THE TECHNIQUE OF PSYCHOTHERAPY

IS PSYCHOTHERAPY EFFECTIVE?

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Is Psychotherapy Effective?

In some circles the idea still prevails that psychotherapy is a swamp of marshy theories imbedded in a quagmire of metapsychological slogans and convoluted methodologies. This perhaps was the sentiment behind the Congressional queries several years ago regarding the effectiveness of psychotherapy while asking for demonstrated proof of its value.

Unfortunately, it has been extremely difficult to establish, without question, a causal relationship between techniques and methods of any psychotherapeutic system known today and the changes that have been brought about through the expediencies of that system. Both the futility of all forms of therapy in altering neurotic processes (Eysenck, 1952, 1954, 1955, 1960a, 1964, 1965, 1966, 1967; Levitt, 1957, 1963) and arguments against these conclusions (DeCharms et al, 1954; Rosenzweig, 1954; Bergin, 1971) have been voiced. Skeptics insist that neither clinical studies nor ordered observation and experiment have established beyond reasonable doubt the virtuosity of psychotherapy. This does not mean that psychotherapy is unproductive; on the contrary, the experience of "effective" psychotherapists is testimony to its potentialities. However, because present-day propositions that exist in the field of psychotherapy are not of a high order of empirically tested probability, it is difficult to demonstrate the consequences of treatment by any concrete methods and operations. Attempts to apply probability theory to the events of psychotherapy are blocked by formidable difficulties that have up to the present time defied resolution. This has encouraged some iconoclastic research psychologists to apply themselves to the evaluation of psychotherapy with the dedication of assassins.

Present-day outcome studies have yielded impressive statistics about the effectiveness of psychotherapy that contradict published negative reports (Smith et al, 1980; Andrews & Harvey, 1981; Epstein & Vlok, 1981; Am. Psychiat. Assn. Com., 1982). However, the skeptics insist that evidence from statistics is, upon close analysis, vastly misleading since we have few criteria upon which to gauge the quality of improvement or the specific parameters of personality that are being influenced by psychotherapy. Thus it has been estimated that two-thirds of all patients suffering from emotional difficulties, who turn to and relate themselves with helping agencies other than psychotherapists, will, if

the agencies are reasonably mature, experience "cure" or "improvement" purely as a product of the relationship. It has been posited also by some observers that a similar proportion of cures or improvements will be registered should the same kinds of patients come under the care of psychotherapists or psychoanalysts. With non-specific therapeutic measures, principally rest, sedation, and reassurance, Denker (1946) discovered a recovery rate of 70 percent, while Landis (1937) reported a recovery rate of 68 percent in patients who were not exposed to any therapy. If these findings are true, psychotherapy would seem to be a fraud. It would scarcely be worthwhile to expose oneself to the rigors and expense of psychotherapeutic treatments if at the end the results were no better than one could obtain with less elaborate procedures. On the other hand, if one could demonstrate that the *quality* of the two-thirds cure or improvement was of a better grade, or if the *total* improvement rate with psychotherapy could be increased by at least 20 percent, the effort and financial outlay might be justified.

No matter how strong our conviction may be about the positive effectiveness of psychotherapy that is reinforced by some of the modern studies on outcome, we cannot, with a wave of hands, disregard the negative convictions of the skeptics nor the tenets of past published data pointing out the absence of irrefutable documentation that psychotherapy is more potent than spontaneous cure or counseling (Appel et al, 1953; Teuber & Powers, 1953; Barron & Leary, 1955; Frank, 1961; Eysenck, 1962). Indeed, there are studies that seem to indicate that patients who apply for therapy and are merely put on waiting lists, receiving no further treatment, reveal after a six month's follow-up, a 40 percent rate of improvement (Endicott & Endicott, 1963), and five to six years after the initial evaluation, a spontaneous improvement rate of 65 percent (Schorer et al, 1966). The latter rate is held to be superior to that following exposure of patients to an extensive and carefully designed treatment program.

In the Cambridge-Somerville Youth Study (Powers, 1949; Powers & Witmer, 1951; Teuber & Powers, 1953) 2 equal groups of 325 boys were matched. The first group received therapy from adherents of both the psychoanalytic and Rogerian schools. The second group served as controls. Follow-up studies over a period of years disproved the expectation that the treatment group would be less delinquent than the other. Indeed there was a slight difference in favor of the control group. Brill and Beebe (1955), working with soldiers who had experienced a breakdown in the army, also found that no difference was scored in remission of neurosis between those who did and those who did not receive

psychiatric treatment. Barron and Leary (1955) treated a group of psychoneurotic patients and compared the end results with an untreated control group. They discovered that "for the most part...the changes tended to be in the same direction for treatment and non-treatment groups, and of about equal magnitude." Three groups of patients were subjected to a follow-up study by Barendregt (1961). The first division of 47 patients had been given psychoanalysis, the second of 79 patients received psychotherapy other than analysis, and the third of 74 was exposed to no form of psychotherapy. The results showed little difference among the different groups. Gliedman et al. (1958), on the basis of their work, insist that placebos are as effective as psychotherapy in psychiatric cases exposed to both. Walker and Kelley (1960), working with male schizophrenic patients, reported that short-term psychotherapy brought about no greater improvement than ordinary custodial care; indeed, it seemed to delay the discharge of patients.

The qd results of psychotherapeutic treatment of over 70,000 cases reviewed by Eysenck (1952, 1965) concluded that these "fail to prove that psychotherapy, Freudian or otherwise, facilitates the recovery of neurotic patients." Approximately two-thirds of patients will improve with or without psychotherapy. Exposed to psychoanalytic treatment, the cure-improvement rates average 44 percent, variously being reported as 39 percent (Fenichel, 1920-1930), 62 percent (Kessell & Hyman, 1933), 47 percent (Jones, 1926—1936), 50 percent (Alexander, 1932-1937), and 67 percent (Knight, 1941). With "eclectic" psychotherapy the cure-improvement rate was cited as higher, averaging 64 percent. This figure was drawn from the following: 46 percent (Huddleson, 1927), 41 percent (Matz, 1929), 55 percent (Luff & Garrod, 1935), 77 percent (Ross, 1936), 58 percent (Yaskin, 1936), 61 percent (Curran, 1937), 54 percent (Masserman & Carmichael, 1938), 73 percent (Landis, 1938), 53 percent (Carmichael & Masserman, 1939), 63 percent (Schilder, 1939), 66 percent (Hamilton & Wall, 1941), 51 percent (Hamilton et al, 1942), 50 percent (Wilder, 1945), 58 percent (Miles et al, 1951). The data of the Central Fact-finding Committee of the American Psychoanalytic Association, according to Brody (1962) and Masserman (1963), appear to reveal that of 210 "completely analyzed" cases, 126 were "cured" or "greatly improved." Of the remaining 385 "incompletely analyzed patients," it is estimated that about half achieved some improvement. Levitt (1957), summarizing many studies on the psychotherapeutic treatment of children, arrived at a figure of 67.05 percent of cases who improve at the end of therapy and 78.22 percent at follow-up. Eysenck (1965), in examining this mass of data,

concluded that psychotherapy registers a small effect, if any, on patients, with the exception of therapies based on modern learning theory. His conclusions, while upheld by Astrup (1965), Zubin (1965), Meehl (1965), Davidson (1965), and Wolpe (1965), have been vigorously challenged by Zetzel (1965), Frank (1965), Glover (1965), Barendregt (1965), Matte-Blanco (1965), Strupp (1965), Handlon (1965), and Bergin (1971). To all of these criticisms, Eysenck (1973) has replied that there is not one single study that indisputably demonstrates that psychotherapy succeeds better than no treatment, or behavior therapy, or any other alternative. Indeed, he avows that Rachman (1972) in his book, which exhaustively reviewed the literature, substantiates his own conclusions made in 1952. He states, "I believe that psychotherapy of the usual interpretive kind is simply the premature crystallization of spurious orthodoxy, a verbal exercise without any proof of effectiveness."

