the 20 percent sample (n=73).

Principal Components Analysis (PCA) was conducted on the cross-replication data. For the Interpersonal scale, PCA extracted six factors with eigenvalues, of 4.44 (9, 26.1%), 2.69 (3, 15.8%), 1.53 (3, 9.0%), 1.20 (0, 7.1%), 1.09 (2, 6.5%), and 1.02 (0, 6.0%). For the Developmental scale, PCA extracted five factors with eigenvalues of 2.95 (6, 21.1%), 1.99(3, 14.3%), 1.73 (2, 12.4%), 1.28 (2, 9.2%), and 1.11 (0, 8.0%). For the Existential scale, PCA extracted four factors with eigenvalues of 5.27 (12, 35.2%), 1.91 (1, 12.8%), 1.46 (1, 9.8%), and 1.13 (1, 7.6%). For the Defensive Style scale, PCA extracted six factors with eigenvalues of 7.53 (16, 37.7%), 2.16 (2, 10.8%), 1.48 (0, 7.4%), 1.12 (1, 5.6%), 1.10 (1, 5.5%), and 1.01 (0, 5.1%).

Tables 10-13 contain the item analysis results for the cross-replication sample. A summary of those results will follow the tables. The complete correlation matrix for items in the cross-replication may be found in Appendix A.

Table 10 presents item analysis results for the cross-replication of the Interpersonal scale. Standardized item alpha was .8115. Item 25 remained the strongest correlated item with the scale, however item 84 ("I get nervous in larger groups") had the smallest correlation coefficient in cross-replication. Item 25 and 122 had the lowest Alpha if item is deleted with .7865, item 84 had the largest with .8088. Item 96 had the largest first factor loading with .70154, item 84 the smallest, .23792. Item 25 had a separation index of .1594, while item 122 had a separation index of -.1394, smaller even than its score in the final obtained composition, -.0816. Items changed in their rankings , and there were differences in correlation coefficients in

Table 10

Item analysis results for the cross-replication: Interpersonal scale

Standardized item Alpha= .8115

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
25	I feel very close to my parents	.6205	.7865	.64987	.1594
122	There is a lot of conflict in my life	.6127	.7865	.63086	-.1362
96	When I am around other people who are having fun, I don't know what to do	.5971	.7856	.70154	.0890
90	I get nervous when I go to parties	.5663	.7880	.62083	.1155
9	Ours is not a close family	.5479	.7921	.58403	.1341
87	I get nervous in sexual situations	.5444	.7902	.57166	.1400
55	My family knows that I am there for them, if they need me	.5416	.7925	.55086	.2155
81	I am dealing with a lot of shyness right now	.5190	.7927	.49561	.1483
21	I am not very close to my parents	.5095	.7948	.52742	.1628
49	I have never been able to develop a dating relationship.	.5025	.7951	.48942	.1419

Table 10 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
100	There is a lack of communication between the people I am close to	.4818	.7963	.49510	.0679
93	I'm reluctant to go up and talk to people	.4719	.7967	.41327	.1696
17	In my family we say "I love you" to each other	.4301	.8043	.38050	.1602
77	I tend to put responsibility for relationships on other people	.4214	.8006	.36755	.0446
69	I don't particularly make an effort to see my family	.4046	.8002	.42520	.0757
60	I can usually open up pretty easily	.3760	.8063	.28123	.0964
84	I get nervous in larger groups	.2911	.8088	.23792	.0287

regard to specific items. On cross-replication the Interpersonal scale correlates .6158 with the Developmental scale, .7436 with the Existential scale, and .7474 with the Defensive Style scale.

Table 11 presents results for the cross-replication of the Developmental scale. Standardized item Alpha was .6732. Item 45 ("The thought of being in a relationship really scares me") had the largest item to scale correlation coefficient, .5943. Item 39 ("When I was young, I took care of the family") had the smallest correlation, .2169. Item 45 had the lowest Alpha if item is deleted with .6304, while item 74 ("I am undecided about my major") had the highest, .6944. Item 6 (" There were painful events in my childhood") had the largest factor loading, .72078. Item 74 had the smallest, .01426. Item 57 (" I get irritated when I am in a relationship too long") had the largest separation index score, .1882, while item 390(" I don't think that anyone will ever marry me") had the lowest at -.1179. The Developmental scale, on cross-replication, correlates .6158 with the Interpersonal scale, ..6700 with the Existential scale, and .7404 with the Defensive Style scale

Table 12 presents results for the cross-replication of the Existential scale. Standardized item Alpha was .8571. Item 59 ("I don't know what my identity is")had the largest item to scale correlation coefficient, .7568. Item 79 ("I don't feel like I have enough freedom"), had the lowest, .2949. Item 43 ("I don't know how I feel") had the lowest Alpha if item is deleted, .8273, item 79 the greatest, .8583. Item 59 had the largest first factor loading, .76302, item 79 the smallest, .20624. Item 59 had the largest separation index score of .2494, item 79 the smallest at .0182. On cross-replication the Existential scale correlates .7436 with the Interpersonal scale, .6700 with the Developmental scale, and .8816 with the Defensive Style scale.

Table 11

Item analysis results for the cross-replication: Developmental scale

Standardized item Alpha= .6732

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
45	The thought of being in a relationship really scares me	.5943	.6304	.66073	.1583
6	There were painful events in my childhood	.5885	.6317	.72078	.1818
18	I am not the person I once was	.5547	.6389	.60650	.1721
58	There are things in my life that are basically unresolved	.5509	.6385	.56644	.0743
62	I don't know how to act around people I am attracted to	.5134	.6456	.43678	.0508
57	I get irritated when I am in a relationship too long	.4751	.6518	.42207	.1882
129	Drinking lets my true emotions come out	.4186	.6612	.30265	.0977
29	I have feared that my father would abuse me	.4113	.6590	.56388	.1622
70	I need to develop my social skills	.3883	.6663	.26847	.0267
10	I am worried about getting a good job	.3816	.6658	.27295	.1158
30	I don't think that anyone will ever marry me	.3688	.6644	.32963	-.1179
2	I have been abused	.3520	.6633	.54856	.1185

Table 11 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
74	I am undecided about my major	.2522	.6944	.01426	.0362
39	When I was young, I took care of the family	.2169	.6748	.20342	.0196

