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Date August 6, 1971

THE FIVE MAJOR VARIABLES OF PSYCHOTHERAPY -- A REVIEW

by

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ABSTRACT

The purpose of this review was to investigate some of the literature containing research about the five major variables in psychotherapy: (1) the therapist variable, (2) the client variable, (3) the relationship variable, (4) the process variable, and (5) the outcome variable.

In the discussion of the therapist variable, this paper investigated the manner in which the therapist views his role in Psychoanalysis, Rational Emotive Therapy, Logotherapy, Client-Centered Therapy, Gestalt Therapy, and Behavior Therapy.

The client variables that were investigated were: sensivity to others, client satisfaction, intelligence, sex role identification, client verbal expressivity, and client expectations.

The relationship variable was investigated in reference to how major psychotherapists view the relationship between client and therapist in psychotherapy. Some research evidence was presented regarding the relationship in major schools of psychotherapy and how they compared. Introjection and client-therapist compatibility were also discussed as relationship variables.

In the discussion of process variables an attempt was made to describe the therapy process by means of Brammer and Shostrum's six steps of therapy. There was also some discussion of the critical points in therapy.

The outcome variable discussion centered around research concerning length of time in therapy and the number of contacts with the therapist. A review was also presented concerning the outcome claims of the conditioning therapies of Salter and Wolpe. A number of studies were presented concerning the outcome of client-centered therapy. A summary chart of fifty-two outcome research studies was presented.

The investigation tended to substantiate the fact that research in psychotherapy is ever changing. It also revealed the necessity for every counselor to read and continue to grow professionally.

The above mentioned variables are so complex that no one investigation can adequately discuss them.

CHAPTER I

INTRODUCTION

Counseling and psychotherapy have revealed themselves to the writer as an extremely varied and complex science. As a result of that, this paper is an attempt to tie some of what were to this writer the loose ends concerning research in the science of psychotherapy.

Reasons for Selection of the Topic

As the writer began to assume he had more knowledge about counseling and psychotherapy, it became crystal clear that he knew less and less. So, as a result of that, the writer began to do a very elementary persual of the literature concerning research into counseling and psychotherapy.

The research in the area is overwhelming to say the least and to make the task somewhat easier, it was decided to divide the investigation into the five most commonly accepted variables in counseling and psychotherapy.

(1) The therapist variable - to attempt to isolate all the therapist variables would be assigning the task of isolating every variable concerning every therapist currently practicing in the world, but since therapists tend to grow and change, this would be a never ending task. To facilitate this review, a few of the major schools and theories were investigated.

(2) The client variable - Since clients are human beings, with their ever changing conditions in environment, emotions, feelings, attitudes, etc., only a few of the researched, isolated variables of the client will be discussed.

(3) The relationship variable - To adequately discuss the relationship variable in counseling would require an investigation into the variables that effect every interpersonal relationship that has ever been experienced. Perhaps research has isolated a few of these variables, which will be discussed in this paper.

(4) The process variable - The processes used in counseling and psychotherapy are equal in number to the number of clients ever treated in psychotherapy. But again, this being an impossible task, a few of the major schools will be reviewed.

(5) The outcome variable - This really asks, "Does psychotherapy work?" No attempt was made to prove this one way or the other. The writer believes this to be the prerogative of the reader.

The reader should understand that no attempt will be made by the writer to persuade the reader into one school or philosophy. The writer believes this is a concern of every individual counselor, to adopt a personal philosophy of counseling that is most compatible to his person.

Definition of Terms

A few terms run interchangeably throughout the course of this paper.

Client, patient, counselee - For the purpose of this paper, these terms assume absolutely no difference in meaning. The writer will define a client as a person seeking professional help to find relief from a stressful situation where there is psychological distress arising out of a condition of psychic disequilibrium.

Psychotherapist, therapist, counselor - These will be arbitrarily defined by the writer as meaning the same individual. Counselor will be defined, for the purposes of this paper, as a person professionally qualified and employed to help clients within the framework of the above definition of a client.

Session, therapy hour, interview - These terms will also be understood to mean the same thing. A session will be defined as the face to face contact between counselor and client, professionally, in an attempt to help the client regain his equilibrium and relief from his psychologically stressful situation. It should be understood that very little if any mention of group psychotherapy and group counseling variables will be made in this paper. In the opinion of the writer, group psychotherapy is another galaxy in the universe of counseling and psychotherapy. The research concerning counseling and psychotherapy, in this paper, is concerned only with the one-to-one relationship between therapist and client.

Psychotherapy and counseling - These terms will be used interchangeably throughout the course of this paper. They shall be defined as the process used to achieve therapy.

CHAPTER II

REVIEW OF LITERATURE

A. Therapist Variables

In this discussion of therapist variables, the taks of completely covering the area is equal to the number of counselors or psychotherapists currently practicing or teaching in the world. Each psychotherapist operates under the personal philosophy that best suits his personality and needs. So, it is readily seen that to cover every therapist variable would be an insurmountable assignment.

In the expedition of this task, the writer proposes to examine some of the major systems and theories of psychotherapy and some of the basic tenets that therapists operating in these systems hold to be true concerning their roles in psychotherapy.

Therapist Variables in Psychoanalysis

When Sigmund Freud began to formulate classical psychoanalysis, his early thinking centered around the therapist being a detached, out of sight listener, helping facilitate, by pointed questions and observations, a mental cartharsis in his patients. This was achieved by uncensored recounting and free association by the patients. However, later Freudian oriented people have placed more emphasis on involvement in the therapeutic relationship and the corrective influence of the therapeutic session.

Deviations from strict Freudian analysis principles have modified their roles in various ways. Adler (22:46) (individual psychology) places high value on the social relationship in therapy with the therapist operating from an active teaching role. Steckel (22:49) (active analytic psychotherapy) says that the personality of the analysist is a decisive factor in the process of therapy and that the analysist should be an active partner in the therapeutic relationship. Jung (22:53) adheres to the theory that therapy and the actions of the therapist should be related to the type of patient but that it is best accomplished by the focused interview. Rank (22:57) maintains the therapist should be patient centered in the therapeutic process. The functioning of the therapist should be active, creative and flexible. Ferenze (22:59) believes that the patient should move from an active authoritarianism to love and permissiveness by playing the role of the good parent.

The dynamic centered psychoanalysts are represented by Horney and Sullivan. Horney (22:61) believes the therapist should assume an active-directive role by interpreting strategies to the patient while Sullivan (22:66) maintains the therapist should be a participant observer because the therapist attitudes and ideas effect the therapeutic situations.

Rational Emotive Therapy

The Rational Emotive approach to psychotherapy is based on the assumption that thought and emotion are not two entirely different processes. Rational Emotive Therapy theorizes that irrational philosophies, which are expressed in overt action in the form of emotion, underlie neurotic behavior. (12:16) One has only to structure his thinking rationally, and rational behavior patterns follow. The task of the therapist is to help the client get rid of illogical irrational ideas and attitudes, and to substitute for them logical, rational ideas and attitudes. The essential technique of Rational Emotive Therapy is active directive teaching.

Affective reactions are not of primary concern to a rational emotive therapist. No special emphasis is placed on transference reactions although transference is never deliberately created in the course of therapy. When it does occur, it is directly interpreted and dealt with. (12:41) The therapist serves largely as a good or sane model and does not encourage the client undergoing a classical transference neurosis.

The rational emotive therapist is extremely direct, rational, persuasive, interpretative and philosophical. (12:53) He is distinctly emotive, directive, active and work centered. (12:54) He is assertive and frankly counterpropagandistic.(12:34) The therapist literally teaches the patient to think more clearly and

more scientifically about himself and his life situation. One of the characteristics of rational emotive therapy is the intensive activity on the part of the therapist. Ellis maintains that it is doubtful that empathy is always a necessary condition for effective therapy. (12:65)

In the use of moral codes and laws, a forthright didatic approach to the attack on the basic philosophic orientation of the client is best served by the therapist serving as a good or sane model. (29:254) The therapist's technique largely consists of the use of himself. (39:96)

According to Ellis, rational training with large groups is successful. The clients act as an extension of the therapist by questioning, interpreting as the therapist would do with individual clients. Homework assignments given by the group are often more successful than when given by the therapist. (12:273)

Therapist Variables in Logotherapy

Logotherapy stresses the spiritual aspects of man. It is a form of existential analysis that deals with the patient's world view and his search for meaning. (16:4)

The training of a logotherapist is generally a psychiatrist with training in psychoanalysis, but logotherapists seem to deal primarily with hospital cases. (7:12)

The personal characteristics deemed important in a logotherapist are sensitivity and intuition along with a willingness to genuinely encounter the patient. The therapist must have the ability to be an authentic example to the patient, but he must have the realization that he does not know everything and that he can never completely know the patient. (16:33)

The logotherapist is directive and leads the patient toward realizing his responsibility by paradoxical intention and de-reflection. (16:93) The therapist deals with moral codes and ethics but does not try to impose particular beliefs on the patients. Logotherapists analyze transference in terms of existential anxiety, because the therapists act as consultant and philosopher.

