

A Test of the Phase Model of Psychotherapy Change

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Objective: A comparative trial of 2 forms (interpretive and supportive) of short-term, time-limited individual (STI) therapy provided data that were used to test the propositions of the Howard and others phase model of psychotherapy change.

Method: Patients completed the Integra Outpatient Tracking Assessment Form on 5 occasions during the 20-session treatments. The measure assesses 3 dimensions: subjective well-being, current symptoms, and current life dysfunction. Howard and others regard these as dimensions that represent successive phases in the therapy change process (that is, well-being improves first, followed by resolution of symptoms, and finally by change in long-standing life dysfunction). We conducted a test of their model, using their approach to data analysis.

Results: The comparative trial data provided no support for the phase model.

Conclusions: Possible explanations for the absence of confirmatory findings are considered.

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Clinical Implications

- The phase model may not generalize from moderately disturbed patients in brief open-ended therapies to more severely disturbed patients in short-term, time-limited therapies.
- The original evidence for the phase model may have confounded sample attrition with change in therapy.
- The method used to evaluate the propositions of the phase model may be limited with respect to accurately representing the pattern of change evidenced by patients during treatment.

Limitations

- Ratings of pretherapy status on the measures of well-being, current symptoms, and current life dysfunction were not collected, which may have compromised our test of the phase model propositions.

Key Words: *short-term, time-limited psychotherapy, therapy change process, outpatient treatment.*

The nature of change is at the heart of research on psychotherapy. Researchers have demonstrated that psychotherapy is effective and have begun to address how change unfolds during the therapy process. Eventually, these efforts should clarify how characteristics of the treatment, the patient, the therapeutic relationship, and the therapist's technique singly and jointly influence change during psychotherapy (1).

In this study, we evaluated a contemporary conceptual model of the change process (2), using data from a comparative trial of 2 forms of short-term, time-limited dynamic therapy (3).

The phase model of psychotherapy change, developed by Ken Howard and colleagues, is an extension of the dose-response model of treatment response (4). The phase model outlines a progressive, 3-stage sequence of change. In the first phase, the patient experiences a restoration of subjectively experienced well-being. The second phase focuses on the resolution of the patient's symptoms. This phase occupies a greater number of sessions (generally, between the 5th and the 15th session of therapy). In the third and most protracted phase, changes in maladaptive forms of life functioning emerge more gradually.

An important principle of the model is that change in one phase (well-being) constitutes a necessary precondition for change in a subsequent phase (current symptoms).

Howard and others present evidence for the causal sequence outlined by the phase model, based on a naturalistic sample of 473 outpatients at the point of initial assessment (2). Patients provided ratings of well-being, current symptoms, and current life dysfunction at sessions 2, 4, and 17. In line with the open-ended therapy format, there was a high degree of attrition from the sample: over one-half of the patients had discontinued therapy by session 4. Two predictions were tested: 1) improvement in well-being is a precondition for improvement in symptoms, and 2) improvement in symptoms is a precondition for improvement in life dysfunction. Tests of the phase model were based on 2-by-2 cross-classification tables, representing the frequency of cases at each assessment that did or did not show clinically significant improvement on the dimensions of interest. (The method section provides details on the analysis approach.)

The phase model is conceptually sound and intuitively appealing to clinicians. Other investigations have provided support for the model. Barkham and others reported a dose-effect relationship in a comparative trial of 8- and 16-session therapies for patients with major depression; that is, patients in the longer therapies showed greater improvement (5). They also noted changes in line with the phase model; specifically, well-being and acute symptoms showed the earliest and most rapid improvement. Hilsenroth, Ackerman, and Blagys described early changes in well-being and symptoms that, in turn, predicted changes in interpersonal dysfunction shown by the 9th session of short-term psychodynamic psychotherapy (6). Similar findings have emerged from studies involving cases selected to reflect specific types of emotional problems (7,8). Change in these studies was evaluated in terms of aggregate scores for the entire sample. In contrast, the Howard and others' cross-classification method attends to the changes shown by individual patients (2). A direct test of the phase model using the cross-classification method is important for replication purposes and should produce findings similar to those of Howard and others. Thus, we attempted to provide a replication that duplicated their findings by using the same measure and methods, based on data from our comparative trial of 2 forms of brief psychotherapy (2).

