Therapists' documentation of change in clients' problems and relationships in long-term psychotherapy.

THERAPISTS' DOCUMENTATION OF CHANGE IN CLIENTS' PROBLEMS AND RELATIONSHIPS IN LONG-TERM PSYCHOTHERAPY

A Dissertation Presented

by

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ABSTRACT

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Clinical reports about clients in psychotherapy have been greatly under-utilized as research data about the psychotherapy process. In this exploratory study, reports from a training clinic about clients in long-term therapy were studied to address two main topics: the nature and extent of descriptions of change in romantic relationships during therapy, and the documentation of problem re-formulation over the course of therapy. Findings indicate that within the wealth of clinical material in such reports, specific documentation of these two main topics can be identified. Most cases did reveal changes or transition points in romantic relationships for the set of ninety-two cases analyzed. In addition, specific ways that clients' presenting problems changed over the course of therapy were detailed for a subset of cases. Gender differences in some areas, as well as overall implications for psychotherapy practice and research were discussed.

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CHAPTER 1

INTRODUCTION

Therapists' reports about clients contain a wide range of information, including the therapist's formulation of the client's problems, as well as some information about clients' relationships with others. Clinicians use reports to describe and document their work with clients, and yet what we know about such reports is limited. How is the complex world of the client's life captured and put into the context of the therapy that is taking place? By writing a report, the therapist must put into writing her or his understanding of the client, which is shaped by what she or he has observed, as well as what the client has told her or him. The client's view contains a wide variety of experiences with others, in the past and present, mixed together with a view of a particular presenting problem (or problems) for which they seek help. In the clinical report, the clinician seeks to integrate these stories--the one told by the client and the one developed by the therapist during the course of treatment. This study of a set of such reports will examine how therapists document one broad aspect of the client's life--his or her relationships with others--when writing reports about the therapy, as well as how this relates to problem formulation in reports.

Various theoretical models of psychotherapy have taken particular stands on the meaning and importance of

relationships with others (family of origin, partners, friends, the larger society). The use of information about these relationships will vary depending on the therapist's theoretical orientation, the presenting problem and "diagnosis" of the client, and the context in which the therapy is occurring (the work setting of the therapist, the reason for referral, the constraints of time and money, to name a few). However these variables affect the course of therapy, at the time of report writing clinicians are faced with the task of integrating their knowledge into a concise report, which will reflect some or all of these forces. The resulting document stands as one view (among many) of the information collected and the process which has occurred. An examination of a set of reports allows one to establish one set of theories about what has happened, what was seen as important, and what was seen as unimportant. This view will differ from the perspective of the client (or other observers) in some ways, and the resulting analysis will differ from the results obtained through other forms of data collection (interviews, questionnaires, scales, etc.) but will in the same way provide one unique glimpse into this complex phenomenon.

This study had as its aim the examination of reports of individual therapies in a particular setting (a training clinic), with the original focus being the current relationships of therapy clients. During the course of this exploratory study, a second focus was developed: the

documentation of the course of clients' presenting problems during these therapies. These issues are inter-related in a variety of ways, and these two themes will be explored in some detail. As an introduction, previous work by other researchers and theoreticians in these two areas will be presented, as well as an examination of the theoretical approaches and methodologies that have been utilized in studying such complex data as clinical reports.

Theoretical Perspectives on the Place of Relationships in Therapy

In individual therapy, the therapist relies on information provided by the client to understand the client's relationships with others. In this model of therapy, the therapist typically has no contact with other individuals besides the client. However, psychotherapy can be seen as having as its aim the improvement of the client's functioning in his or her social context. This is the view taken by H. S. Sullivan, who wrote about psychiatry that it "is the field of interpersonal relations - a personality can never be isolated from the complex of interpersonal relations in which the person lives and has his being" (1940, p.10). While traditional psychoanalytic

theory did not begin with this assumption[1], but rather with the assumption that the intrapsychic world was the realm of analysis, the interpersonal perspective has been very influential in recent modifications of psychoanalytic theory (Greenberg and Mitchell, 1983). The development in the last fifty years or so of "object relations" theories has hinged on the question of what is the intrinsic motivation for human development: drive theory, as elaborated by Freud and certain of his followers, or the "relational/structure" model (Greenberg and Mitchell's term) as described by Klein, Fairbairn, Winnicott and others. These latter theorists viewed the need for relationships with others as central, and concentrated their attention on the early relationships the infant has with caregivers (the origins of these theories can be seen however, in Freud's earlier work, before his abandonment of the "seduction theory").

A concurrent development in psychoanalytic thinking has been the increased attention placed on transference and counter-transference in analysis, also questions about relationships, which are seen as the major forces behind changes which occur in clients in analysis and

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[1] Psychoanalytic theory will be explored here, with the assumption that while traditional psychoanalysis is not practiced in the clinic being studied, nor in very many settings, it is important in understanding the origins of a great many forms of psychotherapy, including the loosely defined psychodynamic psychotherapy practiced in the clinic setting of this study.

psychoanalytic psychotherapy[2]. With this increased focus on relationships as a way to understand intrapsychic phenomenon, there has still been little attention paid within this literature to current relationships (that the adult client has with others outside of the therapy) and their influence during the course of psychotherapy.

This is in sharp contrast to the field of family therapy, which has also emerged during this period. In family therapy, the focus is specifically on the interactions between people, and knowing who is involved in the "identified patient's" life is central to any assessment by a family therapist. While there are many schools of thought in family therapy, a common denominator is that family therapists generally do include family members in the actual therapy sessions. Some, however, might conduct sessions with only one member, but continue to include current interactions with others as part of the work (for example, Bowen, 1978, or the cyclical psychodynamic work of Wachtel and Wachtel, 1986). Thus, a

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[2] Originally, Freud used the term transference to refer to the unconscious distortion in the client's mind, based on specific early experiences, imposed on his or her view of the therapist. Countertransference was its counterpart in the therapist's mind; the therapist might distort his or her views of the client based on his or her early experiences. More recent views have expanded the definitions considerably, including in the transference-countertransference phenomenon virtually any interaction, with the implication that unconscious forces drive these interactions. Both sets of experiences (transference for the client, countertransference for the therapist) are now seen as providing valuable data in the therapy, when they can be uncovered and used by the therapist (see for example, Cooper, 1987; Jacobs, 1986).

general distinction between family and individual psychodynamic therapy models is that most family therapy models focus more on interactions between members, while individual psychodynamic models would focus more on the individual's symptoms and pathology. A further distinction between these models is the focus on the unconscious and therapist-client transference/counter-transference issues in psychoanalytic models.

While it is only with the more recent revisions of psychoanalytic theory that relationships with others have become more central in working with individuals, earlier models did not completely exclude the family. For example, in 1931, Flugel wrote a very influential book on the effects of the family on individual development. These early writings, however, focused primarily on the influence of family of origin on intrapsychic development, and did not address ongoing relationships of adults. Psychoanalysts have had to come to terms, however, with the fact that individuals in therapy do have current relationships, and some writers have addressed the issues involved in psychoanalysis of married couples. Writers like Dicks (1967) and more recently, Finkelstein (1988) have discussed ways of working with married couples within a psychoanalytic framework. This kind of approach relies heavily on the object relations tradition, looking for ways that the individual's early family relationships have influenced their choice of marital partner and ways of

relating to a current partner. Within this way of thinking, as described by Finkelstein, one shifts the focus of the therapy from the "psychic reality" (or unconscious) of the individual to what is "actually" happening in the patient's life (p.911), a shift which Finkelstein refers to as "inferior" to psychoanalysis (p.909). Other writers, coming more from a family systems perspective (for example, Slipp, 1984, and Scharff and Scharff, 1987) have not viewed this kind of work as inferior, but have developed models which integrate object relations thinking with a focus on current relationships.

The emerging field of feminist psychology also places a great deal of importance on relationships. A good example of this work is a summary article by Miller and Stiver (1991), who are part of the Stone Center group at Wellesley. In their revised model of psychotherapy, relationships or "connections" with others are central, as they are in the object relations model, and the goals of therapy are focussed around the re-development of the capacity for "empathic" and "mutually empowering" relationships (p. 11). Psychotherapy outcome research which follows this type of model might then be concerned with the extent of the development of actual relationships in the lives of individual clients in therapy, a theme explored in the current research project.

Lastly, another emerging perspective which bears on this question is the study of adult development. Drawing on

the growing research in this area, Howenstine, Silberstein, Newton and Newton (1992), developed a model of psychodynamic psychotherapy in which the focus of therapy is the development of the self, with an additional goal of "helping the patient to build an external life structure that best expresses it" (p. 197). This model draws more on the tradition of self-psychology (which might focus on the client's experience of herself, for example, rather than uncovering internal object relations as the object relations school might)[3], and might be more "supportive" than insight oriented, with specific goals of therapy being addressed directly with the client. Their model focuses on adult developmental "eras" and associated "tasks" for different stages of development. This area has also been addressed in the family therapy literature, where certain writers have concentrated on the "life cycle" and how it relates to families in therapy. Writers such as Carter and McGoldrick (1980) and Feldman and Feldman (1975) have developed models of therapy based on this idea, that it is important to recognize the point in the life cycle at which a family enters treatment, and the ways that a family might be "stuck" at a transitional stage. Research has also been done on life cycle variations in patterns of close relationships (Shulman, 1975) and the idea of the life cycle has also been addressed as a demographic concept by

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[3] For a further explanation of the differences among these schools of psychoanalytic thought, see Pine, 1988.

sociologists studying families (Glick, 1955, 1990). These ideas about adult developmental eras and transition points in the life cycle may have important implications for understanding points at which clients enter therapy. In addition, this may be another intersection point between the life of the individual client and others in her or his family/social network.

While most individual psychotherapies do not use methods which include family members or significant others in the actual therapy sessions (as would be the case in family therapy), through the course of therapy, the individual therapist eventually learns a great deal about the social context of the client, even while concentrating at times on the inner life of the client. And, at termination, the client must learn to take the lessons of the therapy back to his or her actual life, whether that life has remained the same during the course of therapy, or has changed during this time. Between sessions, of course, this process happens repeatedly, as the client must leave the consulting room and re-enter their social world. How does the therapist make use of this information about the social context of the client? This may depend in large part on the theoretical orientation of the therapist. It is likely though, that the therapist has some information, and will use it in constructing a vision of who the client is, how well she/he is functioning, and perhaps how well the interventions of the therapist are taking hold.

In individual assessment of clients prior to therapy, the determination of who is in the client's life, and how the client relates to each of these people, is certain to be an important variable. This information is included in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-III-R) (1987) on axes IV and V (psychosocial functioning and global assessment of functioning), and to some extent is included in many of the diagnostic categories in axes I and II (psychopathology and personality disorders). This kind of information is also included in standard interviewing protocols and guidelines (see for example, Guze, Richeimer, and Seigel, 1990, MacKinnon and Michels, 1971, and Sullivan, 1954). Even the most simple assessments would include marital status, and information about family of origin, particularly for younger clients or those living with family of origin.

The recent trend toward brief therapy has included development of methods to assess the client's central conflict in a few sessions (e.g., Davenloo, 1980, Budman and Gurman, 1988). For the most part this involves using the client's relational style (to the interviewer and to others) as it relates to the presenting problem in order to establish a direction for future interpretations in the therapy. In this method, clients' actual relationships are used as background information for developing an intrapsychic but relationally based formulation.

Psychotherapy Research Addressing the Question of Relationships

Information about clients' relationships with others while in individual therapy, while useful for therapists in decision making and evaluation, is often lacking in studies of psychotherapy. Those studies that do use this information often rely on simple categorizations of marital status and living arrangements. Yet it is the quality and extent of these relationships that are involved in clinical decision making. This kind of information may be included in clinical reports written by therapists during the course of therapy, at termination, or in the report written after the first contact with the client (as in Jacobus, 1990). In these reports, more detailed information may be included than in most questionnaire-oriented psychotherapy research. The writer of a report typically tries to outline (if briefly) the client's social context, often to establish the client's level of functioning in this important realm. In ongoing cases, later reports might document how the client's social relationships have changed (or stayed the same), again to document the client's level of social functioning and current stressors or supports.

Researchers evaluating the effectiveness of psychotherapy have developed a range of instruments to tap into the murky question of what actually changes during a course of therapy. Lambert, Shapiro and Bergin, in a review

of this literature (1986), conclude that there has been a move toward more "acceptance of the idea that the effects of psychotherapy should extend into the daily functioning" of clients (p. 187), and include in this measures of social functioning. This is in contrast to earlier approaches, which emphasized projective tests and therapist ratings of improvement. Examples of the kinds of measures recommended by Lambert, et al., and often used in research, are the Social Adjustment Scale (Weissman and Paykel, 1974) and the Global Assessment Scale (Endicott, Spitzer, et al., 1976). These kinds of measures, while easy to administer and score, do not provide information about who is actually in the family or social network of the client, nor do they assess how the clinician uses this information in the therapy. They focus on the deficiencies in the functioning of the client, and provide a point of comparison between clients.

Another kind of assessment that has been used in research evaluating psychotherapy is one which considers clients' relational style, seen as an aspect of personality which will recur in each new relationship the client enters (the basis of transference). This was studied by Piper, Azim, et al. (1990), who found their measure of "quality of object relations" to be a good predictor of success in therapy. In a set of unstructured interviews, a trained rater established a numerical rating that reflected the client's "life-long pattern of relationships", using a

psychodynamic-object relations framework. These investigators used the Social Adjustment Scale as well as several other interpersonal scales for their therapy outcome measures.

A similar approach was taken by Luborsky, Crits-Cristoph, et al. (1988), who evaluated clients "central relationship patterns" in psychotherapy sessions (p. 223). Their method, called the Core Conflictual Relationship Theme Method, uses trained judges to evaluate narrative episodes from therapy sessions and formulate a set of ideas which characterize the client's main conflict in terms of relationships with others. This is also based on the psychoanalytic concept of transference, in that the core relationship theme of the client is seen as reflecting the kind of relationship that the client will have with the therapist. This method was used by Luborsky and his colleagues to evaluate how well therapists are able to use the core relationship theme in their interpretations, and to test this congruence of themes against outcome measures. The outcome measures were a variety of scales completed by clients, therapists and independent raters, and included a self report inventory of social and personality functioning (Auerbach and Johnson, 1978). Here again, however, the focus was not primarily on specific current relationships so much as relational style and overall functioning. No particular attention was paid to what specific

relationships existed in the clients' lives and how they changed during the course of therapy.

The CCRT method, as used by Luborsky, et al., is somewhat similar to the "Plan Diagnosis Method" used by the Mt. Zion group, as reported by Curtis, Silberschatz, Sampson, Weiss, and Rosenberg (1988). This method uses a group of trained clinicians to evaluate therapy sessions and establish a reliable case formulation. The formulations also revolve around relational issues, but primarily from an intrapsychic perspective. It is relational style that is being evaluated, with knowledge of specific relationships being seen as additional information which helps create the formulation, but not central to it.

In a related study, Kantrowitz, Katz, et al. (1987), examined changes in the quality of "object relations" in a sample of 22 clients undergoing traditional psychoanalysis. Using psychological testing data as well as interviews with both therapist and client, they found that all clients improved in quality of object relations by the follow-up interview, regardless of the ratings of "transference resolution" for each client. In other words, even when the traditional criteria of a "successful" analysis had not been met, clients changed in their manner of relating to others after being in analysis. Again, this study did not address particular relationships that the client had outside of the analytic relationship, but the authors did note that their rated interviews did include information

about "actual relationships", and may have been one part of what was measured as changed after a course of analysis.

Psychotherapy researchers have found that an important variable determining outcome is the quality of the client's alliance with the therapist. As this is at its root also a question about relationships and relational style, some researchers have looked for measures to assess relational style as a predictor variable for therapeutic alliance and outcome of therapy. Moras and Strupp (1982) used a "Clinical Rating Form" that included measures of interpersonal relations, and found these measures to be correlated with outcome. In their study, an independent clinician rated the client on several scales following an interview, including measures of current social relationships and family relationships. While these pre-therapy measures were correlated with outcome, the specific relationships clients were engaged in, and the kinds of changes which occurred in them, were not addressed in this study.

In other areas of research, outside the realm specifically of psychotherapy research, the quantity and quality of "social support" has been quite extensively studied. At times these concepts, including the counting and measuring of social networks and the idea of these social contacts being a possible "buffer" against stress or other problems, are used to describe clinical populations. An example is a research project by Sherbourne (1988)

examining social support and the use of mental health services. Her work supported the idea that those with greater social resources will be less likely to seek mental health services. Miller and Ingham (1976) similarly found that the lack of an intimate "confidante" was related to more severe psychological symptoms. While this kind of research has produced promising models integrating the ideas of social networks, stress, and life events, these concepts are difficult to measure, and at times studies on these issues contradict each other. Billings and Moos (1984), for example, found that in one setting (of three) they studied, those with more friends received longer treatment, while their overall finding was that clients with the most life stressors received the least treatment. These authors hypothesized that this might be due to clinicians making external attributions of the clients' distress in these cases (those with the most life stressors) and therefore not offering as much treatment. Generally, this kind of research is not based in individual clinical work, but is done from a sociological or social psychology framework. An exception is the clinical model developed by Tracy and Whittaker (1990), who advocate the development of a "social network map" for clients in therapy, as part of a general assessment of client resources. They also note the need for further research in the area of "change in social support from intake to

termination", as this may relate to treatment outcome (p. 469).

How Therapists Use Relational Information

The studies mentioned above relate to the importance of using information collected about clients' relationships in developing a thorough understanding of the client. This is done in initial sessions and intake sessions with clients, using for the most part, unstructured interviews. The clinician then uses her or his reactions to the client, as well as information gathered in an interview to determine a diagnosis and formulation, as well as a therapy plan. Clinicians doing individual therapy often use a DSM-III-R diagnosis and a narrative report to communicate to others their impression of the client, as well as for documenting their interaction. It is during this process of compiling the information gathered, and writing it down, that the clinician decides which pieces of information are important and which to leave aside, perhaps for further exploration at a later date.

In using a DSM-III-R diagnosis, the clinician usually uses some of the information about the client's relationships which have been discussed in the interview, but the diagnosis itself is very much individually-oriented. There has been some controversy about this individually oriented form of diagnosis (Denton, 1990)

particularly from the growing marriage and family therapy field. Alternative systems using interpersonal data have been explored (e.g., McLemore and Benjamin, 1979), but for the most part they have not been accepted, at least not as universally as DSM-III-R.

Some writers have also expressed dissatisfaction with the diagnostic method of DSM-III-R in that it is too limited in scope. This is the view taken by those who advocate a broader "formulation" to be used to describe individuals in treatment (Cleghorn, 1985; Friedman and Lister, 1987; Perry, Cooper, and Michels, 1987; Sperry, 1989; and Cameron, Kline, et al., 1978). While the models presented by these writers differ somewhat, they all include some information about relationships with significant others as part of a formulation, especially a client's pattern of relating to others. Generally, in this kind of formulation, the information about the client's relational style takes precedence over the documentation of specific relationships that the client is engaged in, as the client's style is seen as central to the psychodynamic formulation.

Besides the question of how the clinician formulates the case at the beginning of therapy, and what part interpersonal relationships play in this process, there is also the question of how changes in relationships during the course of therapy are understood. Freud advocated that those entering psychoanalysis make a commitment that

included not changing significant aspects of life such as marrying or divorcing (Freud, 1914). This seems to be almost forgotten now, as people seem to enter therapy at critical choice points in their lives, and use therapy to help them with these decisions. There are also those who enter therapy disturbed but uncertain as to where their distress is coming from, and who use insights developed in therapy to make changes in certain aspects of their lives and relationships. What role do these external events play in individual therapy? How does the therapist use this information? For the most part it seems that therapists, even of different theoretical persuasions, are trained to be somewhat neutral about changes in a clients life, neither advocating change such as marriage, nor discouraging it, as Freud might have.

The Impact of Therapy on Relationships

An important question, which has not been researched in depth, is whether clients' actual relationships change while they are in therapy and how they change. Several studies have looked at married couples entering therapy either individually or conjointly, to see if these two modalities lead to different outcomes. Gurman and Kniskern, in reviewing this literature, advocated conjoint therapy (pointing to the positive outcomes in a number of studies), over individual therapy for one partner, as the studies

they reviewed showed no positive effect for the couple in this form of treatment (Gurman and Kniskern, 1978 and 1986). Gurman and Kniskern's initial conclusions were that there was a possibility that a couple's relationship could deteriorate if one partner was in individual psychotherapy, while there was more of a chance of improvement if the couple was in couples or family therapy. They later revised this statement about "deterioration" of relationships for couples in individual therapies, concluding only that there were no positive effects for this form of treatment, while positive outcomes were found in the conjoint therapy studies.

A few writers have addressed the issue of how marital partners react to a spouse being in therapy (Barcai, 1977; Brody and Farber, 1989; and Hatcher and Hatcher, 1983). With case studies (Barcai) and questionnaires (Brody and Farber; Hatcher and Hatcher) filled out by partners of those in psychotherapy, these writers have concluded that there is an effect of psychotherapy which goes beyond the effect on the individual participant. While some of the significant others felt left out, or were resentful of the cost of therapy, there were also cases where positive changes were noted, such as increased communication in the marital pair.

Kaltreider, Becker, and Horowitz (1984) studied the changes in marital relationships following loss of a parent in psychotherapy clients, and found that a large percentage

of these clients experienced deterioration in current relationships following this loss. They initially noted this phenomenon in the clinical setting, and followed up on this observation with a study comparing clients in therapy with other individuals who experienced such loss but were not in therapy. They found demographic differences in these two samples, but also found patterns of differences that they then related to the psychodynamic paradigm they were using. For example, they found many of the clients who experienced disruption in a relationship to be re-experiencing a great neediness following the loss of the parent, which was related to the disruption in the marital relationship. They found these patterns using process notes, self-report inventories, ratings of videotaped sessions, and clinicians' ratings of various materials. This kind of pattern, first observable through case studies, then seen in a larger sample (N=35) is an example of the rich information to be found in intensive clinically-based research.

While individual, insight-oriented psychotherapy and family therapy can be viewed as irreconcilable theoretical perspectives, it can be helpful to consider both together, and in the comparison one can understand each better. One way of comparing these two models is to view individual therapy as a "closed" model, and family therapy as an "open" model, as described by Pattison (1973). In the closed model, the effects of therapy are made by acting on

the individual, in a system where the therapist and client stand apart from society and the social network of the client. The client can choose to return to the same social network as before the therapy or can alter her or his social network as a result of the therapy. The therapy may have some impact on the social system; however, this change originates from the impact the therapy has on the individual. In contrast, in an open model the therapist works with the social system directly, as a family therapist does in inviting the entire family to the consulting room. The therapist's work is to change the way that people in the system relate to each other, and as a result the "identified patient's" behavior changes.

The studies of how partners of individuals in therapy are affected by the therapy can thus be seen as part of how the closed system, which excludes the partner and the rest of the social network, does indeed affect the social system. The changes in an individual inevitably change something about the way he or she relates to others. There is still the question of how others in the social system affect the therapy, as it is sure to work both ways.

It is interesting to note that studies of the impact of families on individuals in therapy have been primarily focused on the treatment of severely disturbed clients, such as those diagnosed with schizophrenia. As a result of national deinstitutionalization policies, much has been written on the increased burden on families caring for

these clients (e.g., Gubman and Tessler, 1987). Falloon, Boyd, et al. (1982) and others have researched the impact of the family's involvement in treatment on the individual client, and the impact of certain family characteristics on the client's likelihood to relapse. This kind of analysis of the effect on families of psychopathology and treatment of individuals has not been studied as intensively with higher functioning clients, such as those in outpatient psychotherapy.

The Nature of "the Problem" in Therapy

In general, the model of problem formulation for individual therapy goes as follows: the client comes to the therapist with one or more "problems", the therapist and client discuss the problem(s), the therapist develops a diagnosis or formulation, and, once guidelines of treatment are established, they work on the problems based on the therapist's approach to working on such problems. The reality of psychotherapy is much more complex, and does not fit neatly into this model, which might be described as the "medical" model. Within the medical model, the client is only able to describe "symptoms", which the "expert" can fit into a system of decision trees, and eventually emerge with a particular diagnosis that fits the symptoms. Treatment is based on matching a treatment strategy to the diagnosis. This kind of model also assumes that the client

desires the reduction or elimination of "symptoms" as soon as possible, and that the "expert" will know how to do this.

One way that the simplified medical model presented above does not fit psychotherapy is that psychological problems do not always fit clearly into diagnostic niches. One of the main obstacles to this is that psychological problems are contained in, and described by, language. The clinician and the client can only come to understand each other through the use of language, and the problem itself can only be uncovered by a conversation between the two. The client may use very different language to describe his or her problem than the clinician, and there is a great deal of room for misunderstanding on this basis. In addition, the clinician can shape the nature of the problem by introducing new language, asking particular questions, or by refining or redefining the client's original language. It is the perspective of this study that a client's problem (as it is seen in therapy), only exists in this context, in the interchange between the two individuals discussing the problem, and that this context is important in understanding the resulting problem definition.

This constructivist position is well defined by Anderson and Goolishan (1988, also Anderson, Goolishan and Windermand, 1986; Goolishan and Anderson 1987). In their view, therapy is a collaborative process in which the

therapist becomes part of the "problem determined system" and helps facilitate a conversation about the problem. In this view the client is the "expert" on the problem, and resolution of the problem comes from a shift in the way that the problem issues are understood and discussed.

Anderson and Goolishan's ideas come from work with families, but similar views have also been discussed in reference to work with individuals. Atwood and Stolorow (1984) describe psychoanalysis in similar terms, emphasizing the "intersubjectivity" of the understanding developed about the client in analysis. From their point of view, psychopathology itself cannot be understood outside of this "intersubjective context" that develops between the two participants.

The recent emphasis on understanding psychoanalytic work as the development of a "narrative" has also included the view that the narrative developed by the client about his or her problems is developed in the context of a relationship; therefore both participants play a role in its development. This is the view taken by Russell and Van Den Broek in a recent paper (1992) in which they claim that "successful therapy results in the client's acquisition of a more adaptive behavior, which is facilitated by achieving new understanding of self and the 'events' making up the inter- and intrapersonal world". They go on to describe that this "change takes shape in the collaborative problem-solving behavior of the therapist and client" (p. 348).

This view is then quite different from earlier psychoanalytic ideas about "uncovering" or discovering the true problems of the client, and closer to what Anderson, Goolishan and Windermand (1986) call "the basic constructivist position," that "we do not discover the structure or reality of families," but "rather, we invent the families we work with..." (p. 4).

While not described specifically as constructivist, this is the kind of perspective taken by Davis (1986) in her paper entitled, "The process of problem (re)formulation in psychotherapy." In this paper, she describes her study of one intake interview by an experienced psychodynamic psychotherapist of a woman seeking therapy at a university clinic. Using the qualitative research methods of Glaser and Strauss (1967), she analyzed the text of the interview, looking for patterns in the process of problem formulation. The initial segments of the interview are presented and characterized as the client presenting her "initial version" of "her troubles." In later segments, Davis demonstrates how, using specific interventions, the therapist "constructs" or "transforms" the discussion into a conversation about the client's style of dealing with her emotions, and of ways of relating to others. She notes that at a certain point the therapist "no longer formulates what the client has actually said...but rather how she has been saying it." Later still, the (male) therapist shifts to "devote his energies to establishing it" (the client's

style) "as a problem warranting therapeutic treatment" (p. 59). Throughout the rest of the interview, Davis notes that he uses further formulations (or interpretations) to "organize topic talk" around this newly formulated problem, and that the new kinds of statements made by the therapist are "particularly useful in marshalling evidence for the problem". By using the way that the client expresses herself, and her style of relating to the therapist, the therapist in this case develops a formulation quite different from the set of "troubles" that the client originally presented, and continues to use formulations to "organize her consent" to address the problem he has discovered. Davis's point is to demonstrate that "the process of finding a therapy problem (or diagnosis) emerges as an interactional activity," that the problem can be seen as a "construction" driven by "considerable work on the part of the therapist," and that by examining the process in detail one can "de-mystify therapy" and better understand it (p 70). While she also began with a political agenda, namely to show how women's problems are "individualized" and taken out of a social context, her work goes a long way toward showing the process of problem construction in therapy, and highlighting the idea that the problems of therapy patients are developed through conversation between therapist and client.

Similarities can be seen between Davis' ideas and the writings of those who have recently tried to outline for

students of psychotherapy the methods of problem formulation in the psychoanalytic tradition (Cleghorn, 1985, Friedman and Lister, 1987; Perry, Cooper, and Michels, 1987, Sperry, 1989; and Cameron, Kline, et al., 1978). All of these writers include as an important part of a formulation the client's social context or ways of relating to others, and advocate the use of the relationship with the clinician as a way of evaluating the client's style of relating to others.

Friedman and Lister (1987) make an important distinction between formulation and diagnosis, stating that a formulation is "explanatory", while a diagnosis is "a nosologic abstraction that summarizes and labels the observed data but does not explain them" (p.132). It seems that there are at least three divergent trends in the field, with one toward a focus on diagnosis in the medical model (with the clinician being the "expert" who labels the problem in terms of a "diagnosis"), another trend toward the preservation of the dynamic formulation as a way to more fully understand clients (this system being more "explanatory" as noted by Friedman and Lister), and a third trend toward a more standardized problem focus and problem definition in reports as a way to be more accountable for the work done with clients (Kagle, 1991). In this latter conceptualization, the client's problems are generally more broadly defined, including symptoms, social issues, and

whatever else the client may bring to the therapist as a "problem".

In the area of report writing, there has been considerable interest in shifting from "narrative" formats toward a "problem focused" approach, called by Ryback (1973, 1974) the "problem oriented record" (and originally described by Weed, 1969, as a tool for the medical setting). In this system, specific problems are listed separately, and goals and outcomes are clearly specified. This is similar to the SOAP method of record keeping advocated in psychiatry (Subjective data, Objective data, Assessment, Plan), in that both focus more attention on objective measures and explicit treatment plans than earlier record keeping models.