Therapist Variables in Client-Centered Psychotherapy

The client-centered therapist views the client as a person of worth in himself and is therefore respected as such. Each individual has the right to self-direction, to choose or select his own values and goals and to make his own decisions. The client is accepted in a non-judgmental setting, where he feels free to express his intermost feelings without fear of threat or censure. A criticism has been made of client-centered therapy that it only deals with well adjusted persons. (10:324)

Rogers states that the client-centered therapist should have a graduate academic background and be a well rounded person, both in his attitudes and experiences. He should have a broad background of knowledge of a human being in a cultural setting and in possession of a basic philosophy of life. He must have a thorough understanding of the dynamics of personality. (34:25)

The personal characteristics of the therapist must include intelligence, acceptance, couguence, understanding, and the ability to communicate these to his client. (34:28)

The use of moral codes and laws have no place in a client-centered therapeutic relationship because the client is free to choose which course he may take in his life. As a result, the client-centered therapist is extremely non-directive.

The client-centered therapist is concerned in listening to the client on a feeling level. His concern is understanding, not evaluation, of the client's internal frame of reference and entering the perceptual field of the client. When this is accomplished a communication of understanding is achieved.

Transference in the orthodox, psychoanalytic tradition rarely occurs. If it does, the transference feelings and attitudes are handled in the same way as are all other feelings and attitudes. (29:256-257)

Therapist Variables in Gestalt Psychology

When we perceive a thing, we are perceiving a unified whole--a gestalt. The analysis of perception in terms of unified wholes has been the outstanding concern of Gestalt psychologists. Gestalt therapy concerns itself with bringing resistences, emotional blocks, etc., into the foreground so they can be experienced, understood, and finally accepted as part of the individual's gestalt. The gaol of the therapy is to help the individual become self-aware enough to accept what he is in his environment. (31:17-21)

The word gestalt has no exact one word English translation but could be described as a perception of the unified whole. Gestalt means the whole situation of the individual and his environment with the relation of figure and background.

In Gestalt therapy the patient must be self aware enough to help himself and he must be able to accept what he is in his situation. To remove emotional blocks, he must develop an awareness of himself and his feelings. He must develop a sensitivity and perceptiveness about other people and the world around him.

In Gestalt therapy, the therapist takes an active role in therapy. He might meet anger with anger or he might meet obstruction with impatience within a larger patience. Role playing is used quite extensively. (31:132-136)

Therapist Variables in Behavior Therapy

Behavior therapy or conditioning therapy was first introduced by Skinner and Lindsley (1953) and owes its wide acceptance to (1959, 1960, 1964). Behavior denotes the use of experimentally established principles of learning for the purpose of changing unadaptive behavior. Unadaptive habits are weakened and eliminated; adaptive habits are initiated and strengthened. (3:28-33)

A blend of objectivity and permissiveness is required. The client must be assured that his unpleasant reactions are reversible and misconceptions must be corrected as early as possible. (15:231-232)

The behaviorial therapist must make a careful clinical history by collecting personal details about the client--name, age, sex, etc. He must explore the client's neurotic reactions and circumstances. He must determine the client's sex life as traced from his first awareness of sexual feelings. (3:59-64) The therapist must determine the client's present social relations.

The client must complete three inventory forms. (52:36-38)

1. The Willoughby Personality Schedule.
2. Bernreuter Self-Sufficiency Scale.
3. Fear Survey Schedule.

The therapist must discuss therapeutic goals and strategies with the client, with the therapist deciding where priority should be given.

The therapist is solely responsible for the client's recovery and this is contingent upon: (1) The correctness of his analysis of the case, (2) The degree to which the techniques applied are appropriate. The therapist does not blame the client when treatment fails and only evidence of change can justify in continuing more of the same. The therapist must be able to separate tenets of his own moral code from the moral requrements of the client's situation. (3:176-197)

Outstanding characteristics of Behavior Therapists are considered to be: (52:101-111)

1. The therapist believes all neurotic habits are learned and can be unlearned.

2. The therapist is always in command in planning the therapy and controlling the details.

3. The therapist is very directive and demands the client follow his directions.

4. The therapist does not display a great deal of emotion or let it interfere with therapy.

5. The therapist is not dogmatic.

6. The therapist deals with currently revelant relationships--does not dwell on historical events.

7. The therapist has a sincere belief that behavior therapy is effective in all neuroses.

The reader should understand that the writer has not made an attempt to cover all systems of psychotherapy in this discussion of the therapist variables, but the number of schools discussed do indicate that variables in the therapist's roles and method of operation do indeed run the gamet of human psychological thought.

B. The Client Variable in Psychotherapy

Sensitivity to Others: A Client Variable

The client variable "Sensitivity to Others" was researched primarily during the last stages of the "non-directive" period of client-centered therapy as indicated by Cartwright and Kirtner. (9:196-214)

From a study by Sherer it became apparent that an evaluation of self must prelude that of sensitivity towards others. (42:169) For example she found that:

1. Three-fourths of the client responses were occupied with self-evaluation and less than one-fifth dealt with evaluation of others.

2. Client statements seem to describe two things: the degree to which he accepts and rejects himself and the degree to which he accepts and respects others.

Stock (44:176-180) carried these implications farther and showed that feelings toward self are correlated in varying degrees with diffrent aspects of feelings toward others. The question as to a sequential relationship exists was not substantiated. In other words,

can a change in one or the other of the two variables be shown to take place characteristically and consistently before changes in the others? However, Stock found that attitudes toward individuals in a social relationship correlated more highly with self-attitudes than did feelings in the area of family relationships or more personal relationships.

A classic example of often impersonal relationships where the concepts of self and others interact in conflicting and emotional ways is in the area of ethnic difference. Barrow defined "ethnocentrism" as "stereotyped, negative, imaginary, hostile attitudes regarding groups." (60:196-214) Using some of Barrow's hypotheses, Tougas substantiated that the presence of ethocentric attitudes appeared to be related to some causes of failure in client-centered therapy. (60:196-214) In other words, the concept of self-determined attitudes which were projected upon and effected the relationship with others as determined by the therapeutic setting.

Research seems to substantiate that if there is a relationship between therapeutically determined outcomes and actual outcomes, it appears doubtless that client personality variables measurable effect not only the amount of therapeutic success, but the degree to which a person is actually sensitive to others.

Client Satisfaction: A Client Variable

Client satisfaction, typically measured by follow-up questionnaires, has been the object of considerable recent speculation and research.

Rogers has found that clients who are dissatisfied with the counseling process as mere coincidence. (23:301) Client dissatisfaction can only lead to distorted perceptions of the effectiveness of counseling. The clients will not regard counseling as a technique for solving any new problems that develop nor as a procedure to recommend to their friends or relatives. Therefore, client satisfaction is one important factor in any multifactor approach to the problem of the effectiveness of counseling (as shown by Rogers, Kirtner, and Cartwright). (22:301-308)

There is some evidence on the relationship of client satisfaction to other counseling variables.

Barahol, Brammer and Shostrom reported that clients who had received client-centered counseling reported greater satisfaction with the results of counseling than those who had been counseled by tradational techniques. The follow-ups of these clients, however, showed they no longer had these feelings after a three year period of time.

The relationship between client satisfaction and counselor activity was a fairly complex one. This matter depended not only upon the techniques used but also upon which counselors used them. (30:136-138)

From his sense of satisfaction, then, the client is able to locate the problem source from one of three possibilities:

1. He looks within himself for the cause of his discomfort or dissatisfaction.

2. He is driven to search outwardly for those things which affect him.

3. Or else he will be hopelessly lost. (27:820-821)

Different authors hold different types or working hypothesis that each counselor can adopt to fit his own modes or techniques of counseling in order to develop satisfaction within his clients.

Intelligence: A Client Variable

Although having lost considerable status in recent years, the I.Q. is still used extensively for diagnostic and prognostic purposes in a number of situations. Its greatest usefulness is in the diagnosis of retardation and school difficulties as well as with problems of voicational guidance and rehabilitation. When used in therapy it should be considered merely as a level of information and as a part of a more detailed analysis of additional test information.

Some factors which affect the consistency of the I.Q. readings are cultural status, socioeconomic status, and inadequate cooperation on the part of the testee. Several administrations over a period of time which yeilds some consistency tend to make the I.Q. a better predictor. However, this again is affected by the fact that the difficulty level of test questions is not equal for the tests for each age level. Thus, when a major portion of decisions depend upon the I.W., it is wise to remember the quotient's instability.