The comparative study used a randomized clinical trial design to investigate the efficacy of interpretive and supportive forms of short-term, time-limited individual (STI) therapy, with a diagnostically mixed and clinically representative sample of 144 outpatients (3). Attendance for both therapies was high; essentially the same patient cohort provided ratings of well-being, current symptoms, and current life dysfunction across

the repeated assessments. At posttherapy, patients in both forms of therapy demonstrated statistically and clinically significant improvements of equivalent magnitude. Follow-up assessments at 6 and 12 months indicated equivalent maintenance of gains or further improvement (9). During therapy, we examined patient ratings of well-being, current symptoms, and current life dysfunction to test the sequence of change predicted by the phase model.

Method

Setting and Procedure

Details of the methods of the comparative trial are provided in our report of the posttherapy outcome findings (3). Patients were referred from the Psychiatric Treatment Clinic, at the University of Alberta Hospital Site, in Edmonton, Alberta. The clinic serves a catchment area that extends across Central and Northern Alberta. After obtaining informed consent, patients participated in interview and questionnaire assessments of predictor, demographic, diagnostic, and outcome variables. Patients were matched in pairs on personality variables, use of medication and, when possible, sex and age. Matched pairs were then assigned randomly to interpretive therapy or supportive therapy and to 1 of 8 therapists. Seventy-two matched patients completed each form of STI therapy ($n = 144$).

Patients and Therapists

The computer-administered Structured Clinical Interview for DSM-III-R determined the patient diagnoses (10,11). Axis I diagnoses were validated by an independent clinical diagnosis, assigned jointly by the intake assessor and a staff psychiatrist, both of whom saw the patient on the day of presentation. Nearly three-quarters (72.9%) of the patients received an Axis I diagnosis. The most frequent diagnoses were major depression (48.6%), dysthymia (26.4%), anxiety disorder (7.6%), and adjustment disorder (7.6%). A total of 60.4% of the patients received an Axis II diagnosis. The most frequent personality disorders were avoidant (29.2%), obsessive-compulsive (24.3%), borderline (22.2%), and paranoid (21.5%). Slightly less than one-half of the sample (46.5%) received both Axis I and Axis II diagnoses. Patients with primary problems related to psychosis, substance abuse, or antisocial behaviour were excluded. Pretherapy scores on the following 3 familiar measures of psychiatric disturbance exceeded outpatient norms, confirming the clinical representativeness of the sample: Beck Depression Inventory (mean 18.83) (12); Spielberger Trait Anxiety Scale (mean 52.64) (13); and Global Severity Index of the Symptom Checklist (mean 1.15) (14).

The average age of the patients was 34 years (SD 9.6, range 18 to 62 years), and 61% were women. Of the patients, 42% were living with a partner, 21% were separated or divorced, and

37% had never been married. Two-thirds were educated beyond high school, and 71% were employed. Three-quarters of the patients reported receiving previous psychiatric treatment, but few (8%) had a history of psychiatric hospitalization.

A total of 8 therapists (3 psychologists, 2 social workers, 2 occupational therapists, and 1 psychiatrist) each treated 18 patients, 9 in each form of therapy. There were 5 women, with an average age of 44 years (SD 6.1, range 37 to 52 years), and their average experience practising individual therapy was 11.8 years (SD 4.9, range 3 to 19 years).

Therapies

Each patient received a form of therapy that emphasized interpretive or supportive features. The primary objective in interpretive therapy is to enhance patient insight about a recurrent intrapsychic or interpersonal conflict. The therapist emphasizes the exploration of uncomfortable emotions, abstains from gratifying the patient, and makes use of the here-and-now relationship to clarify the patient's difficulties. The therapist is active, interpretive, and transference-focused. In supportive therapy, the primary objective is to improve the patient's adaptation to his or her life situation. The therapist acts to minimize anxiety and regression during sessions, encourages collaborative problem-solving, and makes use of advice, guidance, encouragement, and praise. The therapist is active, noninterpretive, and other-focused, (that is, focused on current external relationships).