An advantage to this strategy, because of its emphasis on "objective" data is its greater applicability to research on treatment outcome, a point made by Sturm (1987), who notes that such a chart then becomes "an analogue of the classic single-subject research report". One example of this kind of research is a study done by Webb, Gold, et al. (1980), in which they found that therapists reviewing tapes of intake sessions could reliably identify presenting problems using the problem-oriented record approach.

In the area of therapy itself, there has also been interest in more clear problem definition as part of the process of therapy. While the original notions of analysis

done by followers of Freud might have as a goal "the acquisition of self-knowledge" (insight) or "bringing into consciousness that which is unconscious", which may be related to symptom reduction (Fisher and Greenberg, 1977, p. 304), the more recent trends toward brief therapy have developed the idea of establishing a particular focus for treatment with more definable goals. Budman and Gurman (1988), for example, use a model where one "major focal area" is established, and it is "the responsibility of the therapist to keep the major theme of the treatment always at the forefront of the interaction" (p. 66). In their model, the focus of treatment can be "relatively independent of diagnostic category" and can include interpersonal difficulties, a symptom focus, or even a focus on character pathology. The focus, as they see it, originates from the problems presented by the client, but is often developed further by the clinician and client together at the onset of treatment.

The question of problem focus (versus uncovering unconscious conflict, developing self knowledge, or other kinds of aims for psychotherapy) again may be one of theoretical differences, in this case with a distinct difference between followers of psychoanalytic/ psychodynamic traditions (taking a more open-ended approach) and more recent behavioral, cognitive-behavioral and most family systems approaches where a problem focus is central to the therapeutic contract. Messer (1986) attacked

this problem head-on, examining the differences and similarities between psychoanalytic and behavioral views, and concluding with a proposal for a movement toward integration of ideas. In terms of goal setting, he cautioned behaviorally oriented therapists to consider that clients "cannot be the sole arbiter of therapeutic goals" and notes that therapists may have to challenge the "initial objectives the client brings to therapy". He similarly cautions psychoanalytic therapists to establish a focus of therapy early on, and to give clients the opportunity to understand and consent to the goals set. This kind of message, printed in a major journal for psychologists, may indicate a move toward more integration of perspectives, as well as an appreciation of what each approach has to teach the other. In terms of focus and goal setting, the current climate does seem to be one where completely open ended therapies for "self-knowledge" are quite rare, and that problem definition, and goal setting are an important part of the work of therapy.

Several writers have commented specifically on the need for more clear problem definition, and proposed methodologies (that generally reflect the theoretical orientation and setting in which they work). In a classic study, Battle, Imber, et al. (1966), noted the similarity between the development of "target complaints" in psychotherapy and "treatment criteria in other areas of medicine" and went on to describe a series of studies done

to explore the assessment of target complaints pre- and post-treatment. In these studies, they found that clients could easily (and reliably) give a list of problems for which they were seeking therapy, and rate them for severity. They also found that reduction in these "target complaints" were correlated with other outcome measures (therapist and client ratings of improvement) after termination of brief therapy. They found that these client statements of "target complaints" did not change significantly after one intake interview, but did change for some clients after a course of therapy. In asking clients to state the "three problems" they "most want help with in psychotherapy", they found that the greatest number of problems could be categorized as "specific interpersonal problems" (40%), with other kinds of problems being anxiety or depression (31%), and physical complaints (12%). These writers also noted in this paper that they found "a significant relationship between acceptance in psychotherapy and the willingness of a patient to accept some responsibility for his malfunction" (p. 192). Unfortunately, Battle and her colleagues wrote little about the context of their findings, and did not discuss the kind of therapy conducted by therapists in the study.

Family therapists, particularly those following the "strategic" methods have also advocated finding a particular problem or set of problems to work on in therapy, including Haley (1976) who wrote that therapy must

"begin properly" by "negotiating a solvable problem" (p.9). In this kind of work the various family members are the "experts" about the problem, and the interventions are based specifically around particular problems. This kind of approach may include establishing a contract with the family and the definition of treatment goals or criteria for change (Weber, McKeever, and McDaniel, 1985). Weakland (1983) notes that a distinguishing feature of this kind of work is "taking problems primarily at face value," rather than viewing complaints as "merely the sign of some deeper and more fundamental disorder in the person or family" (p. 2).

Wynne (1988) takes a somewhat different perspective on presenting problems, also noting the tendency for therapists (and researchers) to "reformulate" the initial presenting problems of families. He specifically differentiates these initial problems "for which the family is coming to the professional" from those ideas developed later by the professional that refer to "family functioning" or patterns of interaction between members (pp.94-95), and advocates that these differences be taken into account in psychotherapy research. Tomm and Sanders (1990) also note the extent to which problems change over the course of family therapy, "as more data accumulate" about the family, and as the problem is "redefined" during the course of therapy (p.109). They advocate a system of a "problem oriented record" (based on Weed, as noted above),

in which lists of problems can be noted as well as changed as therapy progressed, and note the advantages of this system over "diagnostic distinctions" based on the medical model.

As noted previously, researchers using a psychodynamic model have also worked on developing systems for more objective measures of the "central conflicts" or "formulations" of the case for outcome research (Curtis, et al., 1988; Luborsky, et al., 1988; and Piper, et al., 1990). Piper et al. (1990) make quite explicit in their research design that the client's "underlying conflicts" are "differentiated from his or her presenting complaints" (p.476), as would be indicated from this theoretical perspective. Problems have been noted in this approach however, as noted by DeWitt, Kaltreider, Weiss, and Horowitz (1983), who reported on the use of this methodology as part of an outcome study. In this study, teams of judges were not able to agree on formulations, and outcome measures (global ratings by judges based on audio and videotaped sessions) were found to be correlated with symptom change rather than formulations by judges.

The findings of DeWitt, et al. (1983), point to possible differences between "symptoms" and "formulations". Yoken (1988) also found differences between clients' self-reported "problems" and "symptoms" in a study of clients requesting therapy. Using a standardized symptom checklist and a categorical system of problems based on judges'

ratings of clients' written version of their problems, Yoken found no relationship between most problem categories (e.g, emotionalness, relationship problems, self concept) and symptomatology. She did find a relationship between one problem category (achievement) and total symptom score.

Hatcher, Huebner, and Zakin (1986) further elaborated on these ideas, studying the "evolution" of the formulation through the course of brief therapies. Studying the cases of 47 individuals seen in a clinic, they compared the client's version of the problem, the initial focus developed by the clinician, and the revised focus as formulated at termination. They found significant differences between the presenting complaint and the clinician's two formulations (based on ratings by judges) and found that the initial formulation and termination formulations were "similar to one another but not the same" (p. 516). Providing many examples from cases, they demonstrated a variety of ways that the focus can change. Some problems only emerged after the initial consultation and then became the focus. Other clients presented with vague complaints that were later clarified. In a few instances, cases with a specific focus were reported at termination to have a more diffuse focus. They concluded that even in brief "focused" therapy the focus does shift, and that this flexibility is probably appropriate as long as the therapist is aware of the changes and makes note of

them. They also noted that a change in focus is more likely to happen the longer the therapy lasts.

Hoffman and Remmel (1975), in outlining interviewing strategy, tried to clearly differentiate and define certain aspects of presenting problems, such as the "precipitant" and "precipitating event". They also make the point that the clinician should "not accept the target problem at face value because it has been found that the presenting complaint or problem is rarely what is really stimulating the client's call for help" (p.261). This kind of perspective can be seen in psychodynamic work as well as in some family therapists' work, where the presenting problem or symptom can be seen as a "trigger" or "manifestation" of greater problems (e.g., Clulow, 1985), as a "metaphor" for other problems (e.g., Madanes, 1980), or as a "ticket" into treatment (Hatcher et al., 1986).

This brief review of various views of problems in therapy indicates that there is some confusion and wide differences of opinion about the nature of problems (are they to be defined as symptoms, "underlying problems", etc.), who should be in charge of deciding the problem for which therapy is indicated (the client, the therapist, both together, or in some cases an outside party), to what extent there should be agreement on these issues before beginning therapy (goal setting versus addressing problems in an open-ended way with the expectation that problems will shift), and how all of these issues should be recorded

in clinic records. These issues of definition and of the relative importance of various theoretical perspectives cannot be completely sorted out and resolved here. Instead, the intent of this brief review was to outline some of the perspectives that have been taken into account in considering the concept of "problems" and to help set the stage for the analysis of problems in the therapy records in this study.

The Use of Clinical Reports

Clinical reports about clients are used by most agencies, and are used for a variety of clinical and administrative purposes. Often, a report is written at the beginning of therapy in which the therapist clarifies the nature of the presenting problem(s), the therapist's assessment of the client's problems, level of functioning, and a recommendation for treatment. More variety exists in the kinds of reports that are written after this point, but generally some kind of report is written to assess the client's progress and eventual disposition at the end of treatment.

Despite the widespread use of this format for documenting and communicating information about clinical work, little research has been done examining these kinds of reports (as noted by Barrett, 1988, and Kagle, 1983). Researchers have instead used questionnaires, scales and

interviews to answer questions that they deem important. These kinds of measures are designed to tap into areas that the therapists and clients may or may not already be considering, but the assumption of using these instruments is that the information is not already available in the existing reports. Other reasons that reports may not be used as readily is that clinicians may see the use of such reports as violating confidentiality, or perhaps researchers see them as presenting information that is too complex and varied.

Fulero and Wilbert (1988) reviewed the record-keeping practices of 169 practicing psychologists and found great variability among them, particularly in regard to kinds of information excluded from records (e.g., damaging information). They, like several other recent writers, recommended more standardized record keeping (Kagle, 1991; Sturm, 1987). Several other studies have been done in clinic and hospital settings examining the reliability of reports and to check for whether such reports contain "complete" information about clients (Small and Fawzy, 1988; Perlman, Schwartz, et al., 1982; Kagle, 1982; Strauss, Carpenter, and Nasrallah, 1978; Demlo, Campbell, and Brown, 1978; and Kiernan, McCreadie, and Flanagan, 1976). The findings overall from this group of studies indicate that records are highly variable, and that they do have much missing information. Most commonly, records are most accurate and complete in areas where data collection

is simple and the information is more objective (e.g., age, occupation) and least accurate and complete on more complex issues (such as developmental history, family history of illness, precipitating events, etc.). Some researchers have been able to use records for research despite these problems. An example is the work of Simons, Morton, et al. (1978), who found that they could train raters to make reliable ratings of "goal attainment" from records at a community mental health center. They also found that these ratings were highly correlated with the clients' ratings (contacted for follow-up) and that forty-nine out of 50 clients contacted reported the same problem areas as the records had indicated.

Even taking into account the difficulties that arise in using clinical records, and limited examples of such research, clinical records may contain information that may shed new light on the psychotherapy process. Psychotherapy research is moving in the direction of trying to bring more complex kinds of information into the realm of research, with the assumption that psychotherapy itself is such a complex phenomenon that only by understanding the context and subtleties of this work can it be fully understood. Orlinsky and Howard (1987), for example, are developing a "generic" model of psychotherapy, which includes many layers of participants and interactions among them. They include variables that relate to the therapist and the setting in which the work takes place, but do not include

reports written by therapists about clients as part of the process of therapy.

The Clinical Report as a Narrative

The clinical report may be viewed as a kind of narrative, a "story" written by the therapist about her or his understanding of the client, the client's problems, and the relationship between the therapist and the client. The narrative in this case is written for the client's file, the agency, and the therapist's supervisor, and used by the therapist to document and further elaborate the therapist's understanding of the case. When several reports are written by the therapist about the case over time, changes in the therapist's knowledge and understanding of the case can be seen.

There has been some discussion in the psychoanalytic literature about the framing of psychoanalytic work itself as a kind of narrative process (Mishler, 1986; Polkinghorne, 1988; Sarbin, 1986; Spence, 1986; Schafer, 1980 and 1992), a dialogue which occurs between two people resulting in a "story" which is developed by the two participants. There is some controversy about whether this view implies that what happens outside of therapy (or in the past life of the client) is valid or knowable in its own right. An extension of the "narrative" perspective might be that one can only view the statements given by

clients as part of a constructed reality (i.e., that no reality exists). This extreme constructivist view is disputed by Leary (1989), who states that while clients are "unreliable narrators", psychoanalysis must rest on the idea that what the client presents as his or her past has some "reference" to actual events (Leary, 1989, p. 188). Similarly, what clients present as happening currently outside of therapy must in some way refer to actual events.

The same problems are implied in an analysis of reports written about psychotherapy. These reports only report imperfectly the "reality" about the therapy, and understanding the content of the reports requires an appreciation of the context within which they are written. They do provide a unique view of the therapy however, one which relies on the therapist's understanding of the work. These texts, which are written and used by therapists in the course of their work with clients, have an important role in the clinical context. An outsider reading these reports can have access to information which the therapist has already determined, for clinical reasons, to be important.

In using narratives for research, the researcher's task is to understand the context of the narrative, and to extract meaning from the "story" told by the narrative (Mishler, 1986). This can be done by developing themes, concepts, or categories present in the text, and then

referring back to the original to test and refine the themes (Corbin and Strauss, 1990).

Polkinghorne (1988), in reviewing the use of narrative in psychological research (which he sees as part of a "more inclusive human science"), points to descriptive narrative research as one of two basic forms (explanatory narrative research being the other). In descriptive narrative research, the aim is to describe "the narrative accounts already in place which are used by individuals or groups as their means for ordering and making temporal events meaningful" (p.161). Polkinghorne describes the resulting research report as being an "argued essay" where "alternative narratives and interpretations are recognized and evidence from the interview text is used to argue for the conclusion that the researcher has reached" (p.169). The process involves "detection, selection and interpretation of the data, which in narrative is the text of the interview (and the common cultural presuppositions necessary for understanding it)" (p. 169). While Polkinghorne's account focusses primarily on interview data, this process can also be used for the analysis of other kinds of texts, such as clinical reports. From these texts, themes can be extracted, specific sections of text can be compared to the overall intent of the document, and the process of "expansion" can add to the analysis (the introduction by the researcher of additional knowledge "about the speakers and their personal and general

circumstances", which is "presupposed" by the creator of the text) (Polkinghorne, 1989, p. 165).

The current interest in the framing of an individual's life story as a "narrative" (Agar, 1980, Sarbin, 1986; Reissman, 1989 and 1990, Knudsen, 1990, Robinson, 1990, Borden, 1992) and the use of this kind of framework in psychotherapy (Russell and Van Den Broek, 1992; White and Epston, 1990) may increase interest in the kind of methodology described by Polkinghorne (1988) and Mishler (1986).

Qualitative research strategies, as described by Glaser and Strauss (1967) and recently elaborated on by Maher (1988), Corbin and Strauss (1990), and Patton (1990), may be the most appropriate way to approach psychotherapy research, given the complexity of the issues and data. Qualitative research has been widely used in anthropology, sociology, and nursing research, but has been somewhat neglected in psychology research in favor of more quantitative methods (or in Mahar's terms, hypothesis testing approaches). In contrast, "discovery-oriented" research (Mahar, 1988) or "grounded theory" research (Glaser and Strauss, 1967), includes the idea of developing (and re-developing) hypotheses as part of the research process, as well as different ideas about sample selection, and the development of new theories or ideas, based directly on the data, rather than formulated a priori. This kind of work seems to fit well in the area of psychotherapy

research, where very little is known about many areas of psychotherapy process, and in the case of the current study, about psychotherapy reports and their meaning.

This study uses the grounded theory research methods described by Glaser and Strauss (1967), Corbin and Strauss (1990), and Patton (1990). A set of general questions and strategies were established, as well as an initial data collection strategy. Later, as the first set of reports were analyzed, further questions and new strategies were developed, including a second data collection stage based on "theoretical grounds" (Corbin and Strauss, 1990, p. 8). The process of analysis included many stages of categorization, re-checking the categories with the original data, and the re-formulation of ideas about the data based on this recursive process. This kind of analysis fit well with the data used in the study, clinic records, which were rich and quite varied. An alternative strategy might have been to begin with hypotheses, develop coding strategies to extract certain limited information from the reports, and complete the analysis of the coded information. This alternative might have provided for more standardized information, which could be more easily compared to other settings (and more assurances of "reliability"), but would have missed the richness of the clinical data. In addition, so little is known about what is in this kind of clinical record that initial hypothesis testing strategies might have found very little.

Toward the Current Study

Earlier work (Jacobus, 1990) has shown that many intake reports in a particular setting (a training clinic for doctoral students in clinical psychology) describe clients' actual relationships. In these reports, relationships were often considered to be part of the presenting problem, at least at the time of the initial consultation. It was also found that the "relationship status" of this group of 32 clients was much more complex than the initial categorizations of "married", "single" or "divorced/ separated". Several of the reports could not be categorized in traditional categories, as their relationships could only be described using a narrative format. It was found that in this sample of reports, almost all made mention of the client's family of origin, although these accounts varied in complexity, and in whether they included information about current interactions with family members or included only historical data. Gender differences emerged in this sample; reports written about women clients included more family of origin information, particularly about current interactions with family members. Differences were also apparent between reports about married and non-married clients; more information was reported about current family of origin interactions when clients were not married or involved in partner relationships. Differences were also noted between

different intake workers, in that different styles of compiling and highlighting certain information could be detected.

The Current Study

The current study was designed to follow up on the previous study, and to consider how reports written about clients in therapy include information about clients' relationships. Rather than just focus on the initial intake worker's report, this study examined the entire clinical records of clients in therapy at the same training clinic.

The initial goal of this study was to bring to light how information about clients' relationships is documented and incorporated into clinical reports. Based on the previous study (Jacobus, 1990), it seemed that these reports would include some information about these relationships (e.g., with partners, family of origin and others). Several patterns emerged from the study of intake reports; some intake workers wrote about how the presenting problem was related to relationships, while others wrote summaries of client relationships that were more separate from the presenting problem. Questions remaining following this first study included how these issues continue to be addressed in the ongoing reports about clients, and how changes in relationships are integrated into the understanding the therapist has about the client. Questions

to be addressed about relationships and relationship changes in the reports included the following: (a) how well did the reports document romantic relationships and changes in these over the course of therapy; (b) how could the variety of relationships and changes be categorized, i.e, were there any patterns in these changes; and (c) were there any sex differences in these issues.

The open-ended nature of this study allowed for the development of additional questions to be formulated as the analysis proceeded. A second main focus was developed, based on preliminary data, concerning changes in descriptions of clients' problems over the course of therapy. Seeing that some cases involved shifts or changes in the nature of the problem as it was described in the reports, I became interested in looking at how problems change--if there were patterns in the ways that problems changed. This question was addressed in this research, as well as the development of an additional idea based on the preliminary research. There seemed to be a set of cases where a particular problem of patterns in choices of romantic partners was articulated, and I was interested in the similarities and differences between these cases, as well as the course of therapy in these cases.

The perspective taken in this study is primarily psychodynamic. From prior work, and from the researcher's perspective in this case as a participant-observer in this setting, it was noted that a great deal of the work in this

clinic is done within a psychodynamic-object relations model. The researcher, while accepting this as an individual therapy approach, will incorporate the ideas of Sullivan, and other "interpersonal" psychodynamic theorists, where clients' relationships to others in the present are included in psychodynamic formulations. At the same time, this writer acknowledges the importance of family systems work in bringing to the field of psychotherapy the perspective that all clients are embedded in a social network. When possible, these ideas will be included as well, in order to further understand the complex role of current relationships in individual therapies.

An important consideration in this work is the setting of the reports and the therapies they document in a training clinic. Some changes in reports over a period of time are to be expected as the therapists, the writers of the reports, change through supervision, didactic learning and personal growth. The impact of particular supervision on cases may be a factor also in certain kinds of changes in reports over time. The reports themselves are written in a context of evaluation by supervisors, which may affect their content and style. It is also possible that outside pressures (changes in clinic policies, other end of semester deadlines, etc.) may affect the kinds of reports written and the nature of the information included. This context will be described, and a few examples of the effect

of supervision will be explored, but this will not be a focus of this study, since specific data on this topic was not available in the clinical reports.

CHAPTER 2

METHODS

The data used in this study were a set of clinical reports written about individual therapy cases seen in a training clinic. This section will describe the setting in which these therapy cases were seen, the procedure followed for screening and assignment of cases (established by the clinic prior to this study), the selection of a sample of cases from the available pool, the specific documents that were included in the study, and some additional information about the therapists who wrote the documents. Following this descriptive information about the sample and the setting, the format of the analyses will be presented.

The Setting

The Psychological Services Center (PSC) is the training clinic for the doctoral program in Clinical Psychology at the University of Massachusetts at Amherst. The clinic operates eleven months out of the year (closed in August) and is open to potential clients from the University community as well as local residents. Referrals are made from the Student Mental Health facility (SMH), operated by the University, as well as other local colleges, and other local therapists. Some priority was given to cases referred directly by SMH therapists, but

otherwise area residents were given equal access to low-cost (sliding scale) therapy by trainees. The PSC served an average of 70-100 clients a year, with an average of 30 therapists actively seeing clients at any one time.

Upon calling the clinic with a request for therapy, a potential client was screened briefly over the phone by an advanced graduate student (an intake worker). This consisted of listening to the kind of request for therapy (making sure it was compatible with services offered), screening for suicidality and substance abuse (not problems that could be handled in a training clinic of this kind), and giving the client information about the clinic services. At this point, eligible clients were scheduled for a one-hour intake interview. In this interview, the intake worker would continue to ask about the referring situation, additional psychological and social problems, and background information. At the time of this interview the potential client would fill out the Personal History Questionnaire (PHQ, see Appendix A) (this became standard clinic procedure in 1987), and the informed consent form (see Appendix B). At this point, cases that were not screened out during the phone interview, but which did not fit the criteria for therapy at the clinic, would be referred elsewhere. Clients screened out might be those with potential needs for hospitalization, questions of suicidality, substance abuse, or other needs which the clinic could not meet. It should be noted also that some

clients decide not to pursue therapy after an initial evaluation of this kind.

Following the intake interview, the intake worker would complete the Initial Information Sheet (IIS, see Appendix C), summarizing the information collected about the client and her or his request for therapy.

After the intake interview, the intake team (consisting of advanced graduate students, the clinic director, and the administrative assistant) would review the information collected and make assignments to therapists. Occasionally, clients would be screened out at this point as well. The completed IIS was reviewed by the clinic director at this point. After the PHQ became a standard measure in the clinic, it was filled out by potential clients at intake, and reviewed at the time of therapist assignment as well. Assignments were made on the basis of client's requests, as well as therapist availability, and clinical opinions (of the intake team) about suitable matches between therapist and client.

The IIS was therefore a document that was used for supervision of intakes, and then passed on to the therapist for the case. The therapist for the case usually saw the client for the first time within a week after the intake. Occasionally this wait between intake and the "opening" of the case was much longer, if there was a waiting list at the time of intake. Once the therapist was assigned and the

case was "opened", therapists typically saw clients on a once a week basis.

The procedure described above was for individual adult clients only. The clinic did see a smaller number of family and individual child therapy cases, and procedures for these cases differed somewhat.

The Sample

The sample of cases was selected from the pool of cases seen at the PSC since the establishment of a computerized database[4]. The criteria for inclusion in the sample were as follows:

1. The therapy involved only one individual client (i.e., not family or couples therapy).

2. The client was at least 18 years old.

3. The therapy case had already been closed, meaning that the therapy was terminated and that all necessary paperwork was already completed by the therapist, as of February 1991.

4. The case had been open for at least eight months (from date of first session to termination date).

The selection of reports about individual therapy followed from the research questions, concerning individual

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[4] The PSC computerized database was established beginning in 1986 and has been described elsewhere in detail (Todd, Jacobus, and Boland, 1992).

therapists' use of information about client relationships, and their depiction of change in the process of individual therapy. There were relatively few couples and family cases seen in the clinic, and while they might have provided for an interesting comparison group, the reports written about these cases differed greatly in format, so, given the small number of these cases available, direct comparisons to these cases would have been likely to be less useful than a thorough examination of these individually oriented cases.

The rationale for selecting terminated cases is that the full record could be examined, including termination reports. The selection of cases which were open for at least eight months was made so that all case records would include several reports written by the therapist(s). In cases where only one report was written (if a client was in therapy one month, for instance), there would be less opportunity to observe variation and change over time. The eight month mark was selected to include the common pattern of cases beginning in the fall months with a termination in May.

Using these criteria, a sample of 98 cases was selected. Examining this sample of cases, it was determined that five of these cases were duplicates, where the same individual had returned to therapy, but had been assigned a new case number. The data from these five duplicate cases were then included as additional information for the original case, reducing the number of cases to 93. One

additional case was removed from the sample when the data from the case could not be found (the file was found to be missing from the file cabinets after an extensive search). This left 92 cases as the final sample.

The Data

The data examined for each of the 92 cases consisted of the following:

1. The IIS, a document completed by the intake worker, after an initial one hour interview, which summarized the client's presenting complaints, request for therapy, and a section entitled "brief history of the presenting problem". On this form, the intake worker also included demographic information (age, marital status, occupation), referral information, and at times, more information about the client's living situation and family members (see Appendix C).

2. Reports written by the therapists for the case, including the Initial Psychotherapy Summary (IPS), the Progress Notes (PN), and a Termination or Transfer Note (TN). The IPS was written by the therapist assigned to the case, after approximately three sessions with the client. This time line was the one set up by clinic policy, although at times this report was delayed several weeks or even months until the end of the first semester in which the client was seen. The Progress Notes were then written

at the end of each semester, until a Termination or Transfer Note was written. The reports were written in a variety of styles, depending on the nature of the case and the supervisor for the case. Generally these were two to three page typed documents. The IPS was often the most structured of these, following a format provided in the therapist's clinic policy handbook (See Appendix D). The Progress and Termination Notes (also called Psychotherapy Summary) were more likely to be written in an unstructured format, although potential items for inclusion were outlined in the handbook as well (see Appendices E and F).

The kinds of documents described above made up the main part of the data examined, as they were the main source of information about therapies conducted in the clinic (for clinical purposes, as well as for this research).

In addition, several other sources of information were available for some cases, as follows:

3. The PHQ was completed by some clients in this sample (the use of the questionnaire was optional until September, 1987, when it became standard procedure in the clinic). When available, the completed questionnaire was included in the documents read for each case. The questionnaire addressed such issues as presenting complaints, family history, employment history, past mental health services utilized, and medical problems (see Appendix A).

4. Session Notes, or Contact Notes, were written by the therapist about each session, to be included in the case file. These were handwritten notes that varied in length from very short entries (i.e, client attended session"), to lengthy descriptions of therapy process. These notes were consulted on some cases, particularly when information in the Progress Notes was unclear in some way, but the notes were not systematically analyzed as part of this study.

5. The Case Summary questionnaire was completed by the therapist at the end of each case (see Appendix G). This short questionnaire asked the therapist to indicate the date of termination, the number of sessions the client was seen, the orientation of the therapy conducted, as well as several scales concerning the therapy process and outcome. Previous analyses done by the research team at the PSC had not found these scales to differentiate between cases, and many therapists did not complete the scales at all, so these scales were not used in this study. In this study, these forms were used mainly to identify the therapeutic orientation that the therapist used to describe the work done with a particular client. No outcome measures were obtained directly from the client during the course of this study (data collection of this kind began in the period after this study was initiated).

6. In some cases, clients' previous therapy records were included in the case file (the paper documents--these

records were never included in the computerized database). When available, these were read, but not included in any analysis of information for this study.

The Therapists

The therapists in the PSC were graduate students in the Clinical Psychology program, usually beginning to see clients after a year of observation and classroom education about therapy. A few graduate students from other disciplines (Developmental Psychology, Education and Counseling) were occasionally invited to participate in a year of supervised therapy training as well. Several "re-specialization" students were also being trained in the clinic at the time of this study, these being graduates of Ph.D. programs in other areas of Psychology, completing a two-year re-specialization program in Clinical Psychology. These re-specialization students typically began therapy cases after several weeks or months of orientation.

Therapists in the clinic were supervised in one of two ways. Most were part of a supervision "team," that consisted of a faculty member, an advanced graduate student, and about six beginning level graduate students. The graduate student trainees typically were assigned from one to three therapy cases. Supervision would occur in a group setting once a week, as well as individual supervision once a week. The trainee was typically

supervised by both the advanced graduate student and the faculty member on an individual basis, each supervising one or two of the trainees' cases. The advanced graduate student was then supervised by the faculty member on his or her supervision of the beginning level trainees, with the final supervisory responsibility for each case being in the hands of the Ph.D. level faculty member.

A few cases included in this sample were conducted by therapists supervised outside of this "team" structure, being supervised weekly by a faculty member or other Ph.D. level instructor.

Regardless of these distinctions of prior training and current supervision of cases, all therapists for cases will be referred to as "therapists" and no distinctions will be made between them for the purposes of this study. Information about level of training within the graduate program will be presented in the results section.

Therapists typically worked in the clinic for a period of one to three years. At the end of this period therapists would often leave the clinic to do placements elsewhere, or because they had finished their graduate training. Assignments to supervisors were made for the academic year (September to May) or for the summer semester (June to July). Terminations that were based on therapist unavailability typically occurred in May or July.

The Clinical Psychology program at the University of Massachusetts at Amherst, at the time of this study, was

known for its eclectic training program. At the time that this study was conducted this consisted of a history of the PSC being run for many years by a psychodynamically-trained director, but one who encouraged other forms of psychotherapy to be taught as well. The other faculty members engaged in training were identified primarily as either "psychodynamic", "cognitive-behavioral", "humanistic", or "family-systems" oriented. At the time that the study was conducted, the direction of the training clinic was shifting over to a new director, known more for an "eclectic" theoretical orientation. Team supervision continued to be primarily either psychodynamic, cognitive-behavioral, or family-systems, with some overlap in the training by faculty members who combined different orientations. The majority of cases were seen using broadly defined psychodynamic psychotherapy, however, and this was reflected in this sample, as will be seen in the results section.

