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A CLINICAL INQUIRY INTO THE THERAPY EXPERIENCE OF INDIVIDUALS SEEN FOR THERAPY BY CLINICAL PSYCHOLOGY STUDENTS AT CITY UNIVERSITY: A FOLLOWUP OF TWELVE ADULT PATIENTS

by

JO-ANN TOWNSEND

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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date

Paul Wachtel
Chairman of Examining Committee

May 18, 1977
date

Florence L. Denmark
Executive Officer

Paul Wachtel, Ph.D.

Arthur Arkin, M.D.

Harold Wilensky, Ph.D.

Supervisory Committee

The City University of New York

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REVIEW OF THE LITERATURE

The aim of this study was to conduct an intensive clinical inquiry into people's views of their therapy experiences and the changes and events which have occurred since termination. It sought to understand the extent to which patients consider therapy to be a significant life experience and the manner in which it relates to and influences subsequent events. The approach adopted in this study was to interview 12 individuals, similar with regard to age, race, student status, marital status and initial diagnosis, who were seen for more than 40 sessions of psychotherapy between five and ten years ago, to ascertain the effect that this therapy had on subsequent life events or relationships and to understand those qualities of the therapy which influenced or failed to influence these events.

Psychotherapy Outcome at Termination

The usefulness of the approach utilized in this study can be seen in part from a review of the difficulties or problems apparent in existing studies. Most researchers have attempted to ascertain the effectiveness of psychotherapy by focussing primarily on an evaluation of the therapy immediately following its completion rather than on an assessment of its relevance and general applicability to life experiences which have followed it. However, even an interest in general outcome studies has been relatively recent. Until 1952 when Eysenck published a major critique of the existing studies there had been only one or two studies published per year (Bergin, 1971, p. 228). His review precipi-

tated a great interest in psychotherapy outcome to the point that by 1960 approximately 15 studies per year were being published. By 1970 this figure had doubled (Bergin, 1971, p. 228). In fact most researchers still find themselves addressing the points which Eysenck raised 25 years ago. As Bergin notes, "It is slightly amazing to find that 18 years after his original critique of therapeutic effects, Professor Hans Eysenck is still agreed and disagreed with more than any single critic on the psychotherapy scene" (1971, p. 217).

Eysenck argued in his original article (1952) and in a subsequent review (1966) that roughly two-thirds of neurotic patients improve whether they are treated or not. He relied principally on published studies of therapy outcome as well as on statistics of other studies in which a comparable percentage of individuals improved with treatment and without treatment. He has received some support from among others Rachman (1971) who maintained that psychoanalysis and other traditional psychotherapies are ineffective, that there appears to exist a two-thirds spontaneous remission rate for neuroses with or without therapy, and that behavioral methods of treatment seem to be most effective.

But Eysenck has more critics than followers. Some say that his studies were not objective because they were based for the most part on the therapist's assessment of outcome or that they were technically flawed because he incorrectly computed percentages in the original tables and made errors when transferring figures to his own table. For example, in Eysenck's review of Fenichel's report of the Berlin Psychoanalytic Institute patients considered to be "improved" or "slightly improved" were excluded from the rating "improved" in which he included only those considered to be "cured" or "much improved". Bergin (1971)

points out that if this is readjusted so that these three groups of improved patients are considered to be "improved" and also if premature dropouts and nonneurotics are removed from the figures, percent improvement increases from Eysenck's 39% to 91% (p. 221).

Kellner (1965) took issue with Eysenck's review of the existing studies as being incomplete, a flaw which he believed biased Eysenck's conclusions regarding the effectiveness of psychotherapy. Luborsky (1972) challenged Eysenck's contention that a nontreatment control group necessarily contained comparable patients and stressed the importance of more carefully selecting control grups. Malan (Bergin and Suinn, 1975) took issue with symptom relief as the measurement of outcome which Eysenck used, arguing that while there may be similarities between treated and untreated patients with respect to this measure, when a dynamic assessment is made, control groups fall far short of treatment groups. Bergin (1966) cites seven studies in which it was found that while there was improvement in both treated and untreated patients there was a significantly greater variation in the treated patients (p. 235). This finding that some patients evidenced improvement while others evidenced deterioration suggested to him that therapy must be extremely powerful. This will be considered at greater length in the section on "Change with and without Therapy."

The charge of bias can go both ways. Although often cited as one of the better surveys, this reviewer finds Meltzoff and Kornreich's review of over 100 controlled outcome studies (1970) to be biased. Meltzoff and Kornreich divided outcome studies into four groups: adequate studies with positive results, adequate studies with negative results, questionable studies with positive results and questionable studies with negative results. Adequate studies were defined as having 1) freedom from major de-

sign flaws that might invalidate the findings, 2) use of appropriate control groups and sampling, 3) relative freedom from bias, 4) employment of reasonable, reliable, objective and valid criteria measures, and 5) presentation of suitable analyzed data (p. 76). They concluded that there were 48 adequate studies with positive results and nine adequate studies with negative results. But their results must be interpreted cautiously. They ask whether certain techniques, such as counselling or a didactic approach, are or are not "therapy" when negative results are considered but not when positive results are presented (p. 146). In fact in several instances the authors acknowledge that they violated their original criteria when describing "adequate studies" and seemed to do so somewhat more frequently when reviewing those with positive results (pp. 94, 99, 110). Unlike Eysenck who maintained that the better the quality of the research the weaker the findings their conclusion was that the better the quality of the research the more positive the results.

Bergin (1971) has similarly concluded that the better the quality of the research the more positive have been the findings. While Meltzoff and Kornreich attempted to evaluate a large number of studies comprised of different populations and different treatment modalities Bergin attempted to do so womewhat less rigorously for studies which involved a population of individuals who were diagnosed primarily as "neurotic" and who were treated primarily in individual analytic therapy. Of a cross section of 52 reported in the literature 22 were rated as positive, 15 as in doubt and 15 as negative (p. 229).

Malan (1973) found that very few psychotherapy outcome studies had been adequately carried out but that among those that exist studies with positive outcome outnumber studies with negative outcomes by three

to one (p. 724). He concluded that the evidence for psychotherapy in general was relatively strong but that the evidence for psychotherapy in the treatment of neuroses and character disorders was weak (p. 725). This is an unusual finding and somewhat contradictory of the more widely held belief that psychotherapy is effective in the treatment of neuroses and character disorders as opposed to the treatment of psychoses where its effectiveness is less clearly documented.

Overall, reviews of psychotherapy outcome suggest that modestly positive evidence exists for the effectiveness of psychotherapy, neither as positive as Meltzoff and Kornreich affirm nor as negative as Eysenck asserts. We can find it for the followup studies as well. Since this present study involves a population of individuals with diagnoses of character disorders or neuroses who were treated in outpatient therapy, the review of the literature will focus on followup studies or followup reports of individuals with diagnoses predominantly of character disorder or neurosis treated in individual outpatient psychotherapy. They vary as widely as do studies of outcome at the time of termination with regard to quality.

Followup Studies

Nine followup studies or reports which have utilized specific scales or measures to assess patient improvement provide simple but unsatisfying results. Twelve others which have employed questionnaires provide richer information but are limited by the questions posed. Nine others which have used interviews allow for clarification and elaboration of questions asked but for the most part involve shortterm followup. Six which have utilized clinical interviews try to assess the effect of therapy over time and offer the greatest insight into what thera-

py meant. It will become evident that none of the studies have attempted to put therapy into a perspective of events that preceded as well as followed it. Yet they do offer some valuable information and some implications for further research. They will be discussed in terms of the four groups described above. Following this, a more detailed consideration of issues which they raise will be presented.

Studies utilizing specific scales

Various measures which have been employed to assess how the patient's status at followup compares with his condition as measured by pretherapy or posttherapy testing include the following: observation (Bartlett, 1950); the Rorschach (Carr, 1949); the Bernreuter (Combs, 1945); the Health Sickness Rating Scale and measure of Absolute Global Change (Horwitz, 1974); the Social Discomfort Scale and Social Ineffectiveness Scale (Imber et al., 1968); the MMPI (Martin and Alvord, 1966); personal contact (Oberndorf, 1942); the IPAT Anxiety Scale, Pittsburg Social Extroversion-Introversion and Emotionality Scales, and IPA Scales (Paul, 1967); and the Symptom Check List (Rosenberg et al., 1968). Such comparisons generally have been positive with the particular technique utilized showing change or improvement in the specific areas measured. An exception to this is the study carried out by Carr (1949) where Rorschachs administered before and after therapy to nine students showed no reliable or consistent changes. This may have been related to the quality or duration of the therapy or possibly to the fact that the indices used were unable to adequately reflect the changes that did occur.

Those studies which have employed only one measure have been

relatively limited in the conclusions which they have been able to draw, and some of the "measures" are open to question. Bartlett (1950) utilized observation to assess change in personality disturbance, the initial complaint of the population studied, and "observed" that 40% were "much improved" following an average of five counselling sessions. Casual observation would not seem to be a satisfactory means of assessing personality change. Oberndorf (1942) found that the effect of therapy had been positive but based this on impressions from the receipt of Christmas cards.

Two studies which utilized more than one measure, those carried out at the Phipps Clinic by Imber et al. (1968) and at the Menninger Clinic by Horwitz (1974) are richer in their findings and conclusions. The Phipps study is one of the most interesting as it involves testing the same patients at various intervals. Thirty-four individuals were divided into three groups which received different forms of therapy over a four month period: one group was assigned individual therapy one hour per week; another, group therapy one and a half hours per week; and a third, minimal contact therapy one half hour every two weeks. A Social Discomfort and Social Ineffectiveness Scale was administerd at the beginning of therapy and again at six months, one year, two years, three years, five years and 10 years. Gains in the treatment group as opposed to the control group were most marked according to both measures six months to one year after treatment. Five years after therapy the two treatment groups did better than the control group on the Discomfort measure although at 10 years all differences had disappeared. More interesting and more difficult to understand was the change in the Ineffectiveness score which was negligible at five years and markedly dif-

ferent at 10 with the two treatment groups showing considerably more improvement than the control group. This finding would suggest that it cannot be assumed that there is a continuum of change at five and at 10 years. Certain treatment effects may be sustained at five years but disappear at 10. Others which reemerge at 10 may actually be the result of or related to another event in the patient's life, an event which may or may not be a reflection of the therapy itself. This was pursued in the open-ended interview in this study in which patients were asked to put certain events into a perspective with others.