Bergin (1971) reviewing the data that Eysenck cites in his 1952 review comes up with a different statistic by taking another point of view. For example, Eysenck qs a study by Fenichel evaluating the work of the first ten years of operation of the Berlin psychoanalytic clinic and shows that the improvement rate was two-thirds. However, Eysenck obtains this rate by including those patients who dropped out of treatment after brief contact with the clinic. If these patients are not included, then the improvement rate jumps to 91 percent. Scientifically, however, one can validly argue for either including or excluding the dropouts in computing the percentage rates as improved. Bergin has also demonstrated that the spontaneous improvement rate of two-thirds shown by control groups supposedly receiving no treatment is fallacious. The reason that one cannot have an adequate control group in an outpatient psychotherapy study is because patients who are suffering and are refused help will usually look elsewhere for assistance. They will go to friends, neighbors, or practitioners of various sorts (Gurin et al, 1960). They thus do not constitute a scientific control group. At best we must compare the results of professionally trained therapists with the results of nonprofessional operators in the community. Some of the latter may influence patients toward improvement as or more effectively than professional therapists, largely perhaps because they are adept at impressing on their clients an unshakable optimism and thus stimulating non-specific elements of the helping relationship. Published reports of spontaneous recovery or improvement rates on emotionally ill persons in whom no formal therapy had been validated are below the two-thirds figure and range from zero upward: for instance, *negligible* (Orgel, 1958; Cappon, 1964; O'Conner et al, 1964; Koegler & Brill, 1967); *30 percent* (Shore & Massimo, 1966); *25 percent*

(Kringlen, 1965a) and *18 to 22 percent* (Paul, 1967). These studies, which indicate a median rate of 30 percent, deal with varying patient populations with widely different syndromes and hardly satisfy rigorous empirical criteria (May, 1971). Despite later writings disputing Eysenck's ideas (Bergin & Lambert, 1978; Vandenbos & Pino, 1980), these continue to influence opinion and are upheld by some (Erwin, 1980).

To round out the statistical muddle, the different schools of psychotherapy cannot agree among themselves regarding the fruitfulness of their particular brands of therapy, published figures displaying a greater divergence among proponents of a special approach than between those of different schools. There is general agreement, however, among non-analytic groups that results with their methods are superior to those of psychoanalysis. Behavior therapists, for example, score their curative yield as roughly double that of psychoanalysts. Psychoanalysts, on the other hand, label the results of non-analytic therapy as "temporary" and "superficial."

THERAPEUTIC IMPROVEMENT IN RELATION TO GOALS

Comparison of the effectiveness of competitive brands of psychotherapy is meaningless without considering the goals to which they direct themselves. Symptom relief or cure, a legitimate and important target, is easier to achieve than attitude and behavior change, which, in turn, is more readily attainable than reconstructive personality change. The reason for this is that habit patterns constitute for the individual a way of life. They contain vital defenses and security operations, interference with which is bound to provoke anxiety. The painful confrontations to which the ego must inevitably be exposed will promote resistance that may take diverse forms, one of which is flight from therapy. Where a patient interrupts treatment before the goal of reconstruction has been reached, the initial symptoms, kept alive by resistance and transference, may still be present. Therapy may then be graded as a failure. Paradoxically, had treatment been discontinued during the early treatment phases when the salubrious glow of the placebo effect was still felt, and before resistance and transference had restored some symptoms, therapy may have been considered successful by the patient. However, more extensive goals would not have been reached where potentially achievable.

Whereas an effective psychotherapist can obtain 80 to 90 percent of symptom cure or improvement,

the positive results will be reduced where behavior change is the goal. In the event the therapist seeks reconstructive changes in patients, a figure of only 40 percent will probably be as high as can be attained, even where the therapist is highly trained.

There are many reasons why so small a percentage of patients can be influenced beyond the benefactions of symptom relief and attitude change. With the best of intentions the therapist may succeed in tearing down, in sicker patients, their defensive structures, expectantly waiting for a new personality edifice to rear itself. Helpless and deprived of customary neurotic resources, which have been "analyzed away," the patient will cling to the therapist with a dependent desperation that will confound both participants. Hopeful expectations go unrewarded, the patient symptomatically being worse off than before treatment.

As in major surgery, the risks are greater in reconstructive therapy than where palliative measures are employed. The results will best justify the risks where cases are carefully selected. This calls for diagnostic skills that enable the therapist to exclude patients who are least disposed toward extensive change (such as fragile psychotics, severe alcoholics, psychopathic personalities, drug addicts, borderline cases) profound characterologic dependencies, severe obsessive-compulsive neuroses, etc. Reconstructive treatment necessitates sophisticated training and wide experience in the handling of stormy, long-term therapeutic relationships. Nevertheless, with the skillful application of techniques, the rewards should more than justify its application in selected patients as the preferred treatment method.

THERAPEUTIC IMPROVEMENT IN RELATION TO TREATMENT PHASES

At the beginning of any treatment effort, irrespective of type, extratherapeutic helping agencies operate to bring about improvement in symptoms. Counteracting these positive non-specific influences during early treatment phases are (1) defective motivation, (2) continuing conflict that, sponsoring anxiety, revitalizes symptoms, and (3) the defensive dividends and secondary gains that make the retention of symptoms advantageous for the patient. These interferences must be dealt with energetically by therapists as part of their technical pursuits.

Assuming that negative forces are not too prominent, or that they have been handled with proper

therapeutic craftsmanship, the patient will register symptomatic improvement. This boon is the conjoint product of such forces as the placebo influence, emotional catharsis, the projection of an idealized relationship, suggestion, and group dynamics (see Chapter 4). Abatement of tension and anxiety and restoration of a sense of mastery will then promote a better outlook toward life.

If therapy is stopped at this period, the patient may be able to continue improvement, particularly if the sources of difficulty are dealt with constructively. This can best be accomplished during the brief therapeutic effort after existing troubles have been explored and especially when a continuity has been established between the immediate complaints, habitual personality operations, and determining childhood experiences and conditionings. If, however, therapy continues beyond this early phase, initial benefits may soon expend themselves in the wake of the patient's realization that the idealized properties with which he or she has invested the therapist are truly nonexistent. Faith, hope, and trust no longer will temper the therapeutic climate. It is, of course, possible where the patient's need is sufficiently great—as in certain characterologically dependent personalities—for the patient to continue to endow the therapist with godlike qualities, particularly where the therapist narcissistically shares the patient's omnipotent delusions. Under these circumstances the patient will bask in the therapist's sun, soaking up the power of celestial exposure, and feel protected and continue symptom free as a result.