The reports used in this study were written by therapists (trainees) under the supervision of these Ph.D. level psychologists. They were written entirely for clinical (and training) purposes, although all clients were made aware that any clinical material could be used by PSC-approved researchers for research projects, given appropriate protection of confidentiality (see Appendix C). PSC therapists were made aware of the development of a research database through clinic meetings and notices, but

were probably still writing reports mainly for clinical and supervisory purposes. The exceptions to this may be the Intake workers, who began entering the Initial Intake Summary on the computerized database during this period. In addition, the scales on the Termination questionnaire filled out by therapists were labelled as research items.

The Analysis, Part I

In the first part of the analysis, the 92 cases of long term, adult, individual therapy were examined in detail. This consisted of reading the entire case records (items 1-6, outlined above) for each case. I began with a smaller sample of 30 cases (the first 24 cases in chronological sequence, then six cases drawn from later dates). From reading these initial cases, the information to be drawn from the larger set of cases was established. This included the following information (when available in the records): client's age and sex, occupation, marital status information, information about romantic/partner relationships, the nature of the presenting problem and the course of documentation of the problem(s), any other symptoms mentioned in reports, statements of "problem formulation" written by the therapists, any family of origin information available in the reports (primarily current relationships with family of origin), and past treatment history. In addition, information about

treatment length and information about the therapists was compiled using the database. The information about therapists that was considered was as follows: number of therapists involved in the case (and number of transfers), sex of therapist, age of therapist, and the number of months of training in the training clinic completed before beginning each case. Treatment length for each case was determined using the database, calculating the weeks from the date of the first session (with the therapist) to the date of termination).

The next stage of this analysis consisted of reading through the entire sample of 92 case records, and taking careful notes concerning the issues described above. Throughout this process, I considered which themes were recurring in case records, and noted which cases fit the particular themes (these will be described in detail later).

When these notes on the 92 cases were compiled, a list of variables were established, and the notes were reviewed for classification based on these variables. The process of establishing these variables included creating categories which seemed to fit the data, then re-reading the notes to decide which cases did fit, and modifying categories when problems were noted with the existing categories. The kinds of categories were thus derived from the data, rather than purely theoretically derived before data collection.

The following variables are those that will be discussed in Part I of the results section, and which were derived from the data set as described above:

1. Sex of client
2. Age of client
3. Race of client
4. Nationality of client
5. Occupation
6. Connection to University community
7. Treatment length
8. Number of therapists involved in the case
9. Therapist age
10. Therapist sex
11. Therapist level of training
12. Theoretical orientation utilized
13. Client marital status at intake and termination
14. Client "relational status" at intake and termination
15. Changes in "relational status" during therapy
16. Clients who were noted to desire a relationship
17. Sexual orientation of clients
18. Past treatment history
19. Mention of family of origin
20. Mention of problems in current family of origin relationships
21. Clients who may be in the process of "leaving home"

While a few of these categorizations seemed to present little difficulty, most were quite complex, and required me to keep refining the meanings of the categories and returning over and over to the notes from the 92 case records. The process of creating these categories is seen as an important part of the "results" of this project, and therefore will be discussed in more detail in the results section.

The Analysis, Parts II and III

After the reading of the 92 case records was complete, and the categorizations were beginning to take shape, I began to examine the "themes" or ideas that had emerged from reading these records. Three main ideas were selected for further study. One was examined within the larger sample; this was the idea of (and extent of) changes in relationships during the course of therapy. This will be presented in Part I of the results.

The other two ideas were concepts that seemed to recur in several cases in similar ways. The first was the idea of problems changing over time in therapy, and eventually this became a more central research question in this project (33 cases of the 92 seemed to fit this idea in some way). The second was an observation that several cases described a female client as "seeking" certain kinds of male partners,

and that this in some way was a problem for the client (15 cases seemed to demonstrate some aspect of this idea).

To examine these ideas in more detail, a set of cases in which these ideas were most prevalent were selected for further re-reading. Eleven cases were selected, with seven examples of the first theme represented, and six examples of the second theme represented (two cases seemed to be good examples of both themes). The criteria for selection of these cases was that they provided clear and varied examples of the phenomenon being examined. The cases were selected because they contained the most information about these themes, or best represented these ideas. This is what Patton (1990) has described as "purposeful sampling" (pp. 169-186).

These cases were read again many times in detail to further elaborate the ideas behind each theme. When the ideas had been outlined, examples from each case were selected, going back and forth, refining the ideas to fit the examples. The results section referring to these two themes are the product of this analysis, a set of ideas about each theme, with examples from the texts to demonstrate where the ideas originated.

As a precursor to the presentation of these themes, four cases (from the set of 11) will be presented. These will be in narrative form, written by the researcher, attempting to describe the information to be found in each case record. This will allow the reader to follow more

closely the process of the researcher, as this section provides some of the complexity of these cases, as well as some beginning clues to the development of the two themes.

Confidentiality

In order to protect the confidentiality of the clients, all names have been changed. In addition, any information that may be identifying to others has been altered or removed from the data. Parts of the text that could not be altered without changing the meaning were omitted from this manuscript. This applies to therapists as well as clients. Identifying information about therapists or supervisors was also disguised or excluded.

CHAPTER 3

RESULTS

For the preliminary analysis, the 92 cases of "long term individual therapy" (as defined in methods, above) were examined in detail. Part I will include the results of these analyses, including information about the cases, therapists, and treatment parameters, followed by information about relationship changes found in this sample of cases. This will be followed by a section concerning the classification difficulties found in examining this clinical material.

Parts II and II of the results will be the further examination of a smaller subgroup of the cases, with a further elaboration of particular themes noted by the researcher in doing the first analysis of 92 cases. In Part II, a selection of four cases will be presented in detail, as summarized by this researcher, for a fuller understanding of the kind of data to be found in such a record, and to begin to outline the themes found in the data. In Part III, two important themes will be presented, with accompanying examples from a subset of cases that were examined in more detail. The final part of the results section will be a presentation of additional issues noted in the material that were not examined in detail, but which would merit attention in further studies of clinical material of this sort.

Part I: The Analysis of 92 cases

This section will provide an overview of the 92 cases selected for the initial analysis. This will begin with descriptive information about the cases, demographic information about the individual clients, and some information about the therapists involved in treating these clients. The main part of this results section will be the analysis of marital status and "relationship status" of the 92 individual cases, as described in the treatment records. It should be noted again that the information compiled here was gathered after the cases were completed, with the writers not having written the reports for this study but for clinical (and training) purposes. Thus, the information I was looking for was not always complete, and many problems were encountered in classifying and coding. The problems with coding will be discussed in a separate section immediately following this overview of the 92 cases.

The information gathered in this section (and subsequent results sections) was compiled into categories by only one rater. While it might have been helpful to continue this project one step further and establish reliability of the rating scheme with several raters, this was not done for this study. The purpose of this study was not to establish definitive statistics about this particular sample, but to look at the kinds of information

found in such reports, and establish what categories might be possible to extract from such data. This set of results then, is the product of this exploratory research, in which the categories are those that emerged from the data. Further studies of the reliability of the ratings are left for a future study. The reader will be able to examine the kinds of decision making involved, however, by consulting the section on classification and coding at the end of Part I.

The Cases and the Reports

These 92 cases were opened between the years of 1982 and 1989, with the majority (88 cases) opening between 1985 and 1988. The case records examined were the IIS completed by the intake worker, the PHQ completed by the client, and the series of clinical reports completed by the therapist and approved by the supervisor for the case (IPS, PN, and TN). These case records contained anywhere from 2 to 10 clinical reports, each ranging from 2 to 8 type-written pages.

Demographics of Clients

The individual clients in these 92 cases were 62 female clients and 30 male clients. The ages of these clients ranged from 18 to 64, with a mean of 27.25, and

most clients (84 of 92) were between 18 and 36 at the time of intake (see Table 1). Most clients were caucasian Americans, with 10 non-caucasians in this sample (including those reporting themselves to be of mixed race), and six clients who were foreign nationals (see Table 1). Race and nationality were viewed as two separate categories (two of the foreign nationals were also non-caucasians, as documented in the reports).

Sixty three of these clients were students, including 24 graduate students (see Table 2). Among the non-students, nine were employed in the areas of education and human services, seven were employed in blue collar, manual labor, or unskilled jobs, five were employed in offices, three were skilled technicians, two were artists and three were unemployed throughout their therapies (see Table 3). While some clients changed jobs during therapy, these classifications were based on what the client did for the most part during the course of the therapy. As seen in Table 3, two of the non-students had other part time work in a second category of type of employment, and five female non-student clients were mothers besides being employed outside the home.

In this group of records, 75% of the cases seemed to show some direct connection to the University community, including 63 students and six more who were graduates of a local college or employees of a local college. The undergraduates ranged in age from 18 to 45, and 21, or 58%,

Table 1: Demographics for total sample of 92 cases

	Female	Male	Total
Total N	62	30	92
Mean age, at intake	26.90	27.97	27.25
Age range	18-64	21-58	18-84
Race, number of non-caucasians	7	3	10
Number of foreign nationals	4	2	6

Table 2: Student/Non-student status in sample of 92 cases

	N	female	male	mean age
Under-graduate students	36	24	12	23.78
Graduate students	24	15	9	29.17
Part-time students	3	2	1	24.00
Total, Students	63	41	22	25.84
Total, Non-Students	29	21	8	30.30
Total Sample	92	62	30	27.25

Table 3: Occupations of 29 non-students

	Primary employment, number of cases	2nd job, if any
Education or Human Services	9	0
Blue Collar or Unskilled work	7	1
Office work	5	1
Skilled technical work	3	0
Artist	2	0
Unemployed	3	
Mothers of young children (all employed)		5
Total, non-students	29	

of these undergraduates were above the traditional college age of twenty-one. The average age of the group of 63 students was 25.84, and the average age of the non-students was 30.30 (see Table 2).

Treatment Length and Transfers

These cases were open anywhere from 31 to 235 weeks, with a mean of 81.90 weeks (about a year and a half from first session to termination date). This was calculated by counting the weeks from first therapy session to termination date. For cases where the client terminated a first therapy and then returned for a second therapy (with a new case being "opened" in the clinic), the several weeks or months that the case was closed was not included in this measure of length of treatment. With these weeks included (the weeks that a case was "closed" during a break in therapy), the longest therapy would be 265 weeks. While there were a few such long lasting therapy cases in the sample, most of the cases (85) terminated within three years, and 36 of the cases terminated within one year. Note again that the sample was limited to cases that had stayed open for at least eight months.

Most cases had one therapist only, but 25 cases were transferred to a second therapist, and of those, four clients were later transferred on to a third therapist. While some cases were supervised exclusively by one

supervisor throughout the time the cases were open, some cases were supervised by as many as seven different supervisors.

The Therapists

There were 60 therapists represented in the written reports of the 92 cases. There were a total of 121 therapist-client pairs, since some cases involved more than one therapist. These therapists were graduate students who began the clinical training program at the University of Massachusetts in the mid to late 1980's. The therapists had from one to five years clinical experience when they began seeing these clients, with the mean number of months of training being 14.15 (see Table 4). Thus the "average" therapist in this sample would have started seeing their first case in the sample in November of their second year of graduate school. In this setting, during the time period of this study, graduate students often started seeing their first client in the summer of their first year, which would mean that while therapists often began their first therapy case at that time (after about 10 months of training), the average first case which became a long term case (and therefore would be included in this sample) would have been started a few months later (after about 14 months of training). A few therapists had just begun the clinical training program the same month as they began seeing the

Table 4: Information about therapists' sex, age, training, and number of cases included in sample (and comparison to clients' ages)

	Therapists	(Clients)
Total N	60	(92)
Female	41	(62)
Male	19	(30)
Mean age at time of first case (or time of intake, for clients)[5]	29.69	(27.25)
Range of ages	22 - 40	(18 - 64)
Months in training, prior to first case included in sample, Mean	14.15	
Months in training, Range	1 - 96	
Number of cases included in sample, Mean	2.02	
Number of cases included in sample, Range	1 - 4	

[5] There were two therapists in the sample whose age was missing from the database, so this mean was calculated with N=58.

client (primarily, these were re-specialization students already trained in another area of psychology). The majority of therapists were in their first or second year of clinical training (51 of the 60 therapists).

The therapists' ages ranged from 22 to 40 when they began seeing the clients, with a mean age of 29.69. The 60 therapists included 41 females and 19 males (see Table 4).

The pairing of therapist and client was a decision made by the director of the Psychological Services Center, with the assistance of advanced graduate students. In some cases, the client made a particular request as to kind of therapy or sex of therapist, requests which were honored when the match seemed appropriate and the therapist was available. In terms of gender, female clients were often matched with female therapists, as can be seen in Table 5.

The orientation of the therapists doing the therapy and the writing of case reports was mainly psychodynamic (loosely defined here, meaning generally insight-oriented, and sometimes based on object relations theory), according to therapists' self report or specific information in case records. About two thirds (61) of the cases were primarily psychodynamic. A few (7) were behavioral only, and a little less than a third (24) were reported to use mixed techniques, or an eclectic framework (some of these cases shifted from one orientation to another based on a change of supervisors). While the sample seems to be primarily of cases that involve psychodynamic treatment it should be

Table 5: Therapist-client pairs in regard to gender (N=121)[6]

	Male client	Female client
Male therapist	20	20
Female therapist	21	60

[6]This table contains the data for all 121 therapist-client pairs found in this sample of 92 cases. 25 of these cases had more than one therapist and therefore are included twice in this table. Of these 25 cases, 10 ended up with a second therapist of the opposite sex from their first therapist.

noted that 29 cases of 92 reported to have included some behavioral component.

Marital Status of Clients

At the time of intake 15 (16.3%) of the 92 individual clients were married, 2 (2.2%) were engaged (and not living with their fiance), 10 (10.9%) were living with a partner (some of these were engaged to be married as well), 10 (10.9%) were divorced or separated, and the remaining 55 (59.8%) were single (see Table 6, column 1).

At the time of termination (or termination of the second therapy if the client returned), 16 (17.4%) were married, 5 (5.4%) were engaged, 9 (9.8%) were living with a partner (and some of these were also engaged to be married), 10 (10.9%) were separated or divorced, and 52 (56.5%) were single (see Table 6, column 2).

Relationship Status of Clients

While the data presented above represents the traditional marital status coding used in most studies, another way to look at this is to consider how many clients were reported to be in romantic relationships at the beginning and end of the therapy. Here again the issue of reporting comes up, since some reports only mention relationships in passing, or fail to make clear the nature

Table 6: Marital status and relationship status of sample of 92

	Marital status		Relationship status (Number in romantic relationships)	
Status	(1) Intake	(2) Termination	(3) Intake	(4) Termination
Single	55 (35 female, 20 male)	52 (34 female, 18 male)	16 (13 fem, 3 male)	19 (16 fem, 3 male)
Living with or Engaged	12 (9 female, 3 male)	14 (11 female, 3 male)	12 (9 fem, 3 male)	14 (11 fem, 3 male)
Married	15 (9 female, 6 male)	16 (8 female, 8 male)	15 (9 fem, 6 male)	16 (8 fem, 8 male)
Separated or Divorced	10 (9 female, 1 male)	10 (9 female, 1 male)	3 (3 fem, 0 male)	5 (5 fem, 0 male)
Total	92 (62 female, 30 male)	92	46	54

of a client's relationships. Given this proviso, a coding was developed based on the information available from the written reports. A further discussion of specific coding dilemmas follows, and a specific example of coding from the text in reports can be found in Appendix H.

As noted above, at the beginning of therapy 15 clients were married, 2 were engaged, and 10 were living with a partner (some of these were engaged also). In addition to these, 16 of the single clients were reported to be involved in a relationship, and 3 of those who were separated or divorced from a spouse were reported to be currently involved in a new relationship. This adds to a total of 46 who were reported to be involved in some kind of romantic relationship at intake (see Table 6, column 3).

At termination, 16 were married (two had divorced and three had married), 5 were engaged (one was reported to be "unofficially engaged"), 9 were living with a partner (some of these were engaged also), 19 of the single people were reported to be involved in a relationship, and 5 of the divorced or separated clients were involved in a relationship. This adds to a total of 54 who were involved in a relationship at the end of their therapy. (see Table 6, column 4).

Reviewing the data from Table 6 (marital status and relationship status), columns 1 and 2 (marital status only) shows three changes in status: two who became engaged or moved in with a partner and one who married, along with the

accompanying decrease by three in the category of "single". Relationship status data (columns 3 and 4) show somewhat greater changes (eight new relationships overall; from 46 to 54 "in relationships"), as well as much greater numbers for being "in relationship" when the definition is broadened to include romantic relationships other than marriage, engagement or living together (37 married, engaged or living together compared to 46 "in relationships" at intake, and 40 compared to 54 at termination). These numbers, however, do not reflect the full extent of changes in relationships, since these are net changes. The following section will address more of the specific changes seen in relationship status.

Changes in Relationship Status

Considering those who changed their relationship status during the course of the therapy, there were 15 who seemed to have left a relationship during this time. Two marriages broke up, two clients who were living with a partner moved out and ended the relationship, 11 of the clients who were single broke up their relationships (although one was during the seven month break while he was not in therapy), and the three who were in relationships following a divorce broke off these relationships. Interestingly all of these 11 cases were women except for the case of the man who broke off a relationship during the

seven month break while he was away from therapy (see Table 7).

Many of the single clients were reported to enter into relationships during the time of the therapy, however many of these relationships also ended by the time the therapy terminated (this seemed to be the case for 12 of the cases). Considering those who entered into new relationships that lasted to the time of termination, 3 married during the therapy (two of these were marriages to partners that the client had already known at the time of intake), 4 moved in with partners (one of these was a woman who moved in with a partner she already knew at the time of intake), 3 got engaged, and 16 single clients started new relationships that lasted until the time of termination. Of these 26 cases, 5 were male clients (see Table 8).

Twenty-two cases were reported at intake to involve clients who had ended a romantic relationship within one year prior to entering therapy (whether or not this was the sole precipitant for entering therapy). Of these cases six were male clients. The question of which cases to include in this count was a complex one, and will be discussed in the section on the difficulty of developing classifications and coding material.

Of the 92 cases, 16 cases reported no romantic relationships during the course of therapy (or just prior to the beginning of therapy). Of these cases, six involved

Table 7: Changes in relationship status during therapy: Endings

Endings in Relationships	# cases	female	male
Marriage that ends	2	2	0
Partners living together, one moves out[7]	2	2	0
Single, in relationship, relationship breaks up	11	10	1
(Total, of 92 cases)	15	14	1

[7] This category also included two additional cases in which the partners continued the relationship after one moved out.

Table 8: Changes in relationship status during therapy: Beginnings

Beginnings of Relationships	# cases	female	male
Marriages during therapy	3	1	2
Engagement during therapy	3	2	1
Partners move in together during therapy	4	3	1
New relationship develops (that is still enduring at termination)	16	15	1
(Total, of 92 cases)	26	21	5

male clients (the way that this number was derived will be discussed later as well).

Looking at this information about relationship changes as a whole, several trends seem to emerge. First, there were more beginnings of relationships than endings of relationships over the time period from intake to termination (15 endings and 26 beginnings). Second, looking at these tables, particularly the traditional marital status information, one might assume that relatively few changes in relationships took place over the course of these long term therapies. In fact, another way of looking at this data makes it seem that very few cases in this sample have either "stable" relationships or no relationships at all.

Cases with No Apparent Changes in Relationship Status

Looking first at "stable" relationships, there were 13 cases where the client was married at the intake and at termination, and seven cases where the client was living with or engaged to someone at the time of intake and at termination (the same partner throughout). Looking first at the group of seven women who were married at intake and stayed married through termination, the reports noted several interesting things: two women had babies during this time (one of whom was fearing the break up of her marriage at intake, according to the therapist's report),

one woman made the decision not to have a child, and in two cases marital problems emerged over time. In another case the client was reportedly a battered wife. In a sense, these different pieces of information about the relationships of these married women does not group them together. However, from the perspective of the family life cycle, or of stress on the family system, these women can be seen as those experiencing change or significant stress on the marital relationship. Taking this perspective, there is only one case in this group of seven in which no marital disturbance or change was noted, if one considers that having a child constitutes a form of marital disturbance or change, as well as the decision not to have a child. This broader definition will be taken here for all the cases in long-standing relationships, in order to form a group for whom the reports do not characterize the relationship as undergoing significant change or disturbance, or ones that might be described as having a "stable" relationship during the course of therapy.

Following this course of analysis, the cases of the six men who were married at intake and still married at termination were examined. One man's wife gave birth to twins, and another man (and his wife) was considering adopting a child, two men reportedly had a trial separation and reunion with their spouses during the time of therapy, and one other case had mention in reports of marital and

sexual problems. This also left only one case (of six) in which no marital disturbance or change was noted.

Seven cases involved clients who were engaged or living with a partner at both intake and termination (six female and one male client). Five of these cases included mention in the reports of disturbance or change in these relationships, including the following: problems in the relationship, a case where the client had an affair and returned to the original partner, and a case where the client moved out, but remained engaged to be married to her partner. Two of these clients entered couples treatment with their partners during this time. The remaining two cases (of seven), both with female clients, seemed from the reports to have fairly stable relationships.

Five female clients and two male clients were reported to be involved in long term relationships (not married, engaged, or living together, but noted to be involved as "boyfriend", "girlfriend" or "partner") at both intake and termination that did not end during therapy. All of the cases of the five women had mention in the reports of difficulties in the relationships. One moved in with her partner and later moved out, one had an affair but continued the relationship with the original partner, one noted that she was ending the relationship, and had moved out prior to the intake, but continued the relationship, and two noted problems and changes in the relationships. Of the two men, one noted at intake that the relationship had

ended, but continued to see the partner and eventually moved to be in closer proximity to the partner. The other case (of a male client in a relationship) seemed to be one where the relationship was "stable", although the partner was married to someone else and the status of her separation/divorce from her husband was unclear.

Next, the cases with no stable relationship lasting from intake to termination were examined. This included 17 women and 15 men. Of the 17 female clients, six did have relationships during the therapies, but these began after intake and ended prior to termination, including one who started a relationship and moved in with the partner, only to move out later, and another who had a vaguely defined relationship and did get pregnant, but no lasting relationship was described in the reports. Two additional female clients were described as having just recently broken off romantic relationships before the intake interview. The remaining nine women were not described as being involved in any romantic relationships during the course of therapy, although two of these had joined dating services, and one case record mentioned several infatuations with unavailable men.

Of the 15 men who had no lasting relationship mentioned in the reports that lasted from intake to termination, the pattern was fairly similar. Eight of these had some relationship mentioned, for example a man who had a relationship lasting three months during therapy, two men

who had several sexual relationships that did not last long, and one case which mentioned a "girlfriend" but also included the idea that this was a "companion" and did not refer to her again. Four of these eight had recent endings of relationships that continued to be discussed throughout the treatment. This leaves seven cases in which male clients were not described as having any relationships at all.

In total then, it seemed that 16 cases (nine women and seven men) were ones in which the client was not engaged in any romantic relationships during the course of therapy, or at least none that the therapist commented on in reports. Only five cases seemed to describe clients who were in stable relationships that endured from intake to termination. Adding these two groups, it would seem that, given the definitions used here, 21 cases involved no changes or disruption in relationship status during therapy and the remaining 71 cases did involve some form of change in relationship status.

Additional Information about Relationships

Seventeen cases included mention in one or more reports that the client desired a relationship, or wanted to marry. Six of these were male clients. These desires seem to have mostly been unfulfilled as 12 of these cases

ended with no relationship, and none of these cases ended with the client married, engaged or living with a partner.

Seven of the individuals in the 92 cases are reported to be gay men (2) or lesbian (5), with an additional two cases where the client was described as grappling with their sexual orientation. These cases were about evenly divided between different relationship status categories, with some living with a partner, some dating or entering into long term relationships, and some having no relationships during their therapy. One of the clients who was questioning her sexual orientation was also married (to a man) during the time of her therapy at the PSC. This information was compiled to give additional context to the rest of the data in the study; no specific analysis was done on these cases.

Past Treatment

Most of the clients considered in this sample had used psychotherapy services in the past. Only seven had never consulted a therapist of any kind before being seen at the PSC (7.6% of the sample). The remaining 85 clients had had therapy before, sometimes very long histories of therapy, although a few cases (about six) seem to have had only very brief exposure to counseling or therapy prior to their intake at the PSC. In 14 cases it is reported that the

client had been in a psychiatric hospital at some time in the past.

Family of Origin Information in the Case Reports

While family of origin information was not the focus of this study, some information about clients' families was collected and compiled. Family of origin is discussed to some degree in all the cases, either in the intake report, the later psychotherapy reports, the termination reports, or in all of these. Twenty cases include mention of the divorce of the parents of the client. Eighteen cases include the mention of the death of one parent, 10 of these during the therapy or in the two years prior to the intake. Most of the cases (over 50) note clearly some kind of conflict in the present relationship with the parents and/or siblings.

This sample contains a great number of individuals who may be seen as very involved with their family of origin, either in a continuing way or as being in the phase of "leaving home". Seventeen of the clients in the 92 lived at home or with family members either just before the intake, during the therapy, or during some part of the therapy. An additional five cases should be considered here, as they are under 21 at the time of intake. This adds up to 21 cases where the client may be classified as working through the issues of "leaving home", at least on the most

superficial level, or a little less than a quarter of all the cases (22.8%). Certainly, if the client's problems with this issue were rated by therapists or clients, the count could be quite different.

Issues Concerning Classification and Coding of Information about the 92 Cases

So for, data have been presented without discussion of the development of the categories in order to allow the reader to concentrate on the general patterns. In this section the specific ways that decisions were made about coding will be presented, as well as examples of difficult cases.

Demographics

This section will follow the same order as the previous sections containing data about these cases, starting with the classification of male and female clients, which was the only categorization that did not present any difficulties. The ages of clients were the age of the client at intake. For those with several beginning points of therapy, the age at first intake was the age used for this analysis. Race of clients was a more problematic categorization, since this was not systematically coded, or even noted correctly by intake workers. The data used here

was collected by reading the reports, which sometimes included information that other sources did not. For example, a client who was "Hispanic" to the intake worker (from a Latin American country) listed herself as "caucasian" in the personal history questionnaire. A few other cases that were noted in later reports to be biracial, in that one parent was of another race, were not so noted at intake. The count of 10 non-caucasians was made by including any case where there was mention of another racial origin in any report.

The occupations were also counted using a compilation of information from the reports. These occupations were those that the client was in for the longest time during the treatment. For example, a student who graduated several months before termination and worked in a research job was classified as a student. The categories were derived from examining the list of occupations of the 92 cases rather than being derived from previous researchers' work in this area, since this seemed to fit the data more appropriately and describe the sample more accurately. It should also be noted that parenting small children was not noted by therapists or clients as an "occupation" but was added by this researcher from reading the reports, and a way to further describe this sample.

Describing the Therapies and Therapists

Treatment length was calculated in the PSC database as the number of weeks from first session with the therapist to the date of termination. The several cases that terminated once and re-opened at a later date were calculated by adding the weeks in treatment from the two cases separately, not including the weeks the case was closed. The time from intake to first session was not included for any case, although this time did vary from several days to several months (a several month wait occurred for only a few cases, at times where there was a waiting list). The biggest problem with accuracy for this data was the date listed by the therapist as the date of termination. For most cases this was straightforward, although in a few cases the client left therapy without notice and the termination date then could vary depending on the therapist's interpretation of "termination". Some counted this as the last session date, while others sent a letter or tried to call the client, and listed the termination date as the date that they no longer believed the client would return (which could be weeks or months later). In reading the case records, there did not seem to be any cases included here where this change of definition of termination date would have meant the client was actually in therapy less than the minimum of eight months.

Therapists' level of training was a very crude measure, consisting of months of training from the time of entering the Clinical Psychology program at the University of Massachusetts. This measure, therefore, did not include any information about prior clinical training (which was extensive for some trainees). Age was calculated as the age at which they started their first case included in this sample of 92 cases. Therapists did give their date of birth to the training program as part of the establishment of the PSC database, but it should be noted that two of the 60 therapists included here did not give their date of birth, so the mean age was derived from the remaining sample of 58 therapists.

The therapeutic orientation of therapists was not data that was collected systematically by the clinic, and in fact many therapists changed orientations and ways of working through the course of their training in this eclectic training program. The data provided here was derived from the following two sources: primarily, the data was from the Case Summary Questionnaire filled out by therapists at the termination of a case. Most therapists filled this out and wrote in the kind of work they did on this case. On cases where this information was missing or unclear, the researcher re-read the case records for information about this. Only 13 cases were initially unclear to the researcher and needed further examination. In fact, the orientation of the work on a particular case

was fairly easy to obtain, since in the termination report most therapists included this information in a straightforward way, such as "psychodynamic psychotherapy", "insight-oriented therapy", or "cognitive behavioral interventions", etc. The cases using cognitive-behavioral work were quite clear about this and easiest to categorize. The category of psychodynamic/insight oriented therapy was considered as a broad category here, including any cases that mentioned a focus on the transference relationship or the development of insight as a goal for therapy.

Marital Status

Marital status is a category that would seem quite easy to code, but in fact turned out to be quite complex. The information compiled in the results section above came from reading and re-reading reports carefully, rather than relying on categorizations made by therapists. Problems encountered were ones such as cases of clients who were noted to be divorced, but labelled as "single" by intake workers or even by therapists in the first sentence of their reports (i.e., "John is a single white male..."). Similarly, clients who were living with a partner were not always identified initially in this way, and may also have been listed as "single" at intake or in reports. If "living together" is a category to be considered, as it would seem from this data as well as current demographic patterns in

our society, categorization of this variable is far from simple. Some clients could fit two categories, as was the case for Kristin[8], who was divorced, but had been living with a partner for many years since her divorce. There were also several cases where it seemed from reading reports that the client lived with a "partner" in what could be described as a romantic relationship, but did not engage in sexual relations; are they to be categorized as living together? In this study, both of the above examples were categorized as "living together". This study also included as "living together" those clients who lived with a same-sex romantic partner, broadening the definition somewhat.

