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Rorschach Changes Following Brief and Short-Term Therapy

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Two groups of 35 patients each, one treated with brief therapy, averaging 14.2 sessions on a once per week basis, and the other group, treated with a short-term type of therapy, averaging 47 sessions on a once per week basis, were administered the Rorschach and the Katz Adjustment Scales–Form S three times. The first administration took place before entering therapy. The brief therapy group was tested a second time at termination of treatment and again 8 to 12 months following termination. The short-term therapy group was tested the second time at therapy termination and the third time 10 to 12 months after termination. Each group reported substantially fewer symptoms at termination and continued to report about the same level of symptom reduction at the second retest. The Rorschach data seem to provide an ample basis from which to argue that considerable improvement occurred in the psychological organization and/or operations of both groups, and this appears to have some confirmation in the self-report data.

The duration of psychotherapy varies considerably depending on many variables such as the modality of treatment, the severity and duration of the maladjustment, and the objectives for which the treatment is designed. Historically, treatment often has been described as long term when the duration exceeds 12 months and short term when the duration falls in the range of 12 months or less. During the past 20 years, another nomenclature has evolved, that of brief psychotherapy—the practice of which appears to have increased considerably. These are not abbreviated models of longer term treatment methods; rather, they are deliberately planned intervention strategies that are designed to meet some precise client needs within a limited time frame, usually of 4 months or less. The literature concerning the impact of brief therapy

suggests that it is an effective and efficient treatment option when the treatment goals are identified appropriately in the context of the time available (Koss, Butcher, & Strupp, 1986).

Butcher and Kolotkin (1979) reported that studies using adequate controls and objective criteria show rates of improvement between 60% and 70% among short-term therapy clients, including brief therapy crisis intervention patients. For instance, Johnson and Gelso (1980) reviewed the results of 60 treatment studies and concluded that short- and long-term therapies appear to have equally durable effects. Cross, Sheehan, and Khan (1982) reported that 30 patients, treated during a 3-month interval either with short-term insight-oriented therapy or behavior therapy, showed positive change for both therapy types in 4 month and 1 year follow-up evaluations. Piper, Debbane, Bienvenu, and Garant (1984) studied 106 patients divided into four groups, each treated with a form of psychoanalytically oriented therapy. For two groups, treatment lasted 6 months, whereas the remaining two groups were treated over a 24-month period. Their results favored the short-term individual model as contrasted with the long-term individual model.

Although the data regarding brief intervention are encouraging, there are some obvious limitations inherent to this form of treatment. As Koss et al. (1986) pointed out, brief methods may not work for those patients who cannot quickly establish a working alliance with the therapist; similarly, the treatment can be expected to have a less favorable impact on change in patients who have diffuse and chronic difficulties that tend to resist any formation of a treatment focus.

A variety of tactics have been used to evaluate treatment effects; as argued by Persons (1991), psychotherapy effects are often difficult to evaluate because outcome studies are sometimes conceptually incompatible with the models of psychotherapy evaluated. The question of the validity of the criteria chosen to evaluate change as a result of therapy is extremely complex and involves epistemological issues. Change criteria may take any of several forms (social and vocational adjustment, behavioral or test data, subject's own evaluation, or therapist's judgments). One tactic that has been employed involves an inferential test–retest model. The logic of using a Rorschach retest model as an indirect measure of change is based on findings that Rorschachs of nonpatient adults remain highly stable over both short- and long-term intervals (Exner, 1986; Exner, Armbruster, & Viglione, 1978).

Weiner and Exner (1991) employed this model, offering data concerning the long-term changes in Rorschach data for two groups of subjects. One group (n = 88) were in an intense form of psychodynamically oriented therapy, from which no patient terminated treatment prior to 2 years and some were continuing in treatment as long as 5 years. A second group of 88 subjects were treated with behavioral or gestalt therapy from which 49 terminated before the 12th month

and all had terminated by the 16th month. All subjects were tested at the beginning of treatment and on three subsequent occasions, after 1 year, 2½ years, and 4 years.

Weiner and Exner noted that significant changes in Rorschach data occurred in both treatment groups, and the changes appeared to be sustained over time. The long-term treatment group showed a significant decrease in the frequency of 24 of 27 Rorschach indices of adjustment difficulty, which conceptually suggest improvement in six dimensions of personality functioning. The short-term treatment group showed a significant decrease over the 4-year period from the inception of their treatment in 20 of 27 Rorschach indices of adjustment difficulty, which also conceptually suggest improvement in six dimensions of personality functioning.