On the other hand, neither the patient nor the therapist may be capable of keeping alive such a sainted image. Indeed the therapist may purposefully retreat from playing a protective role and, particularly where striving for reconstructive goals, may even challenge the patient's defenses by pointing out existing behavioral improprieties. An inescapable increment of the protracted therapeutic time period to which patients are exposed for purposes of extensive personality alteration is the furtive or dramatically explosive obtrusion of resistance and transference. Where the patient's inherent personality strengths are sufficient to reconstitute personal defenses in a new climate of strife, and where the therapist is sufficiently skilled and by disposition equipped to handle the patient's insurgency, the patient will best be enabled to proceed toward a remodeling of relationships and toward values beyond the benefactions of symptom relief. At any rate, we may expect that by-products of most therapeutic endeavors that extend themselves in time are an eruption of symptoms and a mobilization of tension and anxiety. Stopping treatment at this middle phase will usually expose a patient who insists that therapy has brought little benefit. And yet, had treatment halted earlier, at the crest of the non-

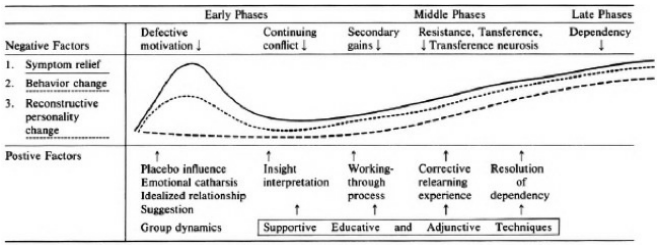
specific improvement wave, the effectiveness of the effort might have been endorsed.

In reconstructive therapy, therefore, we may expect a recrudescence of symptoms. Challenge of resistance, maneuvers toward insight and working through, are aspects of the therapeutic process, however painful they may be, that force patients to learn new modes of adjusting.

It is to be expected also that prolonged therapy will tend to promote dependency. This silent saboteur may interfere with the patient's efforts toward self-actualization. It may keep the patient reduced to an infantile status, violently promoting a return of original symptoms when the patient perceives a threat of termination of therapy. As the therapist works through this "separation anxiety," the patient may be able to rely more and more on himself or herself and gradually to expand the feelings of assertiveness. Table 8-1 outlines some of the foregoing processes.

Table 8-1 Course of Psychotherapy

(in relation to symptom relief, behavior change, and reconstructive personality change)



During early phases of therapy there is often an immediate and dramatic relief of symptoms brought about by such positive factors as the placebo influence, emotional catharsis, idealized relationships, suggestion, and group dynamics. There is some attitude and behavior change, but little or no reconstructive personality change. Therapy interrupted at this point – as it is in short-term therapy – will show a considerable degree of symptomatic improvement. However, if therapy continues, and particularly where habitual behavior patterns are challenged, resistance and transference will erupt and will reduce or temporarily eliminate symptomatic and behavioral improvement. Treatment stopped in the middle phases will then tend to show a poorer response than if it had been discontinued before. However, as working-through of transference and resistance goes on, and, as corrective relearning takes place, symptomatic and behavioral improvement will rise accompanied by reconstructive changes. A propitious experience during short-term therapy may initiate reconstructive changes that will still require protracted time span outside of the therapeutic situation before they become manifest. This eventuality is not as consistent as it might be in properly motivated patients, who are able to endure the rigors of long-term depth therapy conducted by "effective" therapists.

Table 8-2 Estimated Results in Psychotherapy

Estimates of symptom improvement, behavioral and reconstructive personality change with various kinds of approaches

Area of change	"Spontaneous" Improvement	Helping Situation with a Non-trained Helper*		Counseling Situation (Trained Counselor)		Therapeutic Situation (Trained Therapist)	
Symptom relief or cure		"Effective" Helper	"Ineffective" Helper	"Effective" Counselor	"Ineffective" Counselor	"Effective" Therapist	"Ineffective" Therapist
	60%	70%	30%	80%	30%	80-90%	30%
Behavior change	40	50	20	60-70	20	70-80	20
Reconstructive personality change	10	15	5	20	5	40**	5

* The same results will be obtained with untrained and unskilled counselors and therapists.

** Where therapist is not trained in depth techniques the figure will approximate 20%

The average person with an emotional problem will spontaneously seek out solutions for one's problems that will result in a certain degree of symptomatic and behavioral improvement, as well as of personality change. Opportunity for the *greatest improvement* above that of the "spontaneous" rate in all three areas will be afforded one with an "effective" psychotherapist, for *considerable improvement* with an "effective" trained counselor, and for *some improvement* with an "effective" helping agency. In the hands of an "ineffective" helping agency, counselor, or psychotherapist, changes for improvement will be approximately half that of the spontaneous rate.

THERAPEUTIC IMPROVEMENT IN RELATION TO THE THERAPIST'S PERSONALITY

One of the most important variables in psychotherapy is the helping or therapeutic personage, whose character traits and technical skills are bound to influence results. In Table 8-2 an attempt has been made to grade rates of cure or improvement that we expect in relation to desired areas of change (goals), the kinds of processes to which the individual is exposed (techniques), and the quality of the agency administrating help.

Starting with the baseline of what we might anticipate should the individual spontaneously exploit random avenues of help, we may then compare these rates with what could happen if the individual related himself or herself to some "helping" person, such as a minister, physician, teacher, friend, or authority who, while trained in a particular field, has had no special schooling in counseling or psychotherapy. "Effective helpers" are those who possess personality qualities that inspire in the subject with whom they are working *hope, faith, trust, liking,* and *freedom to respond.* Such helpers generally have characteristics of sincerity, honesty, a capacity to respect people, confidence in what they are doing,

positiveness of approach, and what Rogers (1946) has called "genuineness," "empathic understanding," and "non-possessive warmth."

Whitehorn and Betz (1960) and Betz (1962) substantiate the vital role the personality of the therapist plays in securing results with schizophrenics in psychotherapy. Effective therapists, they discovered, see a patient as a person and not a problem, stress assets of the patient not liabilities, challenge self-depreciatory attitudes, are reasonably permissive, behave naturally with the patient, and focus on securing a trusting relationship. Ineffective therapists are too permissive, focus on the patient's mistakes, evince the qualities of an aloof teacher, and are more passive and permissive. Betz (1967) suggests, however, from research studies that the outcome of therapy depends on the quality of the relationship that develops as a result of the blend of the personalities of therapist and patient.

Truax and Carkhuff (1967) have derived three scales of traits of effective therapists derived from ratings of typescripts: (1) positive regard for the patients, (2) accurate empathy, and (3) congruence. The *accurate empathy* scale would seem to be related to the concept of accuracy of interpretation of what is going on within the patient, although no studies have been done to date to relate these two concepts. *Congruence* refers to therapists being in touch with their own feelings. If therapists assert that a patient is "liked," yet by tone of voice and previous statements show anger toward the patient, they are rated to be in low congruence. Truax and Mitchell (1972) have reviewed the results of 10 years of such studies and have found that the results are very consistent across many studies employing different diagnostic groups, with therapists of different theoretical persuasions and with differing lengths of therapy.

Rogers et al. (1967) reported an extensive controlled study of psychotherapy with schizophrenic patients who were hospitalized at a state hospital. They found that patients whose therapists offered high levels of non-possessive warmth, genuineness or congruence, and accurate empathic understanding achieved significant positive personality and behavioral changes on a wide variety of indexes; while patients whose therapists offered relatively low levels of these interpersonal skills during therapy exhibited deterioration in personality and behavioral functioning.

These studies point to the existence of a "therapeutic personality" that effective therapists possess irrespective of their operational modes (techniques). Ineffective helpers do not possess therapeutic

qualities and traits, and their absence, as may be seen from Table 8-2, will damage their capacity to render proper help. Parenthetically, every helper (or counselor or psychotherapist for that matter) will relate differently to special persons. Warmth and liking may be shown toward some individuals with whose personalities and problems the helper identifies and with whom there is a feeling of security. On the other hand, detachment and hostility may be manifested with other persons toward whom the helper feels alien and who tend to light up countertransference. All helpers will consistently be more effective with certain individuals than with others.