Table 12

Item analysis results for the cross-replication: Existential scale

Standardized item Alpha= .8571

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
43	I don't know how I feel	.7485	.8273	.76302	.2373
59	I don't know what my identity is	.7568	.8278	.76738	.2494
85	I am confused about how to deal with a problem I am having	.7028	.8306	.68169	.2397
63	My friends don't actually know me	.6637	.8351	.69039	.1806
67	I have become what people think I am, not who I really am	.6415	.8351	.65603	.1743
71	I am a creation of what people think I should be	.6303	.8358	.63499	.2197
15	I am afraid that my friends would not like who I really am	.6208	.8367	.65842	.1730
3	I am really lost	.5630	.8401	.58337	.0694
7	I don't know what I should do in my life	.5418	.8418	.54877	.1603
86	I really don't care much about anything	.5388	.8410	.55031	.0846
75	I will be alone for the rest of my life	.5289	.8414	.55683	.0982

Table 12 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
82	I am struggling with an important decision right now	.5114	.8485	.44644	.1159
94	I have so much to live for	.5100	.8450	.52248	.0605
38	I'm caught in the middle on a lot of things	.3890	.8503	.35369	.0188
79	I don't feel like I have enough freedom	.2949	.8583	.20624	.0182

Table 13 presents the item analysis results for the cross-replication of the Defensive Style scale. Standardized item Alpha was .9087. Item 76 (" I have a lot of repressed anger") had the highest item to scale correlation coefficient, .7864, item 4 (" I am dealing with a lot of stress right now") had the lowest, .4863. Item 76 also had the lowest Alpha if item is deleted at .8966, and item 4 the highest at .9051. Item 76 had the largest first factor loading, .78197. Item 4 had the lowest, .43718. Item 121 (" I keep having negative thoughts") had the largest separation index, .2428. Item 92 (" I am a very closed person") had the lowest separation index score, .0515. The Defensive Style scale correlates with the Interpersonal scale .7474, with the Developmental scale .7404, and .8816 with the Existential scale.

Upon cross-replication the Defensive Style scale was the most stable, and also had the highest reliability coefficient. Three of the scales Interpersonal, Existential, and Developmental appear relatively stable in terms of their Standardized Item Alpha. For the Interpersonal scale Alpha went from .8330 to .8115 in the 20 percent sample, Existential went from .8776 to .8571, and Defensive Style from, .9186 to .9087. The Developmental scale was not as stable with alpha going from .7773 in the final obtained to .6732 in the 20 percent sample. Additionally, specific item's performance changed upon cross-replication. Item 122, for example, had its separation index go to -.1362. An indication that it correlates strongly with the other scales, and may not be a good item for the Interpersonal scale. Item 60 and 84 had first factor loadings of .28123 and .23792, which may be an indication of the need for subscales within the four domains, for both of those items have to do with extroversion. Item 30 ("I don't think that anyone will ever marry me") had it's separation index change from .0809 to -.1179 an indication of low homogeneity with the Developmental scale. Item 74 ("I am undecided about my major") had a first factor loading of only .014261, an indication

Table 13

Item analysis results for the cross-replication: Defensive Style scale

Standardized item Alpha= .9087

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
76	I have a lot of repressed anger	.7864	.8966	.78197	.2100
44	I don't like myself	.7359	.8989	.78130	.1641
121	I keep having negative thoughts	.7341	.8982	.74083	.2428
125	I am nervous and tense frequently	.7113	.8990	.69195	.2263
111	I am comfortable with who I am	.6728	.9003	.71502	.0525
68	Sometimes I wish that I had never been born	.6613	.9006	.69803	.1389
126	Sometimes I feel really depressed	.6567	.9009	.63929	.2288
14	I have ended up not very happy in my life	.6520	.9011	.70598	.1226
32	I have low self-esteem	.6496	.9009	.66495	.1828
97	I need to talk more about my problems	.6127	.9023	.56627	.1284
92	I am a very closed person	.5935	.9024	.60077	.0515
83	Little things are just overwhelming me	.5666	.9035	.52883	.1168

Table 13 cont.

Item #	Item	Item to own scale Correlation	Alpha if item is deleted	First factor loading	Separation Index
15	I am afraid that my friends would not like who I really am	.5651	.9031	.60035	.0854
56	I just try to bury my bad feelings	.5230	.9047	.52193	.0472
16	I have experienced a lot of pain in my life	.5226	.9049	.51125	.0818
80	I have a lot of guilty feelings	.5200	.9045	.49805	.1259
4	I am dealing with a lot of stress right now	.4863	.9051	.43713	.1174
20	I am not a good person	.4833	.9049	.53221	.0951
89	When I get mad, I don't know the right way to express it	.4774	.9059	.41948	.0762
119	I feel that I am being fake with some people	.4614	.9067	.42866	.1063

that it does not, in the cross-replication, belong in the Developmental scale despite it making conceptual sense. Item 79 ("I don't feel like I have enough freedom") had the lowest first factor loading on the Existential scale, .20624. Once again, this item may represent a subset of existential theme items, that will need to be further examined.

Despite using the separation index to maximize intra-scale convergence and inter-scale divergence there are still substantial correlations between the scales. There was a decrease in the correlation coefficients for the Interpersonal scale from the original item composition to the final obtained composition, however that decrease was not maintained on cross-replication. The other three scale remained highly correlated with each other with coefficients in the .66 to .84 range. A summary and discussion of the results will follow in the next chapter.

CHAPTER FIVE

The purpose of this study was to develop a clinically useful assessment instrument that would help counselors more effectively and efficiently determine a therapeutic focus in their work with clients commonly seen at university counseling centers, or other settings utilizing a brief therapy model. Additionally, this study aimed to combine two methods of inquiry that have been traditionally separated into competing camps. This study demonstrated that both qualitative and quantitative methods may be used in a complimentary fashion. In Phase One, the richness of counseling intake sessions was analyzed, and in Phase Two, a large sample was used to examine the psychometric properties of the IDE Assessment Inventory (IDEA). In this chapter there will be a summary of the results of this study, as well as a discussion of use of client statements in item construction, of previous research in this area, limitations of this study, and directions for future research.

Summary of results

In Phase One of this study, transcripts from counseling intake sessions were audiotaped and transcribed. The transcripts were then analyzed for statements that would fit into one of four domains: Interpersonal, Developmental, Existential, and Defensive Style. A total of 202 client statements were then translated into an item format. The client's language was used where possible. Items that were confusing or redundant were eliminated, leaving a 129 item IDE Assessment Inventory (IDEA).

The IDEA was then administered to 394 undergraduate psychology students in order to examine its psychometric properties. To provide a cross-replication sample, the original sample was randomly divided into two samples, one representing 80% (n=321)and the other 20% (n=73) of the original sample. The items were analyzed using the 80% sample for the original scale composition and the final obtained composition, the 20% sample was used for cross-replication purposes.

Means, standard deviations, minimum score and maximum score remained stable on cross-replication. For the most part, internal consistency estimated using Chronbach's Alpha also remained stable. However, the Developmental scale did have its Alpha decrease on cross replication, moving from .7773 to. 6732.