Public school counselors use the I.Q. in ascertaining discrpancies between level of intelligence and level of school achievement. This may be used as a barometer of emotional disturbances and indicate a need for professional help. School personnel also use the I.Q. extensively in vocational guidance.

Two distinct uses of the I.W. in psychotherapy are:

1. Use in selection of the therapeutic process.
2. As a predictor of psychiatric outcome.

Therapeutic processes vary in the degree of verbal ability and general intelligence they require of the patient. Thus, intellectually dull individuals are not very suitable subjects for psychoanalytic, client-centered or similar types of therapy in which a preimum is placed on verbalization, abstraction, and conceptualization. Rogers in Counseling and Psychotherapy, states, "The client should possess adequate intelligence for coping with like situations, with an intelligence rating of dull normal." (35:74-75)

The I.Q. has been found to be a fairly good predictor of improvement of psychiatric patients. In separate studies Stotsky (1952), Plumeau, Machover and Puzzo (1960) found that remitting schizophrenics and remitting alcoholics scored higher on the Weshsler-Bellevue than non-remitting patients. (45:489-496) (32:240-242) Hiler and Nesvig found improvements of hospitalized children were reflected by upward changes in the I.Q. (24:288-293)

Healy and Bonners study of treatment showed a striking relationship between intelligence and outcome of therapy. (23:34) They found a positive correlation with children possessing higher I.Q.'s having a greater ratio of success in life following therapy than those with lower I.Q.'s. They found a positive relationship between intelligence and outcome of therapy. They found a positive correlation with children possessing higher I.Q.'s having a greater ratio of success in life following therapy than those with lower I.Q.'s. They point out, however, that this material "should be interpreted with caution and that unfavorable outcomes may be owing to the concomitant circumstances which so often accompany low intelligence rather than the low intelligence itself."

Sex Role and Identification: A Client Variable

"From direct and open expression of sexuality, with good control of feelings, to extreme conflict, uncertainty, and confustion about

sex..." (40:45) This is a client variable that must be taken into account by the counselor. "Certain individual differences between clients give rise to different kinds of therapeutic processes." (27:6) It is a variable that may influence the final outcome of the therapeutic process.

The ideal situation would be, "the client would ideally have the feeling that it is good to be a person of one sex in relation to person of the same sex and also to a person of the other sex. His sex role should be clearly understood by himself. He should be able to be aware of his role." (40:45)

Various factors that can alter the situation have been pointed out by Satir. (12:48) Growing up experiences may not have been adequate for him to clearly identify his sex role. He or she was never able to attain self confidence in this area.

1. The child by virtue of being male or female already looks like one parent or the other. He is sexually identified with one parent.

2. If the child is forced to one side with one parent(because of dysfunctional family situation), he will run the risk of losing the other parent. This choice, if thrust upon him, will invariably hurt him.

The child needs to have both parents as he or she must learn how to respond as expected by the society to members of the same and opposite sex. "The child needs to esteem himself in two areas: as a masterful

person (as related to sexuality), and as a sexual person. A child will develop self-esteem as a sexual person only if both parents validate his sexuality." (40:46)

1. "He must identify with his own sex, yet that very identification must include an acceptance of the other sex." (40:48)

2. "Sexual identification is a result of a three person learning system. Parents validate a child's sexuality by how they treat him as a sexual person. But they mainly validate it by serving as models of a functioning, gratifying male-female relationship." (40:49)

3. "The whole world is made up of males and females. The most psychologically influential roles people play are sex linked roles. Males and females also fill roles which are not sex linked roles, such as teacher, boss, etc.; but usually the sex of that boss or teacher carries meaning derived from earlier relationships which are sex linked." (40:49) When parents are not able to validate each other as sexual people, they will not be able to validate the child as a sexual person either." (40:49)

These factors are where conflicts arise. When the child is exposed to unexplained conditions, he will try to explain them himself, often coming up with incomplete or incorrect solutions. Also, the child is unable to establish self-esteem and has difficulty in becoming increasingly independent of his parents. This inability to establish self-esteem results in a dysfunctional person (now an adult) who still clings to his parents or to substitute parent figures, or relates to his sexual partner as if that person were in fact, a parent.

Another study by Halup, Moore, and Sajer is based on the assumption..."That appropriate sex role behavior is in part, a function of avoidance of inappropriate sex role behavior." Such avoidance may be acquired by the child via both identification with available models and direct discrimination learning. The important point is that masculinity in boys is assumed to involve avoidance of feminity, and feminity in girls is assumed to avoid masculinity. The hypothesis is consistant with most theories of identification, and also with the assumption that sex typing stems from direct sex role differentiation by parents. (20:467-473)

There are many other factors that could cause difficulties in people properly developing sex role identification in their particular society. The factors mentioned in this paper are meant only to give some insight into a variable that could be taken into consideration by a counselor in regard to his clients and the type of therapeutic process to be employed.

Verbal Expressivity: A Client Variable

In a study by Halpern, a scale measuring client verbal expressivity in the context of counselor-client interaction, was designed. Initial estimates of its reliability and validity were discussed. (19:693-701)

The study utilized a sample of 28 retarded subjects and a control group of non-retarded subjects.

The initial validity suggested:

1. That the scale discriminates differently in retarded and non-retarded populations.
2. That the diagnostic information provided by the scale might be in addition to that which is provided by standardized tests of intelligence and language ability.
3. That changes in client verbal expressivity might be expected to occur over the course of counseling.

Consideration must be given to three aspects of the study before any generalizations are made. First, the major research efforts were focused on the identification and measurement of client verbal expressivity, with only secondary attention paid to its relationships with other phonomena. Second, the construct validity of client verbal expressivity was restricted to the operationally defined categories of the Verbal Expressivity Scale, since no other instruments were available for measuring this construct. The interpretation of the results was somewhat limited by the heterogenity of the population from which the sample was taken.

"It is possible that a client's verbal expressivity will not normally change over the course of counseling, so that his VES score could be regarded as a limiting and constant factor in the choice of a counseling technique to be used with the given client." (19:699)

This study is essentially a pioneer research venture in the area of counseling process with the mentally retarded. It is evident that the assessment of client verbalizations is possible with clients who are classified as mentally retarded, and further research would be indicated in order to clarify the usefulness of the VES as a diagnostic process and outcome variable.

Client Expectation: A Client Variable

In researching expectations as a client variable, it became obvious that we cannot refer to "the counseling relationship" in the same manner that psychoanalysts talk about "the transference." Tyler suggests that each relationship has its own unique characteristics, and feels, especially at the beginning, it is important that the counselor himself asks the following questions: (50:53-59)

1. What are this person's expectations from counseling?
2. What does he think is going to happen?
3. What does he hope to get out of it?

While some authors, Daskin, 1955, (11:22-27) and Pohlman, 1964, (33:340-343) have found that clients and counselors do not have to agree in order for clients to be satisfied with their counseling experience, there is some evidence to suggest (Issard and Sherwood, 1964) (25:920-921) that when client expectations are not met, they will not be satisfied.

Because of these contradictory studies, Gladstern, 1962, has suggested that future research concerning client expectations should provide as much nonstructure as possible in obtaining the data involved. Gladstern indicated that a counseling relationship can be more easily developed if the expectations of the client are taken into account by the counselor. (18:476-481) The above mentioned studies resulted in the following conclusions:

1. The client may come to his sessions with more than one expectation.
2. The client will be generally satisfied if only part of his expectations are met.
3. Client rapport can be established without always meeting all of the client's expectations.
4. Expectations are diverse and multiple.
5. Clients who have some of their expectations met do not show appreciably less satisfaction.
6. Clients who receive little or no benefits exhibit strong dissatisfaction.
7. Most expectations, if identified, are met.
8. What various individuals and groups expect of counseling often differs from the goals and expectations expressed by its practioners.
9. The expectations from counseling are diverse and sometimes impossible.
10. Expectancies are derived from experience, and are nutured by hope among those who seek assistance and those who provide it.

Studies involving expectations constantly attempt to distinguish between client-counselor expectations and client-counselor goals, which in many ways are similar and interrelated. Consensus favors the term "expectancies" referring to the anticipation held for inferences made about counseling and "goals" referring to the end result sought through counseling by either the counselor or the counselee. One quality reflected by both expectancies and goals, almost without exception, is that there is little or no limitation upon what counseling can do. It is almost as though counseling is the answer to all manner of societal and personal difficulties. Expectancies are likely to stress remediation and repair, while goal statements from the counselor more often imply that counseling should be preventative in nature. The overwhelming lay expectation for counseling is that it directs or manages the affairs of those who seek it.