The report of the Menninger Research Project is particularly interesting because researchers conducting the followup of 10 individuals have attempted to look scrupulously at the therapy experience of this population in order to understand the process and the manner in which it might be conceptualized. This will be discussed in the section on "Therapy and the Therapy Relationship." Their general finding was that five of the 10 individuals stabilized or improved with little or no contact with their therapist, improvement which they believed could be explained in terms of 1) supportive environmental factors, 2) positive reinforcement for their new, adaptive behavior, and 3) a continuing and durable positive feeling toward the therapist (Horwitz, 1974, p. 244). Of the five other patients, two required further therapy, two were described as destined to become "lifers," individuals who would probably always need treatment, and a fifth showed a definite relapse (Horwitz, 1974, p. 244). They believed that the lack of a successful outcome for this fifth individual may have been a reflection of the shortterm therapy; only 46 sessions were attended during an 18 month period. This issue of therapy duration was taken into considera-

tion in this study in which individuals selected had completed only approximately 55 sessions of psychotherapy.

Two of the more rigorously conducted studies in this category, studies which involve control groups, were those carried out by Martin and Alvord (1966) and by Paul (1967). In Martin and Alvord's study two groups of individuals were given the MMPI on two occasions, first before one group received shortterm therapy and again after two years. They found that patients in therapy showed significant change in both the Social Responsibility and Self Sufficiency scales while those in the control group showed a smaller improvement on the Social Responsibility scale only. Paul's study was superior in that in addition to utilizing a control group, several scales or measures were employed, three types of treatment were carried out (desensitization, insight, and attention-placebo), testing was done before treatment, after treatment, and at followup, and a category of individuals considered to be "significantly worse" was included in addition to categories of individuals considered to be "significantly improved" and "no change." The general finding at followup was that the group treated with desensitization was most improved (36%) and that unlike the other groups none were significantly worse (p. 341). An interesting finding was that 18% of those in the control group were significantly improved from pretreatment to the time of the two year followup, raising the issue of spontaneous remission or improvement without formal therapy which will be dealt with in detail in the section "Change with and without Therapy."

Studies utilizing questionnaires

Twelve studies or reports have been carried out utilizing pre-

dominantly a questionnaire. In three the questionnaire was not presented (Avnet, 1965; Forgy and Black, 1954; and Whittington, 1960). In two the questionnaire was of a multiple choice type (Board, 1959 and Mendelsohn and Geller, 1965). And in seven it was open-ended (Cappon, 1954; Feifel and Eells, 1963; Fiske and Goodman, 1965; Pichel, 1974; Sager et al., 1964; Stewart, 1972; and Strupp, 1964 and 1969). A disadvantage of using a questionnaire in comparison with employing a specific measure to assess change is that results may not be as precise and clearcut. An advantage is that considerably more information can be obtained about the quality of the therapy and the therapist.

Both Mendelsohn and Geller's (1965) and Feifel and Eells' (1963) studies stress the importance of certain therapist qualities, particularly warmth and understanding. Feifel and Eells were impressed by what they believed was a persistence of the patients' attitude toward the therapist over time. In their study which involved a four year followup of 45 patients they found that patients indicated at the termination of therapy that the most important factors in the therapy process were 1) the opportunity to talk over problems, 2) the therapeutic relationship, 3) therapist skill, 4) administrative factors, and 5) satisfaction of emotional needs, and that at followup the order was the same except that therapist skill was last (p. 316). This finding contrasts greatly with the view that therapists held concerning the process, which was that therapist skill was most important (p. 316). On the other hand, enumerating what was not helpful about therapy, patients rated deficiencies in therapist skill as fourth at the time of termination from therapy but first as they looked back on the process (p. 316). It seems that individuals who thought that therapy was helpful associated this

with a positive relationship with the therapist rather than one which focussed on technique while those who felt therapy was not helpful associated it with a negative relationship with a therapist who was too technically oriented, a view which became more pronounced with the passage of time. It was hoped that in this study patients might be able to specify those relational and technical qualities of therapy which were and were not perceived to be helpful.

Contrasting views held by patients and therapists concerning the therapy process are well highlighted by Avnet (1965) whose study showed that while patients and therapists both estimated that 75 to 80% of the patients had improved, they differed in their views of who comprised this group. For example, two-thirds of the patients who estimated that they were worse were judged to be recovered or improved by their psychiatrist (p. 16). This raises the question of how patient perception of results correlates with other measures or with other individuals' perception of results and will be discussed in the section on "Design Considerations."

Two of the studies which utilized primarily a questionnaire are interesting in that they find, unlike most studies, that patients are not generally benefitted as a result of being in therapy. In a study carried out by Pichel (1974) 25 individuals reported that psychiatric contact had been positively helpful while 28 indicated that it had been unhelpful or detrimental (p. 143). In a study by Whittington (1960) 40% of the expatients said they had experienced no further emotional problems although 44% of this group felt that the therapy had been of no benefit to them (p. 336). While the lack of satisfaction with therapy experienced by the population in the Whittington study might be ex-

plained in terms of the shortterm therapy (a mean of eight and one half sessions) in the Pichel study where individuals were exposed to up to 200 hours of therapy this is more difficult to assert. What is similar about the two is the length of the followup, eight years in Whittington's and 10 years in Pichel's. Perhaps after the passage of a significant period of time the benefits of treatment seem more difficult to recall or may be associated with a life experience other than therapy. The possibility of this occurring was taken into consideration in this study. Questions were included in the open-ended interview which it was anticipated might clarify this further.

One of the most extensive and intensive uses of a questionnaire has been by Strupp et al. (1964, 1969) in a three year followup of 44 individuals seen for an average of 166 therapy sessions. Many of the questions which they asked were of a multiple choice variety although they felt that they obtained their most interesting, rich and frank responses from those questions which were more open-ended, similar to the type of question utilized in this study. Unfortunately their sample was probably positively biased, not only with regard to those who responded (58% response) but with regard to those who were selected for the study initially; they obtained their population by asking experienced therapists to select patients from their own files. Among the results highlighted by Strupp et al. were the following: 1) a substantial retrospective consensus between patients and therapists concerning the essential aspects and outcome of the therapeutic experience which they believed provided support for the value and validity of patients' assessments of their experience; 2) impressive data concerning the patients' reports of the kinds of changes they attributed to the experi-

ence of psychotherapy including an increased sense of ego mastery and the achievement of conscious control over impulses, symptoms and neurotic trends often despite the persistence of some neurotic problems; and 3) the emergence of a large general warmth factor, that is, the importance of the patient's conviction that he had the respect of the therapist (1964, p. 36). These latter two findings were not unusual but reinforce what other studies which are less thorough have found.

Of greater interest and unusualness are the observations made about patients who did not view their psychotherapy as helpful. Those who described themselves as therapeutic failures were judged to have been more poorly motivated at the beginning of treatment, were judged to have shown less symptomatic improvement and were rated as lower in overall success than those who described themselves as satisfied with therapy. They tended to be younger, better educated, more likely to be single and more likely to be students than others in the sample. They also tended to have been treated by a greater percentage of psychology students than was true of others in the sample. More will be discussed concerning therapist qualities in the section "Therapy and the Therapy Relationship." In terms of patient qualities it was speculated that the fact that the student's general commitment to relationships and to work was generally less than that of an older more settled adult might have been reflected in a lack of motivation for continuing in treatment and for self scrutiny and change in therapy. Since both the patient and therapist characteristics of the failure group were of relevance for this study it seemed important to ascertain whether, in line with Strupp's finding, there was a larger number than might be expected who tended to view therapy as a "failure." Because this study involved an interview

in which questions responded to could be pursued, it was anticipated that an understanding of why this is true, if it is true, could be better understood than in Strupp's study.

Studies utilizing interviews with shortterm followup

Fifteen studies or reports reviewed in the literature have utilized interviews in order to assess the effects of therapy over time. Nine of these involve followups of three years or less. Six involve followups of five years or more. A disadvantage of studies which focus on interviews as opposed to questionnaires is that the sample included is generally smaller. However, what is lacking in quantity is more than compensated for by quality. The advantage over questionnaires is that certain areas which are unclear or which require further elaboration can be pursued. This results in richer, more detailed information about the therapy experience. An interview also provides the interviewer with a clinical impression of the individual which is difficult to obtain from a questionnaire.

The nine studies or reports which have utilized an interview with a shortterm followup are: Assum (1948); Cowen and Combs (1950); Klein (1960); Luff and Garrod (1935); McNair et al. (1954); Meyer and Zegans (1975); Rogers and Dymond (1954); Sloane et al. (1975); and White et al. (1968). It is interesting that the percentage of individuals who kept appointments to be interviewed was somewhat less than the percentage who completed questionnaires. Approximately six out of 10 kept interview appointments as compared with approximately seven out of 10 who completed questionnaires. It could be that individuals who have negative or ambivalent therapy experiences are more reluctant to be in-

terviewed than to complete a questionnaire, as they are reticent about having the possibly unpleasant experience probed. In fact, Meyer and Zegans (1975) discovered that adolescents who refused to be interviewed were generally not pleased about the original therapy. This finding may be relevant to other studies as well, studies which do not include a discussion of why individuals fail to keep appointments for interviews and if it is would raise questions about the overall weighted evidence that therapy is viewed positively. It also underscores the importance of attempting to interview as many of the original sample as possible in order to learn what was bad as well as good about therapy.

Klein (1960) found that individuals who agreed to be interviewed expressed varying attitudes when contacted: seven were grateful and enthusiastic, 20 were accepting or cooperative indicating no positive or negative feelings, and four were complaining or dissatisfied (p. 163). It is interesting that their attitude toward being interviewed corresponded with their level of improvement. The possibility that this could occur was kept in mind in this study.

One of the most rigorously conducted studies in this group, similar to that carried out by Paul (1967), was the study described by Sloane et al. (1975). Ninety-four individuals were divided into three groups, one treated in individual psychotherapy, a second in behavior therapy, and a third in minimal contact therapy. After the four month therapy was completed individuals in all groups showed significant improvement with individuals in the psychotherapy and behavior therapy groups showing the greatest amount of change. At the time of the followup one and two years later improvement was maintained or continued in most patients. This raises the issue of change or improvement without formal therapy

which will be considered in the section on "Change with and without Therapy."