Each patient received regular weekly 50-minute sessions for 20 weeks. Therapists followed a 2-part manual that outlined and contrasted the technical emphasis associated with each form of therapy. For both treatments, the manual recommends that sessions 1 to 2 be devoted to history-taking, the building of rapport, and the formulation of a central focus. The manual outlines specific techniques associated with each therapy for sessions 3 to 20. We found therapist adherence to the therapy manual to be high (15). Adherence ratings also clearly differentiated the 2 forms of treatment.

Most (94%) of the patients attended 15 or more sessions. For the 144 patients in the sample, the mean number of sessions attended was 18.1 (SD 2.0, range 11 to 20 sessions).

Measure of Change

To assess change during therapy, patients were asked to complete the Integra Outpatient Tracking Assessment Form (16) at sessions 4, 8, 12, 16, and 20. This self-report comprises 68 items, divided into 3 scales. We assessed well-being by using 4 items that address present levels of distress and energy, global adjustment, and life satisfaction. Further, we evaluated current symptoms with 40 items that address the symptomatology associated with 6 prevalent Axis I conditions (depression, bipolar disorder, adjustment disorder, anxiety,

obsessive-compulsive disorder, and phobia), experienced by the patient during the previous month. Next, current life dysfunction used 24 items that focus on present levels of functioning in family, intimate, and social relationships; in work roles; and in health maintenance and self-management. Higher scores on each scale represent healthier functioning. Howard and others report strong short-term test-retest reliability and convergent-discriminant validity for the Integra scales (16).

Due to absenteeism or failure to complete the form at particular sessions, the total n for a given assessment ranged between 106 and 118 cases (74% to 82% of the total sample). The Integra measure had not been administered prior to treatment. Pre-therapy estimates of well-being, current symptoms, and life dysfunction were therefore unavailable. The patients' ratings from session 4 were employed as the baseline standard for evaluations of subsequent improvement. These ratings were provided following the initial sessions that were devoted to history-taking and formulation, at a point where the therapy process itself was being established.

Approach to Analysis

For each Integra variable, patient change was represented by the difference between scores at a given assessment and the baseline (session 4 ratings), which were expressed in baseline score SD units. Baseline and assessment change scores were then converted to T-score values.

Howard and others note that statistical regression to the population mean is a potential confound when considering an individual's improvement over time (2). Specifically, in some circumstances, improvement across observations might be expected on the basis of regression and independent of treatment effects. Using the approach described by Speer, we identified that regression to the mean was evident for each of the Integra variables across assessments (17). Like Howard and others, we calculated "true score adjusted" versions of the baseline ratings to correct for possible attenuation in the scores associated with regression to the mean. This adjustment took into account the test-retest reliability and population mean associated with each Integra variable, derived from Howard and others (16).

Following Howard and others (2), patients whose adjusted baseline score was at the extreme positive tail of the distribution (1.5 SD units or above from the sample mean in the direction of improvement), and who were therefore unlikely to show much further positive change, were excluded from all analyses. This resulted in the exclusion of 8 cases from the distribution for the well-being scale, 4 cases for the current symptoms scale, and 9 for the current life dysfunction scale. The sample at baseline was reduced by 15 (available $n = 103$), when the cut-off for all

3 variables was in effect. Missing data resulted in a sample of 83 to 89 cases for a given assessment.

To define improvement, we followed Howard and others' definition of clinically significant change (2). This was represented by a change in the direction of improvement that exceeded the standard error of measurement associated with each scale. In T-score terms, a change of 5 points (or 1.67 standard errors of measurement) in the direction of improvement represented a clinically significant change. Thus, for a given Integra variable, each case at each assessment point was classified as either improved (a positive change of 5 T-score points or more) or nonimproved (a negative change, no change, or a positive change of less than 5 T-score points), relative to the adjusted baseline score. To test the predictions of the phase model, Howard and others used a 2-by-2 cross-classification procedure (2). The frequency of improved and unimproved cases is represented for each pair of Integra variables at each assessment (for example, well-being and current symptoms at session 8). If improvement in well-being serves as a precondition for improvement in current symptoms, few if any cases, should be observed in the well-being nonimprovement and symptoms improvement cell of the cross-classification. Cross-classifications, involving each pair of Integra variables (well-being and current symptoms, current symptoms and current life dysfunction) were generated for each assessment (sessions 8, 12, 16, and 20).