There could also be difficulties in coding a case such as that of Arlene, who, at termination, was pregnant but seemingly not in a serious relationship with the father (she was categorized as single). If she had then decided later to enter into a more lasting relationship with the father, the marital status category of "single" would then miss some important information about her relational status. This kind of case points out the way that marital status could end up being seen as a more fluid or continuous variable than the strict categorical variable that it is commonly described as.

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[8] As noted previously, all references to specific clients in this text have been edited to protect confidentiality. Names have been changed and other identifying information has been deleted or altered somewhat to disguise the identity of the client.

The way that marital status was categorized for this study considered only marital status at two points, intake and termination, which helped somewhat to define the limits of each category. It would have been much harder to consider this as a single variable that described clients throughout therapy, as there was such ambiguity and change over time. Even considering only two points can lead to misleading data however. For example, in the case of Kathleen who was "separated" at the time of intake and "married" at the time of termination, these categories do not reflect the fact that she divorced and re-married, but to a different partner during this period. This kind of information was therefore included in the counts of "changes" in relationships. Even this set of categories did not help to capture the information about Glenn, who was in the process of moving out of his girlfriend's apartment at the time of intake (since the decision had already been made, he was categorized as "single" and not "living together").

Relationship Status

From the realization that marital status was not capturing all or even most of the information about relationships, the data were re-analyzed looking for whether clients were noted to be in a relationship of any kind during the course of therapy, and specifically at

intake and termination. Clients who were described as "married" or "living with" or "engaged to" a partner were easy to classify. Also included in the "in a relationship" category were those where a "boyfriend", "girlfriend", "partner", or "lover" was mentioned. Most cases seemed to use one of these words to describe relationships, although there is no independent validity check on this data to answer the question of what these terms might have meant to the client or the writers of the reports.

For the most part, categorization of those who were "in relationships" was fairly straightforward if a partner was mentioned, and if it was clear that the relationship was existent at both intake and termination. Difficult cases were those such as the reports about Sal, where one report mentioned a "boyfriend" in another state, but none of the other reports about her mention this man again. Since in this case the "boyfriend" was mentioned quite briefly (apparently a relationship was developing at the time of the IPS) and that none of the subsequent five reports about Sal mention this relationship, this was coded as someone who was "dating" but not in a relationship at intake or at termination. The problem with this kind of coding from reports is that the relationship could have been more involved than was indicated from this brief mention in one report. A similar problem was found in coding the relationship status of Arlene. In one of the five reports written about her, mention was made of a

"boyfriend" who she hadn't seen in several months, but this relationship was never mentioned again. This too was coded as someone who was "dating" and not "in a relationship", although with further information this coding might have been different. Another case with similar coding problems was the case of Malcolm, who was reported to have a "casual" relationship with a lover, then later reported to be considering moving in as a roommate with a lover/friend; this case too was coded as not being "in a relationship" in the way that the category was defined here. Two women clients who were described in reports as having joined dating services were also not coded as being "in relationships", since no particular relationship was noted. However, in the case of Ned, a different coding decision was made. He was reported to have ended a relationship of seven years prior to starting therapy, but with the possibility looming that the relationship would re-start. During therapy the relationship continued and at the time of termination, he had moved to another city to be closer to his partner. This case was coded as one where he was "in a relationship" at both intake and termination, since the relationship did seem to continue at both points.

In summary, the coding of relationship status was based on material in the reports that made it seem that a relationship with a partner was an ongoing one, more than a one-time date, "casual" relationship, or friendship. The two time points of categorization, intake and termination,

were used to make a comparison to marital status data, and as a way of simplifying the coding, although information from the entire record was considered in making the final decisions on difficult cases.

The two tables indicating changes in relationships (Tables 7 and 8, pp. 84-85) were then derived from considering any changes from these two points of intake and termination. Table 7 includes any relationships that are coded to be in existence at intake that end any time during the therapy and are ended by the time of termination. Table 8 includes any relationships that had not begun by the time of intake but started after that point and, according to data in the reports, continue past the termination date. The only cases included in Table 8 that are not true "beginnings" are the cases of two men who married during therapy and who had already been living with or engaged to their partner at the time of intake (two of the three who married during therapy), and one woman who was in a relationship at intake and moved in with her partner during therapy (one of the four who moved in together during therapy).

The coding of cases where there was an ending of a relationship <u>prior</u> to starting therapy was quite complex. This kind of information is even less systematically included in reports than current relationship information, or so it seems from this sample of reports. A few cases were easy to consider as part of this group, for example:

Janet who entered treatment apparently because of the dissolution of her marriage, Josephine who was noted as being depressed since the ending of a relationship nine months prior to beginning therapy, or Glenn who was ending a relationship at the same time as starting therapy. The more complex cases where those that, for example, ended a relationship prior to beginning therapy, but became re-involved during the therapy, or those that were divorced some time before the therapy began and whose reports did not include this as a "presenting problem". There were also several cases where the reports indicate that a relationship was in trouble at the time of intake and ends in the first month or two of therapy. This might also be considered in a similar category conceptually, since it is possible that the relationship was already over in the mind of the client. These more complex issues are left to another study, and the most simple count was included for the purposes of this study, including only those cases where there was a clear ending of a relationship in the last year before seeking treatment. The issue of whether the relationship starts up again during therapy was not considered (i.e., they were still counted if they did seem to start up again), and the issue of whether this was the "focus" of therapy was also not considered for this coding.

For the categorization of those cases that could be described as being in a "stable" relationship in therapy and those that were then excluded from this count, the

issues were again very complex. This categorization came about from considering that the marital status information and even the relationship change categories did not fully account for the shifts and problems in relationships noted in the set of 92 cases. In several of the cases where the client was married at both points, significant portions of the reports seemed to be devoted to problems in the relationships. For example, in the case of Elizabeth (a detailed description of this case follows in the next results section) marital problems emerged during therapy, including the client's threat to leave the relationship because of increasing problems. The decision to have a child or not have a child seemed to also be a kind of marital disturbance, or at least a form of change in the marital relationship and was thus considered exclusion criterion for the category of truly "stable" relationships (a better label might be those that were not at a transition point in their relationships). The several cases that remained, from those who were married, were those where the records note that the relationship was "going well", as in the case of Bruce, or where little information about the relationship was found in the treatment records, as in the case of Veronica. Similar criteria were used in categorizing cases where the partners were engaged, living together, or in a long term relationship that continued from intake to termination.

Establishing which cases had "no relationship" during this period was equally complex. The main criterion here was that no relationship was mentioned, or that the only relationship mentioned consisted of "infatuation" or "meeting" a person who was of interest, but where no further relationship was noted to develop. Several cases were quite clear on this issue, noting in the reports that a client had not had any relationships. For example, Sarah, age 20 was noted by the therapist to "never" have dated, as was Erin, age 19. Cases where the client was reported to be struggling with the recent break up of a relationship were not considered here to have "no relationship" since they were involved, at least on some level, in a part of the relationship process, and at times were still having contact with the partner.

Other Information about Relationships

The cases that were included in the count of those where the client was reported to want a relationship were counted in a very straightforward way, with only those that included a specific quote or paraphrasing of the client's desire for a relationship. An example is the case of Jane (described in more detail in the next results section). The intake report notes that Jane wanted to work on "relationships" as a topic in therapy. Then, in the IPS, after describing some difficulties Jane has had in

relationships, the therapist wrote "Jane would like to find a serious male partner whom she could confide to (sic) and explain...(things about her life)". The paragraph goes on to explain what happens when Jane meets possible male companions, and ends with the sentence, "She does not like to be alone". While this is not a direct quote from Jane about her desire for a partner, the elaborations and specific statements by the therapist seem to indicate that Jane most probably said something to this effect. Cases were only considered for this category if they had this level of specificity about the client's desire for a relationship.

The count of cases that included gay and lesbian clients was made to further elaborate the description of the sample, and because it may be relevant in discussions of relationships and relationship changes. Cases were included only if they had specific mention of this issue, so it is quite possible that in some cases the clients had yet to disclose this information to others, although with the long term nature of these cases this possibility may be minimized.

Other Information about Cases

The information about past therapies was included here because the numbers seemed quite striking and may add to the understanding of the sample of cases. Cases were

included if the reports included any mention of past therapy. This information was included in almost all of the intake reports, as it was part of the standard information collected at the time of intake. A few cases included further information about this in the reports that was not included in the intake. The categorization of "brief" therapy as the only past treatment was less systematically included in reports, and the count of 6 cases fitting into this category may in fact be too low. In this categorization, cases where the information provided seemed to indicate that the client had been to between one and four sessions with a therapist was included in this count. For the most part, however, the remaining 79 cases did have extensive therapy histories, including cases with several years of psychotherapy, and the 14 cases with histories of hospitalization. The count of 85 cases with past therapy history is given here as a general measure of the extent of psychotherapy experience in the sample.

The categorization of cases with current family of origin conflict was also a way of giving a general sense of the sample, and a less than perfect measure of this concept. Cases were included if the reports indicated a current conflict with a parent or siblings (mostly parents), or if the records indicated a major mental illness in the parent that the client was currently struggling to come to terms with. Examples of such cases are the case of Cathy, where a report indicated that her

"family relationships are very bad"; Peter, whose father was noted to be an alcoholic and Peter was noted to have a desire to "confront" his father; Sophia, who was "struggling with separation" from her family; and Ruth, who was estranged from her father who was "abusive" to her. Several cases focused on the particular problem of parents disapproving of the client's lifestyle or partner. Cases were excluded from this category if the relationship with the family of origin was described as "a good relationship with..." or other such phrases, or cases where the only information about the family was historical information about the client's childhood growing up in the family environment. Again, the count of at least 50 cases with "problems" noted in the relationship with the family of origin was given as a general measure to give a sense of the sample, and as an indicator that further study on this could be interesting. It should also be noted that of the 13 cases where the client is reported to have children in the home, only four cases seemed to be ones where family of origin problems were discussed in reports. This may be interesting also to follow up on, as it may be that clients and/or therapists shift to looking at "family of procreation" rather than "family of origin" when the client has children, or alternatively, that those clients with children are those that mastered or overcame family of origin problems, or that they are those that did not have significant current conflicts with family members.

Part II: Four Case Examples

This section will provide summaries, as seen by the researcher, of four of the cases that were read and reread carefully for the preparation of Part III. This will allow the reader to develop a sense of what was in the sets of reports, the variety among these cases, and among the writers of reports, as well as a view of how the researcher came to develop the themes in Part III. These summaries of reports are, in a sense, like case vignettes, although it should be kept in mind that these were developed on the basis of reports written by therapists, and that what was seen as important here was not only the case material, but how it was presented by the writer/therapist for the case. These summaries should also provide a sense of how the case developed over time, and how this was seen in the writings about each case. These particular four cases were selected because they provided a good variety of kinds of cases, and demonstrated some of the issues to be addressed in the following results section.

Case 1: Jane

This case involved a woman in her mid twenties, Jane, who was an unmarried, white, graduate student. She shared an apartment with a roommate.

Jane was seen first by a female intake worker (Sheila), then by a female therapist (Jacqueline) for a period spanning 15 months, although during this time she took a five month break from therapy. At the time of termination of this therapy (due to the therapist's leaving) she requested a transfer to another therapist. She then saw another female therapist (Emily) for a period spanning 14 months, which also included a five month break.

Following the intake session, Sheila, the intake worker, wrote that Jane has "a tendency to get moderately depressed, although she is currently not depressed," and that Jane "wants to work on issues related to relationships ...and her future career plans."

Sheila noted no clear precipitating event, although she did write a paragraph about Jane's health problems, which had interfered with her sex life, and of a rejection by a potential male lover several months prior to the intake.

Much of the intake report is devoted to a description of Jane's relationships with her parents and brothers. While the relationships are not described as particularly conflictual, Sheila found that Jane was "struggling with whether she needs to follow in her family's footsteps" and pursue a career similar to her parents.

Other themes touched on in this three paragraph summary were about Jane's sense of alienation in her graduate school department and a similar feeling when she

was an undergraduate. Sheila also noted Jane's successes in the social sphere in college and her "good sense of self esteem" "despite the rejection" by a man several months prior to intake.

Jacqueline, the first therapist, summarized her work with Jane after the first nine sessions in a four page report. Jacqueline described Jane as having "difficulties in her relationships" as well as experiencing moderate depression. The report included, as did the intake report, that Jane felt that her health problems had created a problem in her sexual relations. Jacqueline wrote that Jane often talks about sex, which Jacqueline incorporated into an interpretation about Jane's self esteem, which she saw as being closely related to Jane's sexuality. In this instance, as in many others, it is unclear if this interpretation was shared with the client.

The first psychotherapy report expanded on a topic hinted at in the intake report--Jane's desire for a relationship. Jacqueline noted that Jane wanted a male partner, but also added that Jane is "frightened of intimacy".

In this case the intake report written by Sheila was closely tied to the client's version of the problems, or so it seemed from the writing style (e.g., "she wants to work on...", "she is feeling uncertain about...", "she described her situation..."). Thus the IPS, the first report written by the therapist, is the first time in this clinical record

where the clinician's formulation is articulated (although the intake worker certainly used her own judgment in deciding what to write about, and did add her view in a few sentences, such as "Clearly, she is struggling with...").

While the intake report included the notion of Jane "wanting to work on relationships" the IPS went beyond this general statement and explored in many different ways the idea of Jane's interpersonal style. Jacqueline wrote here of Jane's current lack of someone to confide in and her fears of disclosing personal information to friends and family, then turned to a description of Jane's style of frequently talking about sex and her tendency to "turn to others for their approval." The "initial formulation" section ended with a description of how these dynamics were played out in the therapeutic relationship and the therapist's interpretations about this. Jacqueline noted that Jane has cancelled sessions but has also asked to see the therapist over the summer and summarized this contradiction with a comment about Jane's simultaneous desire for relationships yet fear of intimacy, which she then noted was "reflected in" her contradictory behavior with Jacqueline.

Jane's depression was mentioned prominently in the IPS but was not elaborated on. The causes and current dynamics of her depression were not discussed. Instead, Jane's dynamics of relating to others in her life were tied to her style in the therapy room and thus the formulation is

ultimately about Jane's internal object relations and their current manifestations. Jacqueline in fact wrote that she planned to use an insight-oriented approach, and was supervised by a psychologist known to follow an object relations orientation.

Following another five sessions, Jacqueline wrote a progress note of two pages. In it she wrote that "it has become apparent that Jane often talks about sex as a defense against more sensitive issues." The formulation is much shorter, but fairly similar to the earlier version. Jacqueline found Jane to have an "underlying" "low self esteem" and a desire for the "approval of authority figures."

Nine months later Jacqueline wrote a termination note summarizing the therapy that occurred before and after a five month break. Here the formulation included mention of "a pattern of constantly trying to induce other people to act as authority figures" and referred to Jane as someone who "acts out her internal conflicts."

Jane apparently left therapy abruptly, then called and asked to continue the following semester. In the report written at this time, Jacqueline wrote that Jane had "similar complaints" to her original presentation at intake. She quoted Jane as saying that she had realized that she "had not gotten over" her health related sexual problems. Additionally Jane "reported some difficulty with her roommate". A month after resuming the therapy

Jacqueline left the clinic and the case was transferred to a new therapist.

Jacqueline did not include any clear mention of outcome criteria or improvement she has seen in Jane, but did include increasingly more elaborate formulations of Jane's problems. It seems then that one part of the outcome of this therapy up until this point was the expansion of Jane's original problems into a psychodynamic formulation which included past and present relationships. In this particular set of reports Jane's current relationships and transference relationship with Jacqueline were emphasized more than her early family of origin relationships. These family relationships were documented separately and were not incorporated overtly with Jane's current problems. It may be, however, that the therapist used information from discussions of family of origin to understand and formulate her view of Jane's style. For example, Jacqueline wrote that Jane has difficulty with her father because she does not pursue a career track he has suggested. In a separate section she wrote that Jane solicits advice from others then "resents" them for it.

After an unspecified number of sessions with Jane, Emily, the second therapist, wrote a progress note. A surprising development noted by Emily is that Jane revealed in their first session together that she had an important issue to discuss which she had kept from Jacqueline: that she had a history of stealing. Interestingly, two thefts

were noted in the reports from the first 15 months of therapy but with no indication that Jane had committed them.

While Emily wrote that both she and Jacqueline practice psychodynamic therapy, their writing styles are very different. Emily included many details of Jane's current life and used a five axis DSM-III-R diagnosis as an "initial formulation". Emily did include a section called "restatement and reformulation of treatment goals", however. In it she wrote that Jane presented with "low self esteem" and particularly a sense of "floundering" in "interpersonal relationships." Jane apparently told Emily she wanted to stop stealing as well. By the end of the three month period covered in this first report, Jane apparently reported to Emily that she was no longer concerned about her health/sexual problems (which seemed to have brought her to therapy originally).

Six months into the second therapy Emily wrote another progress note of two pages. In it she documented Jane's success in her career as well as some success in relationships. In her reports Emily often focused on Jane's sense of being "special" and how it affected her (she noted this need to be "special" as playing a part in Jane's problems with sexuality and stealing).

In this set of reports Jane's depression was now absent. Emily noted in the six month progress report that Jane's goal was now to work on dealing well with coworkers.

The therapist added that other issues about relationships and identity should also be addressed.

At termination Emily wrote that Jane's initial presentation included low self esteem and feelings of isolation (neither were mentioned in the initial intake report). Emily, like Jacqueline, found ways that Jane's behavior toward the therapist reflected patterns that existed in other relationships. Emily noted that Jane "stayed away from the clinic" after a therapist-imposed break and went on to characterize Jane as having a "pattern of rejecting others at the slightest hint of rejection." In contrast to Jacqueline's report at termination, Emily noted many areas of improvement, an "increased ability to see her role" in relationships, an "increased self acceptance", and that her urges to steal had stopped.

In summary, Jane's problems seemed to shift a great deal through the course of therapy as documented by these three writers who spoke with and re-interpreted Jane's situation. While a tendency for depression was mentioned earlier, it was not a focus of therapy nor was it discussed by the therapists who worked with Jane over a course of 29 months. While Sheila (the intake worker) found Jane <u>not</u> to have low self esteem, Jacqueline and Emily (the two therapists) did find this to be a central concern. While Jane was reported to have been attending a diet center at the time of her first psychotherapy summary, and later to have gained weight, this was never a focus of therapy

either. Jane mentioned her career as a central concern at intake, but there was no discussion in the reports of Jane's using the therapy to discuss career options. Jane apparently kept secret a central concern but later disclosed it when, it seems, she was ready to change her behavior (although Jane apparently made casual reference to thefts to her first therapist, Jacqueline seems to have missed their importance. Jacqueline's interpretation of one of Jane's initial complaints, problems with sexuality, was that it was a defense against talking about deeper concerns. Later, Emily, the second therapist, found that Jane felt that sexual problems were no longer a concern in the second therapy. Jacqueline's interpretation of Jane's conflicts with authority were later replaced by Emily's description of a need to feel "special" and a fear of rejection. Jane's life circumstances changed as well, as she left graduate school and began work, and new concerns about co-workers emerged.

Case 2: Elizabeth

Elizabeth was a 30 year old white woman who was married and had two children. She had just moved to the area, and her career as an artist was in question at the time of the intake.

Ralph, who wrote the intake report about Elizabeth, had a very different writing style than was seen in the

intake in Case 1. He used few of the client's own words and instead wrote of his construction of Elizabeth's problems at intake. He wrote, for example, that her desire to "erase the underlying problems" was "indicative of her orientation toward repression and her rigid demands of herself" and wrote a paragraph about the discrepancy between her "overt presentation" of cooperation and what he believed was an underlying "anger which she will have to confront in the course of her treatment".

The intake report focuses initially on Elizabeth's concerns about her weight, which apparently began in her childhood. Tying together Elizabeth's problems with weight and her impression that her feelings of "not being good enough" were "passed on" to her from her parents, Ralph went on to describe Elizabeth's fears that her daughter will also have problems passed on to her.

Ralph also included a paragraph about Elizabeth's current relationships. He hinted here at problems in her marriage, writing that the birth of their children "put a strain on their intimacy," but also wrote that she describes her marital relationship as "very close". He also noted that Elizabeth keeps in contact with her parents with phone calls "usually twice a week" (this is unusual in that reports do not often "quantify" relationships in this way, although it is interesting that some do).

Ralph's initial formulation of this case is quite short, describing Elizabeth's problem as "dysthymia

disorder with associated low self esteem and concern about weight problem". While this case could have been conceptualized as involving a specific symptom (weight) it was instead put forth as a more open-ended therapy which might involve the client's interpersonal style and sense of self, and which may lead to a discussion of "underlying issues" (rather than current symptoms exclusively). From this short narrative, it seems that this approach fits both the client's request (wanting to use therapy to "erase the underlying problems") and the intake worker's theoretical position (he uses the terms "repression" and "treatment frame," and the idea that she might "devalue the treatment", all comments based on psychodynamic concepts). The intake worker also seemed to be using his own reactions to understanding the client, although he did not make this explicit. He writes, for example, that "there is a sense in which she is not satisfied unless she is perfect" and that she "may have a tendency to withdraw quietly or to put pressure on the therapist to come through with solutions." Presumably these comments come from Ralph's own experience in the room with Elizabeth[9].

Following the intake, Elizabeth was seen by Don for 11 months in weekly psychotherapy until Don left the clinic. The case was then transferred to Alex, who saw Elizabeth

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[9] See Jacobus (1990) for further exploration of the ways that the writer can document their own experience either explicitly or implicitly.

for 24 more months, at which point Alex also left the clinic, and Elizabeth terminated therapy.

Don's writing style is considerably different from the intake worker's. He wrote a four page IPS (after three sessions) in which he included mainly Elizabeth's statements about herself ("she feels...") and added little of his own interpretation (although there is certainly interpretation in the selection of comments and in the nature of the material that comes out in a particular interview). In contrast to Ralph's statement that Elizabeth has a tendency toward "repression" and "rigid demands" on herself, Don wrote of her desire to have a career and raise children and concluded that "she is frustrated that she cannot do everything 100% all the time" a much less theoretically based comment. In contrast to Ralph's report, Don's report seems to focus on strengths ("good communication" with her husband, "highly motivated" to deal with her depression, a "high-functioning mature adult").

In the IPS the problems outlined seem to be the same as at intake: depression, low self esteem, and perfectionism. Don laid out his plan to do a "combination of psychodynamic work aimed at understanding the source of her conflicts" and "cognitive behavioral work aimed at exposing the unrealistic nature of her expectations". He also wrote that she could benefit from learning to "express her real feelings of anger in her close relationships."

Elizabeth's relationship with her husband was elaborated on a bit more in this report. Don wrote that they have "minor conflicts" which are resolved "shortly". Don began the process of elaborating Elizabeth's dynamics in light of these conflicts, writing that she turns her anger inward, "assuming that it all must somehow be her fault." Elizabeth's mother was mentioned twice in this report, in the context of the development of Elizabeth's problems (she is described as "over demanding" and "controlling") but not in terms of their ongoing relationship.

After four more months of therapy Don wrote another report about Elizabeth (Progress Note). He noted here that she seemed "less depressed" and had made "progress" in the area of self esteem. In this report Don wrote of Elizabeth's coming to terms with her "unrealistic" expectations, especially about her career. There seemed to be a return in this report to a discussion of Elizabeth's concerns about weight, which had been minimized in the earlier report.

Five months later, Don was leaving the PSC and wrote a termination note before the case was transferred to a new therapist. In this report the initial problems were restating as involving low self esteem, weight, and Elizabeth's career. Elizabeth's sense of "not being good enough" was included again, but the word "depression" was not.

Don again described his work as involving exploration of "unrealistically high expectations", and now called his approach "primarily cognitive". He noted moderate success in several areas, including exploration of the roots of the problems and a shift toward Elizabeth's "modifying her attitudes." Don noted that Elizabeth was able to lose some weight which also seemed to improve her self confidence. He linked this though, to a concurrent "increase in tension with her husband". Don also wrote that Elizabeth was now more able to "assert her anger" in this relationship.

Don concluded his report with Elizabeth's request that the therapy shift to a focus on her "compulsive eating" rather than her career. Don noted his own confusion however, about whether this approach would be most helpful, writing that this could be an "attempt" on Elizabeth's part "to focus the therapy, perhaps too exclusively, on a particular issue."

The case was then transferred to Alex, who wrote his first report after two months of therapy with Elizabeth. Alex's writing style is again quite different from the preceding writers, as he includes a great deal of detail about the process of the therapy sessions (omitted by all the other writers considered so far). He wrote for example that the sessions were "difficult" and "strained" and that they (Elizabeth and Alex) spent much of their time "talking about her experience of this initial phase of [their] relationship."

Alex did little analysis initially of Elizabeth's problems in the first report. He wrote though that she had little more than "a rather cognitive grasp of her extreme perfectionism and self depreciation" and that she had "repressed a whole world of turbulent ambivalent angry feelings". Aside from the initial presentation of problems, there is no discussion of weight (nor depression) so it is unclear how it was determined what the focus of the therapy would be (it seems to be Elizabeth's interpersonal style and sense of self, and not her weight).

Alex wrote the next report after four more months of therapy. His report again focuses mainly on process: on the events in the therapy room and Alex's interpretation of them. He did note briefly, though, that Elizabeth was having a "more positive experience" in her career and was showing more "strength" in her relationship with her husband. Alex indicated one part of his theoretical position at the end of the report, where he wrote that "much of the most difficult work of self understanding yet remains" (one might assume from this that he considered self understanding an important part of the outcome of therapy).

In Alex's third report (after another five months), he began to take a stronger position about the nature of Elizabeth's problems. He wrote that her "neurotic tendencies have a pre-Oedipal quality," that early on she was "made to feel responsible for a depressed controlling

mother," and that she could "experience rage but not understand it." As an example of Elizabeth's dynamics in relationships, Alex wrote of a recent fight between Elizabeth and her husband, when she got angry and threatened to leave him. This scene from her current life seemed to be used as an example of how her early life and the internalized versions of it are replayed in the present, not as documentation of her current situation.

Alex changed supervisors during the next two months of therapy, then wrote another progress note. While this one also focused on the process, it had a different quality. In this report, Alex noted some content of sessions other than the transference relationship (discussion of relationships with mother, father, husband, not just the relationship with Alex). He also wrote that Elizabeth's "attempts at assertiveness" have "improved the quality of her relationship" with her husband.

Alex changed supervisors again during the next phase of therapy, and wrote a report following an additional four months of treatment. Surprisingly, Alex wrote here that he had "mostly before described Elizabeth's problems in terms of a symptom picture," "referring to terms like depression and anxiety" (these words in fact are hardly mentioned in his reports). He wrote that as of now he was conceptualizing Elizabeth's problem in terms of "identity" --that she is struggling to find out who she is. In this report Alex wrote of a change in Elizabeth's career

(recognition of her work by others) and a shift toward differentiation from her family (on the level of internal recognition of this issue it seems). Alex saw these changes as "meaningful" but also wrote that her problems can be "activated in Elizabeth's every meaningful interpersonal relation."

After another five months Alex left the clinic and the therapy with Elizabeth was terminated. In his termination report Alex wrote that the work was "informed by" his "strong psychodynamic orientation." He characterized the therapy as allowing Elizabeth to "turn her vision inward" and that the work involved "the slow process of her struggle to feel safe." Despite a brief mention of his style and of their relationship, this report was much less process oriented and included much more interpretation and summary (e.g., "Elizabeth only finds human connectedness through her empathy with the pain of others"). Alex described Elizabeth's progress with the "difficult relationship with her husband," and stated that in the last several months Elizabeth had "both the greatest highs in her career and the greatest lows in her relationship with her husband."

In reading this final report, where Alex described Elizabeth's "marital struggles", one wonders how this relates to the initial version of Elizabeth's relationship to her husband. Has the reporting of the problem changed on the level of what the therapist writes, has it changed on

the level of what Elizabeth discloses, or has the problem actually changed? At one point in Don's reports it seems that the problem emerged in the marriage because of Elizabeth's improvement in other areas, but this theme is not elaborated on, and otherwise there is no evidence to support any of these theories about the change in the reports. This would certainly pose a problem for outcome studies, since from reading these reports it seems that this relational problem is worse now than at intake (although, as mentioned, it may ultimately be a sign of improvement in the individual).

It is interesting to note how little the issues of weight and depression are focussed on in these therapy reports, given their importance at intake. It seems that in this therapy, as in Case 1, the focus became the client's interpersonal and intrapersonal world, without a focus on a particular symptom. In this last set of reports the focus was often on the transference relationship, but this may or may not mean that this was emphasized more in the room with the client than in other therapies. As in Case 1, the general direction seems to be the expansion of the problem(s) (or elaboration, using Hatcher's term, 1986) into a conceptual scheme that takes into account symptoms, developmental history, and current relationships (including the therapeutic relationship).

Case 3: Linda

Linda was an unmarried 24 year old graduate student seen by one therapist over a period of a year and seven months.

Linda was seen for an intake by Shiela (the same intake worker as in case 1), who wrote that Linda was struggling with "recurrent bouts of depression," but not currently "in the middle of a crisis." Right from the beginning of this case, Linda's problems were described as having interpersonal characteristics. For example, one characteristic of this problem, as described by Shiela, is that Linda "withdraws from, rather than reaches out to friends." In addition, Linda apparently described herself as needing to appear "all powerful" to her friends, to avoid being seen as "weak". Shiela's intake report tied together these problems with Linda's ambivalent feelings about wanting a boyfriend, and her history of observing her mother's "dependency on men." Apparently, Linda herself described a "pattern of attraction to men" who are "independent, charming, and don't need people." Linda was also noted to have "recently started a relationship with a man whom she describes as 'undependable.'"