In 1969, Andrew Thompson and Robert Zimmerman conducted a study attempting to determine what relationship is between client expectations and the expectations of their counselors and if this relation changes over time. (47:121-125) A goal checklist was developed which could be completed by both clients and their counselors, and this checklist was administered at several points during the counseling process. Thompson and Zimmerman feel that a goal checklist would be superior to the more traditional problem checklist because goals and/or expectancies are more directly related to follow-up criteria and the

stating of problems in terms of expectancies placed a more positive emphasis on the counseling process. There seemed to be a real discrepancy between the goals that the client chooses and those that his therapist chooses, regardless of time period.

The findings of this study suggested that outcome research in counseling and psychotherapy would be greatly improved by immediate determination of the discrepancies between expectancies of the client and the expectancies of the therapist. Also indicated by this work was the need for determination of the stability of these goals and expectancies throughout the counseling or therapy and that the one strategy which would be least justifiable would be to assume that there are some goals which are appropriate to all clients.

While the majority of counselees expect counseling to produce personal solutions for them--unpopular to popular; failure to succeed; lack of employment to job placement--group expectancies of any counseling situation vary widely. Teacher expectations are usually to reduce or eliminate pupil behavior that causes classroom friction or disturbances, while the expectations of school administrators range all the way from achieving toleration and the solving of all educational difficulties making for an efficient school organization to little or nothing and toleration of the counseling idea itself.

A statement by Clyde A. Parker would seem to adequately summarize the research completed on client expectations: (28:12-13)

> "Because of the extensive research on expectancy states and client suseptibility to persuasion, there is reason to believe that the change we have attributed to the counseling process and to counselor effectiveness might be better explained by other constructs. One of the hard facts with which counselors must deal with is the frequent occurance of "faith healing" in a variety of forms. At best counseling may be a giant placebo which relies mainly on the client's expectancy of being helped, his susceptibility to persuasion, and the counselor's own belief in his ability to help. At worst counselors may be merely purveyors of their own brand of religion, which has no relevant substance beyond the ability to evoke the faith of the patient in the counselor's ability to help him.

C. The Relationship Variable

The counseling relationship is the term used to define the interaction between the client and the therapist. This relationship provides for the interpersonal dynamics that make psychotherapy effective.

One of the most prolific writers in the area of the counseling relationship is Carl Rogers. Rogers states that six conditions are necessary and sufficient for constructive personality change. (36:126-141)

1. That two persons are in <u>psychological contact</u>.
2. The client is in a state of incongruence.
3. The therapist is congruent, or integrated into the relationship.
4. The therapist experiences an unconditional positive regard for the client.

5. The therapist experiences an empathic understanding of the client's internal frame of reference.

6. The communication to the client of unconditional positive regard and empathic understanding is minimally achieved.

Many others are in agreement or partial agreement with Rogers. Truax and Carkhuff maintain the effective ingredients for successful therapy are accurate empathy, non-possessive warmth, and genuineness. (49:23-79) Shapiro says that for psychotherapy to be effective the relationship must include empathy, non-possessive warmth and genuineness. (41:350-361) He says, "Despite unanswered questions awaiting further research, the work reviewed here has made, for the first time, a substantial step toward the specification of variables whose manipulation may be expected to make psychotherapy effective." Betz maintains the relationship starts "where the patient is" and therapists encourage the patient to reveal his own attitudes and feelings. (5:477-485) This revealing is an attitudinal growth process.

Many psychotherapists, from a wide range of schools, disagree with Rogers. Ellis (12:38-59) steadfastly maintains that Rogers' six conditions are not always necessary for personality change. Gassner believes that patient therapist attraction is not always important for patient improvement. (17:408-414)

One of the more vocal of those in disagreement is Thorne. (48:101-102) Thorne refutes the necessity, in a therapeutic

relationship, of Rogers' tenant of unconditional positive regard, unconditional prizing of the client so that the client comes to prize himself and feel he is of value.

Thorne says that, in his experience, it is sufficient for the therapist to be normally friendly and neutral so that the client feels that he is getting a fair deal. Thorne maintains that when you are working with attractive college students, Rogers' six conditions are easy to attain and very pleasant, but when you are working with rapists, people convicted of infanticide of their own babies, liver eating cannibals, Klu Kluxers and other deviant personalities, it is impossible to view them with unconditional positive regard. Thorne says that you should be friendly, tolerant, neutral and patient, but the therapist should be free to express negative judgmental emotions whenever he likes. He says the therapist has to be the bridge between the client's mixed-up phonomenological world and reality. "We know of some very good therapists who are blunt, outspoken, critically evaluative persons who make very good good therapists." (48:101-102)

From the above sample of diverse opinions by therapists of different schools, the question might understandably arise in the reader's mind, "What does the research show regarding the relationship variable?" Perhaps the classic and most quoted study is the study by Fiedler in 1950. Fiedler conducted an investigation to ascertain

whether therapists of divergent schools of therapy would describe the ideal relationship similarly. (14:3390345) Fiedler further attempted to answer the question as to whether or not the therapeutic relationship is unique to psychotherapy, or whether it resembles a good everyday interpersonal relationship.

A number of therapists of different schools and with different degrees of training were asked to sort out arrays of statements descriptive of the therapeutic relationships into categories ranging from the most characteristic to the least. The better trained and more experienced therapists of different schools agreed more highly with each other than they agreed with the less trained therapist in their own school. Naieve subjects were well able to describe the therapeutic relationship. These conclusions could be drawn from Fiedler's study:

1. Therapists of different schools do not differ in describing their consept of an ideal therapeutic relationship.
2. The ability to describe this concept is probably a function of expertness rather than theoretical allegiance.
3. Non-therapists can describe the ideal therapeutic relationship and it may be, therefore, but a variation of good interpersonal relations.

A composite rating of the ideal therapeutic relationship was obtained from the pooled ratings in Fiedler's study. These were:

1. Empathic relationship.
2. Therapist and client relate well.

3. Therapist sticks closely to patient's problems.
4. Cleint is free to say what he likes.
5. There is mutual trust and confidence.
6. The rapport is excellent.
7. The client assumes an active role.
8. Therapist leaves patient free to make his own choice.
9. Therapist accepts all feelings of the client.
10. A tolerant atmosphere exists.
11. The therapist is understanding.
12. The client feels he is really understood.
13. The therapist understands the client's feelings.

A study in 1950 tends to support the findings of Fiedler. (1:324-328) A factor analysis study of Psychoanalytic, Non-Directive, Adlerian therapy relationships was attempted. The results were found to show that no factors were found that clearly differentiate therapists of one school from those of another. Factors that were found differentiated experts from non-experts. The study found that experts had greater understanding of patients' feelings and that experts had greater security in the relationship. Experts tended also to act in a more neutral manner.

Introjection: A Relationship Variable

Farson attempted to see what part introjection plays in the psychotherapeutic relationship. (13:363-369) Using methods of analysis the self-descriptions of 18 clients and their 6 therapists were compared before and after client-centered therapy to investigate the possibility that the personality of the therapist is introjected by his client. Six colleagues (judges) were asked to rank the therapists as to their psychological adjustment, therapeutic competence, and the liklhood that their clients would come to resemble them. The findings suggest that if introjection occurs, it is most likely to occur in the care of less competent therapists. The findings also suggest that it is possible for a client to come to achieve an adjustment in therapy which is independent of the personality of his therapist. The findings also imply that the less adjusted, less competent therapist tends, in his relationships to his clients, to introduce conformity to himself.

Client-Therapist Compatibility: A Relationship Variable

An important variable to be considered in establishing a therapeutic relationship is client-therapist compatibility. One such study dealing with compatibility was conducted by Gassner at the University of Massachusetts. (17:408-414) The purpose of this research was to study patient attraction to the therapist, therapist attraction

to the patient, and patient change as a function of interpersonally oriented therapist-patient compatibility.

Twenty-four theological students participating in a summer program for clinical training in pastoral counseling were matched with twenty-four patients at Warcester State Hospital, who were the most compatible with the therapist, and twenty-four who were least compatible. A no-treatment control group of 24 was randomly chosen for a control group. These patient groups were comparable with regard to their age, proportion of males and females, number of years hospitalized, and their diagnosis.

Results of this research revealed that high compatibility match patients viewed their therapists more favorably than low compatibility match patients, buth after three and eleven weeks of contact. Therapists rated their relationship more favorable for those patients with whom there was high-compatibility match in the beginning, but not after eleven weeks of contact. It was concluded that by use of matching procedures, a higher level of interpersonal attraction can be promoted between patients and their therapists. The significance of treatment effectiveness remains to be demonstrated.

Smith and Martinson carried on research at Indiana University in the area of effect of compatibility of learning styles on interview behavior. They isolated differences that occurred with various combinations of impulsive counselors and counselees, and constricted

counselors and counselees. (Impulsive learning styles were defined as those with preferences for unstructured learning; the constricted learner was defined as the one with preference for unstructured learning.)