Results

No significant differences between the 2 forms of STI therapy were identified for any Integra variable, either for single-session assessments or for repeated assessments across sessions. The Integra data were therefore pooled over the 2 treatment conditions.

Analyses of Improvement

Table 1 presents data relevant to the first proposition of the phase model; that is, improvement in subjective well-being is a necessary precondition for a reduction in symptomatic distress. Improvement or nonimprovement in well-being (rows in Table 1) is crossed with improvement or nonimprovement in current symptoms (columns in Table 1) for each assessment. Support for the first proposition would require that there be no patients who showed improvement in symptoms who did not also show improvement in well-being. According to Howard and others (2), if the relative frequency of the row (well-being) nonimprovement and column (symptoms) improvement cell is notably lower than would be expected, support for the first causal proposition of the phase model is considered evident.

Table 1 indicates that, across the replicated cross-classifications, no single cell consistently reflected a lower-

than-expected frequency of cases. For sessions 8 and 12, the lowest frequency was recorded in the well-being improvement and symptoms nonimprovement cell. For sessions 16 and 20, the lowest frequency was recorded in the well-being nonimprovement and symptoms improvement cell. These differences were relative; in no instance was the lowest cell frequency substantially smaller than for those other cells in the cross-classification. Therefore, the improvement data presented in Table 1 provide no support for the first proposition of the phase model.

Table 2 presents the data relevant to the second proposition of the phase model; that is, that symptom resolution is a necessary precondition for improvement in life dysfunction. Improvement or nonimprovement in current symptoms (rows in Table 2) is crossed with improvement or nonimprovement in current life dysfunction (columns in Table 2) for each assessment. Across the 4 replicated cross-classifications, the lowest cell frequency was recorded for symptoms improvement crossed with life dysfunction nonimprovement. As a result, the data failed to provide support for the second causal proposition of the phase model. According to the method of Howard and others, the patterns represented in Table 2 actually suggested a sequence of change running counter to the phase model: improvement in current symptoms was less likely if improvement in life dysfunction had not already occurred (2).

Following Howard and others, the chi-square values associated with the cross-classification from each session assessment have been noted at the bottom of the tables. These values

Table 1 Improvement in well-being vs current symptoms between session 4 baseline and session assessments

		Occurrence of symptom	
		Not improved	Improved
Occurrence of well-being in session	Not improved		
	Improved		
Session 8 ^a			
	Not improved	64	8
	Improved	6	9
Session 12 ^b			
	Not improved	50	9
	Improved	8	16
Session 16 ^c			
	Not improved	55	12
	Improved	7	13
Session 20 ^d			
	Not improved	30	11
	Improved	9	34

^a $\chi^2(1, n = 87) = 18.87, P < 0.0001.$
^b $\chi^2(1, n = 83) = 21.42, P < 0.0001.$
^c $\chi^2(1, n = 87) = 16.67, P < 0.0001.$
^d $\chi^2(1, n = 84) = 23.03, P < 0.0001.$

Table 2 Improvement in current symptoms vs current life dysfunction between session 4 baseline and session assessments

Occurrence of symptom in session	Occurrence of life dysfunction	
	Not improved	Improved
Session 8 ^a		
Not improved	61	10
Improved	13	4
Session 12 ^b		
Not improved	51	8
Improved	11	14
Session 16 ^c		
Not improved	55	8
Improved	11	14
Session 20 ^d		
Not improved	35	6
Improved	16	29

^a $\chi^2(1, n = 88) = 0.92, ns.$
^b $\chi^2(1, n = 84) = 16.36, P < 0.0001.$
^c $\chi^2(1, n = 88) = 17.90, P < 0.0001.$
^d $\chi^2(1, n = 86) = 22.05, P < 0.0001.$

indicate the likelihood of a relation between the variables in the population, given data from this sample, but are not necessarily a test of the phase model propositions. For example, in Table 1, the significant chi-square value for the session 8 cross-classification is largely a function of the cell having a high frequency of cases (that is, 64) that were classified as not improved on both variables. The test does not indicate the likelihood of a sequential relation between the variables as proposed by the phase model.