Linda's tendency for depression seemed to be described by Shiela as a serious problem, but perhaps not the only problem, or one needing immediate attention (i.e, hospitalization or immediate referral for medication were

not mentioned). She included a description of the symptoms of Linda's usual depressions and noted that while Linda was at times subject to suicidal ideation, she had made no attempts. She also elaborated on Linda's feelings that the depressions were related to "academic pressure," and described a cycle that this concern brought about, where Linda would work hard for a number of months, then when "her work starts to go poorly" she "starts to panic" about her general life situation and "begins to hate herself."

Linda began therapy with a female therapist, Nancy, but attended only one session before terminating abruptly, saying she did not have the time to "devote to psychotherapy." A month later, Linda recontacted Nancy and asked to begin therapy again, saying that her new relationship was falling apart, and that this had led to renewed unhappiness.

After two sessions, Nancy had written two short reports about her brief contacts with Linda, resummarizing Linda's desire to enter therapy to work on her bouts of depression, and giving some background information about Linda's childhood and current functioning. Nancy described Linda as seeming "very depressed at present," but also noted that "there does not appear to be any impairment in her current daily functioning." The "daily functioning" seemed to refer more to her work, since a few sentences later Nancy noted that Linda was "very confused about her

feelings about social relationships," and "avoids social contact by filling up her hours with her work."

In the progress note written three months into this therapy, Nancy included several statements which may be good indicators of her theoretical position (which seemed to be psychoanalytic) and her idea of goals of this therapy. She wrote, for example, that it was "still too early for Linda to delve into areas such as her childhood and her relationship with her parents." At the same time, a later paragraph notes that Nancy's current goal is to "link Linda's current behavior and cognitive style with her past experiences and with her relationships with her parents," as well as "how these issues might get played out in the therapeutic relationship."

Nancy noted that the content of the sessions focused on a set of topics that included Linda's "relationships with men" and feelings about her career and herself. The romantic relationship that Linda had begun at intake had continued, and problems in that relationship were noted. Nancy at this point described how Linda's "pattern of choosing un-dependable men...may be related to" issues with Linda's father. Meanwhile, the report also included mention of "positive changes" in Linda's career, leading to changes in her area of concentration in graduate school, and a job possibility. Linda's "negative pessimistic thoughts" and "suicidal thoughts" continue to be mentioned in this report as well.

Eight months into therapy, Nancy wrote the next progress note, which followed up on previously mentioned themes. Prominent among these was Linda's current relationship, which was noted to be discussed "in every therapy hour." Nancy described Linda's involvement with this man as "dependent", as well as involving "suspicion" and "jealousy" on Linda's part. Nancy noted that she had made "efforts...to link her ungratifying relationship with this man to similar relationships in the past as well as to the current therapeutic relationship."

Nancy seemed to be continuing in the psycho-analytically-based direction mentioned previously, although perhaps less than successfully, noting that Linda "requires guidance and continual probing in order to begin to discuss some of her history and her feelings," and that Linda instead led the discussion to a "less threatening topic area." Nancy also noted that Linda was quite "tentative" in responding to interpretations, and concluded that Linda "doesn't feel she really knows herself, what she wants, or what she believes." Instead, Nancy writes, Linda is overly concerned about others' opinions, a concern that Nancy speculates may "stem...from her early relationship with her mother," and one that has "generalized to the therapeutic relationship."

Nancy's reports are notable in that they include a great deal of mention of specific transference/counter-transference phenomenon that is less evident in some other

writers' reports. In the eight month progress note, Nancy wrote that "one striking trend in the therapy over the past several months has been the sense of boredom in the therapist," and offered hypotheses and interpretations of this phenomenon. Most striking to this reader was Nancy's interpretation that this might have been due to the "detached" quality of Linda's "repetitive verbal reports" and that this might have been "a defense against Linda's underlying feelings of anger and fear of abandonment."

Nancy's reports about Linda continued to be quite similar from one to the next, although with elaborations of various intrapsychic and interpersonal themes. Nancy had two supervisors for this case, with the switch occurring after Linda had been in therapy for ten months. This switch did not seem to change much in the content of the reports, as all her reports followed the psychoanalytically-based ideas mentioned above. These reports continued to mention Linda's pattern of choosing certain "types of men" and the further expansion of this into the idea that Linda "fears intimacy." The reports also continued to point out transference and countertransference phenomenon and how they helped Nancy to understand Linda's way of relating to other people. These reports note "progress" in this case, in particular in Linda's "understanding" issues about relationships and "recognizing" patterns.

When Linda terminated therapy after a year and seven months, it was noted in Nancy's report that this was

because both Linda and Nancy were leaving the area, although the reasons for these moves was not given. A surprising piece of this termination report was that during the final phase of therapy Linda's father died, and that was not discussed until the following report. Nancy wrote only that while the death "seemed to have a strong impact" on Linda, "she spoke very little about this in the therapy hour."

At the end of this therapy, Linda was apparently involved in a new romantic relationship, with "a man who is different from other men with whom she has been involved," in that he "treats her well". Nancy noted this as a positive change for Linda, as well as Nancy's perception that Linda was "beginning to see herself as an active agent in these relationship."

Depression was not a major theme in any of the reports after the first three, and in fact was not mentioned at all in these reports, except to note that this was her presenting problem. However, in the termination note, Nancy wrote that Linda "will most likely continue to become depressed every now and then" but that she will be less likely to "feel...that she has to hide her depressive feelings and deal with them on her own". No mention is made of a current assessment of level of depression.

Surprisingly, the recommendation made by Nancy is that Linda re-enter therapy in the future when she "feels ready to work on her feelings of dread at the thought of not

being in a relationship," although this theme was not mentioned directly in previous reports.

Case 4: Anne

Anne was a 21 year old college student, also seen by one therapist only, for a period of one year and five months.

Rebecca, the intake worker, gave the initial formulation about Anne as follows: "Fairly well adjusted young woman with long-standing concerns about her weight and low self-esteem. Is presently slightly overweight and has conflictual relationship with an obese mother." This seemed to characterize well the initial presenting problem as restated later, but not at all the way that this therapy developed.

The intake worker did give more information in the "brief history of the presenting problem" section about where the therapy might be headed. Rebecca wrote that Anne "clearly stated that she wants to talk about herself in therapy and understands her weight problems to be related to her style of cutting off feelings." A later paragraph details the family problems, which is summarized by: "As Anne puts it, 'weight is a family issue in my family.'" The final recommendation made by Rebecca is that Anne is "apt to benefit from a supportive, psychodynamically-oriented therapy which explores her self-esteem issues and concerns

about intimacy". Note that there is already a shift here to a broader set of problems and that weight is not mentioned.

In the initial psychotherapy summary written by the therapist, Lisa, the theme of intimacy is again introduced. First, Lisa wrote that Anne "is saddened by her lack of intimacy" with her parents, and that "they do not know who she is." Later, she wrote that Anne had found a previous therapy very helpful and that she had felt that "she would like to someday enter long term therapy to explore problems around intimacy". Then, the issues of weight were discussed, restating Anne's belief that her weight problem is "related to her style of cutting off feelings" and that these issues have "interfered with her relationships with men." Anne is noted to be interested in exploring issues of family relationships as well as "explore her difficulty expressing emotions and sharing herself with others."

Lisa's initial formulation of Anne's problems is quite lengthy, and approximately three quarters of it focused on Anne's relationships with her parents. The final section elaborated on Anne's development of a "false self" to defend against "threatening, destructive forces," such as "rejection from her parents." Lisa also describes how "interpersonal conflict is scary for Anne," and that "intimate relationships are problematic because she has difficulty asserting herself."

Lisa's description of "treatment goals" are for Anne to focus on how her "relationship with her parents and

early childhood experiences have influenced her poor self-concept, weight problem, and difficulties with intimacy." She went on to say that the "transference relationship" was to be used as a way to "reveal" Anne's style of relating to others. From this point on, the reports did not include weight as an issue, but took up the other issues mentioned, and elaborated on them considerably.

Three months into this therapy, Lisa wrote a progress note about this case, in which she wrote that they had focused during this time on Anne's "relationships with her parents and with significant persons, her struggle to achieve a sense of autonomy, problems related with intimacy, and general feelings of worthlessness, inadequacy, emptiness, and paranoia." Lisa's style for these reports was to start with this kind of summary of issues, then elaborate on them in a two or three page report, at times finishing with a restatement of goals of therapy. These initial statements of themes varied only slightly, with new words popping up at times (e.g., vulnerability, anger, sadness), but with most of these initial themes being repeated each time.

Lisa's elaborations of Anne's problems include mention of current relationships (as well as the therapy relationship), and of how they demonstrate the issues that Anne was working on. For example, Anne apparently started dating a man during the first five months of therapy, and a situation was described where Anne wanted to confront him

about his continuing relationship with another girlfriend, but found it impossible to do so. Lisa describes this situation as "representative of Anne's broader issue of wanting to assert herself but fearful that if she does, conflict will ensue and she will be rejected." Lisa's descriptions of Anne's dynamics tended to be quite elaborate in these reports, including many different levels of the conflicts Anne was facing, such as interpretations of actions, defenses, and inner fears that she believed Anne was experiencing.

In the next progress note, written five months into therapy, Lisa returned to the theme of the "false self" experienced by Anne, a "facade she presents to others to gain their acceptance," and described as well the hidden material "underlying the facade," which included "pain and confusion." This description also continued to tie together these theoretical concepts with vivid examples from Anne's life, and further elaboration of the effects of Anne's interpersonal style on relationships. The therapeutic relationship continued to be addressed as well, for example, Anne's "difficulty in trusting" Lisa was part of this report.

Later reports continued in a similar vein, with themes being explored and examples from Lisa's current life being intertwined with them. The changes in supervisors (Lisa had three different supervisors), did not seem to lead to significant changes in the style or content of the reports

written by this therapist. In the report written ten months into therapy, Lisa returned to the themes of parental influence, noting that it had "become more apparent how Anne's difficulty with intimacy is related to her parent's emotional unavailability," and discussed how this affected Anne's current relationships. The therapeutic relationship was also discussed, with Lisa writing that Anne had become "resistant to therapy" (perhaps related to "increasing intimacy" with the therapist, Lisa noted) and that Lisa felt that Anne "may terminate...soon," because of feeling so "overwhelmed."

Anne did not terminate therapy at this point (ten months), but at fifteen months into therapy, termination by the therapist was beginning to be discussed. In the termination note, Lisa wrote that therapy was terminating because she was leaving the clinic (a common experience in a training clinic). Anne then decided to end the therapy a few weeks earlier than planned, and a section of this report was devoted to discussion of Anne's expressed feelings about this termination.

The termination note written by Lisa about this case did not re-hash the history of the case, or the background history about Anne, as some reports do, focusing instead on recent developments. Despite this, it was still notable that in this entire three page document, Lisa did not include the word "weight," nor did she include any mention of this as the original "presenting problem." The report

instead described Anne's increasing commitment to a love relationship, her problems with "interpersonal conflict" and how they might relate to her relationship with her parents, her "inner sense of depletion," and the course of the termination. Presumably these other issues had taken on a greater importance by this point for both therapist and client, although the absence of any information about this leaves this point unclear.

Part III: Themes and Examples from a Smaller Sample

This section will present data from specific cases, relating to the themes found in reading the cases from the larger sample. The examples will be drawn from the set of 11 cases that were analyzed in greater detail (and includes the four cases just presented). The first section will be about the elaboration and re-formulation of problems over the course of therapy, as this was seen in the reports. This section will also include some other, specific, ways that changes in problems were seen in these reports. The final parts of this section will outline some of the other ideas that were developed on the basis of this smaller sample, some that were explored in detail, and some that were not.

In these sets of reports, the clients' problems and/or symptoms were first stated in the initial intake report, then often restated in the Initial Psychotherapy Summary (the first report written by the therapist for the case), then commented on, and restated and expanded on in the subsequent Progress Notes. The Termination Note generally included the original problem(s), and often provided the course of the problem/symptoms and any progress made on the symptoms.

The writers of these reports often include further elaboration on their understanding of the problem(s) during the course of treatment, as well as statements about how the client's understanding of the problem is changing. The elaboration of problems can take the form of expansion into a broader problem or set of problems, clarification of the problem, re-naming of the problem, or focusing and specifying the problem from an earlier vague statement. This elaboration of the original problem into a more complex set of issues can be seen as a central part of the process of therapy, as one view of therapy would be that the task is for the client to come to understand themselves and their dynamics over the course of conversations with the therapist. Both participants, then, can be seen as coming to a greater understanding of the client during the

therapy. This part of the study looks at how the therapist describes this process in reports.

The first set of examples will be cases where there is some evidence of the "expansion" or elaboration of the problems presented at intake, and the ways that these shifts are seen in later reports written by the therapist. This will be followed by some other, specific ways that therapists used particular ideas as part of the expansion process: the use of theory as part of the expansion of problems, the use of the idea of "an underlying problem" as a way of elaborating the original problem(s), and the linking together of separate ideas from earlier reports as a way to further elaborate the nature of the client's difficulties.

The next section will address the intersection of treatment goals with problem-formulation. In some cases it is the goal of therapy that may be changing as the therapist and client come to a greater understanding of what the client's problems and needs are. This can also be seen as a shift in the understanding of the problems faced by the client, and seems to be tied in with this process of problem reformulation.

Clients can also be seen as changing through a change in symptoms, and the final sections will give particular examples of this. In some cases new symptoms emerge as difficult topics come up in therapy, or because new situations in the client's life lead to new symptoms. It is

likely also that some clients become more trusting over time and reveal new symptoms or new information. This can also occur because a client may emphasize a particular symptom in the initial phases of therapy as a means of getting the help they need for other problems. Other kinds of "new" information may emerge in reports as well, and examples of this will be given.

In the following pages, different ways that reports indicate shifts in the identified problems will be outlined, using examples from the four cases described previously, as well as including several other examples from the smaller sample of eleven cases that were analyzed in detail.

Elaboration of Problems

These psychotherapy reports show a great deal of evidence for the idea of problems being expanded on in the course of therapy. The following examples demonstrate the overall ideas of elaboration or "expansion" from one phrase or idea about the client to detailed descriptions, in later reports, of the same concepts, as well as some additional concepts added on later by the report writers.

Examples of Problem Expansion. An example of a set of reports that shows this expansion of the description of problems is the case of Linda (case 3), described above. At

intake, among other problems, Linda is reported to "withdraw" from others and feel a need to "appear all powerful" to others. In the initial psychotherapy summary by the therapist, about a month later, the therapist notes that Linda is "very confused about social relationships" and fears both "dependency and abandonment." Later in the therapy Linda is described by the therapist in a report as "fearing intimacy."

Throughout these reports about Linda's therapy, these issues are expanded into a variety of statements about Linda's style of relating to others, her beliefs about herself, and the possible origins of these issues in early family relationships. The further expansion of this problem includes the statements by the therapist that Linda feels "that one is in a very vulnerable position if one needs other people" but that her "concern about what others think of her and of what she should be, based on the opinions of others, dominates her thinking." The therapist notes that Linda has a need to "constantly search for approval and reassurance" from others and that she "overextends herself for the sake of others, and then gets angry that she has done so." The therapist went on to say that "by demanding reassurance of others, Linda gives other people the power in the relationship, leaving her defenseless and unsure of who she really is and what she really feels," and that Linda "is quick to assume that others are thinking the worst of her, which is probably a projection of how she

feels about herself." The therapist described a pattern that Linda had learned in her interaction with her mother where Linda "learned to please her mother and get what she needed from her mother by being everything that her mother wanted Linda to be," and the therapist concludes, "perhaps this is why Linda tries so desperately to be what she thinks her friends, lovers, and therapist want her to be."

A later report by the therapist includes another piece of this interpersonal style. The therapist wrote about Linda that she:

> "always needs to know what others are thinking of her. There appear to be two reasons for this need. First, she uses what she learns to see if she is behaving appropriately, that is, to make sure that she is not doing anything wrong to hurt the other person. If she is doing something wrong, Linda will try to change the behavior, regardless of whether or not she is the one who should be changing. Secondly, Linda uses these opinions as a yardstick against which to compare herself to others. She is fairly competitive, especially with women, and this competition contributes to her interpersonal difficulties with women."

In a later segment, the therapist went on to describe another aspect of this interpersonal style, writing that Linda:

> "frequently complains about how people around her always 'have walls up,' that is, that people around her will never let her get too close to them. Yet, it seems that it is Linda who invites others to get close to her, but then does not follow through with the invitation, because she fears intimacy. The other person is left hanging and confused. Perhaps it is for this reason that she chooses men with whom she can never get too close."

These can be seen as the same problems as originally stated by the client at intake, but taken to a deeper level and having greater diagnostic significance, as well as showing more specifically how the client's style affects her relationships and her sense of self.

Another kind of expansion of the original problem was seen in the insertion of a new "idea" about Linda, which came in the first progress note written by the therapist, about two months into treatment. Here the therapist notes that a focus on Linda's "ambivalent thinking style" was very "productive". This is a topic not mentioned in the earlier reports, but which relates to some of her problems and symptoms (mainly her depression, as she is noted to turn "her good feelings into depressive ones").

Most of the 92 cases examined seemed to show some evidence of this pattern of expansion of the presenting problem in subsequent reports, but some cases showed particularly good examples of this. Another example of this was the case of Anne (case 4, above). Anne's problems were described originally at intake as involving particular symptoms ("concerns with her weight," "low self esteem," "poor body image"), as well as interpersonal difficulties (a "style of cutting off feelings," and "sharing herself with others"). In subsequent reports further expansion of symptoms and of styles of relating to others were discussed by the therapist, leading to a fuller picture of Anne's internal dynamics, her pattern of relating to others,

including the therapist, and a way of understanding these issues in terms of early childhood experiences (as in the case of Linda, above).

For example, in the intake report, Anne's own comments about having difficulty "sharing herself with others" are quoted. In the initial psychotherapy summary written by the therapist, Lisa, Anne's relationship with her mother is discussed, and her mother is described as an "emotionally volatile" woman, who "breaks down and cries when she feels criticized or let down." Lisa went on to write that "this leaves Anne feeling manipulated and shut out," and that as a result, Anne "has stopped showing her emotions to her mother," and instead "acts strong and invulnerable" and that "this strong veneer has become an integral part of Anne's personality."

Anne's therapist wrote, also in the initial report, that Anne's "feelings and ideas are often presented in a vague manner as to not oppose anyone else's," an observation that presumably is drawn from her direct experience with Anne in therapy. She also wrote that Anne "avoids" interpersonal conflict by "second guessing" others so as to not oppose or insult others, and that this leaves Anne feeling "compromised and ineffectual". This is described as part of Anne's "submissive stance," which is described as having its roots in her relationships with her parents. The therapist, Lisa, went on to describe a "cycle of submissiveness-bullying" that Anne engages in, where she

feels "out of control" in relationships, then "reacts in a forceful, bullying manner" and then feels "guilty and embarrassed" and then "retreats back to a submissive stance."

In another report, Lisa wrote about Anne that her "emotional distancing" also includes the feeling that it is "difficult to accept nurturance from others" and gives as reasons for this that she feels "undeserving" and that she feels that "people's caring is not genuine." Lisa went on to write that she "surmised" that this pattern was related to "early childhood experiences" where "caretaking was inadequate on some level."

Other, less interpersonal themes were similarly expanded on in subsequent reports by this therapist. For example, Anne was described in one report as feeling "alienated from emotional life" and having "reticence to experience, and express feelings." She was described here as fearing that "expressing feelings is potentially hurtful" and that "doing so will make her appear 'vulnerable', 'exposed', 'weak' and 'foolish'." In addition, Lisa noted that for Anne, "strong feelings, both positive and negative are disorganizing" and that she "defends against" this by "denying" her feelings or by "distancing" herself from them. While this is well described in the intake as "cutting off feelings" this further elaboration is much richer, and came from, one

would assume, long discussions with Anne, as well as direct observation by the therapist.

The Use of Theory for Problem Reformulation. Continuing with the case of Anne, a particular kind of elaboration of problems can be noted--the use of theory to explain and further examine the client's dynamics. In the initial psychotherapy summary, and in subsequent reports, the therapist describes Anne's use of a "false self" as a defense against "threatening, destructive forces." While this is may not clearly be a new problem in Anne's own view, the therapist's inclusion of this forms a new interpretation of why Anne is in therapy and has the problems she came to therapy for. In this form of expansion of problems, the therapist uses a theoretical idea (or a diagnosis, or what might be called jargon) to delineate a new problem area.

This set of reports written by Lisa about Anne include a great deal of this kind of reframing of problems in terms of psychological concepts or theory. For example, Lisa wrote of Anne's "tendency to externalize inner conflict," and the expression of this in occasional "paranoid feelings." She quotes Anne as saying that she is fearful that "someone will be convinced that I am a dangerous person who needs to be controlled" and interprets this as possibly the result of "inner, destructive impulses which she [Anne] wants to be controlled." The idea of an "inner"

impulse being expressed as an external event or fear would probably be described by this therapist as a psychoanalytically-derived concept. The use of this concept in this case report also serves to expand on the description of the problem, saying much more than if the writer had chosen only to say that paranoid tendencies were noted.

Another example of psychoanalytic theory found in Lisa's reports about Anne was Lisa's description of Anne as "fearful that her own power has the capacity to 'hurt and destroy people,'" and her interpretation of this as possibly related to "infantile omnipotence" and "anger towards failures in early caretaking." These too, are concepts from a psychoanalytic view of intrapsychic dynamics, in this case most likely an object relations view.

Other examples of this kind of use of theoretical concepts or words to describe and expand on descriptions of problems were noted, although few used quite as much psychoanalytic terminology as did this writer. One such example was seen in the case of Thea, an 18 year old woman who was described as having the problem of "splitting," which is described as her being "unable to integrate the positive and negative experiences she has had with her father." In the case of Jane (case 1), the first therapist described Jane as talking "about sex as a defense against more sensitive issues," as having "a pattern of constantly trying to induce other people to act as authority figures

by forcing them to set limits on her behavior," and as a person who "acts out her internal conflicts instead of putting them into words," all similarly, psychoanalytic concepts which help to expand and refine the problems being presented.

In cases that are not psycho-analytically based, these ways of expanding on dynamics through the use of theory are harder to spot, but seem to be present as well. In this clinic at the time of the study the majority of cases could be described as broadly psychoanalytic or broadly cognitive-behavioral. In a behaviorally oriented case, the case of Leighann, this kind of use of theory could be noted as well.

Leighann had come to therapy at the PSC because of a chronic pain condition, and was assigned to a cognitive-behavioral group as well as later, to an individual therapist. In reading this set of individual therapy reports, written by a therapist who was supervised on a "behavioral" team, it seems that the symptoms are more clearly delineated than in some other reports, and that the progress of these symptoms was more clearly noted. In one report the therapist wrote that Leighann had made a "functional connection" between her pain and a "recurrent mental image" and went on to describe the image and the ways that Leighann felt she used the image for management of her problem. In another report the therapist wrote that "particular attention has been paid to Leighann's reaction

to anxiety inducing events in her life" and went on to list the events and the physical symptoms that were related to them. In this way, it seems that a very different kind of theory can also lead to the writer using the theory to help focus the elaboration of a problem.

The Search for the "Underlying" Problem. A related kind of expansion of problems seen in these reports is what might be seen as the therapist's search for the "true" or "underlying" problem. The therapist gets only certain information at the beginning of therapy, and works towards having a fuller picture of the client's dynamics through the course of therapy. The successful finding of an "underlying" piece of the client's problems may be rewarding not only for the therapist and client in their work, but also to the therapist as a supervisee, looking to have a deeper understanding of the case to share with a supervisor. This kind of search is most common, of course, with psychodynamically trained therapists, but seems to be present in a wide variety of cases.

This search for the "underlying" problem was seen in the set of reports about Anne. The set of reports were written with a generally psychodynamic perspective, and include lengthy depictions of Anne's personality dynamics as understood by the therapist. As described above, a repeated theme in the reports is about Anne's style of relating to others, being on the one hand to act "strong

and invulnerable" and that this is a "veneer" designed to protect her "from feeling hurt or uncared for". A later report mentions Anne's fears that "her own power has the capacity to hurt and destroy people," which the therapist says "may be related to infantile omnipotence and/or anger towards failures in early caretaking." This report also discusses Anne's inner sense of "fragmentation and depletion," which was used to help understand and more fully describe the personality dynamics mentioned above. The therapist went on to write at termination that this concept of "inner depletion" was one which Anne should get help with in any future therapy. This progression of ideas from an interpersonal style to an "inner" experience is one way that therapists seem to document their search for the "true" or "underlying" problem.

Other reports also included specific mention of "underlying" problems which seemed to explain current difficulties, or which seemed to be pointed to by the therapist as a "root" of the problem, hence the area which ultimately needed to be addressed for any progress to occur (again, from a psychodynamic perspective). An example is the set of reports about Josephine, who entered therapy for depression and confusion related to a recent crisis. The therapist repeatedly mentions Josephine's "unacknowledged anger." At one point in the therapy, Josephine is reported to be beginning to realize "that she has lived with a lot of fear and anger" and to be beginning to "take steps in

showing these to [the therapist]." The therapist also wrote in the termination report about Josephine's sense that she was "defective," which was described as a feeling that was "underneath" other kinds of feelings, such as feelings of increasing "competency and success."

Another set of reports that show this pattern are those written about Jane (case 1), where the therapist notes underlying issues as well as a search for the "origin" of the problem. At the time of intake, Jane was described as having a tendency to get "moderately depressed," as well as wanting to work on relationship and career issues. When the initial psychotherapy summary was written by the first therapist, she noted "a low sense of self esteem" as well as other particular issues about relationships. By the time of the first progress note, five months later, the therapist wrote a "current formulation" that included the statement: "Underlying Jane's self-assured appearance is a low self esteem and lack of self confidence," which the therapist also linked to issues with authority figures. The therapist went on to note in a section entitled "future treatment plans," that it would be "important" for the therapy to "explore the origin of her low self esteem," a statement which was reiterated in her termination note, one year and three months into treatment. The subsequent therapy with a transfer therapist seemed to focus more on other, more interpersonal issues, and did not comment further on the "origins" of Jane's problems.

Linking Together Concepts as a Way of Reformulating the Problem. Another part of the process of problem reformulation can be seen as the tying together of disparate parts of the client's presenting problems, symptoms, and history. For example, Linda (Case 3), is described as being depressed at intake, and to have certain patterns of interacting with others. These are not clearly linked in the intake, but after two months of therapy, the progress report written by the therapist includes comments that do tie these together, as she is noted to chose certain types of men, but that when "her need to feel secure isn't satisfied, she becomes depressed". The ideas about her problems are also tied to her early familial relationships. In the second progress note, five months into treatment, her style of focussing on "what others think of her and what she should be" is noted to be related to her relationship with her mother.

In the case of Elizabeth (case 2) the presenting problems were tied together at intake, and continued to be discussed as being tied together further in later reports. At intake, the report included the idea that Elizabeth's "moderate weight problem" was "symptomatic of emotional issues" which referred to her "routine bouts of moderate depression." In the initial psychotherapy summary, the therapist, Don, noted that she suffered from "depression and associated low self esteem" and that these problems were related to her "weight problem" and "frustration over

the progress" of her career. The initial formulation given at this time also included mention of Elizabeth's "unrealistic expectations" and her need to learn to "assert her own needs and values" and to "express her real feelings of anger in her close relationships." In this same report Don wrote that Elizabeth believed that her "low self esteem" had been "fostered by her over demanding and controlling mother."

Later, in the termination/transfer note written by Don, he described a "noticeable change in her general self-confidence," and that "coinciding with this" was an "increase in tension with her husband." He wrote that while in the past she had a tendency to "withdraw" and to "avoid expressing anger," now she had been able to "assert her anger." In the same paragraph it was noted that she had been able to lose a "significant amount of weight," and that she was feeling better about her abilities in her chosen career. So, it seems that in this case, many of the client's issues were connected in the client's mind, and continued to be presented in this way by the therapist, and elaborated on using this style of connecting various issues.

The Shift in Goals During Therapy as Part of Problem Reformulation

While it is difficult or even impossible to separate out shifts in goals from shifts in the statements of clients' problems, some particular examples were noted of cases where the shift in goals are obvious. In some sets of reports, the statements of goals made along the way seem to be part of the problem reformulation, as the statement of goals seem to crystalize what the problems are in a more clear way than the initial statement of problems.

An example of this restatement of goals as part of problem reformulation was seen in the case of Suzanna, a 29 year old woman seen in therapy by a male therapist for one year and four months. At the time of intake Suzanna was described as feeling "worthless," a problem which she related particularly to the problem of academic accomplishment. She also was noted as having a "history of questioning whether she existed," and looking "for external proof" of her existence. The goals for treatment stated in the progress note by her therapist after three months of treatment were as follows:

> "The short term treatment goals for Suzanna are to allow her to feel comfortable and at ease in therapy while focusing more on the role she plays in relationships. The long term treatment goals for Suzanna are for her to generate a greater sense of her self so that she can find some meaning and purpose in life."

While these issues are alluded to in the original statements made in the initial intake report and initial psychotherapy summary, this is the first time that the therapist commented on her need to focus on the "role she plays in relationships" as a therapy goal, and her need to "generate a greater sense of self." In this report, it was only in the section on "goals" that the therapist brought together these ideas about the client's problems.

A similar restatement of goals which seems to capture a sense of the problems seen by the therapist was seen in the reports about Thea, an 18 year old woman seen in therapy by a female therapist for just under one year. At intake Thea was described as seeking therapy for problems relating to "problematic relationship patterns," "inability to trust others," and "strong issues around power and control". In the initial psychotherapy summary, the therapist working with Thea re-summarized these issues, then stated the goal that "treatment will also address Thea's issues surrounding the development of her identity". This was also the way that the writer framed the initial formulation for the case, stating that "Thea is in the process of working through issues of identity and intimacy." The termination note also included this theme, stating that "during the course of treatment we focused upon Thea's fear of intimacy...," so it seems that this restatement of the issues became a guiding idea for the subsequent therapy.