An interesting feature of this study was its use of the Structured and Scaled Interview to Assess Maladjustment, an interview which can be conducted in one half hour and which includes specific questions in the areas of work-school, social-leisure, family, marriage and sex and which can be scaled for the degree of maladjustment. While this interview may be useful in assessing specific change over time, in that the same interview can be carried out at various intervals, it does not allow the interviewer to understand which elements in the patient's life, other than therapy, could have influenced these changes. In this study individuals were asked to elucidate these elements.

In terms of overall satisfaction with therapy Cowen and Combs (1950) found that 90% of the patients seen for therapy thought they had been helped (p. 257). Klein (1960) found that 77% of the patients thought they received "good improvement" or "very good improvement" (p. 164). Luff and Garrod (1935) found that 55% thought they had been helped (p. 59) and Meyer and Zegans (1975) found that about 51% thought therapy had been successful (p. 16). Overall, even when controlling for the length of the followup, this is a lower positive response to therapy outcome than is obtained when various scales of change or questionnaires are employed. Perhaps when people have the opportunity to talk about what bothers them they present complex and mixed impressions which results in findings that are less than "clearcut positive." Supporting this is the view offered by Klein and by Rogers that when more than one interview is carried out the tendency to recall negative as well as positive experiences is increased. This finding points to the

advantage of conducting more than one interview or of having more than one contact with an individual in order to obtain a fuller picture of the therapy experience.

Individuals in studies by Klein (1960) and by White et al. (1968) who specified changes that had been meaningful to them noted increased self esteem as the most important. It may be that this is a difficult change to describe in questionnaires which if not open-ended may be designed to highlight symptom relief or change which is more concrete. The importance of patients viewing their therapists as caring human beings with whom they felt relaxed (Meyer and Zegans, 1975), whom they liked and respected (Rogers and Dymond, 1954) and from whom they felt a sense of personal warmth (Cowen and Combs, 1950) was stressed. This reflects the general findings of many of the questionnaires.

Studies utilizing interviews with longterm followup

Six studies or reports (Deutsch, 1959; Malan, 1976; Masterson, 1967; Pfeffer, 1959 and 1961; Schjelderup, 1955; and Schlessinger and Robbins, 1974) have been carried out in which individuals were interviewed five or more years following the termination of therapy. Schjelderup (1955) was the first to publish a longterm followup of patients he had seen for psychoanalytic treatment eight to 24 years earlier. His article is frequently cited, as is his courage in taking the risk which he took in exposing himself to possible negative responses from former patients. His methodology consisted of sending questionnaires to 41 former patients and then asking those who responded to be interviewed. He found interviewing to have the advantages referred to earlier: "as a rule the interviews yielded a deeper and very valuable insight into

the impressions obtained from the questionnaire" (p. 112). In summarizing his overall findings he rated seven patients as having made "very satisfactory progress" (symptom change, personality change resulting in better social adjustment, and an ability to tolerate severe stress without relapse), 15 as having made "satisfactory progress" (symptom change, personality change resulting in definitely better social adjustment, but the possibility of relapse under stress), two as having made "unsatisfactory progress" (the symptoms remained while other areas may have improved), and four as having made "doubtful progress" (change occurred but was related to change in an external life situation or to later therapy) (pp. 119, 120). His findings that approximately 20% remained unchanged or deteriorated is consistent with studies where specific indices of change have been utilized. In terms of the specific areas of primary change he judged that there had been the greatest improvement in his patients' interpersonal realtionships, second greatest in their capacity for work and enjoyment of work and third in their marriage and sexual adjustment (p. 116).

Schjelderup was impressed with his patients' ability to remember their therapy well over such a long period of time although he thought that their recollection of symptoms was better than their recollection of more general personal difficulties. Pfeffer (1959, 1961) who interviewed two subjects, one at three and another at five years after termination of their analyses, also noted that patients focussed on underlying symptom relief as one of the important effects of their therapy. It may be that as individuals reflect back over the therapy experience what stands out are the specific and tangible differences that therapy makes in terms of symptom relief rather than the more vague and intangible changes. On the other hand Deutsch (1959) found one of her former patients unwilling to

credit her analysis for any of the positive changes that had occurred during and following her analysis, changes which were considerable. Deutsch felt that this probably reflectd the patient's neurotic need to devalue what reminded her of her neurosis (the issue of patient reporting will be discussed in detail in the section on "Design Considerations"). It was hoped that this might be better understood through the openended interview in this study in which patients were asked to describe as clearly as possible what they believed was responsible for changes in insight and behavior if such changes occurred.

It is of some interest that four out of six of those who have carried out followup interviews after several years are analysts interested in understanding change that occurs in patients who have been analyzed (Deutsch, 1959; Pfeffer, 1959, 1961; and Schlessinger and Robbins, 1974) or in patients treated in psychoanalytic psychotherapy (Schjelderup, 1955), patients whose experience in therapy was extensive as well as intensive. Perhaps it is not unusual then that their followup interviews have an analytic flavor to them. Pfeffer carried out six interviews and Schlessinger and Robbins four to six, interviews which were of a highly unstructured clinical character and which as such could permit the interviewer to examine them for transference residues expressed toward the followup analyst. Schlessinger and Robbins thought that the interviews would be more meaningful if they were aware of what the analysis had been like, so that before conducting the followup interview they reviewed the records of the treatment analyst. It was Pfeffer's view that seeing the patient "blind" was preferable. This latter approach would seem to have greater advantages. Following the completion of six interviews a very strong clinical impression of the patient would

undoubtedly be obtained and the possibility of conclusions based on the former analyst's assessment or possible bias would be greatly reduced. In organizing material from the interview Schlessinger and Robbins conceptualized it in terms of the nature of the alliance, the special configuration of the Oedipus complex, the defense transference, and dreams, certainly a very different way of looking at data than considering alterations in subtests of the MMPI or changes in Bernreuter scores!

Malan's report of a followup study carried out at the Tavistock Clinic (1975) bares some similarities to the report by Horwitz of the study carried out at the Menninger Clinic (1974). In both the therapy was psychoanalytic in nature and in both the experience of a few individuals was examined in some depth. An interesting approach employed in the Malan study involved assessing the specific stresses to which the person was vulnerable at the time therapy was sought and designing criteria which could be utilized in evaluating the patient's progress and outcome. He concluded that the capacity for recovery in certain neurotic patients was greater than had been imagined and that the interpretation of the transference, including linking it to childhood, was of critical importance. This study is interesting but does not approach that of the Menninger Research Project in terms of offering a rich discussion of aspects of the therapy process that influenced change.

Before considering several general issues which are raised in the followup studies it might be useful to summarize them in terms of their advantages and disadvantages. Certain disadvantages would be that in several the populations included less than 10 individuals (Carr, Deutsch, Oberndorf, Rogers and Dymond, and Schlessinger and Robbins) and in a few only one person (Assum, Combs, and Pfeffer). In several,

patients were seen for less than 10 sessions (Bartlett, Combs, Cowen and Combs, Meyer and Zegans, Paul, and Whittington et al.) and in some the original therapist conducted the followup (Assum, Combs, Deutsch, Oberndorf, Schjelderup, and Stewart). In several others the followup was carried out less than a year after therapy was terminated (Bartlett, Mendelsohn and Geller, Meyer and Zegans, Rosenberg et al., and White et al.).

On the other hand several studies involved patients seen for at least a year of therapy sessions (Board, Deutsch, Horwitz, Klein, Pfeffer, Sager et al., Schlessinger and Robbins, Schjelderup, and Strupp et al.) and some entailed a followup of more than five years (Deutsch, Imber et al., Malan, Masterson, Pfeffer, Pichel, Schjelderup, Schlessinger and Robbins, and Whittington). Several included control groups (Imber et al., Marin and Alvord, Paul, Sloane et al., and Whittington). A more general "advantage" or strength of several followup studies is that for the most part they tend to correlate well with outcome at the time of termination from therapy. Gains achieved during therapy appear either to hold (Forgy and Black, Klein, Paul, Rogers and Dymond, Sloane et al., and Stewart) or to diminish only slightly (Cappon, Feifel and Eells, Horwitz, and Luff and Garrod). The reports of two studies suggested that patients felt somewhat better at the time of the followup (Fiske and Goodman and McNair et al.).

We turn now to a discussion of some of the issues raised in these followup studies, issues which suggest areas and approaches to pursue in this followup study. The discussion will be divided into three sections. The first will deal with a consideration of the changes that individuals experience after therapy and with changes that others experience in the

absence of therapy. The second will deal with aspects of the therapy relationship, particularly its personal and technical qualities. The third will deal with design considerations.

Change with and without Therapy

In the previous section followup studies were described in which for the most part individuals who received therapy showed improvement in the specific areas measure. In this section consideration will be given to change that occurs without therapy as well as with therapy. It will include a discussion of the following: changes attributed to therapy, deterioration effects, the relationship between initial diagnosis and therapy outcome, the issue of further therapy, control groups, symptomatic versus dynamic change, one session psychotherapy, spontaneous remission, and types of help which individuals seek.

Change with psychotherapy

Changes attributed to therapy

How do individuals who enter therapy view the experience as significant? Among the changes that patients report as being the most important ones which they attribute to therapy, four stand out. One is enhanced self esteem. A second is the development of insight. A third is improved interpersonal relationships. And a fourth is an increased sense of mastery. In the interview in this study an attempt was made to ascertain those areas where change had occurred and to understand from individuals how they believed therapy influenced those changes.

Klein (1960) discovered that over half of the patients in her followup study reported self esteem as the area in which maximum change had occurred. Horwitz (1974) observed that every patient who improved

in treatment had more positive feelings about himself including greater self respect and greater self regard. Strupp (1969) found that an increase in self esteem was mentioned most often when areas of improvement resulting from psychotherapy were elicited. He understood this change as being related to the capacity to perform more adequately in interpersonal relationships which resulted in greater self respect and also to a modification in the way a patient felt about his performance or feelings even though his behavior may not have changed that much. As one person wrote "I have accepted 'me.' I know now everyone experiences anxiety and uses an individual mechanism to accommodate this. I understand my own particular position and can adjust accordingly" (p. 69).