On the whole, the theoretical groupings of items held up satisfactorily. The Defensive Style scale had the highest reliability, both on the final obtained scale composition and on the cross-replication. It also had the greatest number of items (45) in the original item composition, as well as in the final obtained scale composition (20). This scale appears to be a measure of current level of distress, negative thoughts about self and others, indications of repressed anger and guilt, poor conflict management skills, and motivation towards treatment.

The Existential scale had the next highest final obtained and cross-replicated reliability. It appears to be a measure of level of identity formation, sense of purpose or meaning in life, ease of decision-making, level of consistency between how the person sees themselves and how the world sees that individual, and existential angst or worry about finding an ultimately satisfying life.

The Interpersonal scale had the next highest reliability, with 17 items, on the final obtained run. It appears to be a measure of relationship with parents, level of

interpersonal conflict in the individuals life, with high scorers having poor communication and/or social skills.

The Developmental scale had the fewest items (14) and also was the least stable, as mentioned above. It appears to be a measure of blocks in developmental growth, existence of abusive or painful events in childhood, social development and ability to meet developmental tasks such as finding satisfying interpersonal relationships, career decision making, and appropriate use of alcohol in affective expression.

In deciding which items would remain in each scale a variety of factors were considered. Those included the item's correlation with its own theoretically identified scale, Alpha if item deleted, the factor loading on the first factor, and the separation index (or the degree to which an item converged with its own scale and diverged from the other three scales), and finally the content area that item was hypothesized to represent. For each scale a number of iterations resulted with items being deleted, items being moved from one scale to another, or items being included in the final obtained scale composition. Standardized item Alpha was maximized without deleting an entire content area from a scale. Therefore, item 122 was included on the Interpersonal scale despite having a separation score of -.0865, which indicated high correlations with the other three scales, in this case a high correlation with the Defensive Style scale. However, that item ("There is a lot of conflict in my life") was felt to represent a critical content area designated for the Interpersonal scale, namely that of interpersonal conflict. There was an attempt made to keep the scales to approximately the same size, as mentioned previously the Developmental scale had the fewest items with 14 and the Defensive Style scale had the greatest with 20.

This study resulted in a 65 item IDE Assessment Inventory that contains four distinct scales. These scales demonstrate relatively stable internal consistency. Though demonstrating relative intra-scale homogeneity, the scales are correlated with each other, at all three item analysis points. This might be explained by the methodological processed chosen for item construction. Since items were constructed from statements counseling clients presented with, it seems that all the items may have a "general level of distress" similarity. In other words, the high inter-scale correlations may reflect a general factor of distress or depression, which has provided the motivation to seek out counseling services. If this is the case it would not rule out the benefit of identifying this distress as primarily occurring in either the Interpersonal, Developmental, or Existential realms, or to gauge Defensive Style. Further research will determine if there is one overriding factor or if it is possible for cleaner divisions, between the scales identified thus far, to exist.

Use of client statements in test construction

Rather than the reliance on previous methods for item construction, the present study used statements taken from actual counseling intake sessions. Through this process items were constructed using the language of actual counseling clients, in this case undergraduate students, at a large midwestern university. There is a certain approach that relies on one test developer, or even a few, can result in omission of important areas of behavior or inclusion of areas that are relevant only to the specific test developer. Such an approach may result in a subjective or idiosyncratic definition of the construct being examined.

Use of actual client statements lends a sense of "realism" to a psychological inventory, without being too colloquial, the present instrument includes language that is familiar to the population it intends to assess. The instrument constructed, then, is targeted for use with clients at university counseling centers, who will receive treatment within a brief therapy model. It will be determined through further study if the use of actual client statements adds to the constuction of psychological tests, or if simply leads to a unique instrument that does not generalize to the population of interest.

Theoretical and empirical foundations

This study drew on the eclectic brief therapy of Budman and Gurman (1988) as well as a number of other brief therapists, including short-term psychodynamic, cognitive-behavioral, and eclectic theorists. Budman and Gurman's IDE model was a helpful tool in organizing themes brought to counselors at university counseling centers. However, there were themes described by Budman and Gurman that are not represented in the IDE Assessment Inventory. This issue will be discussed in the limitations of this study. As would be predicted, interpersonal, developmental, and existential themes were endorsed by the sample used in this study.

The theoretical foundation for the Interpersonal component comes primarily from Sullivan (1956). In describing the Interpersonal component Sullivan focuses on the processes between people rather than the mind, society, or the brain. Klerman, et al. outlined an interpersonal assessment process that examined current and past interpersonal relationships, the quality and patterning of these interactions, the cognitions of the individual, and associated emotions. In coding client themes, intimate relationships, family of origin relationships, friendships, loneliness, and loss

were evident as clients presented with. Both Sullivan and Klerman represent an important foundation when talking about assessing the interpersonal component.

The Developmental component has Erickson (1950), Levinson (1978), Gilligan (1982), and Chickering (1969) as its foundation. Chickering in writing about the seven "vectors" of development: competence, managing emotions, autonomy, interpersonal relationships, purpose, identity, and integrity, has captured the core developmental issues still facing young adults. The population sampled, with a mean age of 19, described difficulty in making developmental transitions, especially in terms of finding satisfying relationships, as well as making decisions regarding choosing a major and career, and with one individual the difficult decisions produced by an unplanned pregnancy.

The Existential component draws, primarily, on the writings of Yalom (1980). Yalom outlined four themes that existential psychotherapy is concerned with: death, freedom, isolation, and meaninglessness. The issue of death was not raised in the counseling sessions examined. This may represent youth's feeling of immortality rather than the nonexistence of concern about death. Freedom and responsibility came up repeatedly, especially regarding decision making. For many First-year students, this is their first chance to be in control of their lives, and to face the responsibility of making choices. Isolation was also a major theme. Themes of isolation and alienation were relevant to two individuals, one who had been sexually abused and was fearful of any vulnerability, and the other an individual who withdrew from the world. Each expressed pain in feeling isolated, as well as describing lives with little real meaning. Search for meaning was expressed by a number of clients, whose intake sessions were analyzed. This search for meaning was associated with the process of forming their own unique identity.

Many of the components of the IDE model were expressed in the intake sessions analyzed. One of the problems associated with creating an assessment instrument is the breadth of issues that could be assessed. Many of the issues discussed in the theoretical foundations were not described by the clients in this study, an indication of the need for further study of additonal counseling sessions.