This study focused on short-term and very brief forms of treatment, attempting to address two issues by using Rorschach data as the essential criteria, but without neglecting the importance of subject reports. The main issues are: (a) What changes occur in a group of patients treated with either brief or short-term intervention models, and (b) how sturdy are those changes over time? No hypotheses were formulated as this was one of several exploratory investigations concerning the Rorschach that involved patients not drawn from the same population, not randomly assigned to the different treatments, and with no specific monitoring concerning methodologies employed by therapists.

METHOD

The subjects in the study consist of two groups of 35 patients each. One group was treated with brief therapy, that is, tactics designed for short duration with a specific treatment focus or objective. Sixteen therapists were involved, and no therapist treated more than three subjects. Treatment methodology appears to have varied considerably across therapists, although most described their own orientations as eclectic and their methods as directive or supportive. Treatment for this group averaged 14.2 sessions on a once per week basis (range = 12 to 15 sessions). The second group, used for comparison, consists of patients randomly selected out of a larger pool of 259 patients who had entered a short-term type of therapy (supportive, assertive, dynamic, rational–emotive, gestalt, and modeling). This pool of subjects is the same from which the Weiner and Exner (1991) short-term treatment subject were drawn, but none of these subjects were included in the Weiner and Exner data. The random selection of these subjects was stratified on the requirement that this group would not differ significantly from the brief treatment group for presenting complaints and several potentially important demographic features. Twenty-two therapists were involved with this group, with no therapist treating more than two subjects. Treatment for the

short-term group averaged 47 sessions on a once per week basis (range = 34 to 58 sessions). Individual choice between brief and short-term therapy appears to have been mainly determined by the availability of insurance coverage. The subjects volunteered to participate in this study after having been encouraged to do so by their respective therapists, who described it as an investigation concerning treatment effects, and after reading a description of the procedures involved.

The two groups are very similar in demographic make-up and presenting complaints. The brief treatment group included 14 males and 21 females ranging in age from 20 to 37 years (M = 24.6), with an educational experience averaging 13.3 years (range = 11 to 16). The short-term therapy group included 16 males and 19 females ranging in age from 21 to 39 (M = 25.6), with an educational experience averaging 13.6 years (range = 11 to 17). Approximately two thirds of the subjects in each group are married.

In each group, the majority of presenting complaints involved depression, anxiety, tension, or difficulties controlling emotion. Approximately half of the subjects in the brief therapy group also cited ongoing interpersonal/marital difficulties as a significant problem, whereas similar complaints occurred among only one third of the subjects in the short-term group. Only 1 subject in the brief treatment group complained of physical problems (headaches), whereas 7 subjects in the short-term group complained of chronic physical problems (headaches and stomach problems).

All subjects were administered the Rorschach and a self-report measure, the Katz Adjustment Scales–Form S (KAS–S; Katz & Lyerly, 1963), three times. The first administration took place before entering therapy. The brief therapy group was tested a second time at termination of treatment and again 8 to 12 months following termination. The short-term therapy group was tested the second time at therapy termination and the third time 10 to 12 months after termination. In other words, the brief treatment group was tested three times in 1 year, whereas the short-term group was tested three times during a period of 24 to 27 months. None of the subjects had reentered treatment at the time of the second retest.

The data were collected by 22 examiners, and none of the patients was tested by his or her own therapist or twice by the same examiner. Each examiner scored the Rorschach that he or she had collected, and a random half of the 210 protocols were subsequently rescored by one of three technicians, naive to the purpose of the study, to evaluate interscorer agreement. Percentage of interscorer agreement for the 105 records was calculated by subdividing scores into eight categories (location, determinants, form quality, pairs, primary content, popular, Z score, and special scores). The percent agreement ranged from a high of 98% for location (including developmental quality) to 86% for special scores (determinants = 90%; form quality = 92%; pairs = 96%; primary content = 94%; popular = 96%; Z score = 91%).

RESULTS

In that the two groups have not been drawn from the same population or randomized with regard to treatment assignment, between-group statistical analyses were inappropriate. Thus, only within-group analyses have been completed, with the data for each of the two retests compared to the baseline data.

Self-Report Findings

Data for three KAS–S scales were analyzed. The first concerns the presence of symptoms and is derived from 55 items to which the subject responds using a 4-point scale ranging from *have not had this complaint* (1) to *bothers me almost all the time* (4). The second focuses on the performance of free-time activities. This scale contains 23 items responded to on a 3-point scale ranging from *practically never* (1) to *frequently* (3). The third concerns satisfaction with the performance of free-time activities. It includes the same 23 items, but it is responded to a second time on a 3-point scale anchored as follows: *satisfied with what I do* (3), *would like to do more of this* (2), or *would like to do less* (1). Mean scores for the three KAS–S scales for the two groups at each testing are shown in Table 1.