The results of the Smith and Martinson study revealed that counselees' learning styles did not significantly influence their performance of leading behavior during the counseling situation; both the impulsive counselees tended to engage in leading behavior. However, the impulsive counselees tended to engage more in following behavior than the constricted counselees. Impulsive counselors tended to engage in more directive behavior than constricted counselors when both were interviewing constricted counselees. However, impulsive and constricted counselors both engage in similar amounts of non-directive behavior when interviewing constricted counselees.

Although this study is not of great significance, it does point out the importance of compatibility in the relationship of the client-therapist, a therapeutic which many psychotherapists consider to be the most important factor in the psychotherapeutic process, and which Carl Rogers states must be established before the therapeutic process can take place.

Rogers says that perhaps the most basic of the essential attitudes is realness or genuineness in the client-therapist relationship. (26:471)

Effective therapists seem to follow this implicit hypothesis: "If they are themselves in the presence of their patient, avoid compulsions to silence, to reflection, to interpretation, to impersonal techniques, and kindred character disorders, but instead striving to know their patient, involving themselves in his situation, and then responding to his utterances with their spontaneous selves, this fosters growth. In short, they love their clients. They employ their powers in the service of their clients well-being and growth, not inflict themselves upon him." (6:62)

D. The Process Variable

"Process" implies continuous change. Therapeutic psychology, applied through counseling and psychotherapy is primarily a process of building understanding, integrating elements of the personality, and enabling the client to utilize his good judgment, social skills, problem-solving capacities, and planning abilities. It would seem to be a grwoth process.

The approach to feeling related problems is never clear cut. Because of the individual differences in clients and the variations in philosophy and styles of psychotherapy, only a rough sequence of events can by typical of the psychotherapeutic process: (37:142-149)

1. Realizing there is a complaint, problem, stress, or sympton and that there is a need for help.

2. Establishing the relationship.

3. Expressing feeling and clarifying and elaborating upon the problems.

4. Exploring feelings (depth depending on type and structure of the psychotherapy).

5. Expressing deep feelings and symbolisms (if deeper psychotherapy is being attempted).

6. Working through feelings.

7. Developing insight and planning action.

8. Externalizing and terminating the relationship.

Brammer and Shostrom (6:374-425) conceptualized the psychotherapeutic process in eight stages or stepps. (See Charts 1 and 2)

Stage I - Awareness of Need for Help

Clients usually come for psychological assistance because of feelings of distress. They feel they lack sufficient information or competance to deal with a life problem and often their feelings of difference from other people and their desire to be someone different from their present self creates a condition tension and a vague knawing fear that something is wrong.

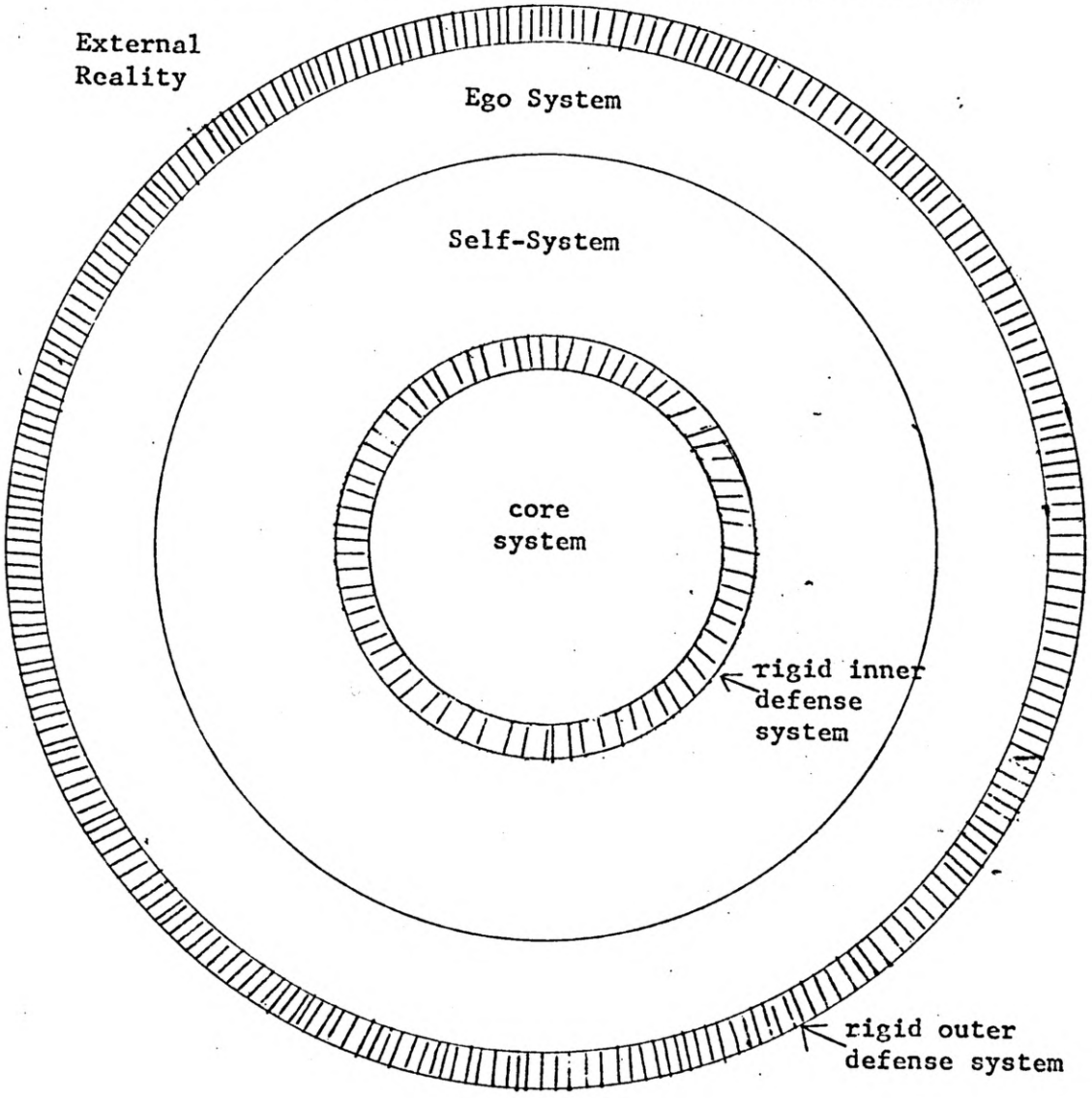
Before psychological counseling can be effective, the client must:

1. Be aware of feelings of distress.

2. Desire and expect change in his personality or life problem situation.

CHART 1

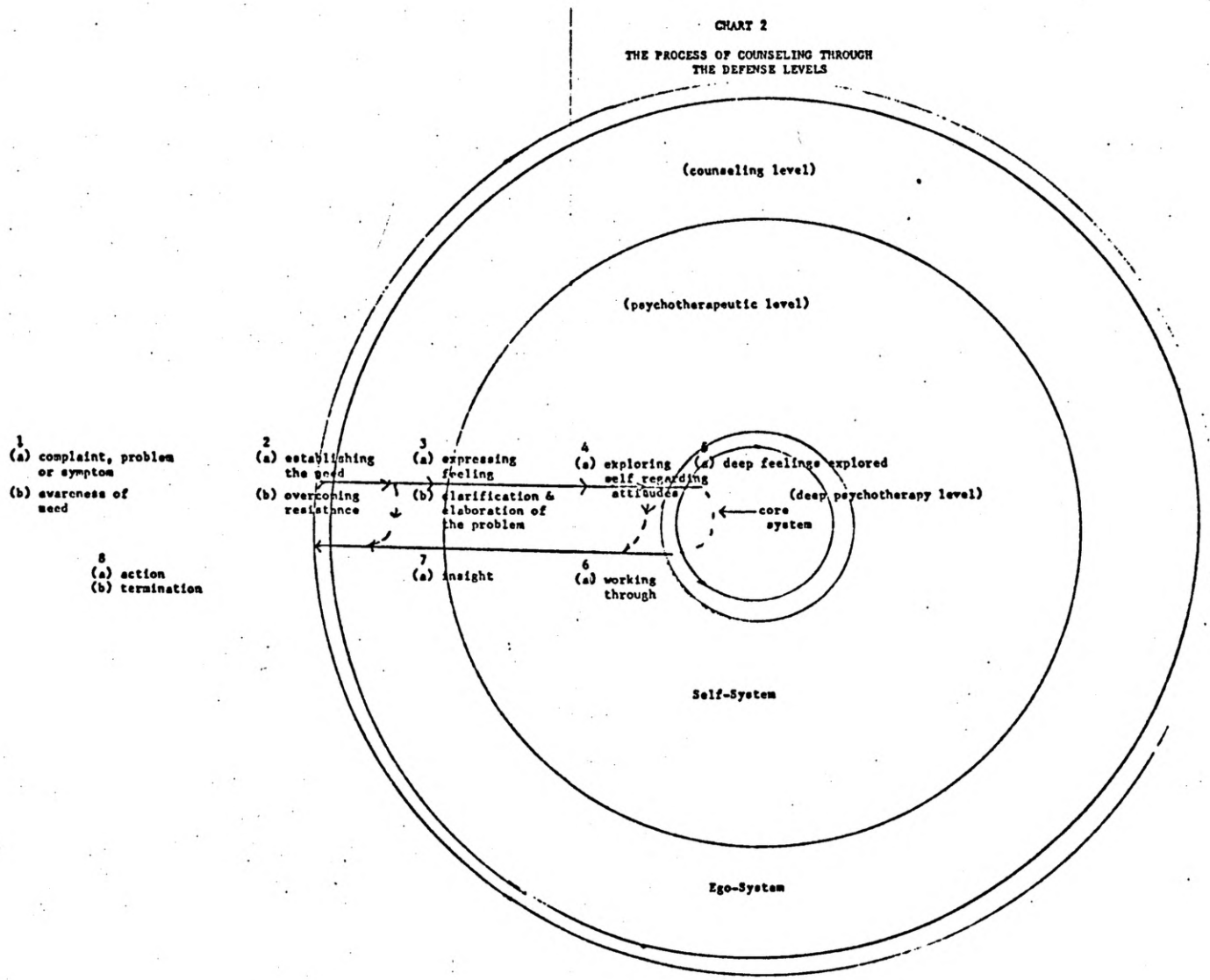
Defense Levels of a Person in Need of Psychotherapy