A review of the literature did not show other instruments that attempted to use the IDE model, or instruments designed for determining therapeutic focus specifically. However, there have been researchers who have developed instruments similar to the IDE Assessment Inventory. Horowitz and Vitkus (1986) used the Inventory of Interpersonal Problems to study the interpersonal elements of psychiatric symptoms. They state that prototypic depression or prototypic anxiety contains a large number of elements. Prototypic depression, for example, contains so many elements that people vary considerably in their experience of depression. Interpersonal problems associated with one subtype of depression can be very different from interpersonal problems associated with another subtype. The Interpersonal scale on the IDE Assessment Inventory attempted to assess a wide range of interpersonal difficulties, ranging from intimate relationships, to family of origin issues, to lack of relationships. This instrument is aimed at helping the therapist identify whether interpersonal problems exist and in which relationships problems exist. It will not attempt to diagnosis depression, which as Horowitz and Vitkus (1986) note cannot be linked with any one cluster of interpersonal problems.

Dworkin and Lyddon (1991) describe the development of a time-limited and managed-care treatment policy at Colorado State University's Counseling Center. They used a pre-intake questionnaire that assessed relationships, alcohol use, and the existence of sexual problems. The staff then made decisions about appropriate

dispositions for treatment. Dworkin and Lyddon concluded that while a time-limited managed care model may not fit every agency or for every staff member, they have developed an effective way to cope with increasing demand on university counseling centers. With the IDE Assessment Inventory an attempt was made to build on the work done by Dworkin and Lyddon. The present study identifies triage as the first step in brief therapy, that is making decisions regarding appropriateness of services provided. Once, the decision has been made that a client is appropriate for brief therapy, the next step would be to determine the most salient focus for that therapy. Future studies, using clinical samples, may demonstrate the utility of an instrument that helps in the determination of a therapeutic focus.

Of the four scales developed the Defense Style scale, was the most stable and the highest estimates of internal consistency. Piper, DeCarufel, and Szkrumelak (1985) examined moderately disturbed patients and found that defensive style and object choice are two independent predictors of favorable process and outcome. As such, assessment of defensive style, or perhaps more accurately therapeutic readiness, seems to be an important addition when determining the focus for treatment. In order to do short-term therapy effectively, an understanding of which defensive mechanisms are at work would save time otherwise spent in a frustrating struggle with those same defense mechanisms. An important feature of being able to determine effective therapeutic focus would be the ability to decide which obstacles to successful treatment exist. An assessment of a client's defensive style or level of possible resistance would save time and lead to a greater likelihood of a positive outcome.

Bond, Gardner, Christian, and Sigal (1983) also developed a questionnaire that assesses a person's perception of his or her defensive style. They hypothesized that

defensive styles might identify aspects of a person's stage of development. The present study attempted to examine level of development, as seen through identification of a developmental dysyncrony, and identification of defensive style. It is not clear from the present results, but it appears that developmental issues may pervade, not only, the defensive style, but interpersonal and existential issues as well. When working with college-aged individuals it seems that a focus on level of developmental growth would incorporate many of the presenting problems seen in the client intake sessions in the present study.

Limitations

It should be noted that this is but the first step in constructing a clinically useful assessment tool. A major limitation of this study was the resources available. Having but one researcher limited the scope of the project. Use of expert raters might prove helpful, both in choosing which client statements should be used for possible items, and for grouping statements in one of the theme categories described. Though use of client statements seems to be a useful method in item generation, one of the limits of this study was the number of intake sessions that could be analyzed. Thirteen intake sessions were audiotaped with eight being transcribed and analyzed.

A major limitation of this methodology is the degree to which the domains identified could be sampled. Statements derived from the sessions studied were consistent with Budman and Gurman's IDE model, with some exceptions. In the eight sessions that were analyzed there were no statements that reflected all the developmental dysynchronies identified by Budman and Gurman. For example, there were no statements that reflected the potential crisis of a woman moving towards the end of her childbearing years without having been able to have children, or the

experience of a significant illness or death in the family for a young adult or middle-aged person. There also was not a statement that dealt with a man or woman in mid-life finding himself or herself with an adult child who is still emotionally or financially dependent.

Another limitation deals with the representativeness of the client sessions studied. It could be argued that taking one person's problem would lead to a relatively unique set of questions. To some extent this is true and in many ways it is not. In one session, excerpted above, a young woman is faced with the dilemma of what to do with an unplanned pregnancy and the effect her decision will have on her academic progress. Though this is a relatively specific problem, it did deal with issues of responsibility and freedom in making appropriate choices. The broader themes of responsibility and freedom in decision-making were endorsed by a large number of the undergraduate sample. The items were written to reflect the broader issues, rather than the specific problem.

In using client statements to generate items there appears to be a rich source of information regarding client's presenting problems. At various points in the item construction stage, additional themes were considered by this researcher, however they were not raised by the clients studied and therefore could not be included in the inventory. Adequate domain sampling seems a necessary facet of using client statements for item construction. As well, future research might include items generated by experts, and then compared to those generated using client statements.

The initial goal of developing an instrument with four distinct scales limited the inclusion of other items that may prove helpful to clinicians. As the analysis proceeded various scales above the four identified became evident. For example, within the interpersonal scale, subscales such as familial discord, interpersonal loss,

and pattern of unstable relationships could be identified which might prove helpful to the clinician. However, construction of subscales within each of the four scales identified thus far, was beyond the scope of the present study.

Future research

As described above, there are numerous avenues for additional research. The next logical step would be to administer the IDE Assessment Inventory to a clinical sample. It will be necessary to attain data from clients seeking services at a university counseling center, to provide normative information and begin a standardization process.

Future research should also include the expansion of the number of client sessions studied. The Developmental scale has the most pressing need for additional items that would adequately sample the domain described by Budman and Gurman. This would require the audiotaping of many more intake sessions to generate these additional items, and include the training of raters to rate various client statements into the various categories.

Additional studies would also examine the instrument's convergent and discriminant validity. Following which would be a study of the counselor's use of such an instrument. For example, a study of identifying therapeutic focus using the IDE Assessment Inventory, and focus identified without the instrument. Ultimately, the clinical utility of this instrument will determine the how, when, and why of its use by counselors.

In summary, this study aimed at developing an assessment tool to be used with less pathological populations, or those who would be most appropriate for treatment within a brief therapy model. Theoretical sources included the brief eclectic

model of Budman and Gurman, as well as a range of brief psychodynamic, cognitive-behavioral, and eclectic theorists.

A review of the literature did reveal past studies that attempted to use the Interpersonal-Developmental-Existential model for constructing a psychological test. Additionally, there has not been an attempt to develop an instrument specifically for determining therapeutic focus. Furthermore, the literature does not describe a process for using client statements in item construction.

Results showed that using client statements was an effective means for generating an item pool. Though there was a limitation in the degree the identified domains could be sampled, using eight intake interviews. Those items, that were generated, demonstrated substantial variability when administered to a large sample of undergraduate students. Additional work will be needed to improve the instrument's intra-scale homogeneity, while increasing inter-scale divergence. Three of the scales demonstrated stability in terms of internal consistency reliability, however the Developmental scale was relatively less stable.