Sequential Change Analyses

The cross-classification approach to testing the phase model may be limited. Improvement is represented in a somewhat coarse way, and the actual pattern of change evidenced by individual cases across therapy is not captured. We developed an alternative procedure for testing the phase model. The procedure involved determining the order in which the patient achieved change on each of the variables—in other words, which variable showed significant improvement first, second, and third. Significant improvement, as described earlier, was indicated by a change of at least 5 T-score points relative to the adjusted baseline in the favourable direction. The 6 possible combinations for the order in which the variables could evidence change are as follows: 1) well-being first, current symptoms second, and current life dysfunction third; 2) well-being first, current life dysfunction second, and current symptoms third; 3) current symptoms first, well-being second, and current life dysfunction third; 4) current symptoms first, current

life dysfunction second, and well-being third; 5) current life dysfunction first, well-being second, and current symptoms third; or 6) current life dysfunction first, current symptoms second, and well-being third.

For the phase model, the expected order of change was well-being first, current symptoms second, and current life dysfunction third (that is, the first combination listed above).

We again excluded cases that provided session 4 ratings that were at the extreme end of the distribution (1.5 SD units or more from the sample mean in the direction of improvement) for any Integra variable. Two additional cases that had provided ratings at session 4 and at no other assessment were also excluded. The sample available for the analysis was $n = 101$. Eleven cases showed no improvement on any of the Integra measures. In addition, 20 cases did not show improvement on more than 1 of the variables, meaning we could not determine an ordering of change. In total, 70 cases provided data for this analysis.

The order of change on each variable for each of the 70 patients was determined. We used a chi-square test to determine whether the number of cases evidencing each of the 6 combinations of change differed significantly from that expected by chance. Because 70 cases provided data, the expected frequency for each combination was 11.7. The chi-square test was not significant, ($\chi^2 = 9.17, df 5, P > 0.05$). The analysis also did not support the central proposition of the phase model; specifically, change in well-being, current symptoms, and current life dysfunction follow one another in sequential fashion.

Additional Analyses

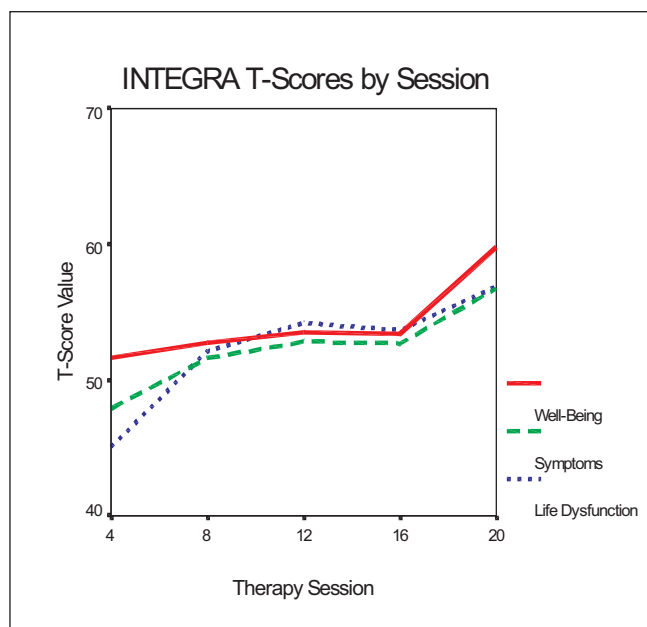
Table 3 presents the descriptive statistics for each Integra variable across sessions for all available cases from the comparative trial. The table includes the adjusted scores for each variable at session 4, representing the baseline for determinations of subsequent improvement. The T-score values for subsequent assessments were calculated relative to the baseline scores, as described. For any given assessment, the intercorrelations among the Integra variables were substantial. The average intercorrelations across assessments were 0.53 for well-being and current symptoms, 0.32 for well-being and current life dysfunction, and 0.44 for current symptoms and current life dysfunction (all $P < 0.01$).