The data from the baseline pretreatment testing for both groups reveals a broad array of symptom complaints. Although the groups were not compared statistically, the scores for each item are quite similar and suggest that the groups were not markedly different for symptom presentation. Similarly, the baseline data for both groups indicate relatively lower levels of free-time activity than is usually expected. Relatively low scores for satisfaction with free-time activities suggest that most subjects were dissatisfied with their social and free-time activities.

The Table 1 findings indicate that each group reported substantially fewer symptoms at termination and continued to report about the same level of symptom reduction at the second retest. Likewise, reports concerning performance of and satisfaction with free-time activities increased significantly at termination for both groups, and those gains appear to have been sustained to the time of the second retest. Overall, each group appears to manifest considerable improvement.

Rorschach Findings

Data for 27 structural variables drawn from seven clusters were chosen to study group trends. They include test variables related to: (a) capacity for control, stress tolerance, and coping styles; (b) affective features; (c) characteristics of ideation; (d) information processing; (e) cognitive mediation; (f) self-perception; and (g) interpersonal perception (Exner, 1991). A positive finding for any of 25

TABLE 1
Means for Three KAS Scales and Subscores Relating to Symptoms and Free-Time Activity for Two Groups of Outpatients Each Tested Three Times

	Baseline–Pretreatment		*1st Retest–Termination*		*2nd Retest–Posttermination*	
Variables	*Brief* M	*Short-Term* M	*Brief (3–4 months)* M	*Short-Term (8–12 months)* M	*Brief (8–12 months)* M	*Short-Term (24–27 months)* M
Symptoms Score Total	169.2	173.6	66.7*	71.2*	79.3*	69.8*
Symptoms Score subgrouped						
Anxiety/tenstion	27.1	33.6	12.8*	14.4*	16.8*	10.6*
Depression	77.2	81.6	37.9*	34.3*	39.6*	35.6*
Interpersonal	19.1	16.2	6.6*	6.1*	7.3*	4.2*
Emotional control	19.4	17.6	6.2*	5.9*	7.3*	5.1*
Free-Time Activity Score	17.1	15.3	28.6*	43.1*	36.8*	49.2*
Satisfaction Score	9.1	12.6	21.7*	26.8*	20.8*	29.3*

*Significantly different from baseline, $t(33) > 2.74$, $p < .01$.

of the 27 variables (excluding introversive and extratensive coping styles) suggests the presence of or potential for adjustment difficulties.

Frequency data for each of the 27 variables have been analyzed within each group using a series of chi-square tests, in which the data from each retest has been compared to the baseline test. The frequency data for each of the three testings are shown in Table 2.

An examination of Table 2 suggests that the baseline frequency data for the two groups are very similar for all of the 27 variables. Thus, even though the two groups were not selected from the same population, there is no reason to suspect that they differed significantly for the number of features that might be considered as evidence of potential problems in adjustment. It also seems clear that both groups evidence substantial change in the first retest.

At termination, the brief therapy group shows a significantly lower frequency of positive findings for 12 of the 27 variables. Four of the 12 relate to affective features; 3 concern self or interpersonal perception; 2 involve processing and mediation; and 1 each from the areas of controls, coping styles, and ideation. However, it appears as if all of the gains reflected in the first retest are not necessarily sustained 8 to 12 months later when the second retest was done. Significantly lower frequencies of positive findings occur for only 7 of the 27 variables, 4 concerning affect, 2 concerning processing and mediation, and the remaining 1 in the controls cluster.

The changes in the number of positive findings in the short-term treatment group are more extensive. The data from the termination retest show significantly lower frequencies for 20 of the 27 variables and involve all seven clusters of variables. The lower frequencies for those 20 variables are sustained in the data for the 1 year posttreatment retest; in fact, frequency data for two other variables, one concerning controls and one regarding coping styles, are added to the list of variables with significantly different frequencies when contrasted with the baseline data.

DISCUSSION

There is a sharp decrease in both groups for the frequency of records in which the *D* score is less than the Adjusted *D* score. That finding is evidence of situationally related stress and appears routinely when a crisis state exists. It seems quite likely that a sizeable proportion of patients in both groups decided to seek intervention because of some ongoing crisis situation. That postulate appears supported by the baseline KAS–S data. Thus, it seems reasonable to suggest that both types of treatment served well to help patients contend with the stresses that apparently caused them to seek assistance.