Limitations of the study included the relatively few client sessions that were analyzed, resources available to the researcher, and yet to be determined clinical usefulness of the instrument. As was noted earlier this study represents only the initial step in developing a test for determining therapeutic focus.

Through this study, then, a 65 item IDE Assessment Inventory (IDEA) was constructed. It was tested for its scale homogeneity and reliability. Future research will determine its validity, and subsequent utility. This study does describe a unique form of test construction, namely, use of counseling client statements in generating an item pool. It is hoped that other researchers will make use of this method for test construction.

APPENDICES

APPENDIX A

CORRELATION MATRIX FOR ORIGINAL ITEM COMPOSITION

	I1	I5	I9	I13	I17	I21
INTERP	.4301**	.4118**	.5538**	.4117**	.4290**	.5822**
DEVELOP	.3472**	.3558**	.2953**	.1235*	.1293*	.3688**
EXIS	.3222**	.3852**	.3177**	.1773**	.1961**	.4268**
DEFENSE	.2802**	.3807**	.2925**	.0831	.0825	.3336**

	I25	I29	I33	I37	I41	I45
INTERP	.5834**	.2889**	.2801**	-.1585*	.1591**	.4326**
DEVELOP	.2689**	.3410**	.2443**	-.0986	-.0045	.4396**
EXIS	.3717**	.2374**	.2605**	-.1510**	-.0156	.4089**
DEFENSE	.2801**	.2693**	.2762**	-.1910**	-.0340**	.4005**

	I49	I53	I57	I61	I65	I69
INTERP	.4644**	.3956**	.3059**	.2358**	.2131**	.4985**
DEVELOP	.4338**	.2828**	.3302**	.1685**	.0163	.3706**
EXIS	.3282**	.2743**	.2799**	.1598**	.0567	.3605**
DEFENSE	.3002**	.2837**	.2661**	.1801**	-.0122	.2840**

	I73	I77	I81	I84	I87	I90
INTERP	.3627**	.4890**	.5207**	.4335**	.4784**	.4231**
DEVELOP	.3099**	.3771**	.4497**	.3117**	.4401**	.3423**
EXIS	.1881**	.4553**	.3594**	.3826**	.3837**	.2659**
DEFENSE	.1900**	.4524**	.4240**	.3824**	.4227**	.3408**

	I93	I96	I98	I100	I102	I104
INTERP	.4579**	.5083**	.3441**	.5677**	.0000	.3900**
DEVELOP	.3868**	.3797**	.1358*	.4305**	-.0168	.3398**
EXIS	.3021**	.4588**	.2982**	.4719**	-.0997	.3026**
DEFENSE	.4157**	.4678**	.2205**	.5142**	-.0336	.4083**

	I106	I108	I110	I112	I114	I116
INTERP	.3223**	.3575**	.0439	.4589**	.1122*	-.0043
DEVELOP	.1298*	.1850**	.0978	.2814**	.1255*	-.1279*
EXIS	.1872**	.2501**	.0524	.3776**	.1081	-.1175*
DEFENSE	.1626**	.2331**	.0878	.3261**	.1518**	-.2210**

	I118	I120	I122
INTERP	.2954**	.3708**	.6419**
DEVELOP	.2701**	.2383**	.5699**
EXIS	.3995**	.2798**	.6758**
DEFENSE	.4399**	.3719**	.6903**

	I2	I6	I10	I14	I18	I22
DEVELOP	.3282**	.5000**	.4339**	.5091**	.5648**	.3169**
EXIS	.2018**	.3589**	.4251**	.5563**	.4625**	.2083**
DEFENSE	.2479**	.4252**	.3955**	.5632**	.4968**	.2008**
INTERP	.2494**	.3785**	.3228**	.4867**	.4370**	.1568**

	I26	I30	I34	I39	I42	I46
DEVELOP	.0965	.4893**	.3148**	.4392**	.0978	.3017**
EXIS	-.1790**	.4187**	.0361	.3139**	.1540**	.3377**
DEFENSE	-.1211*	.4488**	-.0059	.3719**	.0984	.2480**
INTERP	-.1950**	.4117**	.1484**	.3442**	.1846**	.2673**

	I50	I54	I58	I62	I66	I70
DEVELOP	.2407**	.3575**	.6387**	.5571**	.3194**	.5448**
EXIS	-.0425	.2038**	.6241**	.3777**	.1928**	.4497**
DEFENSE	.0189	.2503**	.6002**	.3985**	.1822**	.4648**
INTERP	.0337	.2460**	.5447**	.4770**	.3561**	.5731**

	I74	I78
DEVELOP	.3974**	.3392**
EXIS	.3993**	.1963**
DEFENSE	.2716**	.2414**
INTERP	.2661**	.1446*

	I3	I7	I12	I15	I19	I23
EXIS	.6084**	.6340**	.2392**	.5121**	.3627**	.3430**
DEFENSE	.5357**	.5083**	.2540**	.5045**	.2879**	.3160**
INTERP	.4288**	.4781**	.0962	.3891**	.2397**	.2422**
DEVELOP	.4053**	.4645**	.2618**	.4438**	.2252**	.2590**

	I27	I31	I35	I38	I43	I47
EXIS	.0906	.3527**	.1606**	.5810**	.7125**	.1240*
DEFENSE	.0757	.2172**	.1341*	.5882**	.6732**	.0187
INTERP	.0154	.2231**	.1782**	.4620**	.5644**	.0222
DEVELOP	.1077	.2186**	.0964	.4659**	.5343**	-.0282

	I51	I55	I59	I63	I67	I71
EXIS	.3478**	.2667**	.7161**	.4967**	.5661**	.5245**
DEFENSE	.2978**	.1692**	.6557**	.4700**	.4732**	.4123**
INTERP	.2161**	.2907**	.5370**	.4849**	.4397**	.3999**
DEVELOP	.2512**	.1481**	.5603**	.4116**	.3900**	.3600**

	I75	I79	I82	I85	I88	I91
EXIS	.4961**	.5056**	.5905**	.6825**	.3763**	.2671**
DEFENSE	.3973**	.4426**	.4597**	.5897**	.3280**	.1075
INTERP	.4641**	.4035**	.4271**	.5539**	.2817**	.1423*
DEVELOP	.3740**	.3674**	.4488**	.5076**	.2850**	.0198

	I4	I8	I11	I16	I20	I24
DEFENSE	.5662**	.3400**	.5246**	.5728**	.4748**	.4321**
INTERP	.3703**	.3228**	.3495**	.4213**	.3294**	.2919**
DEVELOP	.3678**	.3283**	.4821**	.5189**	.2991**	.3258**
EXIS	.5032**	.3308**	.4401**	.4348**	.4605**	.3704**