Figure 1 illustrates a plot of the mean Integra T-scores across sessions. The plot bears little resemblance to a similar plot provided by Howard and others (2). The 3 variables evidenced the same pattern across assessments (that is, a sequential pattern of change was not evident). The high degree of covariation suggests that change on the 3 Integra dimensions tended to be concurrent rather than sequential among the comparative trial patients. In addition, the Howard and others plot

Table 3 Integra outpatient tracking assessment T-scores by session

Variable	Session 4 ^a	Session 8	Session 12	Session 16	Session 20
Well-being					
Mean	51.62	52.74	53.49	53.41	59.80
SD	6.66	8.95	10.67	10.49	10.84
<i>n</i>	103	88	83	88	85
Current symptoms					
Mean	47.91	51.60	52.83	52.68	56.75
SD	7.78	5.90	6.84	7.24	8.03
<i>n</i>	103	88	84	89	86
Current life dysfunction					
Mean	45.04	52.09	54.20	53.68	56.91
SD	6.61	9.95	10.36	9.12	11.28
<i>n</i>	103	89	84	89	87

Note: Higher scores denote greater health.
^aSession 4 values are "true score adjusted" after Spear (17) to attenuate effects associated with regression to the mean when employing repeated measures. Adjusted session 4 values were used as the reference to determine improvement at subsequent assessments.

Figure 1 Mean integra T-scores across session assessments, *n* = 83 – 103

indicated substantial improvements early in treatment, with smaller and more gradual changes occurring over the remaining duration of therapy (2). In the comparative trial, gradual improvement was noted for early sessions, with substantial change on all 3 variables recorded only late in the STI therapies.

Despite the different patterns of improvement, the amount of change between the session 4 baseline and the final Integra assessment for patients in the comparative trial resembled the

change shown between intake and session 17 in the Howard and others sample (2). From session 4 through termination, the Edmonton patients reported a mean improvement in well-being of 0.82 SD units. This was similar to the mean improvement of 1 SD between intake and session 17 reported by Howard and others (2). For current symptoms, the Edmonton patients reported a mean change of 0.88 SD units, again similar to the mean change of 0.80 SD units reported by the Howard patients. Finally, the Edmonton patients reported a mean change in current life dysfunction of 1.19 SD units, substantially more than the mean change of 0.64 SD units recorded by the Howard and others patients (2).

Discussion

Our intention in this study was to provide a direct test of the phase model of change in psychotherapy. As much as possible, we wanted to adhere to the methodology in the original presentation of the phase model and, for this reason, we employed the same measure and analytic approach (2). We evaluated reported change over the course of therapy on the Integra variables, relative to the patient's ratings of well-being, current symptoms, and current life dysfunction at session 4. The cross-classification analyses provided no support for either proposition of the phase model. In numerous instances, a sequence of change running counter to the propositions of the phase model (for example, life dysfunction change preceding and being required for symptom change) appeared equally or more likely representative of the changes reported by our patients. Other methods used to evaluate the data,

including a review of the sequential change shown by individual patients and an evaluation of the covariation of the 3 Integra variables, also provided no support for the phase model of change. As a result, the data from the comparative trial failed to provide cross-validation of the Howard and others findings (2). We can suggest 3 explanations that account for this failure.

First, the absence of confirmatory support may indicate that the phase model does not generalize to all forms of psychotherapy nor to all patients. Evidence from the studies by Howard and colleagues (2,7,8) suggests that the model may apply to brief, open-ended therapies. The findings of the present study suggest that the phase model might not, however, generalize to different forms of STI psychotherapy.

With respect to patients, both the Howard and others (2) and Edmonton samples of therapy cases were large and drawn from the outpatient services of university teaching hospitals. Given this similarity of setting, an equivalent degree of pathology might be assumed. Howard and others state only that their patients had presented with "mild to moderate psychological disorders" (2, p 681). The phase model of change may therefore apply to patients with moderate disturbance at most. In contrast, patients in the Edmonton sample presented primarily with mood or anxiety disorders, and many had personality disorders. Their scores were clearly in the outpatient range on well-known measures of psychiatric disturbance. It is possible that, as a group, the Edmonton sample presented with greater illness severity and chronicity. The sizeable proportion with comorbid Axis I and Axis II disorders (46.5%) supports this contention. As a result, the phase model may apply less to more disturbed patients.

Regarding therapies, the open-ended treatments in Howard and others were likely quite varied in terms of goals, therapist technique, and duration (2). In contrast, we recruited the Edmonton sample for a clinical trial study, and the focus of our analysis was solely on those patients who had completed a course of time-limited, 20-session individual therapy. The therapies were conducted in accordance with a manual. Consequently, there was most likely greater consistency across therapies for the Edmonton sample, relative to the Howard and others sample (2).