In the case of Josephine, a different pattern of problem and goal formulation was seen in the reports. Josephine, age 22, was seen for intake at a point of crisis in her life, precipitated by a stressful inter-personal interaction at work. The intake provided very little information about what her "problem" might be, although it noted that she had "felt depressed" and that she was sexually abused as a child. The report instead focused on the immediate crisis and the process that led to her being referred for individual therapy. Consequently, it was not until the later reports that the therapist worked at defining what Josephine's problems might be and making statements about goals for the therapy. While Josephine was subsequently seen by this therapist for three years, the reports do not have one clearly stated problem or set of goals, or even a set of problems and goals, perhaps because of this complicated beginning, and perhaps because establishing the nature of Josephine's problems was one of the goals of treatment. Relationship issues such as a "caretaking" role, "abandonment issues" and anger were brought up, as were, again, issues of identity and the consequences of being a survivor of childhood sexual abuse. The goal stated in the initial psychotherapy summary was for Josephine to "gain a fuller understanding of the impact of her past on her current functioning" as well as developing the therapeutic relationship.

A different form of restatement of goals occurred in the reports about Anne (case 4). While Anne came to the intake with a stated problem about her weight, the intake worker wrote that Anne understood her problem "to be related to her style of cutting off feelings," and that Anne noted that she "has been able to lose weight and she doesn't feel her problem is 'behavioral.'" The initial psychotherapy summary restated this shift in emphasis, noting that Anne's "original motivation" for therapy was around her weight, and going on to explore other, more interpersonal and intra-psychic problems that might be part of Anne's problem. The remaining reports did not discuss weight at all, but focused instead on these other problems.

A similar shift at the beginning of therapy occurred in the case of Ben, a 26 year old man who was seen in therapy by a male therapist for about nine months. Ben presented his problems initially to a female intake worker, and stated that his problems were "mood swings", "self deprecation" and "relationship difficulties." In the IPS, written by the male therapist, the therapist notes that Ben is particularly concerned with his "sexual performance with women" including a history of premature ejaculation. In the course of the first few sessions, however, Ben and the therapist worked out a treatment strategy that would "defer treatment of his sexual dysfunctions and [would] instead be a more interpersonal and exploratory examination of his low self-worth, conflictual feelings regarding his family, and

interpersonal difficulties." As reported in the initial psychotherapy summary, this was a strategy that Ben "agreed to". The issue of who suggested this strategy and how each participant felt about the shift was left unstated in the reports.

In the previous two examples, it seems that the client and therapist agreed that a shift should take place that would allow the client to work on a certain part of their problem(s), while deferring treatment of other issues. In both cases the shift led to a more interpersonally oriented view of the client's situation, and thus to a therapy that could more easily use transference as a vehicle for change. A broader implication of this shift the client's initial presentation was reformulated to fit a theoretical perspective which could allow the therapist to work with the client in the way that the therapist felt appropriate. This could be either because of previous training, current supervision, or because of the idea that given a diadic situation, interpersonal work would be most helpful.

Other kinds of shifts toward a particular therapist's theoretical orientation may take place. One set of reports that seems to show some shifting of the initial goals, (which could be because of theoretical orientation) were those written about Cheryl, a 32 year old woman seen at the PSC for one year and eight months. Cheryl came to the PSC looking for help with "major adjustments in her life" as well as problems with family relationships and low self

esteem. The initial formulation written by the therapist for the initial psychotherapy summary states that Cheryl has never "acknowledged and worked through her feelings about her mother and her death", the death of Cheryl's mother at age five not being mentioned in the intake report. The "plan for treatment" also includes this theme (grieving the death of her mother) as the central one, in the context of an "insight oriented, psychodynamic therapy".

Changes in Client Symptoms, Self-reported Problems, and New Information

In some sets of reports about clients, symptoms or specific problems described by the client (as opposed to formulated by the therapist) seemed to disappear or, conversely, to emerge as the therapy progressed. In this section, issues which come up suddenly or disappear entirely will be examined.

Relationship Difficulties which Emerge During Therapy. As noted earlier, during the course of these therapies, clients reported, and therapists wrote about, changes in the status of romantic relationships the client was involved in. While some clients written about in these reports began new relationships, usually the beginning of a relationship is not seen as a "problem" so will not be

addressed here. Overall patterns of changes in relationship status in the larger sample of 92 cases have already been addressed in Part I of the results. As in the larger set of reports, several in the smaller sample did include mention of relationships becoming increasingly difficult, or ending entirely.

In the case of Linda (case 3), the reports note a new relationship beginning at the same time as the therapy, and at a certain point the relationship begins to become problematic, and several paragraphs are devoted to discussing the problems in this relationship. Similarly, in the reports written about Thea, the writer notes that Thea, who was involved with a man for about a year when the therapy began, reported that the relationship was "beginning to fall apart." In a later note, the therapist wrote that Thea had moved out of the house where they had lived together, and some comments were included about Thea's evaluation of the dynamics of the relationship.

Elizabeth (case 2), a 30 year old woman seen by two different therapists over a period of almost three years, was a client whose reports did have extensive information about a relationship change. The intake report stated that Elizabeth, married for six years, described her marital relationship as "very close," with some "strain" in the relationship due to the recent birth of their second child. Her presenting problems had to do with "moderate depression," low self esteem, and concerns about weight.

The IPS by the first therapist for the case noted "good communication" with her husband, with "minor conflicts" but which they were able to "resolve them shortly". No further mention was made of the marital relationship until the termination note by the first therapist, ten months into treatment, when the therapist noted "an increase in tension with her husband", seemingly related to an increase in Elizabeth's self confidence. The second therapist, also a male, did not note marital issues until the third progress note he wrote, ten months after the transfer. At this point, he commented that Elizabeth "threatened to leave the (marital) relationship" when she "became angry at [her husband] for criticizing her." From this point on, the reports include mention of the dynamics between the couple, for example Elizabeth's "fear of [her husband's] anger," and that her "attempts at assertiveness..." "have improved the quality of her relationship" with her husband. By the termination note, the therapist describes Elizabeth's "difficult relationship with her husband" and that during the final phase of therapy she experienced the "greatest lows in her relationship with her husband". It seems from this report that Elizabeth and her husband stayed together despite these difficulties, although follow up data is not available.

In the case of Cheryl, a more extreme change in relationships came about during the course of therapy. When Cheryl began therapy, the intake report mentioned that

Cheryl "alluded to some problems in the marital relationship," with no further information noted. At the time of the initial psychotherapy summary, Cheryl's therapist wrote that she was "confused about whether or not she wants to remain in the marriage." The therapist also noted that Cheryl was "facing major decisions concerning her career direction and her marriage." By the time of the first progress note, five months after the initial intake, the therapist wrote that Cheryl "talks as if they will split up eventually although she does not envision this happening until their son is older." Surprisingly, then, the therapist made this statement in the same report, summarizing the treatment goals: "issues which she has not extensively addressed concern her feelings about...her husband/marriage." The therapist continued, however, with the prediction that Cheryl "will have to deal with attempts by her husband...to sabotage her progress." In the following note, five months later, the therapist wrote that Cheryl "was quite certain that she wanted a divorce" but that "she remained unwilling to take any immediate action." Apparently during this period the therapy also shifted to an every other week basis, and Cheryl was reported by the therapist to have stated "very bluntly that she was not ready to consider her relationship with her husband" in the therapy sessions. Seven months later, in the next progress note (after a "summer off" and a return to therapy in the fall), Cheryl had "become romantically involved with

[another man]...and had only recently...told her husband." Her husband apparently "immediately moved out" (this had occurred during the break in therapy). At the time of termination, five months later, Cheryl was still separated from her husband, and was planning to live with the man with whom she had become involved. While this was not the only focus of therapy, this issue of current relationship changes became one of the foci, and one that could probably not have been predicted by the initial intake report.

New Symptoms or New Information which Emerges During Therapy. Some sets of reports do note new symptoms or new information about the client after the initial intake report, which had not been mentioned previously. This might be because it had not been observed by the therapist, because it had not been labelled (and written about), or perhaps because the symptom, issue or new information emerged only in the course of treatment.

One such case is that of Suzanna. She was noted at the time of intake to have questions about "whether she existed" and some problematic dynamics with others. While some of her earlier symptoms were expanded on, two new areas were raised during the course of therapy, although neither seemed to become the focus of treatment. One was the description by the therapist of her tendency to "dissociate from her feelings and retreat into her fantasies." Another was one that related to her earlier

difficulties with school; during the therapy she reported to the therapist that this had escalated and that she suffered "from something like 'word phobia'," although this was not elaborated on further.

In the case of Anne (case 4), the reports written after intake include mention of a new symptom, a "paranoia", which was not identified until about three months into treatment. This example may or may not have been one of a new symptom, as this may also be a case of the therapist reformulating behavior which she had seen previously, and only at this point named "paranoia."

Certainly, in some cases, events or problems that were known to the client come up only after a considerable building of trust with the therapist. This was noted in the reports about Leighann, who was in therapy with two different female therapists for a total of two years. After four sessions with her first therapist, Leighann began to reveal the fact that she had been sexually assaulted by a stranger three and a half years previously. This was noted in the first progress note (the second report written by the therapist), and was written about as playing a part in "current marital difficulties" the client was experiencing. In the following report, written by the therapist five months later, the topic of the sexual assault is incorporated more fully into Leighann's set of problems, as it was noted that the assault occurred just prior to the onset of the particular problems she was seeking therapy

for. The therapist noted however, that Leighann was "unwilling at this point to discuss the sexual attack", and it seems from the reports that she did not discuss this event further with this therapist or the transfer therapist. However, the symptom of chronic pain which brought Leighann to therapy were noted to disappear at the same time that the first report noted that she revealed that this attack had occurred.

In the case of Josephine, a "potential rape attack" occurred after she had been in therapy for about two years. This event brought up issues that had been part of the therapy all along, since she had been the victim of childhood sexual abuse, but in a sense constituted a new "problem" as she worked through the feelings about this event.

The case of Jane (case 1) reveals a quite interesting pattern in terms of a new symptom or new information appearing well into the therapy. Jane was seen by her first therapist for one year and three months, then transferred to another therapist. The second therapist then saw her for a little over one year. In the first report written by the second therapist, she noted that Jane said in the very first session after the transfer that there was a problem that she had been "too embarrassed" to tell her first therapist: that for "many years" she had been stealing from stores, work, and family. Interestingly, several earlier reports from the first therapist include mention of items

being stolen by others, although with no indication that Jane herself may have been involved. Over the course of the second therapy, Jane's therapist wrote three reports, none of which indicate that the therapy focused specifically on helping Jane stop the stealing, although stealing was discussed in the context of her other (interpersonal) problems. In the termination report, however, the therapist noted that Jane had "not felt any more urges to steal."

Problems which Disappear After Beginning Therapy. Most definitions of therapy would probably include the idea that the client's problems should improve over the course of the treatment, although the mechanism of "problem reduction" would vary widely across different theoretical models. What was interesting to note in this sample of reports was that at times problems seemed to "disappear" from the reports, rather than being included by the therapist as a particular improvement in the client's condition. It may be that the therapists were unable to explain the improvement and reluctant (being beginning therapists) to claim that their methods had been the cause. What came across in the reports in these few cases, then, was simply that the problem had faded in importance, and often, that other problems or symptoms had taken the place of the original ones.

The reports about Jane (case 1), discussed above, showed a pattern of including a problem at the beginning of the therapy which seems to play a less important role as

the therapy progressed. At the time of the initial psychotherapy summary, Jane's problems included health concerns, which had significant repercussions in her sexual relationships and self esteem. In a subsequent report, the therapist noted that Jane has "significant fears" that others will find out about her health problems and "spread the news." During this period, Jane stopped therapy, returning after several months with several "complaints" including that "she had not gotten over [her] problems" with her health yet. One year into treatment, Jane was transferred to a second therapist, the one to whom she felt more comfortable disclosing her compulsion to steal. Three months into this second phase of therapy, the report written by the second therapist noted that Jane "was struck by the realization that [the health problem], along with a low self opinion due to it, was no longer her major concern." While Jane continued to have health problems during the remaining therapy, she was noted as saying at termination that her condition had improved, and that she "attributes this to her decreased level of stress, and therefore feels a degree of control over [her health problems]." So this may be seen as a therapeutically induced improvement in her medical condition, or perhaps as a symptom that propelled her into therapy, but which improved, leaving her able to stay in therapy to deal with other issues.

A similar pattern was seen in the case of Leighann, discussed above. She was seen originally in the PSC because of a chronic pain condition, which was noted to be improved by the first progress note, written only four sessions after therapy began. The problem did not recur, and the therapy was instead focussed on other issues (i.e., lifelong depression and marital issues).

Several other case histories showed this pattern of the "receding problem" which seemed to have a variety of courses and possible explanations. In the case of Linda (case 3), her initial complaint of depression was no longer mentioned in subsequent reports as the focus of discussions, but rather to explain why she had entered therapy. In later reports it is discussed that she has a problem with "hiding" her depressive feelings from others, and this is linked in with recurrent relational style issues.

In the cases of Ben and Anne, a different pattern emerged, where the goal of the therapy is restated from the beginning, moving away from particular areas of concern that the client brought to therapy. For Ben the issues of concern were shifted from sexual problems to interpersonal problems, and for Anne the shift was from weight problems to interpersonal and personality issues. In these cases subsequent reports did not return to the original concerns as "problems" that the client needs to work on, nor do

these writers comment on any progress on these issues in later reports.

Patterns Noted in Cases of Female Clients who "Choose" Certain Kinds of Male Partners

In reading the larger set of 92 cases, I was struck by a recurring theme in certain of the cases, that involved clients who were reported to have a pattern of "choosing" certain kinds of romantic partners. This occurred in some cases as part of the initial presenting problems, either as a statement made by the client, or a formulation developed by the therapist based on information from the interview. In other cases this was described as a pattern that was uncovered later in the therapy, one that perhaps indicated a kind of interpersonal style. Often these patterns were seen by the therapists as relating to early family issues. In this set of reports, these issues also often were tied in with current romantic relationships (during the therapy), as this group of reports were ones where the client was in a relationship, ending a relationship, or beginning a new relationship during the therapy.

From the original 92 cases, about 15 cases seemed to fit this pattern (16.3% of the sample), and this group of 15 cases included 13 women. Of these cases, six were selected that represented this theme, and several of these will be discussed here in detail. The specific kind of

patterns of problematic relationships described in each case varies somewhat (e.g., "unreliable" men, "unavailable" men, "father figures", etc.), but what was seen as similar was the way that a formulation was developed (by the client, or by the therapist and client together) that included the idea that it was the client (mostly women, and all heterosexually-identified clients), who was seen as perpetuating an internally-driven problem through the choice of certain kinds of relationships.

Linda (case 3), a 24 year old woman seen in the clinic for about a year and a half, was one such client for which a "pattern" in choices of romantic partners was noted at the time of intake. The intake worker wrote that Linda herself "noted a pattern of attraction to men who are 'independent, charming, and don't need people - like women'." She was also noted by the intake worker to have said that "there is a pattern with men worth exploring." The IPS then restated this problem, that she is "continually searching for a strong and independent man on whom she can depend," and gave an example of a previous relationship with a "man whom she characterized as independent, perfect, and never needing anyone." This was also related to other broader issues about relationships, as Linda was noted by the therapist to "feel that one is in a very vulnerable position if one needs other people."

When the first progress note was written about Linda, three months into treatment, the therapist noted that one

content area of the sessions was Linda's "relationships with men." This note was written after Linda had briefly dropped out of therapy and then restarted when a current relationship was "falling apart." At this point the original pattern was restated, but expanded to include the statement that she chooses men who "appear emotionally strong, but are really oversensitive and unable or unwilling to commit themselves to a relationship." The therapist also described the pattern as one of "choosing undependable men" and related this to Linda's "growing up with an alcoholic father, a man on whom she felt she could never rely."

After several more months of therapy, the therapist's next progress note included the comment that Linda "continues to talk about her [current] love relationship...in every therapy hour," a relationship which Linda apparently called "abusive," yet which she wanted to remain involved with. The therapist wrote in this report that "throughout the course of treatment, efforts have been made to link her ungratifying relationship with this man to similar relationships in the past as well as to the current therapeutic relationship." The therapist also notes that a goal of therapy is for Linda to "gain a better understanding of her feelings and of why she enters into ungratifying and painful relationships" and that this will "require a further exploration into her relationship with both her parental figures."

At the time of the next progress note, nine months into the therapy, the focus had shifted even more onto this "pattern" in Linda's relationships as a central concern. The therapist noted that Linda had made "progress in understanding how she relates to other people" and that she had "realized on her own, that she has established a pattern of becoming involved in ungratifying and abusive relationships with men as well as women." The therapist described that Linda "seeks out those people who are confident, arrogant, critical of her, and not interested in making a commitment to the relationship; or she becomes involved with wonderful men who are engaged to be married to someone else or who are seriously involved with another woman." The therapist went on to say that Linda "has come to realize that she becomes involved with [this type of man] because it is 'safe', that is, she doesn't have to worry that the relationship will develop into anything closer." This description of a broader style of problematic relationship pattern continued, and then the therapist noted that Linda "continues to perpetuate" this "maladaptive behavior" by beginning a relationship with a man in another state. The goal of therapy at this point continued to be for Linda to "recognize and understand this pattern of seeking relationships in which it is impossible to become close."

In the next report, written after a year and two months of therapy, continued to state Linda's progress in becoming aware of this "pattern." Now the statement of the

pattern was that Linda "chooses a certain type of man with whom to become involved -- a man whom she feels is superior to her in terms of [work]; and a man who has a tendency to maintain emotional distance from her, either due to his discomfort with getting too close to her, or due to the external constraint of an already existent partner." During this time, Linda began and ended a relationship with a married man, apparently ending the relationship because she "saw the pain that she would endure with this man."

The termination report written by the therapist for this case resummarized the nature of this pattern and the ways that Linda would deal with the problems in these relationships with men who were "not interested in commitment" as well as "arrogant and inconsiderate". The therapist also wrote of efforts to discuss with Linda possible links to her relationship with her father, while Linda apparently "would resist such comments," "preferring to view these relationships as random unfortunate experiences". This termination report commented on a new relationship that Linda had entered into prior to the end of therapy, with a man who was described as "different from the other men with whom she has been involved", as he "apparently treats her well, wants to take care of her, and adores her." The therapist apparently saw the new relationship as a "positive change" for Linda, and noted as well that Linda was "beginning to see herself as an active agent

in these relationships and to discover what she really wants out of relationships."

Another case in which the idea of a problematic "pattern" of heterosexual relationships was noted at intake was the case of Thea, an 18 year old woman seen at the PSC for eleven months. The intake worker wrote in her report that Thea was "seeking therapy to explore and change problematic relationship patterns that she sees are related to family dynamics." Later in the report, these patterns are noted to be patterns with men, and her current relationship with her boyfriend of one year is given as an example. Her problem with him is noted to be one of being unable to "open up to him and trust him," as well as "issues of power and control." The first report written by the therapist for this case reiterates the original problem, and adds that Thea "has found herself acting like her father in her relation-ships by being manipulative and making others feel guilty." The therapist also wrote that Thea "reports being in constant need of male attention and approval in order to feel good about herself," as well as "a pattern of getting sexually involved with men without developing emotionally based relationships with them." In a similar way to the pattern described about Linda, Thea is described as being "concerned about her pattern of being attracted to men who are not interested to her." Five months later, the therapist wrote in her second report about this therapy that Thea had ended her relationship

with her boyfriend. The issues in this relationship were discussed in terms of overall patterns in Thea's life, including her fear that she would be "destined to repeat old family patterns" and a general "fear of intimacy", as described by the therapist. Thea, like Linda, was noted at the time of termination, to have started a new relationship, which was somewhat different. The therapist noted in the case of Thea that this was "the first time that she feels that she is really good friends with the person she is seeing," and that she "doesn't feel inferior" to her new boyfriend. Likewise, Thea also was described by the therapist as having explored the implications of this pattern, and "specifically, Thea examined the ways in which her unresolved relationship with her father influenced her need to have power and control in her interpersonal relationships with men."

While the particular dynamics of the "relationship pattern" were seen to differ across cases, the kinds of statements made by therapists about the client's need to recognize and change the pattern were strikingly similar. These sets of reports included comments by therapists about how clients needed to recognize the "role" that they played in relationships, and to see how these patterns reflected early familial roles as well as, often, the kind of roles played by therapist or client in the therapeutic relationship.

Another example is the case of Josephine, a 22 year old woman seen in the PSC for three years. Josephine did not mention "patterns" in relationships as being a problem at the time of intake, however, certain patterns were noted in the IPS written by her therapist. Josephine was described as playing a "caretaking role" in relationships with men and of being involved with men who were "lacking 'what was underneath' in terms of their abilities to deal with emotions or problems". The therapist went on to describe Josephine's perception that she "taught her lovers 'how to love,'" and that these men would "bolt" when she herself revealed that she had problems. The therapist also wrote that Josephine felt that she "has always had to give up parts of herself in relationships and has not found men to be able to share as she would like." In a summary section, the therapist described Josephine as having a history of "being involved in intense dependent relationships".

In later reports about Josephine, these dynamics were expanded on, and included the idea that Josephine felt that she had not had her needs met in relationships, and that she had felt "abandoned" by lovers when she "let her vulnerability surface." Josephine was also noted by the therapist to be "beginning to fear that she is attracted to men who will be abusive to her" and thus ended a newly forming relationship with a man. A year and a half into therapy, the therapist noted in a progress note that

Josephine "thinks she gets involved with self-centered men whose worlds revolve around themselves and then centers her world around them also." In this therapy, the reports seem to indicate that the therapeutic relationship was the primary way that these issues were discussed and worked through, or at least this is the main topic of the reports written by the therapist.

The reports about Cheryl, a 32 year old seen at the PSC for a year and eight months, also mention a concern about problematic relationship patterns in the intake report. In this case, the initial statements about this are quite vague, stating only that she had "repeated patterns in relationships that she finds problematic." The first two reports written by the therapist in this case went on to discuss the marital problems that Cheryl was currently facing at the time, as well as familial issues, but did not mention the idea of "patterns" in relationships. This came up again in the third report about Cheryl, written after Cheryl had been in therapy for eight months. Here it was noted that Cheryl had "discovered a pattern in her relationships with men," and that this was part of "acknowledging that she never got anything from her father" and that therefore she "realized that she essentially sought a 'father figure' in her men." The pattern noted was that she "repeatedly got involved with men who could/would take care of her and also provide her with some element of excitement." While these particular dynamics were not

mentioned again in the remaining reports, the final two reports did include discussion of Cheryl's use of a "facade" to "maintain control and a safe distance from others." This was discussed in terms of the therapeutic relationship, and the patterns discussed earlier that had to do with men were not discussed in the reports, although Cheryl had by this time left her husband and started a new relationship.

One other case also included mention in the intake report of a client's concern about "relationship patterns with men." This was the case of Elise, who was a 26 year old woman seen for eight months by a female therapist. While a particular pattern of choosing certain kinds of men was not described in the intake report, the intake worker did note that Elise was "not happy" with her "intimate relation-ships" in that she "feels she has not learned how to identify her own emotional needs in an intimate context." Elise was also described as being involved with a married man.

The IPS written by the therapist included a plan for treatment which said the therapy would "explore the parallels between Elise's family interactions (both past and present) and problems in her present relationships and way of life." The therapist went on to write that "it appears that certain set ways of experiencing relationships prevent her from enjoying mutual, caring relationships."

The first progress note about Elise included the therapist's evaluation that Elise had a "tendency to triangulate relationships", with examples about the relationship between Elise and her two parents, as well as with her lover and his wife. The therapist elaborated on this by writing that "for Elise, triangular relationships seem to offer the semblance of intimacy while also presenting a convenient mechanism by which to externalize the roots of difficulties in the relationships," and that these sorts of relationships also provide the potential for distance from dyadic intimacy when that becomes difficult." The termination note written by the therapist about Elise summarized the problem a different way: "Elise has a pattern of leaving potentially intimate situations when she begins to experience any closeness or dependency in them." This report focused primarily at this point on the termination of the therapy, and did not relate this pattern particularly to relationships with men. The end of the report did include the suggestion that Elise may want to continue the therapy at another time, and that in particular she "might also seek to explore further the problematic relationship patterns she is prone to and their analogues in her family history." The final suggestion made by the therapist was that "more dialogue could be especially useful for exploring her tendency to seek out men who are, for one reason or another, unavailable to her."

The case of Suzanna also included similar ideas, although they were less elaborated on than the cases mentioned above. In the intake report written about Suzanna, the intake worker mentioned that Suzanna "describes never feeling very 'connected' to anyone on a deep level," as well as her fear that she will be "abandoned" by a current boyfriend. The IPS written by her therapist notes that her relationships have "tended to be superficial," and a later note written by this therapist said that the therapy was "focusing more on the role she plays in relationships." The termination note for this case was quite brief, but mentioned that Suzanna had made "a great deal of progress" in therapy, including in her "social life" and went on to note that she was planning to be married in the month following termination.

Other Issues

In reading the larger sample of 92 cases, the two themes described above (problem change over the course of therapy, and issues of problematic relationship patterns in some clients) appeared as important recurring ideas across several cases, and were used as selection criteria for the smaller sample of cases. In the second part of the analysis, the smaller sample of cases was read and re-read numerous times. In going through this process, several other issues emerged that seemed to have some importance.

These issues are ones that were not analyzed in as much detail but which could be developed in further research. These ideas are presented here as ways to further understand the sample of reports, and because the questions they raise may be seen as provisos in drawing broad conclusions about the work presented here. This sample is quite particular to this setting and to the time period in which the sample of cases was seen in this clinic, although some of these issues may be of importance in considering the reports of any clinic's therapy cases.

Clients' Reasons for Entering Therapy and Leaving Therapy

In reading these case records, it seemed that many clients were described, in one way or another, as entering therapy at a point of transition, change or crisis. This may be true for most samples of clients seeking therapy. In earlier research (Jacobus, 1990), this idea was explored for intake reports, using the concept of a "stressor" as a possible precipitant for therapy. The current brief analysis of this issue, using the full records, considered more broadly the idea of the entire period of therapy as a time of change in the client's life.

For some cases, there was a "symptom" based crisis, such as an increase in depression or anxiety. For some cases, it seemed that the client was struggling with life changes and relationship changes. For some, the transition

point had more to do with choosing a direction in life, or a career. For some, the transition had to do with moving to a new area. For some cases the crisis point was a re-examination of old issues that may have been unresolved in the client's life or where new stressors brought past issues to the forefront once again. A few examples drawn from the smaller sample follow.

In the case of Linda, the intake report noted that she had moved away from her family of origin, and that she had recently started a relationship. The IPS discussed in detail her concerns about the direction of her career and seemed to indicate that part of what she was working on was the development of her ideas about her future career. In another case, a female client, Anne (Case 4), also had recently moved to the area and was noted in the IPS as feeling that her "life was going nowhere". Further reports about Anne discussed the development of an "autonomous, self-sufficient identity" and related this to struggles with her family of origin. In a third case, Thea was described as having difficulties in a romantic relationship at the time of intake. In later reports she was noted to be struggling with decisions about "work identity and interpersonal identity". Josephine, the client who came to therapy in the midst of a crisis relating to work, was described as re-evaluating how well she had dealt with issues of early trauma in her life.

As noted above, 63 of the 92 cases were ones where the client was a student during the course of therapy. It is not surprising then, that many of the cases describe struggles with the choices involved in academic pursuits, such as choosing a major, choosing a career path, or finding one's direction in a graduate program. In the smaller sample of cases examined, it was noted that many of the cases included lengthy discussion of these issues, with many finding resolution of these issues in the time of therapy. It was also noted that these issues were not presented as the major issues of the therapy, but rather as examples of the ways that the client was interacting with his or her world. For example, Suzanna, a graduate student who made changes in the direction of her studies, was described as having a difficult relationship with a professor, and her hesitation in approaching him was described as an example of her "tendency to do things more for the benefit of others than for her own". Another interesting trend noted in this very small sample was that often cases seemed to terminate around the time that the client graduated or made decisions and changes in career paths. It may be that while some cases seem to describe therapies where the client may be seeking support for relationship changes (as described in previous sections of this results chapter), some of these cases may be seeking help for career/school changes, but that these issues are down-played in some way. The reports themselves do not

highlight these issues as central to the client's need for therapy or the progress made. This may be related to the need for therapists in this situation to be looking for more "intrapsychic" or "psychological" issues to describe in reports or to work on in therapy.

It should also be noted that many of the cases in the larger sample, as well as the smaller sample, were ones where the therapy seemed to be terminated at the time that the therapist was ending her or his work at the PSC. Typically trainees worked in the PSC for one or more years, leaving in later years of training to do practicum placements outside of the University, or leaving for internship in another city or state. Given this, it is possible that some cases might have ended at different points (earlier or later) if the therapist had not made it clear to the client that she or he would no longer be available for therapy. This might mean that very different outcomes and lengths of treatments might be seen in a setting other than a training clinic.

What was Included and Not Included in this Set of Reports

Another phenomenon that was noted in examining the smaller set of reports was the extent that clients' own words were included in the text of reports written by their therapists. This varied considerably across different writers, and even reports written by one writer varied in

how much they included direct quotes. While some writers included lengthy quotes of the client's own words, some only used quotations of words or phrases, and some writers included these infrequently and instead paraphrased the clients' statements. Some writers included very little of the clients' perspective on issues, instead writing summaries of their own (the therapists') thoughts on what was going on for the client.

It was noted in several sets of reports that quotes from the intake worker were repeated verbatim in the initial psychotherapy summary, with no way for the reader to know if the client had restated the comments exactly or the writer was using the quotes supplied by the intake worker. It was also noted in the smaller sample of cases that the trend was for the first reports about a client to include many quotes, with less and less quotes appearing in later reports. It may be then, that the quotes served the purpose of showing the reader the "style" of the client's speech in initial reports, where later reports are written with the assumption that this has already been conveyed and summaries of the therapist's thinking and the client's progress are more important.