(6:376)

CHART 2

THE PROCESS OF COUNSELING THROUGH THE DEFENSE LEVELS



3. Accept the emotional character of his problem.

4. Accept the possibilities and limitations of psychological counseling as a vehicle for helping him to help himself.

5. Voluntarily arrange to see the counselor.

Stage II - Development of the Relationships and Overcoming Resistance

The development of a working relationship characterized by mutual liking, trust, and respect is one of the first tasks of the counselor. The psychotherapeutic relationship is a bridging element to be relied upon until the inner growth forces of the personality are able to function adequately. In this the counselor "lends" part of his own ego to the client. Although there is the ever-present danger that the relationship may build a dangerous and lingering dependence, there is a greater need to build confidence and support.

Stage III - Expression of Feelings and Clarification of the Problems

This phase of the process, known as "catharsis," is characterized by a release of feelings mainly through the medium of language, although it may come in direct forms such as weeping.

Catharsis is valuable in that it:

1. Provides relief of strong psychological tension.

2. Awareness of relief from emotional pressure the client gains by verbalizing the material he has resisted or avoided facing.

3. Security and courage to pursue the matter stemming from his awareness.

4. Verbalizing feelings avoids direction of aggression towards others, by using the symbolic medium of language.

Stages IV and V - Deeper Exploration of Feelings

Psychotherapeutic counseling often leads to an exploration of the deeper self-regarding attitudes in the self-system. Brammer and Shostrum believe the counseling process does not include work at Stage V, which involves deep psychotherapy at the inner-defense and core-system levels. (50:374-425) Brammer and Shostrum believe most psychological counselors are neither personally or educationally equipped to deal with the intense feelings and intricate problems of the basic character structure of the personality.

They list these as necessary for depth of feeling exploration:

1. Nature and severity of the client's symptoms.

2. Length and persistence of symptoms.

3. The nature of the predisposing and precipitating experiences.

4. Past stability and defensive functioning.

5. Resistance to psychotherapy.

6. Adequacy of therapist's training.

7. Problem level of the counselor or therapist.

8. Amount of time available.

9. The institutional policy on doing psychotherapy.

Stage VI - The Working-Through Process

Brammer and Shostrum (5:399) believe the term "working through" refers to becoming aware of the meaning of past experiences and feelings, as well as present feelings, to the final point of understanding of one's self or insight. The client gains a rational type of understanding leading to deep creative understanding.

Along with rational understanding is a process called "desensitization" which is the reduction of emotional intensity which once surrounded the experience. (50:399) Through re-experiencing via language, the anxiety or psychic pain is reduced.

"Working through" is often characterized by a combination of individual and group psychotherapy by:

1. Clarifying and accepting present emotional difficulties.
2. Rationally understanding the historical roots and problems of the feelings.
3. Working out the problem in terms of the relationship between client and therapist.

Stage VII - Development of Insight

The test of effectiveness in counseling or psychotherapy is the acquisition of insight or understanding of self and others as well as the consequent positive action which is based upon that insight. More closely, insight pertains to the deep understanding and changed

perception of relationships among scattered elements in one's personality in such a way that one can act more positively in terms of an integrated self-system.

Stage VIII - Experience Outside Psychotherapy

Brammer and Shostrum believe that the most significant integrative work in psychotherapy comes from encouraging the client to go into the world to live his therapeutic insights, thereby providing to himself that he is no longer acting in a self-defeating manner. The counselor or therapist makes himself more and more dispensible through the client's ability to utilize successfully in his new skills. (5:414-418)

In Brammer and Shostrum they maintain that both internal and external factors may affect process at any given time. (5:420-424) For example, they say that there are generally three critical points which may occur during the process:

1. Critical point #1 generally occurs in State III of the Process. See Chart 2. In this stage the client confronts many aspects of himself in traumatic form and he may not be able to cope with this. If this can be explored, and if he dares to peek at these threats, the patient can usually persist.

2. Critical point #2 generally occurs in Stage III of the process (see Chart 2). The patient has expressed considerable feeling and becomes aware of his defenses. The therapist must be able to control the relationship to enable the client to cope with the unconscious desires, impulses, and inhibitions at his own rate.

3. Critical point #3 usually occurs during Stage VI. (See Chart 2). The client becomes so elated with the feeling of well-being that he wishes to terminate psychotherapy prematurely.

Aguilera, Messick and Fairell discuss sociocultural factors which affect the psychotherapeutic process. (2:279-294) They maintain that professionals may become frustrated to the point of endangering the relationship, when working with patients from different and unfamiliar backgrounds. They say that patients become frustrated when they do not receive the kind of therapy or assistance they feel they need.

E. The Outcome Variable in Psychotherapy

Outcome research in psychotherapy is directed toward acessing the final product of counseling and usually focuses upon such issues as which techniques work best with which counselees, whether counseling was successful, and whether counseling effects were lasting.

Psychotherapeutic outcome may be studied in relation to duration of a single interview, number of interviews in course of treatment, frequency of treatments per week or amount and duration of a course of treatment.

In the writer's opinion, outcome research has received as much or more research concentration in the last five years than any other single variable area. Bergin and Garfield say that in the interval of years from 1916 to 1920 there were three outcome research studies; from 1941 to 1945 there were ten; from 1951 to 1955 there were seventy; and from 1966 to 1970 there were one hundred and sixty-nine. (4:228)

A sample of the studies may be conducted to find a relationship between frequency of contacts and duration to therapeutic change. (54:522-554) Seeman (1954) reports a trend in favor of higher success ratings for longer cases, but he doesn't have adequate statistical data to uphold his theory. Myers and Auld's (1955) data showed the discharge status of unimproved clients does not vary with the number of interviews. Imber, et.al. (1957) was concerned with the relationship between the amount of contact between patient and therapist as to improvement. An evaluation after six months showed that group therapy patients improved more than minimal contact patients, but not more than the individual patients seen for a shorter session. Cartwright (1955) studied ratings of success in client-centered therapy in relation to length of therapy. In Cartwright's study there was a strong relation between number of interviews and success rating. Nichols and Beck's results (1960) provided little to support the contention that increasing the number of contacts will improve the patient. Lorr, McNair, Michaux and Raskin (1962) suggest that the number of treatments does have some influence on outcome, but length of therapy appears more influential than treatment frequency. A review of all these studies suggests that change appears to require a passage of time.

However, the outcomes of behavioral (or conditioning) therapies of Joseph Wolpe and Andrew Salter claim that therapy can be accomplished

in a short time. Wolpe claims nearly 90% success rates after an average of 30 therapeutic interviews. (5:1242-1247) These cases were unselected in the sense that no case diagnosed as neurotic was ever refused treatment (psychotic and psychopathic individuals were not accepted). Lazarus reports that over a period of four years the total number of patients who consulted him was 408. (51:1242-1247) Of these, 321 (78%) derived "definite and constructive benefit according to specified criteria which are usually stringent." Salter in working with patients involved claustrophobia, insomnia, shyness, low self-sufficiency, blocking of creativity, stuttering, anxiety, masochism, homosexualism, and psychomatic problems claims to also approach 90% success with his clients. (53:423) He eliminates only psychotics, or those excessively high in psychopathy.