Counselors are those who have been trained in casework and counseling techniques. If they have the personality qualities outlined above, such training will enable them to function more expertly than non-trained helpers. Effective counselors should accordingly score higher in results than effective helpers. However, irrespective of how thoroughly trained, if counselors lack appropriate personality qualities, they may be classified as ineffective counselors, and the results will be no better than those of ineffective helpers.

When we consider trained psychotherapists, we view a somewhat complex picture since their theoretical and methodologic orientations vary so greatly. We may expect that the average trained psychotherapist whose personality contains the positive units described above (i.e., an effective therapist) will be able to achieve symptom relief, as well as behavior change, above that brought about by an effective counselor. Additionally, if the psychotherapist is trained psychoanalytically to do "depth therapy," we may expect that the most extensive and difficult to achieve goal of reconstructive personality change, potentially possible in patients selected for this approach, will at least be double that seen with therapists and counselors who do not employ insight techniques, and who depend on the adventitious operation of constructive relearning alone, which, sometimes, in a favorable atmosphere, may result in some reconstructive change. Again, though a psychotherapist has had exhaustive training, should that therapist lack the proper personality qualities, the results will be no better than those of an ineffective counselor or an ineffective helper. Patients may temporarily improve on the basis of non-specific extratherapeutic agencies, but soon these dividends will expend themselves as the patients find themselves locked in a frustrating and unrewarding relationship situation. Where a therapist with suitable traits is not too well trained or skilled in executing therapeutic maneuvers, the results will be no better than those of an effective helper who has had no training. They will, however, eclipse those of the

trained ineffective therapist who may have spent many years in exhaustive postgraduate studies that, though sharpening the cognitive processes, have made no dent on the individual's antitherapeutic personality.

The reason why the patient is impeded rather than benefited by an ineffective helping agency, counselor or psychotherapist is that the patient is blocked, by being trapped in an unrewarding situation, from spontaneously seeking out other helping resources that may bring homeostasis. Moreover, the relationship with the ineffective helper-counselor-therapist will in all probability promote hostility and release transference distortions that will activate regressive defenses, like hostile dependency, lighting up new and galvanizing old symptoms.

We are inevitably drawn to the awesome and unpleasant conclusion that a person suffering from a psychological problem is better off with no treatment at all than if that person enters an emotionally inadequate helping or therapeutic situation, whether this involves an untrained helper, a trained counselor, or an intellectually sophisticated psychotherapist.

A crucial question is whether the appropriate personality ingredients essential for therapeutic change may be taught those who seek to administer help. There is some evidence that helpers, counselors, and psychotherapists who do not inherently possess such traits, may be trained to communicate warmth, empathy, and genuineness without themselves entering into depth therapy. However, this would probably apply only to those personality structures that were not too rigid, hostile, or detached—in short, to basically healthy individuals. There is some evidence, too, that certain inflexible, hostile, and detached individuals may, with properly conducted personal reconstructive psychotherapy, work through extensive flaws in their personalities and acquire the qualities important for functioning as effective psychotherapists. This development, however, is not at all guaranteed, and we see evidences repeatedly of professional persons who have undergone extensive training, including personal didactic psychoanalysis, who are as arrested in their growth as when they first exposed themselves to treatment, and whose contributions to the ailing masses the world could very well do without. The consequences of their education and training have become the target of critics who are constantly sniping at the results of psychotherapy. Available statistics do not convey an accurate picture of the potentialities of psychotherapy since they lump together the results of effective with those of

ineffective therapists that because of the "deterioration" impact (Bergin, 1963, 1967; Truax & Carkhuff, 1967) cancel each other out and reduce the score to a figure not too much higher than that of the spontaneous cure.

Psychotherapy has vast potentials as a healing force, but it is the product of a complex equation, the elements of which require careful scrutiny, contemplation, and unravelment. It can be executed properly only by selected individuals who inherently possess or have acquired appropriate personality characteristics that will enable them to relate constructively with their patients. It is enhanced by scholarly grounding and sophisticated postgraduate schooling best available through disciplined educational resources specialized to teach an extremely complex skill.

THE MEASUREMENT OF THERAPEUTIC IMPROVEMENT

General procedures for the measurement of outcome have been detailed by a number of authorities, including Waskow and Parloff (1975) and Gottman and Mark-man (1978). Of primary concern is identifying the specific variables that are significant to measure and that give us reliable and valid data. Of concern also are the research designs that can best provide answers to our questions about outcome. The instruments that are used for the gauging of outcome must be selected carefully, recognizing that no one instrument is suitable for different patient populations and for varying forms of psychotherapy. Rather, multiple outcome instruments are indicated. Among the measures in use today are: self-reporting that deals with the patient's daily functioning (Cartwright, 1975; Imber, 1975); broad anamnestic material as in the popular Minnesota Multiphasic Personality Interview (Payne & Wiggins, 1972; data from family and friends (Hargreaves et al, 1975; Waskow & Parloff, 1975); a "Community Adjustment Scale" (Ellsworth, 1974); therapist assessment scales (Green et al, 1975; Endicott et al, 1976; Newman & Rinkus, 1978; Mintz et al, 1979); material from community agencies or members (Cummings & Follett, 1968; Halpern & Biner, 1972; Cummings, 1977); and changes in economic and creative output (Riess, 1967; Yates, 1980). Insofar as research designs are concerned, a number of authorities have offered their ideas, for better or worse, including Glass et al. (1973), Luborsky et al. (1975), Bandura (1978), Cronbach (1978), Kazdin (1979), and Cook and Campbell (1979).

Formidable problems exist in any attempt to measure the results of psychotherapy or to verify its

empirical propositions (Pumpian-Mindlin, 1956; Kubie, 1960). Paradigms for psychotherapy evaluation that will identify and possibly quantify clinically relevant parameters that consider the uniqueness of each patient require further development (Glass, 1984). Ideally, we should like to observe exhaustively what takes place in the course of treatment, to study the results by subjective and objective means, to erect comprehensive hypotheses concerning the relationships between events, to deduce the consequences of such relationships, and to elaborate methods of testing inferences under controlled conditions in order to construct scientifically valid concepts. Most efforts in this direction, however, applied to the staggering uncertainties of the clinical situation, have merely accented the fallibility of our present research tools and techniques.

The methodologic problems encountered in studies on the outcome of psychotherapy are compounded by semantic befuddlements. Hazy language and even hazier concepts permeate the field of psychotherapy. When we attempt to put into words what treatment aims have been achieved, we are handicapped in translating the complex formulations of the different psychotherapeutic approaches into abstractions that possess reasonable unity. We discover that each school has its particular way of talking about and emphasizing essentially similar elements in human behavior. The nuances that are being stressed in these ideas are often not as important as the advocates of the particular schools would make them out to be. Another confusing thing is that the same labels may be employed to designate markedly diverse ideas, for instance the words *relationship* and *ego* mean entirely different things when used by select theoretical schools. Furthermore, therapists may inject into words their own private meanings that may not at all resonate with the concepts under examination.

Another pitfall is that the bewildering number of variables, many of which are not manipulable, tempt one to grapple with only a few that can be handled with relative ease. When these are lifted out of the context of the tremendously complex physiologic-psychologic-sociologic continuum that constitutes human adaptation, they often lose their significance. We are rewarded with a catalogue of beautifully compiled categories that mean little, particularly when we try to generalize conclusions beyond the material with which we are dealing.