Second, the findings reported by Howard and others (2) may have been artifacts of the degree of attrition associated with their patient sample. More than 50% of the original cases had discontinued therapy by session 4 and 80% by session 17. Hence, a large proportion of the cases provided no data from later stages of therapy. The Howard and others analysis may have capitalized on the ratings of patients who terminated after only a few sessions (2). Possibly, many of these patients had adjustment reactions, responded quickly to the provision

of a different perspective on their problems, experienced enhanced morale, and left feeling satisfied. This would account for the high early elevation of the well-being scores in the Howard and others sample. It is not known whether these patients experienced subsequent changes in symptoms or life dysfunction. The patients who remained in therapy would be more likely to focus on these latter dimensions and report improvements in these areas as therapy progressed. Consequently, the pattern of change that was reported as supportive of the phase model may have been determined more by the time that patients terminated their treatment than by any sequential pattern of outcome change. In contrast, essentially the same cohort of patients in the Edmonton sample provided ratings of the Integra scales throughout therapy. This would support confidence in the observed pattern as a more accurate representation of outcome change during treatment.

Third, we regard the cross-classification method used to test the sequential change predicted by the phase model to be logically unconvincing. The conclusion that the frequency of occurrence in a particular cell of a cross-classification provides support for a causal principle appears to be subjective. No set criteria exist for determining whether a certain proportion of cases in one cell relative to others in the classification unequivocally reflect phenomena associated with the model. The method also provides no means of determining the statistical significance of a supportive finding. More appropriate statistical tests exist for examining variations in improvement on different dimensions across time (6). In this study, we used a rank ordering of the clinically significant change achieved for each patient on each of the 3 Integra variables and a test of the significance of the frequency of the observed combinations of change against chance.

It can be argued that the absence of information on the patient's status on the Integra measures at intake represented a limitation of the current study. The phase model asserts that substantial improvement on well-being occurs between pre-therapy and early therapy sessions. The comparative trial data provided no assessment of change during this interval. For this reason, it is possible that our evaluation of the first proposition of the phase model in particular was an insufficient one. On the other hand, patient ratings at session 4 came at the point when the therapy process proper was being established (following the first 2 sessions devoted to history-taking, establishment of the alliance, and formulation of a central focus). This therapy model and the data we obtained provided for a reasonable test of the phase model propositions. Even if this had not been the case, the comparative trial data also failed to provide support for the second proposition of the Howard and others model (2).

In summary, the current findings raise reasonable questions about the generalizability of the Howard and others phase

model of change and the method employed to assess its validity (2). The phase model may be only 1 representation of the process of change in therapy—perhaps most appropriate to mildly or moderately disturbed patients in brief, open-ended treatments. The pattern of outcome change during the short-term, time-limited treatment of more severely disturbed patients may follow a different sequence, or different domains of functioning may be impacted in similar ways by certain critical incidents during therapy. It is probable that any sequence of in-therapy change will vary considerably from the original phase model as a function of the characteristics of the patient, the treatment approach provided, and their interaction.

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Résumé : Modèle de phase de changement en thérapie : un essai du modèle de phase de changement en psychothérapie

Objectif : Un essai comparatif de 2 formes (d'interprétation et de soutien) de thérapie individuelle à court terme limitée dans le temps (ILT) a fourni des données qui ont servi à mettre à l'essai les propositions de Howard et collaborateurs sur le modèle de phase de changement en psychothérapie (1).

Méthode : Les patients ont rempli le formulaire d'évaluation de suivi des patients Integra (2) à 5 occasions durant le traitement de 20 séances. L'instrument de mesure évalue 3 dimensions : le bien-être subjectif, les symptômes courants et la dysfonction de vie actuelle. Howard et coll. (1) considèrent que ces dimensions représentent les phases successives du processus de changement en thérapie (c'est-à-dire que le bien-être s'améliore en premier, suivi de la résolution des symptômes et finalement, du changement de la dysfonction de vie de longue durée). Nous avons procédé à un essai de leur modèle, à l'aide de leur méthode d'analyse des données.

Résultats : Les données de l'essai comparatif ne soutenaient pas le modèle de phase.

Conclusions : Des explications possibles de l'absence de résultats probants sont envisagées.