Regarding length of time in therapy, another study by Wolpe compares behavioristic therapy with psychoanalytic therapy. (51:1242-1247) In a series of 618 neurotic cases 87% were successful through conditioning with an average of 30 sessions per case, as compared to 60% cure for 210 psychoanalytic cases which required an average of 700 sessions per case. Less than 20 sessions are frequently necessary for Salter to accomplish what he consideres successful therapy.

The above claims of success should be viewed with skepticism, however, since in order for figures between various systems to be

comparable, the assumptions must be made that the clients are relatively similar, and that the criteria used to evaluate successes are similar.

One allegation frequently made about conditioning therapies has been that the results are temporary and superficial. Some recent evidence, however, tends to contradict this criticism. For instance, a follow-up study conducted at least a year after the termination of therapy on a 25 subject sample of patients who had received behaviorial therapy (for five weeks) revealed that 60% were either cured or much improved and an additional 32% were rated as moderately improved. (29:413-319) Again, Wolpe reports that of 249 patients who received various therapies (excluding psychoanalysis) only four had relapses. (5:1242-1247) According to Wolpe as far as present evidence goes, conditioning therapies appear to produce a higher proportion of lasting recoveries from the distress and disabilities of neurosis than does psychoanalysis. (5:1242-1247) Even if a controlled study were to show an equal or higher recovery rate for analysis than for conditioning, the time which is required remains such an important factor, that conditioning therapy would still deserve preference.

Outcomes in client-centered therapy deserve some attention in this discussion. Client-centered therapy is primarily concerned with the here and now and focuses on how personality change occurs. Proponents of this therapy have amassed a large amount of research in an effort to establish a solid empirical foundation for its development.

Client-centered therapy, as reported by Van der Veen has had its greatest impact in the areas of counseling and pastoral psychology, which it has had minimal impact in the areas of psychiatry and social work. (21:23-32)

Carr in a research project set out to evaluate the non-directive approach by reviewing the pre and post therapy Rorschach protocols of nine cases. (8:196-205) The experiment involved quantitative, qualitative, and counselor evaluations. The results showed that the difference between pre and post therapy protocols were not significant with regard to the quantitative analysis, or the qualitative evaluations. The counselor evaluations, however, did claim 33% of the cases reviewed and resulted in greater improvement. Another 33% had resulted in slight to moderate improvement, while in another 33% of the cases, no significant changes were achieved. This study's primary conclusion was that, on the basis of the Rorschach protocols, no significant changes were occuring in non-directive therapy.

A number of outcome research projects are reported in Rogers (1954) Psychotherapy and Personality Change. The research reported on involved the use of a block or group of clients on which a number of different hypothesis were tested. Dymond employed Q-adjustment scores from an experimental and control group tested at pre-wait, pre-therapy, post-therapy, and follow-up reported significant differences at .01 level

between the two groups at pre-wait and pre-therapy. The scores were not found to be significantly different at post-therapy and follow-up, however, and it was concluded that therapy was successful. (38:76-84)

Seeman using clients from 21 to 40 years old, found that the age of the client was not a factor in the outcome therapy. (38:99-108) It was also observed that there was a liklihood that therapists would view the therapy as successful if the therapy involved more than 20 interviews.

Dymond and Seeman also noted that females showed a significantly higher difference in the adjustment level at the end of the therapy.

Dymond utilizing TAT ratings, substantiated the findings of the two previously mentioned along with correlating the TAT ratings significantly with: Q-adjustment measures and degrees of change, Q-self reports and counselor judgement. (38:109-120)

In an attempt to draw outcome research somewhat together, refer to Chart 1, "A Survey of S$_e$lected Outcome Studies Published Between 1952 and 1969." (4:230-237) Of this cross-section of 52 analyses of literature 22 were rated as positive, 15 in doubt, and 15 as negative evidence in relation to psychotherapy. (4:229)

Taking all of the fore-mentioned variables into account, there reamins some modest evidence that psychotherapy "works." While most studies do not seem to yield very substantial evidence that this is so, the number seems to be clearly larger than would be expected by chance.

TABLE 1

A SURVEY OF SELECTED OUTCOME STUDIES PUBLISHED BETWEEN 1952 AND 1969

Authors	Date	Population	Therapy N	Therapy Type	Average Therapy Duration	Criteria	Control Group	Adequacy of Design	Percent Improved (If Given)	Outcome
Wiepe & Parloff	1965	Psychologists	55	Mixed analytic (exp.)	22 months 60 session	Publication Rate	Yes	2		Negative, but criterion questionable
Cartwright & Lerner	1963	U. of Chicago Counseling Center	28	Client-centered (exp.)	40 sessions	Therapist rating	No	3	54	In doubt; no control
Varble & Landfield	1969	Students	36	Electic (exp.)	8 sessions	Judges' ratings	Yes	2	75	Positive, but weak compared to controls
Lorr, McNair, Michaux, & Raskin	1962	VA out-patients	133	Mixed Analytic (expl)	8 months 17 to 96 sessions	Therapist and Patient ratings (Miscellaneous tests)	No	1		Modest positive
Persons	1967	Institutionalized deliquent boys	41	Group and individual (exp.)	80 hours	Test scores (behavior ratings, parole violations, staying in community)	Yes	1	68 to 74	Positive
Jersild, Lazar, & Brodkin	1962	School teachers	111	Psychoanalysis (exp.)	600	Self ratings	Yes	3	50 to 90	Positive, sample highly selective. Control group inadequate
Endicott & Endicott	1964	Outpatient neurotics	17	Analytic (one therapist - exp.)	20	Miscellaneous tests and therapist ratings	Yes	2		Negative
Heilbrunn	1966	Outpatient neurotics (excluding psychotics)	32	Psychoanalysis (one therapist-exp.)	500	Therapist rating	No	3	44	Negative
Heilbrunn	1966	Outpatient neurotics (Excluding psychotics)	48	Analytic	200	Therapist rating	No	3	48	Negative

Authors	Date	Population	Therapy N	Therapy Type	Average Therapy Duration	Criteria	Control Group	Adequacy of Design	Percent Improved (If given)	Outcome
Heilbrunn	1966	Outpatient neurotics (excluding psychotics)	48	Analytic	200	Therapist rating	No	3	45	Negative
Aronson & Weintraub	1968	Outpatient neurotics--character disorders, borderlines	127	Psychoanalysis (exp.)	2 to 3 years	Therapist rating	No	3	45	Negative
Feifel & Eells	1963	VA outpatients	63	Mixed (exp.)	50+ sessions	Therapist ratings	No	3	57 to 84	Modest positive results vary by criteria and diagnosis
Rogers, Gendlin, Kiesler, & Truax	1967	Inpatient psychotics	14	Client-centered (exp.)	105	Patient and therapist ratings	No	2	63 to 90	Positive
Strupp, Wallach, & Wogan	1964	Outpatient neurotics	44	Analytic (exp.)	166	Numerous tests and behaviors	Yes	1	43	Negative but sample favorably based
Bieber et al.	1962	Male homosexuals	106	Psychoanalysis (exp.)	200	Behavior change	Yes	2	27 to 43	Positive, though sample favorably biased and control group inadequate
McNair, Lorr, Young, Roth & Boyd (3-year follow-up of 1962 study)	1964	VA outpatients	81	Analytic (exp.)	60 sessions	Tests; Patient and therapist ratings	No	1		In doubt due to small changes and no control
Cattell et al.	1966	Outpatient neurotics	46	(exp.)	6 sessions	Cattell Scales	Yes	3		In doubt due to inadequate control group and possible placebo effects
Sajer, Riess, & Grendlach	1964	Out-patients, including borderline	103	Analytic (exp.)	107 sessions	Therapist, Patient and research ratings of questionnaire	No	3	25 to 59 marked improvement; 60 to 37, small improvement	Appears positive; difficult to interpret