Before proceeding, let us review the outstanding problems in applying scientific method to evaluation studies:

1. There is disagreement as to which observable phenomena are worthy of observation.

2. The data available for study are difficult to manipulate and control, interfering with conditions ripe for experiment.

3. It is cumbersome to qualify the quantitative data of psychotherapy due to the complexity of the variables involved.

4. Available units of measurement are ill-defined, interfering with comparisons and with the synthetization of similarities and differences into a homogeneous unity.

5. Theoretic prejudices and personal biases make for a loss of objectivity and an interference with the ability to utilize imagination in hypothetic structuring.

6. The absence of an accepted conceptual framework that can act as a basis for communication obstructs the formulation of inferential judgments regarding order in the observed phenomena— blocking the deduction of valid analogies justified by the available facts, and hindering the exploration of causal connections between antecedents and consequences.

7. The reliability of our results is distorted by a variety of other difficulties that are related to special problems of the therapist, the resistances of the patient, the amorphous status of diagnosis, the prejudiced selection of the sample, the involvements of outside judges, coders, and raters, the inability to employ adequate controls, the interferences of adventitious non-specific changes, and certain complexes inherent in the psychotherapeutic process itself.

With advances in computer technology, the development of treatment manuals to standardize therapeutic operations, the use of video tape recordings to enable independent assessors to monitor adherence to the prescribed techniques, the greater employment of adequate controls, the development of more sophisticated research designs, and improved follow-up studies on research, findings should become more reliable. The question is how much will such findings enhance our techniques for the better. The answer to this is still uncertain because individual interpretations of research findings can be different, and styles of operation vary so much that one therapist may completely foul up a prescribed method that another has utilized with great effectiveness. This is one problem that a prepared "Manual of Operations" poses. How the manual fits in with the preferred style of a therapist will determine its usefulness. It may put some therapists into a straight jacket and may totally cripple their spontaneity and

flexibility. On the other hand, it may structure operations for some and make them more precise. What a therapeutic manual may be able to do is to define more precisely what enters into a specific form of treatment (behavioral, psychoanalytic, eclectic, etc.). When we examine what therapists do under the banner of a specific form of psychotherapy, we sometimes find that their operations deviate from what is commonly accepted as standard (Strupp, 1978).

Problems Related to the Therapist

Not the least of the sources of error are the individuals who supply the data on which we are dependent, particularly the therapists and the patients (Lambert & Utic, 1978; Parloff et al, 1978b). A psychotherapist's assessment of what is accomplished in treating a patient is apt to tell us more about the therapist's narcissism than it does about what actually happened to the patient. One pointed example of how therapists may contaminate the data is their direct or indirect influencing of the verbal content. This is significantly affected by comments and even indications of approval or disapproval as contained in nonverbal cues (Greenspoon, 1954a,b). The material that is brought out may consequently be a facsimile of the therapist's ideas and values that have been subtly communicated and are now being regurgitated by the patient upon proper stimulation.

We repeatedly are confronted with productions from patients that seem to validate the specific theoretical systems espoused by the therapist. Most psychotherapists have a tremendous investment in their theories and methods. By the time they have completed training they have some firmly set ideas about human behavior. As students in training, affirmation of the approach in which they are being groomed offers rewards of approbation, of completion of training, of admission to the special graduate society with status privileges, and of economic security in the form of patient referrals. Denial of the verity of the system poses the hazards of being accused of hostile resistance, of exclusion from the ranks of the privileged, of dismissal from training, of excommunication and possible financial doom. Against these odds, the preservation of the thinking integrity is put under a strain that few students can resist. Glover (1952) has remarked, "There is a tendency in the training situation to perpetuate error." This error may be carried over to the patient who is the recipient of the therapist's values, no matter how passive and nondirective the therapist imagines himself or herself to be. The very nature of the psychotherapeutic process demands that the therapist have a conviction about what he or she is doing. As. F. C. Rhodes

Chalke remarked in his presidential caveat at the Canadian Psychiatric Association (Psychiatric News 9:1, 1974): "It has been demonstrated that much of the therapeutic effectiveness of psychiatrists resides in an inherent faith in one's curative powers. This can be significantly diminished if one were to be confronted in measured terms with one's failures or successes."

Dedication to one's system is an important constituent in the therapist's mental set. If the therapist evinces a scientific attitude of skepticism, it may be interpreted by a patient as unsureness and lack of belief in the method. This may influence adversely the patient's expectations of help and reduce faith in the therapist. The therapist, therefore, may find that dogma tends to stabilize some patients as well as himself or herself. While it may help one area of functioning, it does introduce errors that may be fatal in the experimental evaluation of therapeutic activities and results.

The therapist's bias also extends itself to patient selection, so that our examining the results may be handicapped by a restricted sample. Therapists are inclined to select patients who will, according to their experience, respond best to their methods. A not too inconspicuous screening process may be employed to eliminate a wide spectrum of patients and problems. In intensive long-term therapy, an economic factor also enters into the picture, an important criterion of selection being, not the syndrome or personality, but the ability of the individual to afford the financial drain that will have been made. Thus the patients who avail themselves of long-term treatment may belong to a different subcultural group than those who apply for short-term therapy, with value systems and social pressures that make for distinctive reactions and singular responses to psychotherapy.

Economic and status factors also interfere with the reliability of a therapist's accounting of results. As a recording apparatus, the therapist possesses many defects. Bias may divert from presenting factual data, leading the therapist to some erroneous conclusions. Berg (1952) has humorously commented that when a patient loses his or her job, the therapist will find outside factors responsible; however, when the patient gets a salary increase, the therapist is willing to take credit for singular clinical competence. A therapist is generally unwilling to stand by passively and offer an unprejudiced account of why patients have failed to get well. He or she has, as Greenacre et al. (1948) pointed out, "too great a stake in the patient's recovery." When a researcher seeks to examine records or to listen to session recordings, the therapist most likely will refuse to deliver them. Why become a sacrificial victim? Why should one be a

party to one's own discredit as a therapist?

What constitutes a well-trained professional person who is qualified to do good psychotherapy is another delicate matter around which many heads have been shattered. Avoiding the ever annoying topic of medical-non-medical, we can say that an individual who has been graduated from a reputable postgraduate school run by qualified and trained psychotherapists, which has an adequate screening process for candidates, a well-formulated program of didactic instruction, competent and elaborate supervision of a varied caseload, and provisions for personal psychotherapy or psychoanalysis of its students, can arbitrarily be considered a psychotherapist. A study of cases handled psychotherapeutically by persons whose qualifications are questionable is certainly not a reliable index of the value of psychotherapeutic techniques. After all, not every person who drives a nail can be considered a cabinetmaker. Among the graduates of postgraduate schools for psychotherapy will be those with relatively fair, average, and excellent degrees of competence; there will be differences in the results of the individual practitioners with special kinds of patients and problems; there will be varying personality difficulties and aberrant characteristics among them that will determine, as has been indicated in an earlier part of this chapter, whether they will be effective or ineffective psychotherapists. Of importance also is the ability to utilize methodologies that have proven valuable for special syndromes. Many therapists attempt to squeeze all patients into the kinds of technique with which they are familiar. This is understandable, but the patient may become a sacrificial victim as a consequence.

Problems Related to the Patient

There are many sources of error in the patient's statements about results achieved in therapy. Notoriously, many patients are poor judges of what actually is going on, but unfortunately, they may be the only witnesses at our disposal to testify. They may, however, prove to be reluctant witnesses. Patients are motivated to seek help for their suffering; their objective is not to offer themselves as research vehicles. Asking them to subject themselves to psychological studies, to interviews with observers and research workers, and to follow-up manipulations may mobilize attitudes and feelings that negate therapeutic aims.