Another change frequently noted is an increase in insight, referred to by Rogers as "a loosening of the cognitive maps of experience" (p. 149). Feifel and Eells (1963) reported that patients rated increased insight as the area of greatest change which resulted from psychotherapy. Board (1959) noted that most of those who were helped in therapy felt that therapy centered around understanding themselves. Strupp (1964) found that insight ranked very high as an area of change.

Improved interpersonal relationships is another area frequently cited as an outgrowth of a positive therapy experience. Strupp (1969) found that it was equated in importance with the development of increased self esteem and speculated that it may be a reflection of people viewing their difficulties as problems in living rather than as manifestations of a mysterious force. He quoted one person as saying, "I like being around other people which I did not before. I can detach myself from family problems (mother and sister) more easily and am not so quick to condemn them or offer advice. Many times I put myself in the position

of a 'therapist' and listen -- and try to understand other people's problems as they relate to them rather than to myself" (p. 67). White (1968) observed that the changed group exhibited an increase in certain forms of interactive behavior as well as an increase in self esteem.

A fourth change frequently cited by patients as an outgrowth of their experience in psychotherapy was a greater sense of mastery. Strupp (1969) commented that reports of an increased sense of mastery often overlapped reports of an increase in self esteem. One person noted, "when the pressure is on the feeling of anxiety comes, I am usually able to do some self-analysis and determine why. I understand myself better and know why I believe and feel the way I do about most things. I suppose the greatest thing I learned was to be myself and not try to be a perfectionist in everything" (p. 72).

With regard to this increased sense of mastery some researchers believe that there may be a difference between elements of therapy that produce change and elements that maintain it, and that an increased sense of mastery may explain how change is maintained. Imber et al. (1968) were intrigued by differences in scores obtained on the Social Discomfort Scale and Social Ineffectiveness Scale immediately following treatment and again at five and 10 years, and hypothesized that individuals whose scores remained high might be differentiated from those whose scores remained low in terms of possessing an increased sense of mastery or a greater willingness to come to grips with problems which they had previously avoided.

To test this hypothesis Liberman (1974) devised a study in which 32 individuals were divided into two groups which devoted eight sessions to working on three neutral tasks. One group was given a placebo and

and was told that improvement on the task was related to this. The other was told that improvement was based on their own investment and work. At the close of the eight sessions both groups showed improvement with no difference between them. Three months later, however, individuals in the mastery condition had maintained their improvement significantly more than those in the placebo condition. It would be interesting to follow two such groups after a greater period of time had elapsed in order to generalize from findings of this study to those of studies carried out by Imber et al. in which the followup period ranged from three to 10 years. It was considered that in this study it might be possible to identify areas in which individuals did and did not experience a sense of mastery.

Some researchers have maintained that people who experience a sense of mastery following therapy tended to feel during therapy that they were responsible for their progress and that it is this sense of responsibility which is reflected in greater responsibility or mastery when therapy is terminated. Luborsky (1975) in attempting to understand the components of successful psychotherapy listened to tapes of initial and final sessions of 10 patients, five who improved and five who did not, and found that those who improved could be differentiated from those who did not in terms of who was working on the identified theme, that is, who was actively involved in their treatment. Schroeder (1960) concluded from a study which she carried out that individuals with high responsibility scores (based on the Gilbert Self Interview Test) were more willing to invest in therapy and evidenced greater change while individuals with low responsibility scores had a less self-focussed goal, limited what they would invest and showed less change. Lipkin (1948) in describ-

ing clients' evaluations of nondirective psychotherapy found that the major element appeared to "the taking of responsibility for oneself" in the counselling relationship which some welcomed and some did not. Strupp (1975) noted that in every successful psychotherapy the patient appeared to assume responsibility for his actions rather than feel as though he was a passive object at the mercy of forces over which he had no control. This issue was pursued in the openended interview in this study in which questions about the therapy experience and particularly about active involvement in the process were asked.

Deterioration effects

When individuals report that they have experienced improvement as a consequence of therapy the above four areas are those most frequently cited. However, there is a smaller percentage who report either no improvement or deterioration and consideration should be given to this group. Cowen and Combs (1950), Horwitz (1974), Meyer and Zegans (1975) and Stewart (1972) found that therapy had not been helpful for approximately 10% of the individuals in their followup studies. Avnet (1965) and Schjelderep (1955) concluded that this was true for approximately 20% of the individuals they studied. And Pichel (1974) and Whittington (1960) found that this number reached almost 50%.

While some researchers such as Braucht (1970) have taken issue with the concept of deterioration, this phenomenon seems to be generally well recognized, if not well accepted; most therapists believe that it is "the other guy" whose patients do not improve. Some believe the word "deterioration" is unnecessarily severe. Garfield (1975) suggests the phrase "negative outcome studies." Others such as Stuart (1970) believe

that there should be no minimizing the damage or waste in time and money that can occur when therapy is poorly conducted.

What causes deterioration? While it is recognized that some patients may be on a deteriorating course from the outset which may be difficult for many psychotherapists to prevent or reverse, it is more generally held that when patients deteriorate it is the result of therapists who are ineffective. Hartley (1975), in reviewing deterioration effects in encounter groups, found that leader behavior was the most frequently cited factor in negative outcome. Bergin (1971) concluded in his research of deterioration effects that there are some individuals who even if they are "deteriorating" could be helped if the therapist was not inept and that there are others who may have created a "neurotic equilibrium" which if upset by a therapist could result in a cycle of deeper deterioration (p. 248). Bergin claims that he finds the notion to be exciting, holding that if some people get worse there must be something powerful about therapy which can work in the opposite way; that is, there must be a complimentary "improvement effect." Individuals who suffer from bad therapy, however, probably do not find it "exciting" but distressing or confusing. It was considered important to try to ascertain in the openended interview in this study which patients felt that they were not helped or possibly got worse and why.

Initial diagnosis and therapy outcome

While some individuals evidence deterioration, of those who improve in therapy, some show greater improvement than others and the factors which influence this should be considered. It has been found that the level of initial ego strength or initial diagnosis can be determi-

nants of progress. Although Board (1959) found in his followup study that diagnosis was not related to outcome, many others have found it to be significantly related to outcome (even if diagnoses of psychoses are excluded and only diagnoses of neuroses and character disorder are considered). In studies carried out by Luff and Garrod (1935), Masterson (1967), Pichel (1974) and Rosenberg et al. (1968) it was found that individuals with a diagnosis of psychoneurosis improved more than did individuals with a diagnosis of personality disorder. Knight (1941), summarizing the findings of the Berlin Institute Report, London Clinic Report, Chicago Institute Report, and the Menninger Clinic Report noted that there was a higher percentage of success for individuals with diagnoses of psychoneurosis than for individuals with diagnoses of character disorder. Within the diagnostic category of personality disorder variations have to be considered. Luff and Garrod (1935) found that after five years individuals with diagnoses of obsessional states or depressive states improved considerably more than did individuals with diagnoses of paranoid states. Martin and Alvord (1966) found that individuals with diagnoses of antisocial and inadequate personality did better than did individuals with diagnoses of schizoid personality or passive aggressive personality, with those in the latter category evidencing the least growth.

The tendency of individuals with diagnoses of character disorder to do less well in psychotherapy has to be kept in mind since it is currently more likely for individuals to be diagnosed as having character disorders than neuroses. As Koegler and Brill (1967) state,

> Treatment of passive-aggressive, schizoid, inadequate, cyclothymic, emotionally unstable, and compulsive personalities appears to be a function of psychiatric practice today,

> particularly in psychologically sophisticated areas of the United States. It is possible that cultural factors are tending to decrease the incidence of neuroses and increase the incidence of character disorders and psychosomatic disease. It is possible that diagnostic standards have changed as psychiatrists have become increasingly concerned with the underlying character structure of patients. It is also possible that as psychiatric facilities expand they attract a different kind of patient (p. 163).

That presenting problems more frequently point to a diagnosis of character disorder than neurosis is borne out in Strupp's study (1969), in which the most common complaint of patients entering therapy was a vague "loss of interests, a feeling of being overwhelmed," suggesting a possible diagnosis of depressive or schizoid character disorder. Consistent with the conclusions of other studies, he found that there was less change or improvement in these areas than there was in areas where more concrete or specific symptoms were offered as intial complaints.

There appears to be some consensus among therapists and researchers that individuals who show greater ego strength at the outset do better at the time of therapy termination and at the time of followup. Garfield (1971) puts it somewhat cynically when he observes that "the best therapeutic results have been obtained with those clients who are in the least need of treatment" (p. 294). Burstein et al. (1972) reporting conclusions of the Menninger Research Project view this less cynically but do not minimize the importance of initial ego strength, which they delineate as the patterning of defenses, the quality of interpersonal relationships, the severity of symptomatology, and anxiety tolerance. They observed that "the level of psychic functioning had such overriding influence on the outcome of the treatments in our sample, we concluded that patients with high Initial Ego Strength improve regardless of the treatment modality and the therapist skill" (p. 83). For

this reason, where possible in this study, an assessment was made of individuals' diagnoses at the time of the initial intake interview with the view that these might influence outcome and functioning in the years following therapy termination.

Further therapy

What about individuals who begin therapy but do not work through some of the difficulties for which they sought treatment? If certain problems are identified but not resolved, individuals may experience internal pressure to reenter therapy to achieve some resolution of these difficulties. White et al. (1968) describe what would seem to be two such individuals. One male who felt "hurt" because he was unappreciated by certain men with whom he wanted a close friendship became increasingly anxious during therapy concerning certain homosexual wishes and he was readmitted for further psychotherapy within 10 months of termination. Another who was depressed and disappointed about college life entered therapy "to get rid of some of my anxiety" and "to figure myself out" and within 10 months following termination was arrested for being under the influence of drugs and was readmitted for further treatment. In both cases anxiety was mobilized and further therapy undertaken in response to the anxiety or to a maladaptive means of dealing with this anxiety.

Two followup studies which have attempted to distinguish individuals who reenter therapy from those who do not have found that individuals who entered subsequent therapy had less favorable scores on self report measures and more symptoms at the time of followup (Fiske and Goodman, 1965, p. 171) or experienced the least improvement as a result

of their original therapy (Sager et al., 1964, p. 169).