Often, reports included quotes about the client's description of parents or significant others, such as the client who "described her mother as 'beautiful and a workaholic.'" Sometimes quotes seemed to be used for emphasis, such as the client who was described as feeling

that certain issues come up in her relationship and that then the relationship "inevitably" ends. Another example of this was a case where the client was noted to be afraid that the therapist would find her problems "trivial." Sometimes quotes seemed to be used to make the point that the words were not chosen by the therapist, such as the client who described a problem with "word phobia" (not a known psychological condition), or the client who requested a therapist who is "not real stuffy". Sometimes quotes may serve to show that the writer has considered that there may be more to the client's statement than the client has been able to admit, such as the client who was described as having "let slip" secret information in her family.

The examination of quotes versus text written in the therapist's words was not done in great detail, but again, to draw attention to the great variety of kinds of reports. An important unanswered question in looking at the data on this level is whether in particular cases the client was aware of the interpretations being made by the therapist. Those cases that include quotes of the client's own statements about their growing awareness of issues can at times clarify this, but usually, these were not included. The whole issue of what was directly addressed with clients and what was kept between the therapist and supervisor (and the potential reader of the reports) was rarely addressed in this set of reports.

There were other striking examples of things that seemed to be "missing" from the reports. Few if any reports mentioned how frequently clients saw their families of origin. As discussed above, several cases left the reader unsure if a romantic relationship existed, or if an ongoing one was continuing or not (information that the therapist probably had some awareness of, whereas family of origin contact was probably unknown by a great many therapists). In one termination report, a client's father was reported as having died, but this death apparently occurred during the time period of the previous report, where no mention was made of this. This is a quite striking example of a report that seemed to have left out certain details, but many other reports were found to have other small gaps in information. Other common examples were some cases where the plans of the client at termination were left unclear (with no statement that the therapist did not know the plans), or cases where the termination report did not include a final assessment of the client's state at termination (i.e, treatment outcome and prognosis were not stated). Some of these issues may be particular to this training clinic at this point in time, where the emphasis was on therapy process, no standardized reporting was required, and the trainees were students, who may at times have been rushing to finish reports at the end of a semester.

Reports also varied in how much they focussed on the therapeutic relationship as a part of the treatment, and in how explicitly this was described in reports. Not all reports included mention of the transference relationship, but many did. Some reports mentioned this as a part of the treatment, for example as in the case of Anne. The therapist wrote in the initial psychotherapy summary that "the transference relationship will continue to be used as a means of revealing Anne's fear of being rejected by people..." Later, these issues were linked to a particular style of relating to people, which included Anne's professors and the therapist. In other reports, Anne's ambivalence towards the therapy was noted, as well as specific feelings about the therapist. In some cases, more general statements were made, as in the case of Thea, whose therapist noted that she was "shy and reserved." A later report noted her becoming more "comfortable in the room, but the termination report commented on her "difficulties in trusting others" and went on to note that this pattern was "evident in the therapeutic relationship as well." Some reports went much further in exploring the traditional use of the transference relationship, as was seen in the case of Suzanna. Her therapist, a man, noted that Suzanna had become "very flirtatious" and reported that she had confided in him that she had "fantasies" of various kinds about the therapist. In the case of Josephine, a client who was seen over a period of three years, the reports included

a great deal of information about the transference relationship. The issues of trust, caretaking, and wanting a "two way" relationship were discussed in the first several reports. The client's "chronic lateness" was discussed as part of the therapeutic relationship. In the termination report about Josephine, the therapist expanded on her thoughts about the termination, speculating (the therapist's term) that a "contributing factor" in the termination was a "bind Josephine felt in the transference," having to do with Josephine experiencing the therapist as "needing her as had her mother." As noted above, there was great variety in how much or how little therapists wrote about these kinds of issues, but this may also be an important part of the discussion of an analysis of these kinds of therapy reports, and of the discussion of clients' relationships during therapy.

The Effect of Supervision

An important feature of the training clinic is the fact that all cases were supervised by faculty or advanced graduate students also under the supervision of faculty. The majority of cases were also being presented, at one time or another, in a group supervision situation. It is also important to note that therapists engaged in long term therapy cases were often switched from one supervisor to another during the course of these longer term cases

(supervisory relationships usually lasted for one academic year, with switches made in the summer or fall semester). There is no way to know specifically how the supervisors affected the work going on with the client, but certainly there was some effect. The reports also were influenced by the supervisory process since the reports were submitted to, and approved by the supervisors. Few cases made any mention of the effect of supervisors directly, and it is difficult to tell from the reports how the supervisors and changes in supervisors affected the accounts included in this study.

Only one of the cases in the smaller sample included, in one report, mention of the effect of supervision. In this case, the therapist wrote that a new interpretation was made to the client "after a team presentation where many of the events and discussions of the summer were reinterpreted..." It was also interesting to note in this report that the client responded to the interpretation with the request to work on a "family genogram", since the "team" in question was one led by a family therapist. The report did not mention what information the client was given about the effect of supervision, if any.

In other cases, one can only speculate about the effect of supervision and supervisory changes. In the case of Linda, for example, the researcher noted that after a change in supervisors, the therapist began writing about Linda's "conflict about being a woman and about being

around women," a topic not addressed in previous reports. In another case, a report from the summer months describes the treatment relationship as "stormy", then shifts to describing the fall period in the next report as becoming "productive," at the time when the therapist had shifted to a new supervisor during the summer, then shifted back to the previous supervisory team in the fall.

CHAPTER 4

DISCUSSION

The original goal of this study, to look at the documentation in case reports of current relationships of clients in long term therapy cases, was expanded upon considerably during the course of this exploratory research project. Several interesting themes seemed to recur in the presentations of cases in these reports, including the elaboration and change of problems over the course of therapy in many cases, and the discussion of patterns of relationship difficulties in a smaller set of cases. Several other general ideas about the reports emerged as well over the course of reading and re-reading the case reports.

The discussion of the results of this study will be presented in the following order: First, I will discuss the original questions about current romantic relationships, as they are described in case reports, as well as the changes seen in these relationships, and the implications of these findings. Next the issue of problem re-formulation and expansion over the course of therapy will be addressed, with implications for outcome studies and psychotherapy in general. The following section will discuss possible explanations for the finding of a set of cases where clients (primarily women) were described as seeking out certain kinds of partners. The final sections will cover

the use of this methodology--the use of clinical reports--and the ways that this study fits in with other methods of psychotherapy research.

Relationships and Relationship Status

As expected from earlier work (Jacobus, 1990), the reports contained a great deal of information about current relationships of clients in therapy. As expected also, the kind of information covered in different reports varied considerably, as did the way that the therapist used this information. As described in the previous study (Jacobus, 1990), some therapists use relational information as introductory material to give demographic background, while others rely more on this information to give depth to the nature of the client's problems as the therapist has conceptualized them. In some cases the relationship issues are central to the presenting problems and at times these issues are more peripheral. The goal of this study was to expand on the original findings from intake evaluation reports to the entire case record, and to look at changes in relationships over the course of treatment.

The overall finding was that most cases showed signs of transition and change in the nature of current relationships. This was discovered through a process of beginning with the most obvious changes (marital status) and progressively including more subtle changes (e.g.,

endings of romantic relationships, marital problems). This process will be summarized briefly here.

As in the previous study, problems were found in the coding of marital status. While the examination of a set of reports documenting a long term therapy (as opposed to one short report written at intake only) at times added considerable information for making these decisions, at times the coding only became more complex as more information was added. The general conclusions to be made from this data include the idea that marital status is a much more fluid variable that might be expected, in that many people in therapy are in the process of changing marital status, or in complex situations in regard to their current status. This may be due to changes in American society, where many more people change their marital status than in the past. A further implication is that our ideas of "marital status" have not changed as quickly as society has and may need to be greatly modified for research purposes. There was great variety in the reporting of original marital status at intake, and particularly, changes in marital status during the course of therapy. This may reflect that therapists did not consider accurate reporting at each stage of treatment as an important part of their work in writing this kind of report. Clearly, if this kind of information is important for researchers in such a setting, the therapists writing reports must be made

aware of the expectations in this regard, and systems must be set up to ensure coding of changes in status.

The coding of marital status alone was insufficient to capture the complex current relationships engaged in by the clients in this sample. This led to the re-coding of the cases on the basis of "current relationship," which included information about romantic relationships that did not include marriage or living together, as well as those that did. This kind of coding was also complex, and again, writers varied in the amount of precise information they gave about such relationships. Even with the problems in categorizing and coding of such information, interesting changes were noted.

About half of the cases examined included clients who were in some kind of romantic relationship, as described in the reports written by their therapists, when they began therapy. At termination, the number of clients noted to be in relationships was somewhat higher, but even this change does not capture the full extent of the changes that were noted. Fully describing all relationship status changes led to the inclusion of many more cases where the client was reported to be ending a relationship, beginning a relationship, or mourning the recent ending of a romantic relationship. Thus, there seemed to be quite a bit of change in relationship status over the course of these therapies.

In further considering this data, it seemed that this would imply that those not specifically ending or beginning a relationship would have been ones whose relationship status was unchanged over the course of the therapy. In fact, the reports seemed to indicate that change was also occurring in the interpersonal lives of these clients. Even in those cases where the client was married at intake and stayed in the relationship throughout seemed to have considerable change or turmoil in their relationships. Some, for example, were apparently making decisions about having or not having children (perhaps a "positive" development, but certainly a transition point in a marital relationship). Some cases were described as having considerable marital conflict, including in a few cases, brief marital separations. The same issues could be seen in reports about individuals who had been living with someone for the duration of their therapies, as several of these reports noted problems in relationships or shifts in levels of commitment. The same kinds of issues arose in considering cases where the client was in a long term relationship throughout the therapy, since many of these were noted to have relationship difficulties or ongoing questions of level of commitment.

The same level of complexity was seen in the cases where, on first reading and categorization, the client could best be described as not having any lasting relationship at either the beginning point or end point of

therapy. Many of these did have shorter relationships during the course of therapy, or had very vaguely defined relationships that did not seem to fit the category of a lasting romantic relationship.

The conclusion that seemed to emerge from this re-analysis of relationship status in these cases, as drawn from the available information in reports, was that the great majority of cases did have issues included in the reports that could be considered, in a general way, to be current romantic relationship changes. This very broad definition would then include the most specific and easily identified marital status changes (changing the relationship status through marriage, divorce, or moving in or out of a residence with the partner), as well as relationship status changes that included entering or leaving a long term relationship, and a variety of other, less well defined changes, such as marital problems, decisions to have children or not, beginning and ending shorter relationships, or vaguely defined romantic relationships during the course of therapy. Comparatively, very few cases were seen that had none of the kinds of changes in relationships described above. Also, it should be kept in mind that this group might still include some who might have had shifts in relationships that were significant at the time to the client, but not reported as such in the therapists' reports.

The finding of this kind of information in this set of clinical reports has several implications. One is that this kind of open-ended narrative reporting by therapists does seem to include a great deal of information about current relationships. While the documentation of current relationships were not specifically required in these reports, and while it seemed that the reporting of relationship changes was quite varied across different writers, considerable information could still be drawn from them.

The findings of this study also support the idea that the great majority of clients seen for long term therapy in this setting do report ongoing issues of current relationship problems or change, and that therapists view this as an important enough phenomenon to document some of it in reports. A simple reporting of marital status changes would not have captured the complexity of this phenomenon, and only by examining the reports in detail did the full extent of the changes become apparent. It may be important, in future studies, to consider the broader range of interpersonal changes in order to fully understand the ways that therapy addresses and influences the kinds of relationship changes that were seen in this sample. This would include clients who are considering changes in relationships, desiring relationships, grieving the ending of a relationship, or even renegotiating relationships by such decisions as having children. This may be particularly

relevant for a sample such as this one, where the clients' mean age was in their twenties, but may also be relevant for clients of any age, as therapy may be used by many clients at points of transition in their lives, particularly around relationship changes.

A specific suggestion might then be to compile relational information in several formats. Marital status (defined as "legal" status) could continue to be recorded in the traditional way, although perhaps broadened, as it was in this study, to include "living together", since this may also have legal implications. A second categorical variable, defined here as "relational status", could be developed based on the information in this study. Here this was a two-option variable (in a relationship or not), but might also be expanded to include a length of time in the relationship. Of course the issues of how to define a "relationship" remain complex. Then, a descriptive account of relationship history might also be important to include in clinical data as well as for research purposes. A thorough history could led itself to other categorical variables, such as "never had a relationship", "wants a relationship", or a history of numerous relationships (more than x number of relationships in the last two years for example). A category for "just ended a relationship" might also be an important research variable.

While many clinical reporting systems and psychotherapy research studies use the above-mentioned kind

of information, few use these measures during the course of therapy, or at termination. Given the extent of change in relationships noted in this study, this could be an interesting avenue of research. This should also include, as this study did, categories of "changes in relationships," such as "entered relationship," "exited relationship," "married," "separated," "divorced," "became engaged," "broke off engagement," "moved in with partner," moved out," or more difficult to define categories such as, "entered and exited several relationships," or "dated." This kind of research endeavor could be used, as in this study, to further document thee extent of changes in relationships, or taken further and, for example, compared with other outcome variables.

It should be noted again that the findings presented here pertain specifically to a clinical population, and a particular one at that (drawn from a college-based training clinic). Non-clients, and persons not associated with a college community (as most of this sample was), may have different patterns of relationship change. They may move more quickly or more slowly from one category to another, and may fit more or less neatly into existing categories. Further research which compares clinical and non-clinical populations on this issue could be of interest as well.

The extent of current relationship changes found in this sample may have some implications for understanding the therapy process as well. Some might see these findings

as further evidence that family therapy is indicated in more cases than are currently referred for this modality, or at least that a form of family-oriented work might be indicated (such as the model proposed by Wachtel and Wachtel, 1986; or the kind of work proposed by Bowen, 1978). This would imply a different kind of problem formulation, one that includes the current relationships as a more central piece of the work to be done, and of the resolutions to be aimed toward. In this particular setting, some cases were referred for family therapy, but only when a formulation was developed during the intake session that included current family conflict, and where there seemed to be a willingness on the part of family members to be included in such work.

Even in cases with considerable distress and ongoing concerns about current relationships, the majority of cases in this setting were still referred for individual therapy, and the majority were assigned to therapists working within a psychodynamic framework. Given this, these findings might still imply some revisions of the working models to be used for such cases. Clearly, the original notions of psychoanalysis, where analysands were instructed not to make major changes in their lives, do not apply. Even revised notions of psychoanalytic psychotherapy, however, offer little guidance on how to work specifically with the extent of relationship changes that were noted here.

It seems likely that most therapists in this training setting were working with the idea of "therapeutic neutrality", that might include the idea that they should be neutral about the decisions made by their clients, such as decisions about current relationships. It also seems, from the reports, that therapists used information about their clients' current relationships as data about the clients and their "relational style" rather than as being the presenting problem itself. At the same time, it is very common in literature about psychotherapy, particularly case studies, to refer to a client with a "good outcome" and note that the client married or changed their current relationships in some positive direction. The underlying assumption seems to be that psychotherapy improves some intrapsychic phenomenon that manifests itself in better choices about relationships in the real world of the client.

As pointed out in a recent book by Josselson (1992), the theories used by psychoanalytically-oriented psychotherapists focus more on the idea of the development of the self of the client, and focus little on the needs for relationships in the current "lived experience" of clients. Josselson's book, a compilation of ideas about ways that people engage in relationships (e.g., idealization, caretaking, and passion, to name a few of her "dimensions of relatedness"), is similar to, and draws on the work of Miller and Stiver (1991) and others who have

recently drawn attention to the importance of relationships. These writers base much of their work on the psychoanalytic tradition, and specifically the writers who have included some aspect of relationships as central to development, for example, Fairbairn (1952), and Sullivan (1953). However, they reject the idea that it is only in early development that relationships are central. A key piece of this new formulation is that it is women's development that might be used as a model, as opposed to much of psychological research and theory, which was based, often, on ideas of male development as universal. The research of Gilligan (1982) was ground-breaking in this respect, reformulating the ideas of moral development and the development of the self "in relation" to others (as opposed to separation or individuation as a goal or norm for adult development).

Miller and Stiver (1991) propose a model of therapy based on these ideas, in which the therapeutic relationship moves "toward increasing empathy and empowerment" (p. 7), which is seen as "the key" to the process of therapy. Their model is in some ways quite similar to evolving psychoanalytic ideas about the use of transference and countertransference as the method of change, but does not include the need for the therapist's complete neutrality, nor do they view the interpretation of the transference as a "major work of the therapy". Josselson (1992), a practicing therapist, does not put forth a new model of

therapy, but does discuss the therapy process. In her view, clients' presenting problems "bespeak difficulties of some sort in relationships" (p. 20), and she sees all relationships engaged in by the client as part of the client's "health". Josselson also sees the focus on the transference relationship as important, but perhaps too limited a view for a complete understanding of the client's relational world.

In summary, psychoanalytic and interpersonally-oriented writers and therapists are moving toward the inclusion of a relational focus in working with clients. Often, this includes working through the transference/ counter-transference issues that present themselves in the therapy hour. This perspective may also imply an increased focus on the development of relatedness in early childhood. In the work documented in this set of reports, this kind of perspective could be seen in the therapists' descriptions of clients' "relational style", based on both the transference/countertransference phenomenon and knowledge of early history. In these reports, current relationships were used as specific examples of the theory being developed about a particular client. With this increasing emphasis on relationships of clients, there may come more research, such as the present study, outlining the ways that current relationships figure into the process of therapy.

The findings of this study may also have some implications for the understanding of the ideas presented by Gurman and Kniskern (1978, 1986) who stated that married couples are at risk if one partner enters therapy (based on a review of articles on this topic). This study does not seem to add support to this idea specifically, since there were more beginnings of relationships than endings of relationships over the course of therapy (even looking only at the cases involving marriage or living together). Of the two marriages that ended during the course of therapy, both sets of reports included mention early on (at intake and at the time of the initial psychotherapy summary) of significant marital problems and the desire to leave the relationship. This would seem to imply that it was not therapy itself that helped dissolve these relationships, although it may have speeded up the process, or encouraged a resolution of ongoing problems. In fact, Gurman and Kniskern's conclusions may have more to say about the cases where the client was reported to be in a romantic relationship (but not married, living with, or engaged) at intake, which was later reported to have ended during therapy. It may be that it is these, more tenuous relationships that are most at risk when one partner enters therapy, given the number of such cases found here, and that while some reports about such clients mentioned relationship difficulties at intake, some did not (implying that relationship difficulties began after intake, or that

they only surfaced in the therapy later). Further research might address the risks involved in therapy for those newly involved in relationships, as prior research addressed this question for married couples.

Several trends involving gender differences were noticed in those cases where changes in relationship status was reported. First, it should be noted again that the sample consisted of more women than men (32.6% men), which is not unusual for therapy settings in general, and reflected the general trend in this clinic as well. Taking into account this gender ratio, most of the categories developed about relationship status did not show striking gender differences. In two categories, however, disproportionate numbers of women were seen. This study identified a group of women (and very few men) clients who were single (marital status) but in relation-ships at the time of intake (relationship status) and who broke off the relationship during the therapy. In addition, a group of women clients were identified who were single but started a relationship during the time of therapy which lasted until termination (there were a few men in this category as well). Several interpretations are possible. One might be that some women enter into therapy when they are considering ending relationships, and use therapy as a way to get support for this process. It may also be that therapy inherently supports this process--of breaking off relationships--in some way. This might be by providing

certain insight about the relationship, or by providing an alternative relationship which in some way interferes with the woman's continuing the romantic relationship. Reading the reports, it seemed more likely that an important factor was the additional support provided to women in this situation, which might have helped them to leave relationships which they were unhappy with before beginning therapy, although in some cases no evidence was found in the reports to support this, so other explanations are certainly possible as well. For the group entering into relationships, it may be that women use therapy as a way of supporting the beginnings of relationships as well as the ends of relationships, but this would seem to be possible for men as well. One wonders if the process of being in therapy (often with a female therapist) might interfere in some way with the development of lasting relationships in male clients who were single, or if the process of exploring feelings and patterns about relationships is more beneficial to women for entering into relationships than for men.

Problem Expansion

As noted previously, the analysis of the larger sample of 92 cases led to the observation of several recurring patterns in the reports. Most notable was the way that descriptions of clients' problems seemed to shift and

expand over the course of the therapy, and in the succession of reports written about a client during their therapy.

One aspect of this was the way that relationships were discussed in the context of presenting problems and changes in other symptoms. In general, it seemed that many writers used current relationships as examples of broader themes that they were exploring with their clients. In following general psychodynamic concepts (e.g., Luborsky, 1984), these therapists seemed to be pursing the clients' "core conflicts", which seemed to be often ones of relationship difficulties. In this kind of framework, the ways that a client relates to others is central to understanding the client, and has many implications for other kinds of problems (such as depression, weight problems, problems in the area of achievement of life goals, and others). This is also the main way that therapists can work with clients, using the relationship with the therapist as a basis for understanding these core conflicts. This would fit well with what was seen in these reports, where problem formulation often shifted during the course of therapy, and where these shifts in documentation of problems often moved <u>toward</u> a more interpersonal view.

The kinds of shifts in problem documentation seen in these reports seems to follow very closely the observations of Hatcher et al. (1986) as well as Davis (1986). The presenting problems were often not the same as the problems

seen later on in reports, as the client and therapist moved toward a greater understanding of the overall nature of the problems. While these shifts can be seen as moving toward a greater depth (or more intrapsychic phenomenon), they also moved toward using the therapists' model of understanding problems (i.e., an interpersonally based formulation).

The perspective of this study is not that the original formulations at intake were incorrect, but rather, as also expressed by Hatcher, et al. (1986), that it is the nature of therapy that leads to the expansion and elaboration of presenting problems into a treatment focus that more accurately fits the client. It also seems inherent to the process of therapy that clients will not know the full extent of their problems at intake, and that clients and therapists together can come to a better understanding of them over time. Thus it makes sense that a client would present her problems as depression, but that the therapy (and the reports documenting the therapy) would focus on broader issues of her relationships with others, with the possibility that the client could only express her problems as depression originally, or that she truly was depressed but that the way to work on the kind of depression she presented was to work on the broader issues. The same can be said about a client who was seeking help around issues of weight, but reported right from the beginning as knowing that the issues were much broader. It makes sense then that in the reports about this case that weight was not

discussed in further reports, but that the problem was reformulated by the therapist as involving her interpersonal style or feelings about herself.

There were, in addition, some cases in the sample where new issues came up in later reports that had not been revealed earlier on, either in the therapy, or in the reports (for example, a client who revealed after a year of therapy that she had an ongoing problem with stealing). In these cases, it seems that only time, and the establishment of a trusting relationship could have led to these revelations. It may also be that certain other issues had to be resolved before these clients could reveal these sensitive topics. These cases seem to be closely related to, although different expressions of, the issues seen in cases where the presenting problem seemed to be a "ticket" into therapy. In psychodynamic terms, this might be called a defense against the "real" problems for which they were seeking therapy. The role of the therapist can be seen, in these kinds of cases, as accepting the presenting problem as presented by the client, but leaving open the possibility that the client may have other issues to present once the therapy is under way.

Another perspective to be considered in problem change over the course of therapy is that therapists may, either by design or in more subtle ways, induct the client into the role of client, and shift the problem from the presenting problem into a problem that the therapist views

as important or one that can be worked on within the therapist's way of working. This is the view put forth by Davis, as well as other writers, including Blizinsky and Reid (1980), in summarizing the views of other family therapists.

While it is my conclusion, based on the examination of the data of this study (and, it should be mentioned, clinical experience), that problems do change over the course of therapy, the observations described here are clearly not based on knowledge of "real" problem change. Instead, what was observed here was that descriptions, in clinical reports, of clients' problems, were not identical from one report to the next, and that certain patterns could be seen in the changes noted in these texts. The written products examined and studied in these pages were the result of various forces. The clients' experience and reported experience (which may or may not change over time), were influenced by the therapists' views of the clients and their problems, and indirectly, by the supervisors' views of the problems. The clinical reports are one glimpse into this interactive phenomenon. The process of problem formulation over time, in the therapist-client dyad, and influenced by the therapist-supervisor dyad, was translated by the therapist into yet another level of communication, i.e., the writer-reader dyad. While this leaves the question of how this relates to the "real" change in problems unanswered, I have based my conclusions

on the assumption that there is some relationship between these documents and the consensus developed by these various participants in the process. What is particularly interesting in this study is that changes could be noted over time. The relationships between therapists, clients and supervisors were developing and evolving (part of the "reality" we can only assume to exist but not directly access through these reports), and at the same time the therapists' written accounts also evolved (the part that was accessible).

This problem with knowing what was "really" the problem for the client is not limited to this form of research. Even more "direct" assessment methods could run into this difficulty. For example, the client's internal views or experience may differ from her or his presentation to a therapist, or from her or his responses on a questionnaire. As mentioned previously, the forces that define a problem may come not only from the client him or herself. Different therapists may view a client's problems differently, or may interact with a client in a way that leads to the mutual recognition of different problems. What seems to be important in a study of this kind is to recognize where the data come from, and the forces that influence them. The same can be said for clinical work itself; it is important for the clinician to be aware of the forces that lead to a given problem formulation (forces from the client, their social framework, the setting, and

especially, countertransference forces that could easily be overlooked).

Therapists working with clients in cases where the problem does seem to change over time can take a variety of perspectives on this. They can take credit for changes, such as diminished symptoms, or even conceptualize any change as "progress" in service of this view. They can see the changes as inevitable due to the passage of time. They can view the changes as part of an evolving formulation about the client. They can look to outside forces that might have played a part in creating the change. Most likely, all of these are used by clinicians at different times. Again, what may be most important is recognition of the forces that influence the clinician's conceptualization of change.

In considering the two major issues of this study (relationship change and problem change), the view that I have tried to maintain is that the therapist-client system is in constant interaction with the "external" system of the client and his or her social network. The "internal" system, as defined as the client-therapist dyad, changes as the relationship deepens, as insight occurs, as the two parties clarify goals, and as the client changes her or his views and behavior. The "external" system of the client changes as the client's relationships change (meeting new people, renegotiating relationships, births and deaths, to name a few of the kinds of changes possible). In addition,

other providers may influence the client's life (for example, providing medication, pain relief, etc.), the client's job or educational environment may change, and the social environment may also influence the client and his or her view of him/herself and his/her problems. We can never assume to know the influence of all these factors but neglecting to realize than any part of these systems can be changing (the spouse of a client, for example could also be changing during the course of therapy), could leave out valuable information.

Returning to the issue of specific problem change over the course of therapy, the results of this study still offer some evidence that problems may shift, or at least our understanding of them will shift over time. From the data presented here, it seems that even if one does a thorough intake evaluation, the problem may still shift later on, although it does seem in this study that it is in the first few sessions that many problem and goal shifts were negotiated. Given the current emphasis on short-term problem-oriented work these findings present several problems. One is knowing how long to allow for the establishment of a problem-focus in therapy. Another is knowing whether one can in fact ever find "the problem" in a particular case. The ambiguity resulting from this last question could be a problem for therapists (how to direct their work if "the problem" is so fluid), for clients (how to know if they are getting help, as well as anxiety about

"interminable" therapy), and for third-party payers who demand concrete answers to these difficult theoretical questions.

While these questions can seem overwhelmingly complex, especially given the data presented here, clinicians do figure out solutions to these dilemmas on a daily basis. Therapists do acknowledge and work with the changing problems of clients over time. In terms of conceptualizing or recording these changes, some recording systems work flexibly (as therapists must) in documenting changes in problems, while other was are less easily adapted to this way of thinking. The "diagnosis" model is perhaps the least flexible, in that a diagnosis is meant to reflect something of the "true" nature of the problem. Additional diagnoses may be added, or the diagnosis changed altogether, but the level of shift in "problems" noted in these reports would often not be incorporated in such a model. The "formulation" model has similar shortcomings, although practitioners using these models certainly would acknowledge the use of different strategies and approaches during different phases of work, even given an unvarying diagnosis or formulation (e.g.; crisis management, teaching of coping strategies, insight, etc.). Changes in the actual diagnosis or formulation must occur frequently as well, as more information is available, or as the therapist comes to a new perspective. These models rely most of all on the

clinician's perspective, and so their willingness to be flexible in their thinking is a key feature.

The more recent problem-oriented recording strategies seem to be more easily adapted to a changing set of problems, and also accord most importance to the client's views of problems. Since this kind of recording strategy often uses specific problems noted by the client (unlike the diagnosis or formulation models, if used exclusively), there is a way that the issue of accountability to the client is more clear in this method. The client in treatment for "fighting with spouse and co-workers" can assess more easily if this problem is better or worse than can a client diagnosed as "borderline personality disorder" or described to have "early abandonment issues" in a formulation. In light of the findings here of problem shift and expansion, it is important to note that the problem-oriented recording strategies usually incorporate a system for noting changes.

While these strategies may be seen as leading to more accountability to the client (or consumer), it is often the "diagnosis" model that is seen as the hallmark of accountability to third-party payers. In these systems, relationship issues are of less importance and changes in problems over time are extremely problematic. What would also be seen as problematic for third-party payers in these reports (and for psychotherapy outcome research) is that so few writers directly addressed when, how and how much

clients were "improving". Most made some mention of "improvement" and clients "benefitting" from therapy, but failed to fully spell out the details of these kinds of changes.

The strengths of the narrative, open-ended reporting technique used in this training clinic (and by many practitioners in other settings), are as follows: (a) the reports can be individually tailored to the specific client, instead of fitting all clients' lives and problems into a pre-determined format; (b) that the process of writing the report becomes a way for the therapist to clarify and expand her or his thinking about the work with a given client (as opposed to, for example, a check-list format); and (c) that they provide much more complete and in-depth information if they are written with the kind of effort and attention that these writers obviously put into them. Therefore, I believe that this kind of writing is beneficial to clients, to therapists, and to future readers of such reports.