Authors	Date	Population	Therapy N	Therapy Type	Average Therapy Duration	Criteria	Control Group	Adequacy of Design	Percent Improved (If Given)	Outcome
Fiske & Goodman (15-year follow-up)	1965	U. Chicago Counseling Center	69	Client-centered (mixed exp. levels)	26 sessions	Numerous tests, ratings, interviews and questionnaire	No	1		No Change during post-therapy period
Riess	1967	Outpatients, including borderline	414	Analytic (exp.)	57 sessions	Change in income	Yes	2		Positive
Uhlenhuth & Duncan	1968	Out-patient neurotics	128	Eclectic (inexp. medical)	6 sessions	Patient symptom checklist	No	2	72	Positive, but placebo effects look improved
Weber, Elinson, & Moss	1965	Outpatients, all diagnoses	564	Psychoanalysis (exp. and inexp.)		Judges' ratings of clinic records	No	2	30	Negative
Weber, Elinson, & Moss	1965	Outpatients, all diagnoses	732	Analytic therapy (exp. and inexp.)		Judges' ratings of clinic records	No	2	25	Negative
Koegler & Brill	1967	Outpatients, all diagnoses	27 to 39 depending on criterion	Analytic (inexp. residents)	5.5.months	Tests, patient and therapist ratings, and interview	Yes	1	87 on self-rating, but placebo group was 76 on same measure	Negative at follow-up. Change at termination, but not greater than placebo
Koegler & Brill	1967	Outpatients, all diagnoses but more disturbed	162	Brief contact (inexp. residents)	10 sessions	Therapist and patient ratings	No	3	49 to 86, depending on criterion	In doubt due to criteria and lack of controls
Gottschalk, Mayerson, & Gottlieb	1967	Mostly outpatient neurotics	34	Emergency brief therapy (exp.?)	6 sessions	Research interview and self-rating	Yes dropouts	2	85 but does not distinguish degree of improvement	Positive, but controls probably more disturbed
Shore & Massimo	1966	Deliquent boys	10	Vocationally oriented psycho - therapy - (exp. 1 therapist)	10 months	Numerous tests ratings and behavioral changes	Yes	1	70	Positive; only 30% change in controls
Jonckheere	1965	Outpatient neurotics	72	Electic (exp.)		Therapist rating	No	3	76	In doubt; no control, liberal definition of improved

Authors	Date	Population	Therapy N	Therapy Type	Average Therapy Duration	Criteria	Control Group	Adequacy of Design	Percent Improved (If Given)	Outcome
Schjelderup	1955	Outpatient neurotics	28	Psychoanalysis (exp.--1 therapist)		Questionnaire, therapist rating and observer rating (Pooled)	No	2	79	Positive, criteria rigorously applied and long follow-up
Orgel	1958	Outpatient peptic ulcers	12	Psychoanalysis (exp.--1 therapist)	600 sessions	Symptom removal	No	2	83	Positive, with 10 to 22 years follow-up
Warne, Canter, & Wiznia	1953	VA outpatient neurotics	30	Eclectic (many inexp.)	125 sessions	Ratings of case records	Yes	2	20 (slight)	Negative
Warne, Canter, & Wiznia	1953	VA outpatient neurotics	30	Eclectic (exp.)	27 sessions	Ratings of case records	Yes	2	53 (slight) 13 (great)	Positive, but in doubt because controls not matched
Shlien, Mosak, & Dreikurs; Shlien; and Henry & Schlien	1962 1965 1968	Outpatient nuerotics		Client-centered and Adlerian; brief and unlimited (exp.)	20 to 27 sessions	Q sort, TAT, self-ratings	Yes	1	70 to 85 on one criterion	Positive, except time-limited at follow-up
Vorster	1966	outpatient neurotics	65	Eclectic (exp.--1 therapist)	27 sessions	Therapist rating	No	3	89	Positive
Board	1959	Outpatients	228	Eclectic		Therapist and patient ratings	No	3	64 to 67	In Doubt
Rosenthal	1955	In-and out-patient neurotics	12	Eclectic (inexp. residents)	5 months	Tests, questionnaire, and research interview	No	2	42	Negative
Ellis	1956	Homosexuals	40	Eclectic (exp.)	20 sessions	Therapist rating	No	3	65	Positive
Graham	1960	Neurotics	64	Analytic (exp.)	6 months	Therapist ratings of sexual satisfaction	Yes	2	44 to 76	Positive, but controls not equated
Feldman, Lorr, & Russell	1958	VA neurotics & schizophrenics	5367	Eclectic-analytic		Therapist ratings	No	3	44	Negative, but difficult to interpret
Rosenbaum, Friedlander, & Kaplan	1956	Miscellaneous diagnoses	210	Analytic (inexp. residents)		Therapist ratings	No	3	68	In doubt

Authors	Date	Population	Therapy N	Therapy Type	Average Therapy Duration	Criteria	Control Group	Adequacy of Design	Percent Improved (If Given)	Outcome
Berleman & Steinburn	1967	Potential deliquents	28	Electic (exp.)	5 months	School discipline records	Yes	2		Negative
Mason	1956	Neurotics	31	Analytic (exp.--1 therapist)		Therapist rating and interview at 18 months	No	3	45	Negative'
O'Connor et al.	1964	Ulcerative Colitis patients	57	Eclectic-analytic (exp.?)		Objective symptom change	Yes	1		Positive, with schizophrenic SS deleted
Cappon	1964	Mixed out-patients	201	Eclectic-analytic (exp. 1 therapist)	35 sessions	Therapist, patient, and outsider ratings, and symptom change	No	3	40 to 75, depending on criterion	In doubt, but some positive evidence
L. Rogers	1960	Mixed outpatients patients	4081	Eclectic (exp. and inexp.)	13 sessions	Therapist ratings	No	3	71	In doubt, no control and improved ratings questionable
Harris	1954	Neurotic out-patients	60	Eclectic (exp.?)		Therapist follow-up interviews at 1 year and patient ratings	Yes	2	20 to 27	Negative
Appel, Myers, & Scheflen	1963	Hospitalized neurotics	4790	Eclectic		Various	No	3	68	In doubt
Rosenthal and Frank	1958	Mixed out-patients	216	Eclectic (inexp. residents)	11 to 20 sessions	Therapist ratings	No	2	63 (continuers); 34(drop-outs)	in doubt
Imber, Nash, Stone & Frank	1958	Mostly neurotics	34	Eclectic (inexp. residents)	16 to 18 sessions 10 year f. up	Patient ratings, and interviewer and observer rating	Yes minimal contact therapy	1	59	In doubt; significant changes, but not greater than control
Traux, Wargo, Frank, Et al.	1966	Outpatient neurotics	40	Eclectic (inexp. residents)	4 months	Two global ratings by patient and therapist, and three specific change indexes	No	2	70 on global rating only	In doubt, due to no control and mixed results on different criteria

Author	Date	Population	Therapy N	Therapy Type	Average Therapy Duration	Criteria	Control Group	Adequacy of Design	Percent Improved (If Given)	Outcome
Betz	1962	Schizophrenics	421	Eclectic (inexp. residents		Research analysis of charts and changes in overt behavior	No	2	48	Negative
Betz	1962	Schizophrenics	432	Eclectic (inexp. residents)		Research analysis of charts and changes in overt behavior	No	2	73	Positive
Cartwright	1957	U. Chicago	10	Client-centered	26	Q sort	Yes	2		Both in doubt, amount of change limited and controls - normals
	1961	Counceling Center	19	(exp. and inexp.)	37	Q sort				
Paul	1967 2 yr. f. up	Speech-anxious students	12	Eclectic (exp.)	5 sessions	Behavior change and personality scales	Yes	1	25 to 50	Negative

CHAPTER III

Conclusions and Summary

Perhaps the most difficult task in the preparation of this paper is the drawing of the conclusions. A stated goal of this discussion was to try not to persuade the reader into one specific philosophy or another.

The writer has heard it said that psychotherapy is so inconclusive and nebulous that it cannot dare call itself a science. This paper has shown to me that psychotherapy is indeed a science, not concerned with simplistic laws covering every situation, but concerned with the human being. In the opinion of the writer, the human mind is so complex, in its functions and responsibilities, that research in the area of human psychotherapy cannot help but reflect the nature of the organism being studied.

The writer feels that a beginning counselor may get from this paper a general idea of the task ahead for him if he is to seriously study counseling and psychotherapy. The young counselor owes it to himself, his clients, and his profession to grow and read.

Perhaps some of the variables mentioned in this discussion have been isolated enough to draw some general conclusions about humans, but human interpersonal relationships are in a constant state of flux and therefore, in the writer's opinion, past research cannot always be taken to be an absolute truth.

In the discussion of the therapist variable, this paper investigated the manner in which the therapist views his role in Psychoanalysis, Rational Emotive Therapy, Logotherapy, Client-Centered Therapy, Gestalt Therapy, and Behavior Therapy.

The client variables that were investigated were: sensivity to others, client satisfaction, intelligence, sex role and identification, client verbal expressivity, and client expectations.

The relationship variable was investigated in reference to how major psychotherapists view the relationship between client and therapist in psychotherapy. Some research evidence was presented regarding the relationship in major schools of psychotherapy and how they compared. Introjection and client-therapist compatibility were also discussed as relationship variables.

In the discussion of process variables an attempt was made to describe the therapy process by means of Brammer and Shostrum's six steps of therapy. There was also some discussion of the critical points in therapy.

The outcome variable discussion centered around research concerning length of time in therapy and the number of contacts with the therapist. A review was also presented concerning the outcome claims of the conditioning therapies of Salter and Wolpe. (53) A number of studies were presented concerning the outcome of client-centered therapy. A summary chart of fifty-two outcome research studies was presented.

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