The number or percentage of individuals entering subsequent therapy varies and may be related in part to the length of time of the followup: the longer the time the greater the chance that an individual has reentered therapy. Masterson (1967) in his followup of adolescent boys found that after five years 61% had entered therapy, 14% inpatient treatment and 47% outpatient treatment. Strupp (1969) whose followup study extended over three years, found that 23% had sought further therapy (p. 75). On the other hand Sloane et al. (1975) whose study involved a followup of only one and two years found that 24 out of 95 or 25% who were in analytically oriented therapy or behavior therapy entered subsequent therapy, many with the same therapist. Because this present study involved a followup of relatively shortterm therapy, which may have left major areas unresolved, and because it involved a long-term followup, it was anticipated that a relatively high percentage of individuals might have entered subsequent therapy. While Paul (1967) has suggested that reports about entering further therapy may not be reliable (he found that five people reported that they were in further therapy while 17 actually were), it was considered that if an interview, as opposed to a questionnaire, was utilized to obtain this information that a more frank response might be obtained. Questions were included in this study concerning the type of therapy sought, the reasons for seeking it and an overall comparison between the experience of subsequest therapy and the original therapy at City College.

But what about individuals who never received therapy? Since this study is concerned with the significance that therapy assumes in relation to other life events, this reviewer must consider the changes

that can occur as a result or outgrowth of these events, that is, change that can occur without therapy.

Change without formal psychotherapy

Control groups

One means of examining this issue would be to consider those studies already reviewed which involved control groups. When these were included, specifically in the studies described by Imber et al. (1968), Martin and Alvord (1966), Paul (1967), Sloane et al. (1975) and Whittington (1960), it was found that individuals who received psychotherapy showed greater change than did individuals in the control groups but that in some instances the differences were not very great. Before considering that change occurs regardless of therapy it would be relevant to examine the control groups more closely. In two of these studies (Imber et al. and Sloane et al.) individuals in the control groups received not formal psychotherapy but some form of professional contact with the staff and for that reason were not referred to as control groups. In the study by Sloane et al., for example, the individuals that did not receive either psychoanalytic psychotherapy or behavior therapy had a long interview with the promise of treatment at the end of four months, were told that they could call if a crisis arose and were called every few weeks by a research assistant with whom they had talked before the assessment interview. Sloane et al. suggested that this contact could be viewed as "therapeutic."

However, other studies have been published in which change is documented following more limited contact. In a study described by Dymond (1955) a group of adolescents who decided after a delay on the wait-

ing list of a clinic that they did not want therapy evidenced at a later time as much improvement in adjustment as measured from their self description as did those who went through therapy successfully. However, on projective testing it was found that the "improved" self description of those who did not enter therapy had strong defensive and compulsive elements which were absent or significantly less characteristic of the self description in the successfully treated cases, suggesting that no "deep" reorganization had taken place.

The conclusion of this study, that symptomatic as opposed to dynamic changes can occur in untreated patients, is a view commonly held by professionals in the field of psychotherapy who maintain that only through intensive psychotherapy can underlying change occur. This is challenged by Malan (1975) who found in a followup study of 45 untreated neurotic patients seen once by a psychiatrist that 23 were judged to be improved dynamically. A consideration of the patient "dynamically" included viewing him and his situation "as a whole," conceptualizing the initial difficulty in terms of a maladaptive reaction to a specific kind of stress, and viewing improvement or recovery as an ability to respond to the particular stress in a new and more adaptive way. "Here we state that any disturbance must not merely disappear but must be replaced by something positive" (p. 112).

One session psychotherapy

Malan (1975) concluded after listening to how patients viewed changes within themselves that the initial contact with the psychiatrist had had a powerful effect. Based on what individuals reported concerning the value of their one contact with the psychiatrist he stated, "It was

considerations such as these that finally forced us into the realization that, at least in many of these cases, we had not been studying spontaneous remission at all, but one session psychotherapy" (p. 122). He believed that the most salient features experienced by individuals as a result of one session psychotherapy were insight and the need for taking responsibility for their lives but that there were other features or mechanisms which might have been facilitated by the single diagnostic interview. These included working through feelings with the people involved, the capacity for self-analysis, therapeutic relationships, the breaking of a vicious circle between the patient and his environemnt, genuine reassurance and direct learning (p. 125). While he thought that all of the above could be related to the single session, he felt that they could have occurred in the absence of therapeutic intervention.

Spontaneous remission

When improvement occurs in the absence of therapeutic intervention the term "spontaneous remission" is frequently used to describe what occurred. As Bergin (1971) notes, to say that something is spontaneous is to argue that we do not know what happened. Its use by psychotherapy practitioners underscores their biased viewpoint that if therapy didn't produce the change, it occurred spontaneously! Saslow (1956) found in his followup of 100 consecutive patients seen at a clinic for the treatment of behavior disorders that although only one interview was conducted, four to six years later, 83% were considered to be improved with 37% significantly improved with regard to symptom reduction. Denker (1947), offering one of the original arguments for the notion of spontaneous remission, reported a 72% improvement rate over a

two year period for untreated life insurance disability claimants. However, Bergin (1971) while agreeing that such a phenomenon as spontaneous remission exists, found major deficiencies in the sample and percentages reported. He considered the rate to be approximately 30% rather than 70%, the median figure for 14 studies which estimated the spontaneous remission rate for neuroses (p. 241). Still, 30% is a relatively high percentage. How can change or improvement in this group be explained?

Types of help which individuals seek

Gurin, Veroff and Felt (1960), who conducted a national survey for the Joint Commission on Mental Illness and Health, found that people who sought help for personal problems turned to what could broadly be referred to as psychotherapy practitioners (private or clinic psychiatrists or psychologists, marriage counselors or other private practitioners, or social agencies which treated psychological problems) for assistance 31% of the time while they selected clergymen 42% of the time and physicians 24% of the time. They also found that people rated clergymen and physicians higher than psychotherapy practitioners in terms of who "helped" or "helped a great deal." Gurin et al. concluded "these (results) underscore the crucial role that nonpsychiatric resources -- particularly clergymen and physicians -- play in the treatment process. They are the major therapeutic agents" (p. 341).

This is truly a fascinating finding and raises the question of what experiences or relationships are meaningful to individuals in terms of personal change and how these experiences make a difference. Bergin (1966) maintains that the fact that some of these influences are much like therapy but frequently occur outside a professional setting implies

that nonprofessional help can stimulate positive personality change (p. 239). Frank (1961) found that over a period of years approximately 50% of a group that had sought psychotherapy had also sought help from a variety of non-mental-health services and that the continued positive change that occurred among them over a long period when they were not in therapy was due to the effect of this non-professional "treatment." In the openended interview in this study individuals were asked whether they sought help from individuals other than psychotherapists and if so how they compared this help with that which they experienced as a result of therapy. While other studies have utilized interviews to question people about help received, the quality of this help has not been carefully ascertained.

Beyond professional relationships, individuals are almost always involved in personal relationships which may enable them to change in certain ways. If one component of the therapy experience which results in change is a "relational quality" (more will be said about this in the section "Therapy and the Therapy Relationship") it seems possible that an intimate or personal real relationship may make a positive difference. Some certainly make a negative one. Malan (1975) suggests that while clinicians are aware of the tendency of patients to continually repeat a neurotic type of relationship, they are less aware of the opposite tendency, that is, the tendency to seek out a kind of relationship through which a neurotic process may be broken. It was considered that whether such a relationship had occurred and if it did how it compared with the therapy relationship might be understood in this study.

Bergin (1971) states,

It is evident that several factors may account for 'spon-

> taneous' remission phenomena, that these factors have therapeutic efficacy, that many of them may occur in therapy as well as naturally, but that they are not necessarily unique to the formal therapy process . . . psychotherapy is merely a special case of a much broader range of therapeutic phenomena that exist naturally in society (p. 246).

In order to understand some of these phenomena that exist naturally in society and that affect the quality of an individual's interpersonal relationships, sense of self worth and feelings of mastery, Barrett-Lennard devised a "Formative Life Episodes Questionnaire" (1974) in which a person is asked to list events which he considers to have been important, "directly experienced events that affected you deeply" and then try to indicate which ones influenced others and in what ways. He found that while entering therapy as a patient was an event that was significant it did not rate as high as the experience of bereavement, of personal illness or of a change in the health of a member of the individual's family (Holland and Barrett-Lennard, 1976). Since his study employed only a questionnaire it was considered that in this study it would be valuable to use this in conjunction with an interview to understand further how the particular events noted were viewed as significant.

Therapy and the Therapy Relationship

If certain changes occur as the result of therapy, what is it about therapy which causes these to occur? The viewpoint of this researcher is that it is a therapy in which the patient is positively affected by personal and technical qualities of the therapy and the therapist. The personal aspects of the therapy would include those therapist qualities which facilitate a feeling of liking and respect for the therapist as well as a perception of therapist empathy. The technical aspects of

the therapy would include the particular skills utilized by the therapist which promote the development of the transference. Strupp (1973a) states, "I have asserted that the therapist's contribution is both a personal and a technical one: the personal contribution was seen as uppermost, although technical procedures might naturally further the therapeutic endeavor; on the other hand in the absence of a favorable matrix, no amount of expert technique would shift the psychodynamic balance in the direction of therapeutic growth" (p. 28).

Strupp (1973b) describes what he views as the three ingredients of therapeutic change. The first would correspond to the personal aspects of the therapy:

> The therapist creates and maintains a helping relationship (patterned in significant respects after the parent-child relationship) characterized by respect, interest, understanding, tact, maturity, and a firm belief in his ability to help (p. 1).

The second would correspond to the technical aspects:

> The foregoing condition provides a power base from which the therapist influences the patient through one or more of the following: a) suggestions (persuasion); b) encouragement for openness of communication, self scrutiny, and honesty; c) interpretations of unconscious material, such as self-defeating and harmful strategies in interpersonal relations, fantasies, distorted beliefs about reality, etc.; d) setting an example of "maturity" and providing a model; and e) manipulation of rewards (p. 1).

The third would correspond to what has been referred to as patient ego strength:

> Both preceding conditions are crucially dependent on a client who has the capacity and willingness to profit from the experience (p. 1).