	I28	I32	I36	I40	I44	I48
DEFENSE	.1911**	.6042**	.3275**	.3439**	.6805**	.3839**
INTERP	.1751**	.4419**	.2379**	.1432*	.4839**	.2527**
DEVELOP	.0939	.4426**	.2845**	.1848**	.4570**	.2591**
EXIS	.1996**	.5298**	.2803**	.2330**	.6285**	.2681**

	I52	I56	I60	I64	I68	I72
DEFENSE	.3745**	.5974**	.2850**	.5045**	.5909**	.5236**
INTERP	.2302**	.4678**	.2925**	.4558**	.4366**	.4924**
DEVELOP	.2676**	.4564**	.1780**	.3980**	.3990**	.4028**
EXIS	.3018**	.5148**	.2404**	.4198**	.5525**	.4545**

	I76	I80	I83	I86	I89	I92
DEFENSE	.6525**	.6395**	.5467**	.4526**	.5962**	.5352**
INTERP	.5303**	.5175**	.4090**	.4469**	.4648**	.5007**
DEVELOP	.5123**	.4723**	.3826**	.3440**	.4515**	.4009**
EXIS	.5874**	.5717**	.4764**	.5046**	.5132**	.4434**

	I95	I97	I99	I101	I103	I105
DEFENSE	.4421**	.5796**	.4286**	.4140**	.2648**	.0657
INTERP	.4054**	.4799**	.4054**	.3516**	.1596**	-.0632
DEVELOP	.2796**	.4586**	.3375**	.3023**	.1424*	.0057
EXIS	.4133**	.5161**	.5031**	.3147**	.1263*	-.0362

	I107	I109	I111	I113	I115	I117
DEFENSE	.5353**	.1731**	.6123**	-.3250**	.5321**	.4270**
INTERP	.3911**	.0490	.4890**	-.2867**	.3792**	.3855**
DEVELOP	.3744**	.1454**	.4049**	-.1693**	.3322**	.2792**
EXIS	.4730**	.0270	.6031**	-.2919**	.3964**	.3582**

	I119	I121	I123	I124	I125	I126
DEFENSE	.5435**	.7350**	.3648**	.4180**	.6425**	.7282**
INTERP	.4293**	.5725**	.1433*	.2562**	.5001**	.5400**
DEVELOP	.4129**	.5105**	.2446**	.3033**	.4518**	.4750**
EXIS	.4542**	.5996**	.2334**	.2460**	.4786**	.6331**

	I127	I128	I129
DEFENSE	.3317**	.3669**	.4054**
INTERP	.1685**	.2816**	.2542**
DEVELOP	.1718**	.2053**	.2389**
EXIS	.2593**	.3063**	.3017**

CORRELATION MATRIX FOR FINAL OBTAINED SCALE COMPOSITIONS

	I9	I17	I21	I25	I49	I55
INTERP	.5806**	.4947**	.6073**	.6084**	.4762**	.4690**
DEVELOP	.3457**	.1322*	.4019**	.3237**	.3605**	.1754**
EXIS	.3146**	.1622**	.3840**	.3476**	.3528**	.1879**
DEFENSE	.2904**	.1069	.3414**	.2893**	.2831**	.2055**

	I60	I69	I77	I81	I84	I87
INTERP	.4244**	.5015**	.4857**	.5563**	.4933**	.5169**
DEVELOP	.1516**	.3835**	.4374**	.4120**	.3097**	.4160**
EXIS	.2178**	.3648**	.4296**	.3657**	.3729**	.4072**
DEFENSE	.2468**	.2730**	.4375**	.4217**	.3877**	.4110**

	I90	I93	I96	I100	I122
INTERP	.4802**	.5252**	.4639**	.5310**	.6010**
DEVELOP	.2669**	.3617**	.3834**	.4435**	.6155**
EXIS	.2937**	.3061**	.4753**	.4869**	.6823**
DEFENSE	.3458**	.3911**	.4814**	.5108**	.6958**

	I2	I6	I10	I18	I29	I30
DEVELOP	.3634**	.5432**	.4997**	.6099**	.4158**	.5048**
EXIS	.1826**	.3557**	.4160**	.4363**	.2375**	.4354**
DEFENSE	.2607**	.4420**	.4104**	.4732**	.2395**	.4328**
INTERP	.1834**	.2957**	.3383**	.3579**	.1819**	.3806**

	I39	I45	I57	I58	I62	I70
DEVELOP	.5034**	.5617**	.4944**	.6843**	.5428**	.5324**
EXIS	.3033**	.4026**	.2619**	.6034**	.4000**	.4505**
DEFENSE	.3614**	.3914**	.2468**	.5880**	.3633**	.4751**
INTERP	.2372**	.3479**	.2491**	.4784**	.5047**	.5698**

	I74	I129
DEVELOP	.4174**	.4000**
EXIS	.4023**	.3248**
DEFENSE	.2881**	.3412**
INTERP	.2560**	.2170**

	I3	I7	I15	I38	I43	I59
EXIS	.6633**	.6680**	.5489**	.6069**	.7724**	.7719**
DEFENSE	.5450**	.5346**	.5625**	.5535**	.6680**	.6767**
INTERP	.4114**	.4609**	.3563**	.4136**	.5051**	.5180**
DEVELOP	.4409**	.5141**	.4104**	.5382**	.6052**	.5917**

	I63	I67	I71	I75	I79	I82
EXIS	.5415**	.5970**	.5325**	.5313**	.5186**	.5899**
DEFENSE	.4659**	.4752**	.4261**	.4147**	.4394**	.4709**
INTERP	.4283**	.3839**	.3491**	.4109**	.3982**	.3809**
DEVELOP	.4234**	.4410**	.3627**	.3655**	.3790**	.4760**

	I85	I86	I94
EXIS	.6971**	.5611**	.4821**
DEFENSE	.6008**	.4356**	.4120**
INTERP	.4519**	.4500**	.3767**
DEVELOP	.5768**	.3986**	.2862**

	I4	I14	I15	I16	I20	I32
DEFENSE	.6043**	.6214**	.5625**	.5782**	.5019**	.6351**
INTERP	.3528**	.4598**	.3563**	.3596**	.3444**	.4270**
DEVELOP	.4108**	.4613**	.4104**	.5553**	.3083**	.4588**
EXIS	.5078**	.5550**	.5489**	.4168**	.4465**	.5475**