TABLE 2
Frequency Data for 27 Variables Among Two Groups Each Tested Three Times

Variables	*Brief Therapy Group*			*Short-Term Therapy Group*		
	Baseline	*1st Retest (3–4 months)*	*2nd Retest (8–12 months)*	*Baseline*	*1st Retest (8–12 months)*	*2nd Retest (24–27 months)*
	n	*n*	*n*	*n*	*n*	*n*
Controls						
CDI > 3	8	7	7	11	3*	3*
D < *Adj D*	19	5**	6**	16	1**	2**
Adj D < 0	5	6	5	9	4	3*
EA < 7.0	11	9	10	15	8*	7*
Coping styles						
Introversive	8	9	9	9	14	13
Ambitent	18	16	17	19	8**	5**
Extratensive	9	10	9	10	16	17*
Lambda > 0.99	12	3*	8	10	2**	2*
Affect						
DEPI > 4	19	7**	12*	18	7**	6**
S > 2	11	3*	7	13	4*	5*
Afr < .50	14	11	6*	15	5**	6*
CF + *C* > *FC* + 1	23	12**	13**	21	11**	8**
Sum Shading > *FM* + *m*	25	7**	4**	20	8**	6**

Ideation						
Sum 6 *Sp Sc* > 6	7	5	6	7	4	6
M− > 0	10	8	9	14	6*	5*
Mp > *Ma*	14	5*	12	15	6*	4*
Intellect > 5	9	7	10	8	1*	3
Processing and mediation						
Zd < −3.0	15	3*	4*	12	3*	3*
X+% < .70	24	12*	14*	21	7*	9*
X−% > 20	6	5	5	9	3	3
Self/interpersonal perception						
Fr + *rF* > 0	4	4	4	5	4	5
3*r* + (2)/*R* > .43	13	6*	7	14	9	8
3*r* + (2)/*R* < .33	17	7*	12	16	6*	5**
p > *a* + 1	11	9	10	13	4**	3**
T = 0	18	17	17	15	5**	5**
T > 1	7	0*	2	8	1*	1*
Pure *H* < 2	8	6	7	11	3*	3*

*Significantly different from baseline, χ^2 (1) > 5.41, $p < .02$. **Significantly different from baseline, χ^2 (1) > 6.64, $p < .01$.

Other Changes in Both Groups

A second area of change that appears in both groups concerns affective features. The baseline data suggest that a substantial number of subjects in both groups were prone to depression (*DEPI* > 4), in distress (*Sum Shading* > FM + *m*), less willing or able to modulate affective displays effectively (CF + C > FC + 1), and less willing or able to process emotionally toned stimuli (*Afr* < .50). The data from both retests for both groups shows considerably lower frequencies of subjects beseiged with these liabilities. Both retests for both groups also contain significantly fewer subjects who process information in the haphazard manner of the underincorporator (*Zd* < −3.0) and significantly fewer subjects who translate information in less conventional ways (*X*+% < .70).

The Brief Therapy Group

The other significant reductions in frequency that occurred in the brief therapy group at termination, but which apparently were not sustained for all subjects by the time of the second retest, are not very surprising. Five of the variables relate to core, trait-like features of personality that are not expected to change quickly or easily. For instance, high *Lambda* values or instances in which *Mp* exceeds *Ma* are both marked styles in which the former reflects an orientation to simplify stimulus situations and the latter represents an orientation to replace unwanted complexity with fantasy. It seems probable that the tactics involved in the active brief treatment tended to thwart or supercede these features, but once treatment ended they regained dominance. A similar process probably occurred with regard to the elevation in the variable *S* > 2, which usually signals a more negativistic or hostile view toward the environment, and in those instances in which a low Egocentricity Index occurred. It indicates low self-esteem and a change in this orientation usually involves a more extensive reevaluation of self-concept than might be feasible in a period of 12 to 15 weeks.

The data concerning elevated Egocentricity Indices, which signals an excessive self-focusing, and *T* > 1, which indicates negative feelings caused by loss and/or loneliness, are probably somewhat spurious. At termination, both frequencies had reduced to a statistically significant level. The data for the second retest are not statistically significant, but the frequencies for both variables are much closer to those of the first retest than the baseline.

Although the changes that did occur among the brief therapy patients, especially those that apparently were sustained, are impressive in light of the brevity of treatment, some attention to those variables for which no change occurred seems warranted. As might be expected, no substantial change occurred for basic coping styles. The majority remain ambitent, suggesting that they tend to vacillate much more than is desirable in most coping situations.