The personal qualities described may characterize important helping relationships or personal relationships other than therapy and when present and influential may be reflected in certain changes, particularly

an increase in self esteem and a strengthening of interpersonal relationships. The uniqueness of the therapy relationship, however, is to be found in the combination of personal and technical aspects which when present may effect a more powerful kind of change in the above areas along with the development of insight. Strupp (1975) describes this insight as "a fusion of emotional experiences in the here-and-now with a cognitive appreciation of the antecedents and consequences of a maladaptive pattern in living" (p. 131).

Meyer and Zegans (1975) emphasize the importance that both the personal and technical qualities of the therapy assumed for adolescents who viewed their therapy as helpful. "They (saw) their therapists as people who could understand their difficulties, whom they could trust, and with whom they could speak freely . . . there is a difference, however, between a therapist and a friend; the fact that the therapist is a professional plays an important part. He is capable of empathetic identification, yet at the same time he is removed" (p. 18). They wished for "a charmed balance between supportive care and objective discernment" (p. 18). As the adolescents observed, "the difference between a psychiatrist and a friend is just that word; he's a mind doctor . . . the difference between a friend and a therapist is that you can put your arm around a friend . . . a good therapist is like a friend, but there are things you can't tell a friend on the street" (p. 18).

Fiedler (1950) in describing what he refers to as the Ideal Therapeutic Relationship maintains that this is one in which experts differ from non-experts in their greater ability to a) communicate with and to understand their patients, b) maintain an appropriate emotional distance and c) divest themselves of status concern in relation to their

patients (p. 444). The first refers to the personal nature of the relationship, the second to its technical nature. Mendelsohn and Geller (1965) summarize these two qualities as follows:

> It seems that some minimal level of rapport is necessary to support the counselling work, but once this has been established, whether or not the goals of counselling are reached is a function of other factors. Indeed, it is possible that if the client-counselor relationship is too close, too warm and too enjoyable, that the relationship itself becomes the reason for continuing to the detriment of more specific objectives (p. 71).

An important focus of the interview in this study was to ascertain the relative importance to the patient of the personal and technical qualities of the therapy.

Personal aspects of the therapy

Empathy

A great deal has been written about empathy, one of the personal qualities considered to be extremely important in therapy. Most of the articles published, including studies concerning the effect of empathy on outcome, have followed the conceptualizations of Truax and Carkhuff (1967). They view empathy as "the central ingredient of the psychotherapeutic process (which) appears to be the therapist's ability to perceive and communicate, accurately and with sensitivity, the feelings of the patient and the meaning of these feelings" (p. 285). They believe that two other ingredients in the psychotherapy process overlap each other somewhat but may be defined separately. Nonpossessive warmth involves taking the attitude that "if I had the same background, the same circumstances, the same experience, it would be inevitable in me, as it is in him, that I would act in this fashion" and assumes an "acceptance of what is, rather than a demand for what ought to

be (and) implies neither approval or disapproval" (p. 315). Genuineness refers to the therapist being "a real person in the encounter, presenting himself without defensive phoniness, without hiding behind the facade of the professional role" (p. 329).

In the followup studies discussed in the first section the presence of therapist warmth or empathy were considered by patients to be instrumental in permitting them to change, particularly in terms of allowing them to experience more positive feelings about themselves. Cowen and Combs (1950) found that patients viewed their counsellor's warmth as the most important aspect of their therapy. Feifel and Eells (1963) reported that patients viewed the opportunity "to talk with someone about their difficulties in an atmosphere of interest, warmth, and tolerance" as crucial (p. 317). Sloane et al. (1975) noted that patients who improved reported higher levels of warmth, empathy or genuineness in their therapist. Meyer and Zegans (1975) found that patients who viewed their therapy as successful felt that it was easy to talk to their therapist whom they viewed as a caring human being. Mendelsohn and Geller (1965) in delineating those factors which appeared to be critical to the patient's attitude toward his counselling experience underscored what they referred to as "Comfort-Rapport" as the most important. Examples of comments which patients made were "I felt that the counselor understood my problem . . . I felt comfortable with my counsellor . . . the counsellor understood how I felt . . . the counsellor gave me the feeling that I was more than just another student" (pp. 66, 68).

Strupp found that for the most part psychotherapy was viewed by respondents of his questionnaire as an intensely personal experience in which perceived therapist warmth, respect and interest were important

correlates of the amount of change which they reported. Therapists described by patients were different than the traditional psychoanalysts in that they were viewed as practitioners actively engaged in a real relationship with their patients, at times friendly and warm, not detached or averse to occasionally giving assurance and direct advice and tending to discourage the expression of negative feelings or dependency wishes.

This is an interesting finding which would appear to stress the relationship almost to the exclusion of the technical aspects of the therapy. Since patients were seen for an average of 166 interviews it could not be argued that there was time only for the development or fostering of a relationship. Since patients were seen in both psychotherapy and psychoanalysis neither could it be argued that the therapist failed to utilize techniques which would further the development of the transference. It is possible that since therapists selected patients themselves they chose a group whose therapy they viewed more positively and that in fact it was a generally positive experience for these patients who thus reported favorably about the relationship. This difficulty was avoided in the present study where patients were not selected by their therapists. It is also possible that what the patient remembers more readily is the relationship as opposed to the technical aspects of the therapy. This was kept in mind in the interview conducted in this study and an effort made to help patients recall aspects of their therapy which may have faded. And it is also possible that while the presence of a negative transference and the expression of anger toward the therapist may have been helpful that this was not viewed by patients as beneficial. It was hoped that by utilizing open-ended questions in

a semi-structured interview that this might be clarified.

Although Malan (1973) concluded after reviewing studies of therapy outcome at termination in which measures of empathy were employed that "the cumulative evidence was overwhelming" concerning the importance of empathy to outcome, some others have not been as strongly persuaded. It is possible that the contradictory findings may be explained in terms of the type of therapy being conducted, that is, whether it is or is not client-centered therapy. Bergin and Suinn (1975) pointed out that all of the studies that have failed to replicate the efficacy of empathy involve behavioral or psychoanalytic therapies. They are also studies which have utilized tape-rated empathy as opposed to client-rated empathy, usually measured by the Barrett-Lennard Inventory. Kurtz and Grummon (1972), comparing various measures used to assess empathy, found that client-perceived empathy was most related to outcome (the Barrett-Lennard, Patient form), tape-judged empathy less so (Carkhuff tape ratings) and the remaining empathy measures the least (the Affective Sensitivity Scale, the Interpersonal Check list, and the Kelly Role Concept Repertory Test). This finding lends support to the value of asking patients about therapist empathy and thus to the merits of including questions in an openended interview which would elicit this. Questions were employed in this study which were similar to those from the Barrett-Lennard Relationship Inventory (1964) since this has been the most successfully used measure of client perception of empathy.

Patient liking therapist

Some therapists and researchers stress the importance of the patient liking the therapist, an attitude which may be an outgrowth of or

related to therapist empathy. Board (1959), Meyer and Zegans (1975) and Rogers and Dymond (1954) were impressed by the relationship between the patient liking his therapist and successful outcome. In fact in the study described by Board patients stated that they liked their therapist in 100% of the instances in which therapy outcome was viewed as successful. It seems possible that feelings about therapy, either positive or negative, could contaminate feelings about the therapist, particularly a feeling of like or dislike. This was considered carefully in the openended interview in this study in which an effort was made to isolate components of the therapy experience.

Similarity between patient and therapist

Some studies suggest that similarity or perceived similarity between patient and therapist may have an effect on outcome. Mendelsohn and Geller (1963) found that commitment to counselling was greater when clients believed that their counselors were similar to them. Carson and Heine (1962) found that either extreme similarity or extreme dissimilarity impeded progress. And Gassner (1970) found that while patients who were highly compatible with their therapists viewed them more favorably during therapy that high compatibility had no effect on the amount of behavior change at the time of termination. A question concerning perception of similarity was asked in the interview in this study to ascertain its relevance to perception of other therapist qualities and to therapy outcome.

Therapist training

It has been generally recognized that patients who are seen by more experienced or more highly trained therapists have better outcomes,

a finding which has implications for this present study in which many of the student therapists were seeing patients for the first time in individual therapy. It has already been noted that Strupp (1969) found that a greater percentage of therapists in the failure cases (30%) were psychology students. Similarly, Cowen and Combs (1950) found that as a whole the experienced professional counsellor was more effective than the student counsellor. Individuals in this study were asked if they had any sense of how experienced their therapists were and how they felt this level of experience affected their therapy.

Therapist sex

A final personal quality which may affect psychotherapy outcome is therapist sex although studies are inconclusive in their findings concerning the relationship between these two. Persons et al. (1974) found that college age women dealing with identification, role and sexual issues as well as loneliness, anxiety and vocational issues experienced more help from female therapists. Riess (1973) found that patients remained longer with female therapists and that female/ female dyads continued in treatment longer than male/ male dyads. Heilbrun (1971, 1973) found that undergraduate females were more likely to defect from therapy with males with whom they had discussed more. On the other hand, Meyer and Zegans (1975) found that regardless of the sex of the patient more patients who were ambivalent about therapy or who felt therapy was unsuccessful were treated by women.

Less clearcut findings concerning patient and therapist sex were offered by Cartwright and Lerner (1963) and by Mendelsohn and Geller (1965). Cartwright and Lerner concluded from a study they conducted

that patients who did best were the same sex patients of experienced therapists and opposite sex patients of inexperienced therapists. Mendelsohn and Geller found that there was a strong relationship between patients' evaluation of therapy and similarity between patient and therapist when they were the same sex but that when the sex was different high similarity was negatively associated with patient evaluation of therapy. They hypothesized that for a student trying to solidify identifications the experience of being paired with a counselllor who was similar in personality but opposite in sex may be a source of confusion and discomfort and when present could interfere with certain objectives. This was apparently not true of freshmen students but was markedly true of upper classmen, similar to the population of this study.

These studies raise an interesting question concerning the effect that similar-sex and opposite-sex patient-therapist dyads have on outcome. In some instances patients in this study probably requested therapists of a particular sex suggesting that they felt on a conscious level that it was a relationship with this person, who might represent either a parent figure or a person with whom they were engaging in a close relationship at present, that they needed to clarify and understand, although it is also possible that their greatest difficulties were with individuals of the opposite sex whom they feared and chose to avoid. It was the view of this researcher that when patients feel an empathic relationship with their therapist, the sex of the therapist is irrelevant, but that when they do not, they may find the sex of the therapist as well as other qualities disturbing. This was pursued in the open-ended interview in this study.