	I44	I56	I68	I76	I80	I83
DEFENSE	.7152**	.6047**	.6216**	.7005**	.6706**	.5505**
INTERP	.4670**	.4272**	.3708**	.5019**	.4692**	.3765**
DEVELOP	.5012**	.4956**	.4654**	.5367**	.5412**	.4067**
EXIS	.6334**	.5159**	.5446**	.5758**	.5732**	.5125**

	I89	I92	I97	I111	I119	I121
DEFENSE	.6316**	.5378**	.6123**	.6640**	.5467**	.7451**
INTERP	.4091**	.5071**	.4051**	.4948**	.3663**	.4995**
DEVELOP	.4854**	.3735**	.4977**	.4728**	.4750**	.5358**
EXIS	.5131**	.4459**	.5238**	.5946**	.4477**	.6029**

	I125	I126
DEFENSE	.6426**	.7599**
INTERP	.4573**	.4617**
DEVELOP	.4749**	.5328**
EXIS	.4966**	.6134**

CORRELATION MATRIX FOR CROSS-REPLICATION SAMPLE

	I9	I17	I21	I25	I49	I55
INTERP	.5479**	.4301**	.5095**	.6205**	.5025**	.5416**
DEVELOP	.4608**	.1199	.2957*	.4288**	.2604*	.1821
EXIS	.3843**	.1681	.3044**	.5261**	.3630**	.3185**
DEFENSE	.3718**	.1780	.3319**	.4650**	.3635**	.3145**

	I60	I69	I77	I81	I84	I87
INTERP	.3760**	.4046**	.4214**	.5190**	.2911*	.5444**
DEVELOP	.1422	.3625**	.3960**	.3373**	.2255	.2735*
EXIS	.2344*	.2593*	.3807**	.3431**	.2552*	.4400**
DEFENSE	.2447*	.2557*	.3119**	.3636**	.2284	.4480**

	I90	I93	I96	I100	I122
INTERP	.5663**	.4719**	.5971**	.4818**	.6127**
DEVELOP	.3334**	.1921	.3043**	.2422*	.6844**
EXIS	.5136**	.2153	.5737**	.4702**	.6789**
DEFENSE	.4991**	.2757*	.6172**	.4616**	.7782**

	I2	I6	I10	I18	I29	I30
DEVELOP	.3520**	.5885**	.3816**	.5547**	.4113**	.3688**
EXIS	.0152	.3302**	.1803	.3431**	.0768	.5643**
DEFENSE	.1075	.4726**	.2252	.3987**	.1198	.5060**
INTERP	.0667	.4016**	.0786	.3606**	.0256	.4329**

	I39	I45	I57	I58	I62	I70
DEVELOP	.2169	.5943**	.4751**	.5509**	.5134**	.3883**
EXIS	.1590	.4110**	.1741	.4921**	.4002**	.3231**
DEFENSE	.2308*	.4515**	.1863	.5179**	.4385**	.2921*
INTERP	-.0627	.4602**	.2175	.4208**	.5346**	.4271**

	I74	I129
DEVELOP	.2522*	.4186**
EXIS	.2505*	.2482*
DEFENSE	.1420	.3611**
INTERP	.0130	.2011

	I3	I7	I15	I38	I43	I59
EXIS	.5630**	.5418**	.6208**	.3890**	.7485**	.7568**
DEFENSE	.5481**	.3910**	.5651**	.3877**	.6614**	.6668**
INTERP	.4378**	.3085**	.4984**	.3629**	.5015**	.5207**
DEVELOP	.5006**	.3893**	.2635*	.3400**	.5299**	.5043**

	I63	I67	I71	I75	I79	I82
EXIS	.6637**	.6415**	.6303**	.5289**	.2949*	.5114**
DEFENSE	.6307**	.6178**	.5142**	.4740**	.2057	.4524**
INTERP	.5157**	.4112**	.3762**	.4410**	.3614**	.2903*
DEVELOP	.3407**	.4010**	.3561**	.3540**	.1822	.3847**

	I85	I86	I94			
EXIS	.7028**	.5388**	.5100**			
DEFENSE	.5655**	.4755**	.4927**			
INTERP	.4681**	.4908**	.4696**			
DEVELOP	.4730**	.3876**	.3681**			
	I4	I14	I15	I16	I20	I32
DEFENSE	.4863**	.6520**	.5651**	.5226**	.4833**	.6496**
INTERP	.2199	.5869**	.4984**	.3957**	.3253**	.3768**
DEVELOP	.4818**	.4392**	.2635*	.5324**	.3058**	.5035**
EXIS	.2769*	.6083**	.6208**	.3661**	.4648**	.5676**
	I44	I56	I68	I76	I8_	I83
DEFENSE	.7359**	.5230**	.6613**	.7864**	.5200**	.5666**
INTERP	.6046**	.4547**	.5428**	.6132**	.2548*	.3874**
DEVELOP	.4719**	.4299**	.3907**	.6424**	.3505**	.4603**
EXIS	.7376**	.5361**	.6693**	.6607**	.4956**	.5008**
	I89	I92	I97	I111	I119	I121
DEFENSE	.4774**	.5935**	.6127**	.6728**	.4614**	.7341**
INTERP	.3011**	.6317**	.5538**	.5833**	.2996*	.4823**
DEVELOP	.4591**	.4073**	.4322**	.4794**	.3117**	.5023**
EXIS	.3924**	.5807**	.4968**	.7939**	.3643**	.6352**
	I125	I126				
DEFENSE	.7113**	.6567**				
INTERP	.5560**	.3938**				
DEVELOP	.5156**	.4752**				
EXIS	.5139**	.4759**				

APPENDIX B
CONSENT FORMS AND DEMOGRAPHIC SHEET FOR PHASE ONE

CONSENT FORM

My name is Charles Pap, I am an intern in Counseling Psychology at Iowa State University's Counseling Service. I am currently conducting a research project on the process of brief psychotherapy similar to the counseling offered at the Student Counseling Service. My purpose is to study the variety of issues presented in the intake interview.

As a client at the Student Counseling Service you have the right to confidentiality. I am asking your permission to audiotape your first session. Please understand that you have the right to not participate in this study, and further your decision to participate or not participate will in no way effect the type of services you will receive. Additionally, you may choose to stop the audiotape at any point during the intake.

The audiotape will be kept confidential, and your name will not be associated with it in any way. You will be asked to fill out a coded demographic sheet that will include some information about you, but please not include your name or identification number.

Only the first session will be taped for the purposes of this research project. Following analysis and completion of this study the audiotape will be erased.

I will appreciate your participation in this study, and will treat the contents of each audiotape with respect and consideration. Your participation will help counselors in providing more effective and efficient services.

Thank you.

I have read the above statement and hereby agree to allow my intake interview at the Iowa State University Student Counseling Services be audiotaped to be part of the data gathered for a research project on brief psychotherapy.