These reports could be improved, however, through further attention to the issues raised in this study. Training in report writing is often a neglected piece of overall psychotherapy training, so a beginning point would be more emphasis on this important part of working with clients. In addition, therapists could be made more aware of the issue of change in problem formulation, and their role in this process. While beginning therapists are often

eager for simple prescriptions that lead to a sense of knowing the "truth" about a client, the training process needs to incorporate the development of a more open-minded approach to understanding clients. In this kind of training, the therapist might learn to understand problem formulation as a matter of perspective; i.e., that there are many ways to view and "create" (through discussion) clients' problems. This would leave therapists with more ability to choose among different treatment modalities given a particular initial presentation.

In terms of report writing, therapists need to be able to respond to the increasing demands for accountability be recognizing which problems they are addressing in treatment, recording these, and recording specific progress on these. At the same time, it would be a mistake to accept pressure (for example from insurance companies) to see the process as a simplistic one where each client has one definable problem, that there is one approach to treating such a problem, and that the problem will not change once this decision is made. Problems, diagnoses, and formulations do and will continue to change in therapy, and this needs to be seen as an integral part of the endeavor rather than as a complication to gloss over or deny the existence of. As mentioned previously, these cases showed indications that sometimes when one problem is alleviated, others will appear. In other cases, clients are unable to disclose a particular problem at the outset of therapy. In

other cases, goals will shift as the client becomes healthier or as more information is available to the client and to the therapist. Perhaps these issues need to be addressed more explicitly in training, in literature about psychotherapy, and particularly, to clients beginning treatment.

Patterns in Relationships: A Particular Problem

As noted previously, the initial reading of reports led to the identification of several recurring themes in reports. One of these was a set of reports that described clients (mainly women) who apparently repeated problematic relationship "patterns" by choosing certain kinds of romantic partners. The specific "type" of partner chosen varied from client to client, but the general finding was that these women clients found themselves in relationships with either unavailable or distant partners where the development of a lasting commitment was difficult, or in relationships where the issue of caretaking was played out either through dependency in the partner or through the search for a "father figure". In addition some reports described the partners as "abusive" in some way. In these reports, the problem was identified as being "located" somehow in the client, in that she would "choose" this kind of partner. Several cases indicated some success at resolving these problems, or at least that the client had

moved to choosing a "different" kind of male partner by the end of therapy. The cases also seemed to indicate the perspective that the awareness of the "pattern" was considered part of the successful resolution of such a recurring problem.

The finding that these kinds of issues recurred in reports fits well with the other general findings about problem formulation in the reports. This kind of "pattern" can be seen as a specific example of the overall trend toward movement in these cases toward a formulation that includes interpersonal phenomenon, but one that places the problem in the realm of the intrapsychic. In other words, the general trend was that problems moved toward the "discovery" of the "core conflict" that included a relational component that was repeated in all relationships. These cases can be seen as a specific example of this trend.

This perspective on the development of certain kinds of problem formulations might imply that it was the therapists who were re-formulating clients' problems into ones that fit this model. In this case, women who had a history of unsuccessful relationships might have been encouraged to review the ways that they contributed to the problems in relationships, including their choice of love objects. This might be one way of understanding the set of reports that included this "pattern". Several other interpretations are possible.

A factor in understanding these cases is that this group of clients had considerable therapy experience, and may have worked to understand this "pattern" in other previous therapies. Thus, it may not have been these therapists who introduced these ideas, but past therapy, and perhaps additional reading done by clients on these issues.

A recent book by Faludi (1991) points to the plethora of books and magazine articles published in the 1980's that encourage women to marry, as well as to recognize that they "choose" men of certain kinds. Leading this movement was a best-seller by Norwood (1985) entitled, Women who love too much. This and a set of articles and books drawn from similar ideas put forth the idea in the popular culture that many women are "addicted" to men who hurt them (Faludi, 1991, p. 349). The advice given in these self-help books (as documented by Faludi) was to "recognize" the "addiction", in the way that alcoholics have learned to do through 12-step programs, and to go on to find the "right" man. This came at the same time as various media were reporting a "man shortage" for older women, and implicitly and explicitly encouraging women to marry (Faludi, 1991, pp. 9-18). While there is no evidence to indicate that the media had a direct effect on the clients or therapists in this study, this perspective provides an interesting hypothesis about why these cases might have been found in a group of women clients who were in their mid-twenties at

the time of the study (just after the publication of Norwood's book and a time period Faludi describes--and documents--as the height of this media explosion on this topic).

Conclusion

This study of reports in a clinical setting has focused on several levels of analysis. A broader set of samples of reports on long term therapies was used to explore the issues of romantic relationships and relationship change in therapy. A second level of analysis was the detailed description of a smaller subset of cases (with longer presentations of material for four of these cases in Part II), in order to outline several important themes that were noted in some cases. These themes and examples were then used to draw some conclusions about these cases, as well as some implications for therapy in general. Primary among these was that problem formulations do change over the course of therapy, and that there is indication in these reports that problems change in the direction of including relational information as part of a broader formulation of "relational style", seen as a particular kind of core conflict.

The examples used here demonstrate the complexity of the clinical data found in such reports. This is so, despite the prevailing notion that record-keeping is the

"most time-consuming and burdensome aspect of work" in mental health settings (Rhodes, 1991, p. 109). While clinicians might have found the writing of reports to be a burden, these clinicians did put quite a bit of effort into these reports, and many may have found this process helpful in crystallizing what they were beginning to understand about their clients. Barrett (1988), in a descriptive study of reports written in a psychiatric hospital, describes this as an "interpretive process involving a movement back and forth between oral and written discourse," and one which he conceptualizes as "at the heart of psychiatric work" (Barrett, 1988, p. 266).

The constructivist thinking of Anderson and Goolishan (1986) and others was helpful in developing ideas about the "construction" of the problem in the therapy setting. Similarly, a constructivist view can be taken in understanding the process of report writing. The clinical report, with its particular style and demands, may pull for the construction of a document which validates the idea that the client is in need of services, and that the clinician has a model which will be of use to the client. Barrett (1988) describes this as the production of a "documentary version of reality" (p. 274), which matches its content with diagnostic and theoretical models, as well as providing evidence for the formulation the clinician has selected. This kind of pressure to conform to accepted models in report writing may be present in any clinical

setting, and is very likely to be present in a training setting.

This constructivist position is helpful in understanding the results of this study, which are, as stated earlier, one version or one construction of the information in the reports (compiled by this researcher), based on selected constructions of clinical information written by the therapists. While the views developed in this way may not allow for verification of reliability and validity, as might be found in other forms of research, the study is based on the assumption that in exchange, a degree of depth of analysis was possible that would have not been so in other forms of research.

Perhaps a greater drawback in interpreting the data of this study is that so little was known about the effects of supervision on the therapists, the therapies, and the reports. No records are kept on supervision (except the name of the supervisor) and it was my experience, as a participant-observer in this setting, that trainees would be reluctant to have ongoing analysis of their supervisions, as might be the supervisors themselves. Future studies might incorporate some kind of minimally intrusive interviews with trainees and supervisors, or confidential questionnaire data that would be kept separately from the main administration setting of the clinic. It would be very interesting to know, for example, how a particular report was seen by the clinician as having

been shaped by various influences (e.g., the supervisor, readings, case conferences, or seminars). It would also be interesting to pursue the idea of problem re-formulation, getting the therapist's view on how and when the problem was shifting, and how they accounted for these changes.

While this study included as an original goal the analysis of current relationships in general, in fact I only focused on current romantic relationships. Future studies might include other kinds of relationships that are discussed in therapies, as well as changes in those relationships over the course of therapy. Josselson (1992) provides a beginning point for such a study, with a set of ways that clients relate to others, which includes all forms of relationships.

Therapy outcome studies have been found to be quite difficult to conduct, and with the complexity of the issues, many researchers have tried to narrow the issues they have focused on. In contrast, this study, while also narrow in some respects, was quite open-ended, intending to capture some of the more subtle issues that might be missed in a large scale, less intensive study. The results found in this study might have some implications for future outcome studies. For one, the issue of problem re-formulation uncovered here and addressed by writers such as Hatcher, et al. (1986), imply that it might be wise to consider more than one version of "the problem." This is also the view taken by Wynne (1988) in his recommendations

to family therapy researchers, that at least two points of reference should be included: the client's version of the problem, and the therapist's re-formulation of the problem. The findings of this study indicate that there may be even more than these two points to consider. One might even want to include problem re-formulation as a goal or measure of success in some cases.

Returning to the issue of clients' current relationships, future studies might address the question of clients' goals in terms of this; do clients see therapy as a way to work on starting relationships? Some clients may also see therapy as a mechanism to end relationships they are unhappy in, as seemed to be indicated in they analysis of this sample. Gender differences in this area might be quite interesting, particularly in light of the models being developed about gender differences in the role of relationships in men and women's lives.

This study seems also to have important training implications. Are therapists trained to be aware of their role in the "creation" of problems? The constructivist viewpoint is a difficult one to convey, especially to beginning therapists who seek easy solutions in a complex and anxiety-provoking endeavor. The injection of this way of thinking at early stages may have benefits however, in creating therapists with more adaptability and flexibility in their conceptualization of problems. With more and more therapists identifying themselves as "eclectic," this kind

of flexibility could be quite beneficial, however, in allowing therapists to choose, and be aware of how they choose, to work with a particular client. This kind of perspective could also be helpful in that it could be more "consumer-friendly", recognizing that clients and therapists together "create" the problems which they will work on.

In the current environment, where accountability is of increasing importance, training therapists to be more aware of how and when they are defining problems to work on would be a good first step. In addition to recording a problem or problems at intake, therapists might also consider addressing in a report how they came to decide on a particular problem focus, and whether the client was in agreement with this plan (something that was lacking in the reports considered here). Periodic re-assessment of the problem focus and plan could be included in narrative format in further reports, as well as notes at termination about the overall course of these issues. However, given the results of this study, therapists also need to be trained to be ready for small and large changes in their conceptualizations, problem focus, and treatment plan, as well as to document how these shifts occurred. This may seem like additional work for therapists, but seems also to be an opportunity for therapists to be more acutely aware of the therapy process and the forces that influence it.

APPENDIX A

PHQ

Personal History Questionnaire
Psychological Services Center
University of Massachusetts

The purpose of this questionnaire is to obtain a comprehensive picture of your background. This information will help us provide the services you are requesting. It will also be useful information for research that will help us continue to improve our services. Case records are strictly confidential.

NO OUTSIDER IS PERMITTED TO SEE YOU CASE RECORD
WITHOUT YOUR PERMISSION.

If you do not want to answer any question, just put an "X" in the space. If additional space is needed for responding, use the other side of the sheet, and indicate the number of the question being answered.

****

Rev. 9/87

Date _____

Identifying Information

1. Name: _____ _____ _____
(last) (first) (middle)

2. Address (Local): _____

3. Home Phone: _____

4. Alternate Address and Phone, e.g., work or parents' (optional):

_____ _____
(address) (phone)

5. Birthdate: _____/_____/_____
month day year

Nature of the Problem and Your Request (Use Back of Sheet if Needed)

6. What brings you to seek professional help at this time?

7. When did these particular difficulties begin?

8. What kind of help are you looking for?

9. By whom were you referred (if anyone), and what is their relationship to you?

Mental Health History

10. Have you been in therapy or consulted with a mental health professional before? (Yes No)

If yes, list the dates, name(s) of professional (and agency), and kind of service you received. Make sure you include any current service.

Dates		Name of Agency and/or Professional	Problem and Type of Service (e.g., testing, individual counseling, family therapy)
From	To		

11. Have you ever been hospitalized for emotional problems? (Yes No)
If yes, and not listed above, please give dates, places, and reasons.

12. Have you ever <u>attempted</u> suicide? (Yes No)
If yes, please briefly explain the circumstances.

13. Have you ever seriously <u>considered</u> suicide? (Yes No)
If yes, please briefly explain the circumstances.

14. Have you had any serious problems with the law? (Yes No)
If yes, please explain the circumstances and the outcome.

Family

15. First, list your immediate family members other than a spouse or partner or children. Include parents and brothers or sisters. You may add others (e.g., step-parents, grandparents) if they have been centrally important in your life or if they are important to your present difficulties. When asked "where living," put "with me" for anyone who lives with you. For others list the name of the town if they live in Massachusetts, or the name of the state or country if they live outside of Massachusetts.

Relationship to You	Name (last, first)	Sex	Age	Birthday (month, day)	Where living Or Date of Death
Mother	_____	F	___	_____	_____
Father	_____	M	___	_____	_____
Brother/Sister	_____	M F	___	_____	_____
Brother/Sister	_____	M F	___	_____	_____
_____ (other)	_____	M F	___	_____	_____

(To add more, check here ____ and use the back of this sheet).

16. Spouse, Partner, and/or Children: Now please list any other immediate family, including a spouse or similar partner, and any children. If you have step-children, include them if they live with you on a regular basis.

Relationship to You	Name (last, first)	Sex	Age	Birthday (month, day)	Where living Or Date of Death
Spouse/Partner	_____	M F	___	_____	_____
Son/Daughter	_____	M F	___	_____	_____
Son/Daughter	_____	M F	___	_____	_____
Son/Daughter	_____	M F	___	_____	_____
Son/Daughter	_____	M F	___	_____	_____

(To add more, check here ____ and use the back of this sheet).

Relationship to You	Name (last, first)	Sex	Age	Birthday (month, day)	Where living Or Date of Death
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			

17. What is your current living situation: Where do you live and with whom? (If you live with persons who are not included in the Family listing above, please identify them. If you have children (or others) who live with you part of the time, please describe the arrangements.)

18. Marriage or Similar Relationship

a) For any current marriage or other serious relationship, please describe the nature of the relationship, when it started, any significant problems, and whether your partner is having any difficulties at this time.

b) Please briefly describe your history of previous marriages or similar close relationships. Include approximate dates, length of the relationship, and how the relationship ended, and the nature of current contact.

19. If you have children, do they have any special problems or difficulties? (Yes No) If yes, please describe:

20. Mental Health History of Your Family

a) Have any other members of your immediate family been hospitalized for psychiatric reasons? (Yes No) If yes, please list their names, the dates, and a brief description of their psychological problem.

Names	Dates	Description

b) Has any member of your family suffered from alcoholism? (Yes No) If yes, who?

c) Are there other serious psychological conditions in your family that you think we should know about? (Yes No)

If yes, please identify family member and describe:

21. Racial, Ethnic, and Religious Background

a) What is your racial and ethnic or cultural background?

b) What is your current religious affiliation (if any) and what role does religion play in your life?

22. If there are other facts about your family that would be important for us to know (adoption, who raised you, divorce, etc.), please list them here:

Health

23. What is your height _____ and weight _____?

a) What do you consider your ideal weight? _____

24. Check any of the following that you have experienced:

_____	Thyroid Disease	_____	Kidney Disease
_____	Neurological Diseases	_____	Asthma
_____	Infectious Diseases	_____	Diabetes
_____	Loss of Consciousness	_____	Cancer
_____	Head Injury	_____	Glaucoma
_____	Prostate Problems	_____	Epilepsy
_____	Gastrointestinal Disease	_____	High Blood Pressure
_____	Heart Disease	_____	Menstrual Problems
_____	Major Surgery (what, when?)		
_____	Other Pain _____		

_____ Other: _____

_____

Please describe any of the items you have checked which involve continuing difficulties or concerns:

_____

25a) (For Women Only): If you have had any pregnancies which did not continue to childbirth, please describe them, including your age at the time, and how the pregnancy ended:

25b) (For Women Only): Is there anything abnormal about your menstrual cycle? (Yes No) If yes, please describe.

_____

26. How often do you use any of the following:

	Never	Rarely	Moderately Often	Quite Often	Extremely Often
Alcohol.....	____	____	____	____	____
Marijuana.....	____	____	____	____	____
Tranquilizers.....	____	____	____	____	____
Sedatives.....	____	____	____	____	____
Aspirin.....	____	____	____	____	____
Cocaine.....	____	____	____	____	____
Painkillers.....	____	____	____	____	____
Coffee.....	____	____	____	____	____
Cigarettes.....	____	____	____	____	____
Narcotics.....	____	____	____	____	____
Stimulants.....	____	____	____	____	____
Hallucinogens (LSD, etc.).....	____	____	____	____	____

27. Please specify any drugs or medicines you are currently taking, or have taken during the past 6 months (including birth control pills, or any medicines that were prescribed or over-the-counter). Specify the duration and amount of such drug or medication use.

28. Please describe further health concerns (e.g., allergies, sleep or eating problems, or disturbing physical symptoms) that are not adequately described above (continue on reverse):

29. Overall, what is your general state of physical health?

Other Personal Background Information

30. Education

a) What is the highest level of education you have completed?

b) Are you currently in school? (Yes No)

Where _____

Grade or Year _____

31. Employment

a) What is your current employment (please include the type of business or workplace and your position, title, and duties)?

b) How long have you been at this job? _____

c) What was your last job before the current one? _____

d) How long were you in that job?

32. Does your present work satisfy you? _____ If no, please explain:

33. If married or living with partner, what is their occupation?

_____

34. Your annual income: _____/year

35. Combined family income: _____/year
(If you are still dependent on parents or others, include their annual income)

36. Are you under any serious financial pressures? If yes, explain:

Sequential History:

Please describe your most significant experiences during the following periods of your life. (If you need more room, just cross out the headings and write in your own).

37. 0-5

38. 6-10

39. 11-15

40. 16-20

41. 21-25

42. 26-30

43. 31-35

44. 36-40

45. 41-45

46. 46-50

47. 51-55

48. 56-60

49. 61-65

50. Over 66

In the space below, please provide any additional information which you feel would be helpful for us to know at this point (use the back if you need more room):

APPENDIX B

CONSENT FORM

UNIVERSITY OF MASSACHUSETTS
PSYCHOLOGICAL SERVICES CENTER

To our clients:

The Psychological Services Center is sponsored by the Psychology Department of the University of Massachusetts to provide services to the community, and training and research opportunities for doctoral students in clinical psychology. Our services are provided by these therapists-in-training, under the supervision of our senior staff of licensed clinical psychologist. The Center is supported by funds from the University, by the Town of Amherst, and by the fees paid by clients.

Confidentiality:

We maintain a strict and firm policy of confidentiality on all clinic matters and absolutely no information about you or your family will be passed on to another person or agency without your expressed consent. The only exceptions would be: a life-threatening emergency, a court subpoena of records, or child abuse. Case material may be used for teaching purposes or research, but only under strict assurance that identifying information will not be included in any such presentation unless you give written permission.

Taping and Observation:

Most of our rooms are constructed with one-way observation mirrors and sound systems, and tape recordings are often made during interviews. These facilities support the supervision, training and research functions of the Center. By signing this form, you are giving permission for the taping and observation of your treatment. No one other than your therapist's supervisor and the treatment team of which she/he is a member is allowed to observe your sessions without your expressed permission.

Research:

Research is important in helping us evaluate the effectiveness of our work, and to improve clinical service and psychological knowledge. Your clinical record and related case materials may be used for research, under the conditions of confidentiality spelled out above; in signing this form, you agree to such use. In addition you may be asked to participate in specific research projects. Such participation will be purely voluntary, will have no bearing on whether you receive services, and will take place only with you written permission.

Fees:

Your therapist will discuss your fee with you and determine a fee which is in line with the sliding scale and also take into consideration any special circumstances which you may have. If there are psychological testing sessions in addition to weekly therapy sessions, there is an additional charge for them. It is very important that fees be paid to the receptionist at the time of your session. Failure to pay a fee for four consecutive sessions will necessitate the suspension of therapy, unless special payment arrangements are made with your therapist. Checks should be made out to: Psychological Services Trust Fund. We ask that you give us 24 hours notice if you are unable to keep an appointment. If you fail to do so, you will be charged for the session. It is our intention that fees will not prevent anyone who needs our services from receiving them. However, services will be refused for failure to pay in the absence of discussion of the financial matter with your therapist.

Richard P. Halgin, Ph.D.
Director, PSC

I have read and understand the above statement.

_____ _____

Name Date

APPENDIX C

INITIAL INFORMATION SHEET

Date _____ INTERVIEWER _____

Name of client(s) _____ Age ____ D.O.B ____
Last First Marital Status _____
Address _____ Phone (home) _____

_____ (business) _____

Preferred place and time for client to be reached by phone _____

Referred by _____

Name of person contacting PSC _____

CURRENT LIVING SITUATION _____

_____

Current Employment and/or School Situation _____

_____

Past Mental Health Intervention _____

_____

Preferred Type of Treatment _____

_____ _____

Initial Formulation _____

_____

_____

_____

INSURANCE COVERAGE _____

DATE OPENED _____ ASSIGNED TO _____ SUPERVISED BY _____

DATE TRANSFERRED _____ ASSIGNED TO _____ SUPERVISED BY _____

OTHER DISPOSITION _____

_____

STATUS OF CASE AT CLOSE OF INTAKE _____

_____

ADDITIONAL CLIENT CONTACTS: DATE CONTACT

_____ _____

_____ _____

For Family Referrals:

Members of Household	Age	Place of Employment or School	Occupation or Grade

Presenting Problem and Brief History _____

APPENDIX D

INITIAL PSYCHOTHERAPY SUMMARY
(suggested format)

Client: Therapist:
Date of Intake: Supervisor:

I. Identification of Patient: Age, sex, occupation, education level, class, ethnic - religious identifications; marital, parental, and current household status.

II. Presenting Problem and Symptoms:

III. Mental Status on Admission: Appearance, behavior, thought content, intelligence, insight and judgement.

IV. History of referring situation:

V. Family Background: Relevant data on parents, sibs or other significant relatives as to class, ethnic, educational, religious and social factors. Hereditary history, (presence of outstanding achievements or adaptive failures in family; identified psychiatric illnesses in relatives).

VI. Psychosocial History: Major life experiences and adaptations from childhood through adolescence to current age; past performances in key areas of ego functioning (schooling, work, love relationships, sex, parenthood, friendships, creativity, recreation).

VII. Past Medical History: Major illnesses or operations, including psychosomatic diseases.

VIII Current Life Situation: Any immediate stresses or impending changes such as divorce, loss of job, etc. Present state of physical health including any current medications, drug usage; relevant pleasurable or compulsive activities; brief description of patient's daily life and important people in it with emphasis on quality of current relationships.

IX. Financial Status: Income and sources of it. Style of clothing, housing, vacations, or leisure expenses; any special financial assets (savings, stocks, property) or burdens (loans, medical expenses, etc.), if relevant.

X. Motivation: What does patient say he/she wants? What else do you see as motivating him/her?

XI. Initial Formulation:

XII. Suggested Plan for Treatment:

APPENDIX E

PROGRESS NOTE

{REPORT DUE BY THE END OF THE SEMESTER. ALL NAMES SHOULD BE REMOVED FROM TEXT, EXCEPT OTHER PROFESSIONALS (i.e., PREVIOUS THERAPISTS}

PSYCHOTHERAPY PROGRESS NOTE

Client:
Date of Intake:
Date of Report: (date report written)
Number of Sessions Covered:
Period Covered: (exact dates that this report covers, mo/day/yr)

Therapist:
Supervisor:
Team Leader:

Suggested issues to be touched upon in progress note.

The course of symptoms

Trends in therapeutic relationship

Performance in significant areas of ego strength

Trends in interpersonal relations

New historical material

Restatement or reformulation of treatment goals
(short range and long range)

Modality of treatment

Current life situation

Medications-dosages, changes, and reasons for change
Make note of any psychiatric consultations

Change in diagnostic formulation or prognosis
(reinstate if unchanged)

_____ _____
Therapist Supervisor

_____
Team Leader

APPENDIX F

TERMINATION/TRANSFER NOTE

{DUE IMMEDIATELY UPON TERMINATION. ALL NAMES SHOULD BE REMOVED FROM TEXT, EXCEPT OTHER PROFESSIONALS (i.e., PREVIOUS THERAPISTS}

PSYCHOTHERAPY SUMMARY

Client:
Date of Termination:
Period Seen: (mo/day/yr-mo/day/yr)[3]
Number of Sessions: (total number)

Therapist:
Supervisor:
Team Leader:
Date of Report: (date written)

A. Identifying Information. Age, sex, marital status, and occupational information.

B. Psychosocial History.

C. Presenting Problem. Client's description of the problem.

D. Initial Formulation of the Problem. Therapist's understanding of the client's problem.

E. Treatment Plan. Therapist's initial plan for treatment, and changes that were made in that plan as treatment proceeded.

F. Summary of Treatment Course. Client's response to therapy, brief summary of process, status of treatment goals at termination (i.e., achieved or not). Note any changes in modality/orientation of therapy.

G. Final Disposition. Reasons for termination and information about the disposition (transfer to another therapist, etc.).

H. Recommendations. Thoughts about the client's future needs either in subsequent therapy or general life planning.

_____
Therapist

_____
Supervisor

_____
Team Leader

---

[3]From first session to termination

APPENDIX G

PSC CASE SUMMARY

This form should be completed at transfer or termination. Because the form is used to administratively close a case, it must be completed for every client assigned, even if never seen.

1. Client name _____ Age _____

2. Clinician _____Date of report _____

3. Duration of Treatment (check one)
   _____ Client never seen. (Do not complete rest of form.)
   _____ Assessment only. (Do not complete rest of form.)
   _____ One or more therapy sessions. Number of sessions _____

   Date of first session _____ Termination Date _____

4. Type of Treatment: ___individual ___couple ___family ___group

5. Theoretical Orientation: _____

6. Disposition:

   ___Transfer within PSC ___Referral outside PSC ___Termination

   A. If referral outside PSC, name of clinician, new agency, and address:
   _____

   B. If termination:

      Nature of termination:
      1) Mutually determined
      2) Client determined in interview
      3) Client by no-show some time following first session
      4) Client determined outside of interview with notification
      5) Therapist determined
      6) Other _____

      Reason for termination:
      1) Problems reduced (no further need)
      2) Client dissatisfied with therapy
      3) Client felt therapy could help no more
      4) Therapist felt therapy could help no more
      5) Client unmotivated
      6) Client withdrawal due to external reasons (moving, departure from school, etc.)
      7) Therapist no longer available (end of team, semester, departure from school, etc.)
      8) Other _____

7. Overall success of therapy:

Very	Moderately Unsuccessful	Slightly		Slightly	Moderately Successful	Very
1	2	3	4	5	6	7

8. Degree of need for further treatment:

1) none 2) slight 3) mild 4) moderate 5) strong 6) very strong 7) extreme

The following items are for research purposes:

9. Please rate the level of the following which you feel you provided during the course of therapy.

None			Moderate		Very High	
1	2	3	4	5	6	7

(Please circle appropriate response)

A. Genuine concern for the client	1	2	3	4	5	6	7
B. Insight, understanding of the client	1	2	3	4	5	6	7
C. Empathy (ability to relate to the client's thoughts and feelings)	1	2	3	4	5	6	7
D. Effective emotional support for the client	1	2	3	4	5	6	7

10. Concerning the period between the beginning and end of therapy, what effect did the following have on the client's psychological health?

strong negative effect			no effect		strong positive effect	
1	2	3	4	5	6	7

(Please circle appropriate response)

Therapeutic method	1	2	3	4	5	6	7
Therapist's skill	1	2	3	4	5	6	7
Client having someone (you) to talk to	1	2	3	4	5	6	7
Client's attitude toward therapy	1	2	3	4	5	6	7
Therapeutic relationship	1	2	3	4	5	6	7
Events external to therapy (e.g., passage of time, other relationships, change of circumstances)	1	2	3	4	5	6	7

APPENDIX H

SAMPLE CASE: CODING OF MARITAL STATUS AND RELATIONSHIP STATUS

From Intake Sheet:
..."Ms Y. also alluded to some problems in the marital relationship...".

CODE AS MARRIED AT INTAKE

From Initial Psychotherapy Summary:
..."Ms. Y. is a 28 year old, white, female who currently lives...with her husband and two-year-old son".

CONFIRM THAT MARITAL STATUS IS CORRECT

..."She is confused about whether or not she wants to remain in the marriage...".
..."...apparently lived with a man for a year before getting married to him..."..."this relationship Ended one year later..."
..."moved to X, where she met her current husband...".

CHANGE MARITAL STATUS TO "REMARRIED"

From Psychotherapy Progress Note #1:
..."She talks as if they will split up eventually, although she does not envision this happening until...".

From Psychotherapy Progress Note #2:
..."She plans to begin couples therapy with her husband during the summer...".... "she was then [during a particular session] quite certain that she wanted a divorce..."
..."However, she remained unwilling to take any immediate action".

From Psychotherapy Progress Note #3:
..."had become romantically involved with Q, and had only recently (within the past two weeks) told her husband. He immediately moved out...".

CODE AS NEW RELATIONSHIP, AND CONSIDER CODING AS ENDING OF MARITAL RELATIONSHIP

From Psychotherapy Progress Note #4/Termination Note
..."She has been separated from her husband since last summer, when she began to pursue a relationship with Q."
..."Divorce plans have proceeded since that time..." ..."She has continued the relationship with Q...and plans to live with him (and her son) beginning in the Fall..."

DECIDE TO CODE AS "SEPARATED" AT TERMINATION (MARITAL STATUS), AND "IN RELATIONSHIP" AT TERMINATION (RELATIONSHIP STATUS). ALSO CODED AS ENDING OF MARITAL RELATIONSHIP (CHANGE IN RELATIONSHIP STATUS), AS WELL AS CONFIRM NEW RELATIONSHIP (ALSO CHANGE IN RELATIONSHIP STATUS). DECIDE NOT TO CODE AS LIVING TOGETHER, SINCE THIS HASN'T HAPPENED BY THE TIME OF TERMINATION.

THIS CASE CAN ALSO BE SEEN AS ONE WHERE THE CLIENT IS ENTERING THERAPY AT A "TRANSITIONAL POINT" IN A RELATIONSHIP, WITH THE QUESTION OF WHETHER OR NOT TO END HER MARRIAGE.

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