Technical aspects of the therapy

Technical aspects of the therapy include those skills such as confrontations and interpretations which the therapist utilizes to promote the transference. Since skill is at least somewhat contingent upon experience or training, the technical aspects of the therapy are not completely distinct from its personal aspects. Burstein et al. (1972) consider skill as "the ability to apply appropriate techniques to a particular case," an ability which "implies a knowledge of one's own personality and the capacity to integrate creatively the personality features and specific countertransference reactions into the technique" (p. 83). An interesting finding of their followup study was that for patients whose ego strength was initially low, therapist's skill was a significant factor in improvement, the greater the skill the more likely the improvement. However, for patients whose ego strength was initially high, improvement occurred regardless of either the treatment modality or therapist skill. This suggested that in this study initial diagnosis needed to be taken into consideration as the outcome of various patients was discussed. It also suggested that the level of therapist skill as perceived by patients needed to be considered.

Transference

Malan (1973) found that when an attempt was made to correlate various aspects of patients' therapy outcome it was discovered that of all the statistically significant positive correlations obtained the most important was an aspect of the transference referred to as "the transference-parent link," that is, the therapist's making a connection between the present transference and the patient's relationship to a sig-

nificant parent. It was found that the more often the therapist made transference-parent interpretations the more positive the outcome and that this seemed to be true in brief therapy as well as in psychoanalysis (p. 727).

A similar conclusion regarding the importance of transference interpretations was reached by Burstein et al. (1972), a conclusion at variance with that of Horwitz even though the population being examined was the same. Burstein et al. believed that for the most part when patients with low ego strength were treated by therapists with high skill there was significantly more improvement when the focus on the transference was high. It was their view, however, that interpretations which highlighted the relationship between the patient and therapist in the "here and now" rather than interpretations which connected current feelings with past feelings were most effective. In contrast to the findings of some researchers they did not find that focussing on the negative transference was particularly helpful. Equal emphasis on the positive as well as the negative transference was considered to be important.

Strupp (1969) also concluded that adequate management of the transference and countertransference was related to successful outcome. He believed that problems in the therapeutic relationship which could be labeled transference and countertransference difficulties were evidenced in three-fourths of the failure cases (p. 111). While it is apparent that difficulties can arise when feelings are too positive, in the examples which he presented it was negative transference or negative countertransference which interfered with the process and with positive outcome.

The findings of both the Menninger Research Project and the Strupp study would seem to suggest that negative feelings in the context

of a generally positive trusting relationship can be beneficial to therapy outcome, but that if they are too prominent or occur in the absence of a sense of trust, they can be detrimental, disruptive, or destructive. Bergin and Suinn (1975) observe that the Menninger and Malan studies have provided renewed support for the importance of transference and transference resolution. Certain questions were included in this study to ascertain, where possible, the nature of the transference. It was considered that an understanding of it might clarify the effect that the transference had on the patient's general attitude toward therapy.

It has been pointed out by Kubie (1968) that even when an analysis is carried out to completion, implying a working through of the transference distortions, that impending termination can evoke anxieties around separation and loss which may be reflected in patients experiencing depression or rage toward the analyst. If the therapy is one in which a transference is developed but not resolved, mainly because the therapy is shortterm, the negative feelings may be particularly strong and may persist until the period of followup. Feifel and Eells (1963), whose followup was four years after therapy termination, commented, "the enlarged capacity of the patient, at long last, to forthrightly speak up concerning 'lacks' in their previous therapy lends evidence to the idea that 'transference' feelings are far from dissolved in many patients at the time of termination from therapy" (p. 317). Negative feelings which the individual continues to harbor toward his or her therapist may be expressed toward the individual conducting the followup. This was observed for in this study.

Pfeffer (1959) found that the followup interviews of an "incomplete analysis" could be examined for manifestations of transference to

the followup analyst which might indicate the presence of transference residues and of the patient's ability to manage these. He felt that he could also obtain an impression of whether the transference had been displaced onto a figure in the patient's present life. He believed that in instances where analysis was more satisfactory a second type of transference manifestation was observable. He found that as patients reported life experiences since termination it appeared that there had been a repetition of the analytic experience itself including the conflicts for which the analysis was first sought as well as a repetition of the ego and superego changes that provided new solutions to these conflicts. Individual researchers who hold this posiition (especially Pfeffer and Klein) believe that more than one interview is necessary in order to examine the transference as it is manifested toward the followup interviewer, particularly the negative aspect of the transference. On the other hand, interviewing the patient on several occasions may result in too much probing and may cause wounds to be opened which as Sargent (1960) notes is not really a fair way to evaluate how effectively the healing process has occurred. In this study an effort was made to determine the nature of the transference manifested toward the interviewer. It was anticipated that this might be similar to or different from the transference to the therapist and that the similarities or differences could be discussed.

The therapy process as conceptualized by Horwitz

Horwitz (1974), in conceptualizing the therapy process of patients in the Menninger Research Project, particularly those whose therapy was successful, elaborates what he refers to as "the internalization

of the therapeutic alliance." This is an interesting way of viewing what occurs and as described would seem to include primarily personal or relational aspects of the therapy. "Therapeutic alliance" is a term introduced by Zetzel (1956) and expanded upon by Greenson (1960) which refers to the ability of the patient to perceive the "real" nature of his relationship with the therapist and to feel protected despite the transference and transference distortions that occur at various times. Horwitz notes that in psychoanalysis this permits regression to intensify and deepen while in psychotherapy it probably contributes to significant change per se (p. 250). He holds that the implication for a study of shortterm psychotherapy is that the real relationship, as opposed to the transference relationship, is of prime importance and that relational as opposed to technical qualities are primary. He states, "psychotherapy, especially of the supportive variety, may only require the growth of this therapeutic alliance over a period of time for personality change to occur" (p. 251).

He describes internalization as "the process by which the representation of this new, more benign and more gratifying relationship between the self and a significant other becomes assimilated into the individual's inner world of object relations" (p. 253). He views this internalization as not unlike the ordinary maturational and developmental process of infancy and childhood when the internalized self and object representation become imprinted upon the personality, and conceptualizes psychotherapy as attempting to achieve a "reprinting" of psychological reactions which, when successful, results in a significant change of the inner object world.

He views the development of the therapeutic alliance and of in-

ternalization as reciprocal. He holds that the development of the alliance allows the patient to experience the benign aspects of the therapy for what they are, which in turn allows for a deepening of the therapeutic alliance. He proposes that there are four factors or part processes which contribute to the growth of the therapeutic alliance and which in turn are the effects of a growing positive relationship. One is enhanced self esteem which he describes as the strengthening of the affective bond between self and object. The second is the corrective emotional experience which he believes occurs as the result of the therapist responding differently to aspects of the patient's behavior than the patient expected. The third is transference cure which he describes as the patient's effort to please the therapist by engaging in improved adaptive behavior. The fourth is identification, a basic ingredient in normal development, which he believes refers in therapy to the patient's relationships taking on the characteristics which the therapist has demonstrated toward the patient (p. 260).

Corrective emotional experience

Horwitz notes that the relationship between a corrective emotional experience and enhanced self esteem is that the former refers to an alteration in a specific facet of the self while the latter refers to more generalized feelings. In his view this experience usually occurs without interpretations on the part of the therapist but rather with the therapist responding in a way that is different from what the patient is used to. In the openended interview in this study a question was asked about the patient's perception of the similarity or difference between the therapist's reaction or response to important personal difficulties

and those of other individuals.

Identification

It is very difficult to determine if and when identification occurs although crude means of estimating its presence might involve trying to establish whether during the course of therapy an increase in similarity occurs between patient and therapist. Sheehan (1953) and Graham (1960) found that in successful treatments patients' Rorschach responses changed in the direction of their therapists. Rosenthal (1955) found that patients who improved tended to revise some of their moral values in the direction of their therapists while the moral values of patients who did not improve tended to become less like their therapists. Meyer and Zegans (1975) concluded in their followup study that those who viewed their therapy as successful might have seen in their therapist a happier, less troubled side of themselves and were able to form "some sort of bond with the common goal of help through identification" (p. 16). Kagan (1958) felt that identification might be more likely to occur if therapists embodied a goal state desired by the patient or a successful life adaptation in a situation that was similar to the patient. And Melnick (1972) beleived that if the patient subjectively felt helpless and weak and viewed the therapist as strong that identification was more likely to occur. It was considered that including a question in this study concerning the patient's perception of any increase in similarity or adoption of therapist values which may have occurred during therapy might be of value.

Transference cure

In discussing "transference cure" Horwitz states while the term

is often used depreciatingly by analysts in describing the experiences of a fleeting and transitory result, he believes that if based on a strong internalization which occurs in the context of a trusting relationship one can expect the change to persist. In other words, along with the concepts of corrective emotional experience and identification this would refer to personal or relational qualities of the therapy rather than to its technical aspects.

Design Considerations

Because this study involved a longterm followup of indivduals' retrospective views of their therapy experience, consideration needed to be given to the advantages and disadvantages of followup studies and to the merits and drawbacks of individuals reporting on their own therapy experience.

Followup studies

While many researchers agree that there is a need for followup of psychotherapy outcome, particularly longterm followup, they acknowledge that such studies may be fraught with difficulties, particularly if an experimental approach is highly valued. Many believe that the application of statistical measures to followup studies is very difficult, not particularly appropriate, and that for this reason statistical analyses of data are not that meaningful. Bergin (1971) notes, "I am generally distrustful of group-based multifactorial studies, and of the kinds of statistical operations that are associated with them. The results are too often of no practical use because they amount to nothing more than abstractions on top of confusion" (p. 255).

While some researchers continue to be interested in investigating

the response of a large number of individuals to therapy, there has been a renewed interest in looking closely at a few individuals and the manner in which they view their therapy in retrospect (Howard, 1972, p. 656). There are those who suggest that not very much can be concluded from gross studies of therapeutic effects and that a clearer picture can only be obtained when we break therapy down into its components (Bergin, 1971, p. 238). Some maintain that it is because of the wide range of differences in individual needs that a certain amount of flexibility and adaptability is required (Cowen and Combs, 1950) and that in view of individual differences specific behaviors tailored to the individual should be the dependent variable considered when evaluating psychotherapy (Rickard, 1965). Others suggest that it would be of value to "follow" a few individuals at various intervals of followup (Bergin, 1971 and Gottman, 1973); research to accomplish this would be similar to that carried out by Imber et al. (1968) but more comprehensive measures or indepth interviewing would be utilized.