It is always necessary to validate, by objective criteria, subjective reports by patients, good or bad,

since their judgments are obviously colored by resistances. These may operate either in the service of a false report of well-being, as may be the case where the patient conceives of further therapy as a threat; or they may evoke a depreciation of legitimate developmental progress, for instance, where such progress does not conform with personal value systems or those of the subcultural group to which he or she belongs. The patient may have firm convictions of what is desired out of therapy that do not parallel the objectives of the therapist or meet the goals of reasonably good mental health. For example, Mary Jones may be interested merely in resolving her tension, neutralizing her anxiety, and reducing her symptoms so that she can function comfortably. She may be willing to restrict specific life functions, adopt protective or precautionary defenses, or forego important measures of self-fulfillment in order to achieve peace and relief from suffering. From her standpoint her therapy will be a success, if she achieves these goals, and if she symptomatically feels better she may consider herself cured. From the standpoint of the therapist, Mary Jones may be only moderately improved, since she has not altered any of her basic life patterns. From the yardstick of ideal mental health objectives, she may have retrogressed, in view of her abandonment of vital human functions.

The Problem of Diagnosis

Another factor that interferes with good evaluative research is that our present-day psychiatric nosologic systems are still in need or reordering. They embrace conglomerate labels that depict anxiety, symptomatic manifestations of anxiety, defenses against anxiety, character traits, and disintegrative phenomena. Often a diagnosis is made of that symptom complex that is most disturbing to the individual even though coordinate pathologic elements exist that are more fundamental and more serious, but happen to be less annoying to the patient than the complaint factor. Or the therapist may favor a special group of manifestations and focus attention on these. Even well-trained therapists examining the same case may, therefore, arrive at different diagnoses. This is, to say the least, confusing to the researcher who attempts to establish some unity among the diagnostic categories. The sharpening of diagnostic systems would certainly lead to a greater clarity about goals in therapy and help in our evaluative effort. The authors of DSM-III and DSM-III R have made estimable progress toward this end. New attempts are now in process, of working out more suitable classifications. The problem is a most complex one since emotional difficulties influence every facet of functioning—physiologic, intrapsychic, interpersonal, and

community relationships. What distinguishes one individual from another is the unique configuration of tendencies and traits in the form of residues of faulty conditionings, fingerings of immature personality promptings, defective modes of dealing with aggression and sexuality, manifestations of anxiety and its neutralized derivatives, and defensive and characterologic distortions. A person is qualitatively different from others because each individual is quantitatively constituted and disposed differently. What we perhaps need to do in establishing a more serviceable classification is to determine which clusters of traits and problems, or combinations of the latter, respond best to special therapeutic approaches.

The ability to define significant clusters that have responded to special treatment attempts presupposes that we have a way of identifying them. Of great handicap is improper, and even downright irresponsible, recording at the time treatment was begun. It is manifestly impossible to gauge what has been accomplished for an individual if we have no starting point from which we can begin our measurements. Too often we find ourselves desperately grasping for clues, attempting to reconstruct from memory or from the feeble jottings in our notebooks the approximate status at the beginning of treatment.

The fact that so many areas are pathologically afflicted in any emotional problem makes inadequate our simple designations of change. Labels of "cured," "much improved," "moderately improved," "unchanged," and "worse" mean little in view of the complex systems with which we are dealing. Rarely is the patient influenced similarly throughout the physio-psycho-sociologic spectrum. The patient may have experienced great symptomatic improvement and even cure of a disabling condition, yet the patient's interpersonal difficulties may continue in force. The patient may have improved in work capacities and community relations, but marital and sexual adjustment may have deteriorated. When we utilize ratings of change, it would seem important, therefore, to assign these to the areas to which they relate. This would enable us better to appraise the specific zones of disturbance that respond to special approaches and techniques. In group therapy, for example, we may find that the patient derives great help for interpersonal problems, while entrenched intrapsychic defenses have scarcely budged. Among the areas we may consider for our ratings are the following:

1. Changes in manifest symptoms

2. Changes in interpersonal, family, work, educational, and community adjustment

3. Changes in physical health

4. Changes in feeding, eliminative, sexual, rest, sleep, and activity patterns

5. Changes in consumption of alcohol, sedatives, tranquilizers, and other medications

A fruitful area of research is in the development of scales by which we can assess the various outcome criteria. We may then better be able to compare the results of varying kinds of therapy, performed by different therapists, with diverse types of problems and patients, and then contrast these results with what happens when no formal treatment has been administered. Some years ago attempts in this direction were made by defining change in descriptive and operational terms without evaluating the changes (Witmer, 1935; Hunt & Kogan, 1950; Watterson, 1954). How an evaluative scale may then be employed to utilize such descriptions has been described by Malamud (1946).

The Problem of the Sample

In evaluating a psychotherapeutic system one may tend to neglect how the sample was selected. Because many therapists screen their patients, choosing those whose problems, in their opinion, are best suited to their methods and skills, a prejudiced weighting of the caseload is possible. Our conclusions regarding the worth of a therapy, therefore, may have to be restricted to a special group of patients and problems. For instance, an individual applying for formal psychoanalysis may be rejected if that individual does not possess a balance of characteristics that are lumped under the designation of "ego strength." Other therapies may practice no partisanship in choosing candidates for their methods. Attempts to contrast results between different therapies must obviously take into account the fact that we may be dealing with varying populations. Thus, O'Connor and Stern (1972) studied the effects of psychoanalysis (4 sessions weekly for a minimum of two years) and psychotherapy (semiweekly for no longer than two years) on 96 patients with functional sexual disorders. They reported an improvement rate of 77 percent with psychoanalysis and only 46 percent with psychotherapy. This might sound significant except that the group selected for psychoanalysis "evidenced less illness than those who received psychotherapy." We are dealing then, at least in the area of this sample, with two dissimilar groups.

Some workers, in judging the results of treatment, include all individuals who have been interviewed and accepted for therapy, even though they do not continue beyond a few sessions. Others exclude persons who have discontinued therapy against advice. Obviously this discrimination alters the percentage of individuals improved. It is very easy to manipulate statistics to substantiate almost any bias, such partiality being not always unconscious.

Another error commonly overlooked is failure to mention the cultural and subcultural background of the persons composing the sample. Therapeutic results are influenced to a marked degree by conditions in the social environment to which the patients must adapt themselves after they have completed their treatment. Indeed, certain neurotic defenses may be mandatory if the individual is to survive in a predatory environment. Value systems regarded as constructive from the standpoint of ideal mental health may be a source of victimization where one must adapt to groups perpetuating erratic conventions and folkways. It is essential in doing comparative studies to include a description of the individuals who are being evaluated, how they were selected, their background, their socioeconomic status, the length of treatment, and other information that might influence the treatment results. What is important also is when in time evaluations are made "whether repeatedly, during the course of, or immediately afterwards, or at variable and increasing intervals after it is over" (Kubie, 1973). These considerations will help reduce the error involved in generalizing beyond the sample to the population at large.

In our effort to select a homogeneous sample, we must keep in mind the fact that no two persons are alike even though their diagnosis is similar. Thus individuals in a sample of agoraphobic patients will vary in their physiologic makeup, developmental conditionings, educational backgrounds, environmental experiences, intrapsychic structures, personality organizations, living milieu, values, and sundry other personal determinants, including age, severity of symptoms, and motivation. These will make every patient a totally unique human being, who in a pool of other human beings, looks and behaves in certain ways distinctively from the rest. In responses to the same kind of psychotherapy, we may expect differences.