Less desirable modes of ideation also are unchanged. Among the more important of these are the previously noted elevations in *Mp* as contrasted with *Ma*, plus a substantial frequency (almost one third) who continue to rely extensively on intellectualization as a routine tactic for dealing with emotion. Similarly, many undesirable features concerning self and interpersonal perception have not changed. Nearly one third remain prone to passivity in many interpersonal roles ($p > a + 1$), more than half the group is *T*-less, about 20% remain socially unskilled or inept (*CDI* > 3), and about 20% do not have a very clear perception of themselves or others ($H < 2$).

The Short-Term Therapy Group

As noted earlier, the frequency data show a significant reduction for 20 of the 27 variables at termination, and all of those reductions continue to appear 1 year after termination. In fact, two additional variables also become statistically significant for lower values in the second retest because the values increased or decreased in each instance by one subject (extratensive coping style, *Adj D* < 0). The changes are consistent with those reported by Weiner and Exner (1991) even though their short-term subjects were treated with either behavioral or gestalt therapy, whereas the 35 patients in this sample were treated by any of five methods, including either behavioral or gestalt therapy.

Positive changes appear to have occurred for many of these patients in all areas. In addition to previously mentioned changes concerning situational stress experiences and affective features, significantly fewer of these subjects show problems in control (*Adj D*) or problems with resource accessibility (*EA* < 7.0). Significantly more have marked introversive or extratensive coping styles, and fewer show tendencies to oversimplify stimulus inputs (high *Lambda*). Substantially fewer show low self-esteem (low *Egocentricity Index*) and the number showing potential problems in the interpersonal sphere is very low (CDI > 3, $T = 0$, $H < 2$, $p > a + 1$). In addition, significantly fewer rely excessively on intellectualization (*Intellect* > 5) or fantasy (*Mp* > *Ma*) to contend with external stimuli that are perceived as stressful or unwanted.

The Rorschach data seem to provide an ample basis from which to argue that considerable improvement occurred in the psychological organization and/or operations of both groups, and this appears to have some confirmation in the self-report data. It is tempting to conclude that the benefits of the short-term treatment methods are more substantial than those from brief treatment, but such an assumption is tenuous at best because the two groups did not come from the same population.

It is also important to note that some subjects in each group persist in features that are usually regarded as liabilities and potential precursors to maladjustment. For example, there is no change for the frequency of reflection responses

and no noticeable change for the number of subjects who have more critical special scores than most adults. In fact, if the data are viewed from a treatment failure perspective, it could be argued that as many as one third of those treated with brief therapy and about 20% of those terminating short-term therapy remain vulnerable to adjustment problems. However, Rorschach data are not always the best source from which to make predictions concerning future adjustment. The fact that these patients terminated treatment willfully and that none reentered treatment during the first 8 to 12 posttreatment months suggests that the liabilities might not be as potent or that one of the products of treatment may have been the development of ways to reduce the potential negative effects of these liabilities.

There is another seemingly intriguing finding concerning the short-term therapy group. The convergent positive findings from the external self-reports and the internal Rorschach assessments appear to provide a valid basis from which to conclude that positive changes occurred in both groups, but especially in the short-term therapy group. These changes occurred among subjects that are homogeneous in demographic make-up and the type of presenting complaints, but quite heterogeneous regarding the therapeutic techniques used. Five very different intervention methods were employed among the 35 patients involved in short-term therapy. The substantial gains experienced by the majority of short-term therapy patients tend to suggest that any form of therapeutically oriented intervention with patients undergoing situational stress and seeking psychological help has a strong probability of alleviating the symptoms regardless of the intervention strategy used. In that case, it appears that the variety of interventions have a feature in common that might be conceptualized as a general helping factor such as the one hypothesized by Smith, Glass, and Miller (1980) and Shapiro and Shapiro (1982). Logically, this factor is, or builds on, the working alliance between patient and therapist.

Finally, it seems important to note that these findings, like those of Weiner and Exner (1991), provide some indirect evidence concerning the validity of some structural variables in the Rorschach and the usefulness of a pre–posttreatment assessment to evaluate change. In this instance, data concerning the relationship between the *D* and Adjusted *D* scores, the *Affective Ratio*, the X+%, the *Egocentricity Index*, the relationships between FC and CF + C and *FM* + m and the *Sum of Shading*, the *Zd* score, and the texture and space responses appear to be especially important. Studied independently, the data might seem to be of limited importance, but when contrasted with long-term temporal consistency data for nonpatients (Exner, 1986), the changes noted for these two treatment groups are impressive. They suggest that changes do occur over time in the structural and functional characteristics of many outpatients, apparently as a result of treatment, and some of these changes can be detected rather easily using Rorschach methodology.

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