Signed,

Name:_____

Witness:_____

Date:_____

DEMOGRAPHIC INFORMATION

Please fill out the blanks on this sheet, do not include your name or any identification number. Thank you.

CLIENT

AGE_____

ETHNICITY_____

YEAR IN SCHOOL: FRESH. SOPH. JUNIOR SENIOR GRAD

GENDER M F

HAVE YOU EVER SEEN A COUNSELOR BEFORE YES NO

IN ONE SENTENCE PLEASE DESCRIBE WHY YOU ARE SEEKING COUNSELING AT THIS TIME:

_____

_____

COUNSELOR

GENDER M F

YEARS OF COUNSELING EXPERIENCE_____

THEORETICAL ORIENTATION_____ _____ _____

APPENDIX C
PHASE TWO DEMOGRAPHIC SHEET AND IDE ASSESSMENT INVENTORY

Demographic Information

1. DO NOT PUT YOUR NAME ON ANY SHEET

2. In box labeled SEX
   Mark either Male or Female

3. In box labeled GRADE or EDUC
   Mark the appropriate box: Freshman 13 Sophomore 14 Junior 15 Senior 16

4. In box labeled birthday, enter only your AGE in the Box labeled YR. Then blacken the appropriate circles.

5. In Special code K, answer the following question:

   Have you ever seen a counselor, social worker, psychologist, or psychiatrist?

   Yes Blacken the 0 circle
   No Blacken the 1 circle

6. In Special code L, indicate your ethnicity, blackening the appropriate circle:

   0 = White American
   1 = African-American
   2 = Native American
   3 = Asian American
   4 = Hispanic American
   5 = International student (Non US citizen)
   6 = Other

IDE ASSESSMENT

Please respond to the following items, by indicating, on the Opti-Scan sheet, if that item is:

A= Very true B= Mostly true C= Somewhat true D= Not at all true

---

1. My parents often would criticize me
2. I have been abused
3. I am really lost
4. I am dealing with a lot of stress right now
5. My parents have made me feel badly about things that I have done
6. There were painful events in my childhood
7. I don't know what I should do in my life
8. I believe that the socializing other people do is very superficial.
9. Ours is not a close family
10. I am worried about getting a good job
11. I have had strange experiences in my life
12. I take on a lot of responsibility
13. In our family we often hug each other
14. I have ended up not very happy in my life
15. I am afraid that my friends would not like who I really am
16. I have experienced a lot of pain in my life
17. In my family we say "I love you" to each other
18. I am not the person I once was
19. I have recently ended a very meaningful relationship
20. I am not a good person
21. I am not very close to my parents
22. I don't allow myself to make mistakes
23. I feel bad making decisions that will affect other people's lives
24. I have thought that I deserve only pain
25. I feel very close to my parents
26. I have made a great deal of improvement in my life
27. I would feel guilty if I did something I knew was wrong
28. I deserve the good things in life
29. I have feared that my father would abuse me
30. I don't think that anyone will ever marry me
31. I think that life will be easier once I make an important decision
32. I have low self-esteem
33. I remember one of my parents being gone a long time when I was younger
34. I consider myself a virgin
35. I have a lot of free time
36. Someone in my immediate family has had a nervous breakdown
37. When I am upset I usually try talking with a friend about it
38. I'm caught in the middle on a lot of things
39. When I was young, I took care of the family
40. I cry often
41. My friends and I have talked about sex
42. There are so many things that interest me
43. I don't know how I feel
44. I don't like myself
45. The thought of being in a relationship really scares me
46. The idea of marriage sounds silly to me
47. I want others to realize that they have to accept me the way I am
48. I have had terrifying nightmares
49. I have never been able to develop a dating relationship.

A= Very true B= Mostly true C= Somewhat true D= Not at all true

50. I'm from a small town
51. I am the "black sheep" of my family
52. I have had friends that were in the mental hospital
53. The person I care about is not ready for a real commitment
54. My parents had problems raising me
55. My family knows that I am there for them, if they need me
56. I just try to bury my bad feelings
57. I get irritated when I am in a relationship too long
58. There are things in my life that are basically unresolved
59. I don't know what my identity is
60. I can usually open up pretty easily
61. I don't expect anything from my parents
62. I don't know how to act around people I am attracted to
63. My friends don't actually know me
64. It is really hard for me to talk about my feelings
65. I like to help people
66. I have never had a real date in my life
67. I have become what people think I am, not who I really am
68. Sometimes I wish that I had never been born
69. I don't particularly make an effort to see my family
70. I need to develop my social skills
71. I am a creation of what people think I should be
72. I don't express things well
73. I have not had a significant relationship in my life
74. I am undecided about my major
75. I will be alone for the rest of my life
76. I have a lot of repressed anger
77. I tend to put responsibility for relationships on other people
78. I have a lot of high expectations to meet
79. I don't feel like I have enough freedom
80. I have a lot of guilty feelings
81. I am dealing with a lot of shyness right now
82. I am struggling with an important decision right now
83. Little things are just overwhelming me
84. I get nervous in larger groups
85. I am confused about how to deal with a problem I am having
86. I really don't care much about anything
87. I get nervous in sexual situations
88. I think that I am going to drop out of school and go back home
89. When I get mad, I don't know the right way to express it
90. I get nervous when I go to parties
91. Religion gives you a model on how to live a good life
92. I am a very closed person
93. I'm reluctant to go up and talk to people
94. I have so much to live for
95. I look to other people to make decisions for me
96. When I am around other people who are having fun, I don't know what to do
97. I need to talk more about my problems
98. I have a lot of people that are willing to help me
99. I keep changing my mind on important decisions

A= Very true B= Mostly true C= Somewhat true D= Not at all true

100. There is a lack of communication between the people I am close to
101. I've always had insomnia
102. I'd like to have an intimate relationship
103. I go along with the things that are required of me
104. I want to learn how to have better relationships
105. I often offer suggestions to my friends about their problems
106. I like to talk to people
107. I never think I am good enough
108. I have a lot of friends
109. I am a perfectionist
110. I am trying to be more open with my friends
111. I am comfortable with who I am
112. My friends care for me
113. I always do what other people want me to do
114. It is very important to my family that I am a success
115. I can fool most people on how I really feel
116. I am a very sensitive person
117. I am afraid to burden other people with my problems
118. I tend to care more for other people, than I do for myself
119. I feel that I am being fake with some people
120. The people that I date are emotionally unstable
121. I keep having negative thoughts
122. There is a lot of conflict in my life
123. I think about my eating habits a lot
124. I need to be in control
125. I am nervous and tense frequently
126. Sometimes I feel really depressed
127. I like to get drunk
128. I don't think that I could ever attempt suicide
129. Drinking lets my true emotions come out

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