In measuring change we need to know what area or areas are to be assessed. The selection of different criteria by which to estimate improvement or cure has led to a great deal of confusion. Thus the

measure of successful problem-solving, symptom relief, or behavior change accepted by behavior therapists may not be acceptable to psychoanalysts who gauge improvement by reconstructive personality alterations. Neither may be considered basic by therapists practicing humanistic approaches whose criterion would be inner peace, happiness, and creative self-fulfillment. What has been suggested is the establishment of multiple measures that cut across the different kinds of psychotherapy.

Therapeutic changes involve many facets of an individual's functioning, not all of which are easily measurable. Among these are symptoms, relationships with people, values, self-esteem, work capacity, self-image, economic status, creativity, etc. No patient progresses equally along all dimensions of possible change. To assess these we would require a variety of instruments. The usual pronouncement of "improvement" or "cure" generally connotes merely a relief of symptoms, and does not indicate what sacrifices are being made to achieve this. For example, a patient with depression initiated by loss of a loved person who served as a maternal object may find his or her depression cured when a new maternal companion is found. Should the patient coordinately be in therapy, the cure falsely may be ascribed by the patient to the effect of treatment.

In estimating change, we are confronted with the dilemma that the multiple change criteria with which we deal are not standard and that situation-specific behaviors (like efficiency at work) are more easily assessed than personality traits. To bring some order to this muddle attempts have been made to establish a battery of measuring devices. Waskow and Parloff (1975) have recommended as a standard test battery: the Minnesota Multiphasic Personality Inventory (Dahlstrom et al, 1972); the Hopkins Symptom Checklist (Derogatis et al, 1973); the Psychiatric Status Schedule (Spitzer et al, 1967, 1970); Target Complaints (Battle et al, 1966); and a choice of either the Personal Adjustment and Role Skills Scales (Ellsworth, 1975), or the Katz Adjustment Scales (Katz & Lyerly, 1963). The value of these or any other proposed batteries will require further evaluation.

For the most part, outcome assessment will rely on the patient's divulgences, on disclosures of the therapist, as well as on the reports of family and friends, all of which may be highly biased. Nevertheless, we may have no other way of assessing change than through these declarations and through the use of instruments such as the battery of tests cited above by Waskow and Parloff (1975). Lambert (1979) has written an excellent review of measurement batteries, and useful measures have been described by Miles

et al, 1951; Lorr and McNair, 1965; Strupp et al, 1969; Malan, 1976a; and Meldman et al, 1977. Insofar as personality tests are concerned, they have not been found too useful (Mischel, 1977).

The Use of Outside Judges, Coders, and Raters

Assuming that we are able to define concretely the variables that we wish to observe, we would heighten the reliability of our observations to employ a number of competent and trained judges to go over the data on which we will base our estimates of therapeutic change. A number of problems arise here related to the confidential nature of the material, the need on the part of the patient to retain anonymity, the belief that observational intrusions alter the behaviors of patients and therapists, and the fear of the therapist that his or her therapeutic competence may come under challenge. During the training process in an outpatient clinical setting, the patient may be prepared to accept outside adjuncts as part of the treatment and the therapist may be motivated to work with raters and coders. In private practice, however, this is practically impossible.

In the event we are able to employ qualified accessories, the reliability of the measuring and rating instruments that we have at our disposal at the present time is probably high enough to permit consistency in our results (Herzog, 1959). It is essential, however, that we have dependable data, that we be explicit in the definitions of what is to be coded and rated, and that the accessory workers be properly qualified and trained in the use of the selected categories.

Whether or not accessories are used, once we have settled on the categories to be rated and are satisfied that our methods of rating are reliable, we must still question the validity of what we are doing. Let us say that we have accurate statistics about changes in symptoms and adaptive patterns; does this necessarily give us accurate information about the emotional status, whether the individual has been cured, is improved or unimproved? An example may make this clear. In going over the record of a patient who has completed therapy, the patient's work performance will come up for appraisal, work being one of the factors in evaluation. We discover that shortly after leaving therapy, the patient was demoted. This does not seem to be a good indication of the patient having made progress in treatment. Yet when we examine the circumstances closely, we see that the basis for the patient's demotion is that he or she has become less obsequious and masochistic; hence the patient is more capable of resisting unfair demands.

This independence surely will not endear the patient to a domineering and exploitative foreman or employer. On the other hand, it is conceivable that an increase in salary or job advancement may be the product of a neurotic acquisition of overambitiousness and self-exploitative character traits that drive a person to be dedicated to the job with a merciless grimness that is so often rewarded by money and position. A safeguard to the faulty assessment of environmental data is that each item is not viewed in itself, but rather is related to the totality of the patient's adaptation. Not only must reports of environmental adjustment be questioned for their validity, but other indices of change must also be considered with caution, and only in relationship to the entire range of indices. The relative weights to be given to each variable in the adjustment picture is a matter that needs to be decided individually after all of the elements have been put together. Obviously, variables of change cannot be scored on an even basis, nor can the emphasis in rating extended to a set of criteria in one individual be transferred to any other individual. The total constellation of forces that operate will determine the unique emphasis, if any, that is given to each variable. Ratings of adjustment following a point scale system are consequently invalid unless the scores are considered of unequal weight, depending on special circumstances.

Because the weighting of so many of our items is based on the opinion of the observer, the element of prejudice cannot be eliminated from our results (Miles et al, 1951). The sole safeguard we have is the background, training experience, and reputation of the researcher, which gives us some indication as to the researcher's reliability. Yet we cannot be at all certain that a researcher for emotional and other reasons, consciously or unconsciously, may not abandon objectivity for the triumph of verifying a preconceived idea. A good researcher is one who not merely can do an analysis of variance or compute a chi square, but more importantly, perhaps on the basis of personal experience, can blend common sense with the nuances of therapy.

The Problem of Controls

The problem of controls in psychotherapy is perplexing. Let us suppose that we have a clinic staffed by trained, competent psychotherapists who employ accepted psychotherapeutic techniques, and that we reject every other patient applying to the clinic for help and utilize the rejects as controls. Assuming that we have developed proper criteria for evaluating change in the direction of mental health, that we have evolved efficient ways of data gathering, and a methodology that enables us to deal expertly with

this information, we still would not be able to say with reasonable certainty that psychotherapy was the only dimension of difference between the experimental and the control groups. Our quandary is that there is no such thing as exactly the same kind of an emotional problem. Subtle and oft indetectable cognitive, emotional and behavioral differences within the same syndrome may actually be the determining factor. By no stretch of the imagination can we say that the environmental pressures, or the healing adventitious situational elements, that impinge themselves on any two people are the same, nor can we keep them anywhere near constant throughout the period of our differential study. Experience with control groups shows that it is difficult to regulate the lives of human beings so that they behave the way a research sample should. The matching of similar cases is, therefore, a haphazard process, based more upon hunches than facts. Indeed any attempt to use controls may introduce new errors. It is conceivable that if we followed thousands of cases that had been treated over a period of years, as well as a roughly similar number of control subjects, our errors would be reduced. However, this could not be guaranteed even though we could afford the formidable costs that such research would entail.

From a practical standpoint we are limited in using the sound experimental method of pairing individuals as a means of equating experimental and control groups with respect to relevant variables. The proposals of utilizing each individual as his or her own control in the tactic of "wait" control (Dymond, 1955), the analysis of variance (Miller, 1954), the use of statistical control through covariance methods (Dressel, 1953), the dealing with control phenomena through "control in data" (Gordon et al, 1954), casual visits but no real treatment ("attention" or "placebo" control) (Kazdin & Wilson, 1978), treatment as needed ("PRN contact") (Weissman, 1979b), and the employing of the principles of "randomization" (McNemar, 1949) are ingenious, but they do not resolve all of the essential problems, no matter how we manipulate the sophisticated statistical devices we have at our disposal. It is difficult to obtain a large number of homogenous patients who randomly can be assigned to special treatments for a set period of time.

The use of dropouts ("terminator controls") of those who fail to keep any appointment or stop visits early in treatment also has many flaws (Gottman & Markman, 1978). As a way out, it has been suggested that, instead of using a control group of untreated individuals, we employ two groups of the same population being treated by different methods. Our results would surely then be dependent upon the skill and experience of the therapists, accepting the contention that good therapists get approximately

the same results, irrespective of their theoretical and methodologic differences (Fiedler, 1950a,b, 1951). We would have to make sure that therapists practicing different methods be comparable in ability. Zubin's (1953) idea of establishing a "standard control group" that would act as a basis for comparison with treated groups is interesting, but, as he puts it, still somewhat idealistic. It is impossible to match patients on any more than a few personality variables.

Frequently a "no-therapy" group is set up as a control after an initial interview. No-therapy is an invalid concept. An initial interview *is* a form of therapy and patients can benefit significantly from a single contact with a trained professional person. After the initial interview, the patient who is not accepted for therapy does not exist in a vacuum. That patient will exploit many measures to relieve his or her symptoms or to resolve problems. These range from tranquilizers, to self-help measures, to relationships with sundry individuals through whom the patient may work through some of the difficulties. The idea that the patient is receiving no therapy then is not true, even though the therapy is non-formal.

Other problems relate to informed consent in order to protect the rights of patients, and to the ethical issue of withholding treatment from a needy patient who happens to fall into the control group. To disclose to a patient that he or she is being used as a guinea pig, and an untreated one at that, may not meet with universal acceptance and may thus compromise the research design. To deny a patient treatment we know is needed constitutes a dilemma that the lofty principle of research for the sake of science cannot resolve.

The Problem of Adventitious Change

One of the bewilderments of evaluation is that we have little against which we can compare our results. Statistics, as has been previously indicated, generally uphold the dictum that approximately two-thirds of all patients improve irrespective of the kind of psychotherapy to which they have been exposed. They also attest to the fact that approximately two-thirds of persons with emotional problems also improve by arranging for their own destinies. These figures mean next to nothing because we have no idea as to what is connoted by the words "improvement" or "psychotherapy" or "no treatment whatsoever." We have no data on the practitioners who have presumably rendered therapy, nor on the

constituent problems and syndromes, as well as their severity, that have been treated in contrast with those that have not been treated. We have no idea of the specific parameters of personality influenced in the patients who have received psychotherapy, as opposed to those who have achieved stabilization through the circumstance of extratherapeutic forces. Are persons who apply for professional help those who have in greater proportion failed to achieve benefit through extratherapeutic elements? It would seem more than coincidental that individuals who have exploited every device and resource in quest of relief from anxiety begin to improve with the institution of psychotherapy.

Problems in Dealing with the Statistical Data

It is not irrelevant to point out that research studies in mental health can be flawed by an improper analysis and reporting of the quantitative results. Spitzer and Cohen (1968) describe three common errors: inability to distinguish between statistical significance and magnitude of association, measurement of reliability, and neglect of statistical power analysis. Because professional people in the field of therapy are generally untrained in quantitative techniques, it is essential that a researcher skilled in statistical methods be consulted whenever a serious research study is contemplated. Before data is collected, it is important carefully to review the hypotheses to be tested, the kinds of data to be accumulated, and the statistical techniques to be employed. This emphasis does not justify a deification of statistical methods as ends in themselves, but rather as tools that can order massive data and lead to reasonably valid inferences.

CONCLUSION

Concern with the rising costs of health care has focused the spotlight on the safety and cost-effectiveness of psychotherapy. Governmental authorities and insurers are asking for proof regarding the usefulness of the various kinds of psychotherapy. Can we verify the worthwhileness of an expensive project of psychiatric or psychological treatment? The difficulty of supplying scientific evidence of merit is complicated by the fact that, no matter how good a species of psychotherapy may be, it will not prove cost-effective in the hands of a bad therapist. But even if we accept what the most dubious researchers now concede, that psychotherapy is at least minimally effective and better than no treatment or the use of a placebo, most impartial observers would have to consider it a beneficial enterprise. But can we say it is

cost-effective and that the benefits justify the expenditure of time, effort, and money? This depends on how we rate the tangible and intangible costs of emotional disturbance and how much monetary value we put on human suffering and the misfortunes psychological illness foists on the community. When we consider the misery wrought by neurotic symptoms—the awesome damage to families, the wrecked marriages, the derailed lives, and the shattered productivity that follow in the wake of a neurosis—and add to these calamities, crimes, delinquencies, rapes, arsons, murders, suicides, violence in the streets, and the ravages of alcoholism and drug addiction that are neurotically or psychotically inspired, we may ask: "How costly is it to society *not* to try to prevent these tragedies through some kind of corrective procedure?" Is not even a minimally effective solution better than no solution at all?

The motive on the part of governmental authorities for inquiring into the safety and cost-effectiveness of psychotherapy is understandable. The various procedures employed today in treating mental and emotional problems, such as dynamically oriented psychotherapy, behavior therapy, family therapy, group therapy, marital therapy, pharmacotherapy, and others, are substantially safe and effective *when executed by trained, experienced, and skilled professionals.* What makes a procedure unsafe and ineffective is not the technique itself, but how it is applied. A scalpel in the hands of an unskilled surgeon can be a dangerous and useless instrument. Pardes, while Director of the National Institute of Mental Health, pointed out that the question of solid proof of treatment effectiveness extends across the entire health care field. In a 1978 report from the Congressional Office of Technology Assessment, only 10 to 20 percent of *all* health care technology had been proven effective by formal methods. Many of the commonly employed medical procedures have never been satisfactorily evaluated. Controlled studies in the mental health field definitely show that psychological treatments rate at least no worse than treatments in medicine and surgery. But further research in psychotherapy is necessary.

Research in psychotherapy is still burdened by many handicaps. Yet the literature is replete with studies flaunting impressive statistics that "prove" the superiority of one brand of psychotherapy over others or that downgrade all forms of psychotherapy as worthless or limited at best. We still do not possess a model of psychotherapy research that we can consider uniquely applicable to the special problems and conditions existing in psychotherapy (Frank, 1979; Karasu et al, 1984). Nevertheless, in the opinion of the majority of practitioners, of patients who have received treatment, and of unprejudiced observers, psychotherapy, properly instituted, is the most effective measure available to us

today for the treatment of emotional problems and for the liberation of potential adaptive and creative resources in the individual.

The fact that research in psychotherapy to this date has had surprisingly little impact on contemporary clinical practice, should not discourage future attempts to substantiate the effect of psychotherapy by scientific means. There is evidence that with recognition of the complexity of the variables involved and vitality and sophistication that is currently being manifested by researchers in the field, the outlook is an optimistic one. Malan (1973) in a historical review terminates his paper with the prediction that we will eventually find "that there are particular techniques appropriate for particular types of patients, which give outcomes for which words written very long ago by Kessel and Hyman (1933) are appropriate: 'this patient was saved from an inferno, and we are convinced this could have been achieved by no other method.' "