Populations appear to be getting smaller. Colby (Bergin and Strupp, 1972) maintains that followup studies should focus on single case populations since it is too difficult to generalize about "all" patients because "no 'all' exists about anything" (p. 163). As Bergin and Suinn (1975) note, "perhaps the most widespread version of this trend (toward designing research) is the development of sophisticated single-case methodologies. Such approaches have the advantage of providing results that are most readily applicable to practice and reveal more clearly the causes of change" (p. 525).

It was the point of view of this researcher that the most meaningful information about therapy could be obtained by questioning a few

individuals in depth about the experience, particularly about how it related to other experiences and in a more general way about how it compared and contrasted with them. Some suggest that it would be of value to conduct a long range naturalistic type of inquiry into the fluctuations of pathology and disease in both neurotic and normal groups in order to learn which changes can validly be attributed to the influence of therapy (Bergin, 1971, p. 256). While not necessarily equivalent, it seemed that some understanding of this could be obtained by examining a select number of individuals who had undergone treatment and asking them about those fluctuations which had occurred and the influences that they believed their therapy had had on them.

When individuals are asked about therapy at the time of termination, there is minimal loss of subject participation. The situation is different in followup research where they may not be as available to participate in a retrospective evaluation of their therapy. What are the findings of existing studies regarding response rate and what seems to influence this rate of response? The range of response in the followup studies discussed in the first section varied from 55% (Imber et al., 1968) to 88% (Fiske and Goodman, 1965). The high percentage of response in this latter study may be explained in terms of the fact that 1) individuals were told at the time of therapy termination that they would be asked to participate in some followup research related to their therapy (so that they expected to be contacted), 2) the followup of one and a half years was relatively short, and 3) telephone contact as well as letters was used to encourage participation. Because the population in this present study was seen for relatively brief psychotherapy, because individuals were seen several years before the time of the followup, and

because they were asked to participate in an interview rather than to complete a questionnaire, it was anticipated that response rate might be considerably less.

For this reason it must be asked how individuals who participate in followup research differ from those who do not. In several of the followup studies conducted an effort was made to determine whether the population of respondents differed from the original population and if so how. Feifel and Eells (1963) found no significant difference between individuals who completed questionnaires and the original sample. Imber et al. (1968) determined that in all respects the population of the followup study was indistinguishable from the original population. Sager et al. (1964) believed that their followup population was representative of the total group and Klein (1960) found that individuals interviewed were representative of the original population except by sex.

On the other hand, while there were many areas in which respondents did not differ from nonrespondents, Strupp (1969) found that there were some areas of statistical difference; nonrespondents tended to be rated higher in degree of impairment, tended to have a poorer prognosis, and exceeded respondents in number of previous hospitalizations (p. 175). And Cappon (1964) found that individuals in the followup study which he conducted were rated considerably higher by their therapist at the time of termination than were those who did not participate. It seemed important in order to assure as unbiased a population as possible in this study that maximum effort be made to encourage maximum participation.

Individuals reporting on their own therapy

When an individual relates his impressions of therapy, how do

these impressions correlate with the evaluations and judgments of others? Melnick and Pierce (1971) found that an individual's perception of therapist competence was colored by his feelings of weakness and helplessness and that it bore no correlation with externally judged ratings. This measure of competence, however, is open to some question as it rested on two judges' estimation of three three-minute tape segments. Yet this research does suggest that it would be advisable to keep in mind that if patients are depressed or anxious, a tendency to exaggerate therapist competence may occur. Hansen et al. (1968) found that there was no relationship between ratings of clients and external raters on the individual and overall dimensions and that only the external judges' ratings of counselor conditions were positively related to changes as measured by a Self Ideal Q-sort. On the other hand Fiske and Goodman (1965) found that Client Self Evaluation correlated .54 with Client Scale Score, Q Adjustment Score and MMPI Si-reversed. They concluded that "the client's report of relative gain after termination, as given on this questionnaire, has variance in common with two of the other three measures of gain during that period, is predicted by several measures of gain during therapy, and is related to some measure of pretherapy status" (p. 174). Garfield, Prager and Bergin (1971) concluded that while change does occur in therapy, individuals tend to exaggerate this change.

What about the relationship between patient evaluation of therapy and therapist evaluation of therapy? In some studies it appears that there is general consensus and agreement about therapy; in others there is a lack of consensus. Feifel and Eells (1963) found good agreement between patients' assessments of current status based on questionnaires

and the impressions of the patients' therapists. Rosenberg et al. (1968) found a correspondence between the change in patients and analysts that analysts tended to be harsher in their judgments of patient improvement. This view that analysts may underestimate the changes that occur as a result of their analytic efforts is echoed by Pfeffer (Schlessinger and Robbins, 1974).

On the other hand, Avnet (1965) found only fair agreement between patients and therapists. While approximately the same percentage of patients and therapists believed that therapy had been helpful, it was not the same people! Mintz (1973) found that even though a reasonable consensus existed between the description by therapists and patients concerning the patient's emotional status during a taped therapy session that there was poor agreement concerning the relationship within the session and the goodness of the session. This study involved a small sample and included only the appraisal of sessions that had just ended so that it is difficult to know its relevance to a longterm followup with a large sample. Still, its results should be kept in mind. Rogers and Dymond (1954) found that while there was general agreement between therapists and patients when therapy was considered successful that there was disagreement when therapists viewed therapy as unsuccessful. In these instances therapists saw little movement and patients perceived marked gains.

How does patient reporting correlate with the perception of therapists and the rating of judges? Storrow (1960) found that agreement regarding the progress of patients appeared to be high between experienced therapists and judges and between student therapists and patients. He believed that the criterion used was a factor in the discrepancy since

it was derived by using the judgment of a professional worker based on a scoring system provided by another professional person so that the index was weighted in favor of professional opinion. Garfield and Prager (Bergin and Suinn, 1975) found that patients and therapists tended to rate outcome better than did other observers and more objective measures. However, Horenstein (1971) reported that while patients' evaluations of their therapy were not correlated with those of their therapists that they were highly related to those of independent judges. It was found in this instance that therapists tended to overestimate therapy progress relative to patients and judges.

Luborsky (1971) in a very insightful article takes issue with those who question the value of the patient and therapist reporting about therapy because they are not "objective." He argues that the patient and therapist usually have considerable knowledge of the specific areas which need change in relation to the areas which did change and that when a patient reports that he has changed in a certain way his statement has considerable "face validity." He observes that many criterion measures are broad spectrum or nonspecific even though gains may be quite specific. He also notes that some measures are intrinsically insensitive and that, for example, change from Status A to Status B may not be sufficient for a criterion measure but may be important to the patient in that what appears to be a small change could be a big one to the individual who experienced it; "sometimes a very small change in a critical area can make a difference to the patient" (p. 317). He argues that in some instances change may not have occurred in symptomatology but the patient may be more accepting of his problem.

The issue of what patients report is a significant one. Sargent

(1960) observes that from a clinical theoretical view the selection of what is reported in an open-ended interview can be important in itself. In a report published by the United States Department of Health, Education and Welfare (1967) it was noted that patients tend to report what is "in some sense important." Luborsky (1971) found that while patients who were pleased about their therapy exaggerated the extent to which they had improved, patients who were disappointed indicated via their self reports that they were worse while actually they were unchanged. In this study the possibility of this occurring had to be kept in mind. Imber et al. (1968) discovered that patients' ability to report depended on whether they felt therapy had been helpful or not. The more improved patients could discuss their condition at length. Those who were unimproved could not give a reason for their condition. This finding suggested that in this study greater effort had to be exercised in the interviewing of patients who were not satisfied with their therapy in order to determine why not and what the consequences, particularly negative consequences, had been.

Sargent (1960) suggests that patient reporting may be influenced by a patient's interest in sending a message to his former therapist, a motivation which could color the facts reported. Zax and Klein (1960) similarly points out that clients vary in the extent to which they can report what they feel, that their reports may be subject to unconscious distortions, and that their evaluations may be affected by conscious or semi-conscious motivation. Deutsch (1959) raises the issue of the relevance of diagnosis to reporting. She found one individual she had analyzed unwilling to credit her analysis for any of the substantial changes that had occurred and felt that this may have reflected her diagnosis

of narcissistic personality. This possible tendency had to be kept in mind in this study.

In a followup study of five or 10 years there will naturally be forgetting, forgetting which may be selective. Schjelderup (1955), whose study is interesting because the followup was conducted eight to 24 years after the therapy was completed, found that people remembered well, with only one exhibiting a significant memory loss. Nevertheless, they tended to remember symptoms better than "personal difficulties" (p. 118). Deutsch (1959) thought that one factor which made the experience of analysis easier to remember after termination was the acting out which occurred during treatment and which resulted in the analytic material acquiring a more realistic meaning. It was anticipated that in this study it might be possible but probably would be difficult for individuals to recall such instances of acting out since the therapy was relatively brief, occurred many years ago, and was not as intensively analytic.

Some researchers have attempted to compensate for inaccuracies in patient reporting by asking for information from someone other than the patient (Sargent, 1960). While this may contribute another opinion, it is clear that this approach is open to criticism, one of which is that the person or persons asked for their opinions may be as lacking in objectivity as the patient. Involving other persons also violates confidentiality which this researcher believes is important to maintain.

Summary of Issues Raised

The issues or questions which were raised in this chapter and which were explored with individuals in this study can be summarized as

follows:

With regard to Change with and without Therapy. What are the areas cited as those in which greatest change occurred: self esteem, insight, interpersonal relationships, or mastery? Is outcome of therapy associated with active involvement in the process and the individual's assuming responsibility for work in therapy? Did anyone get worse and if so, why? What is the relationship between initial diagnosis and outcome, specifically, do individuals with diagnoses of character disorder do less well than individuals with diagnoses of neurosis? If an individual entered further therapy, what were the reasons for seeking it and how did it compare with the experience at City? What helping persons other than therapists have been sought out by individuals and how does the quality of this help compare with therapy? How do personal relationships affect change? What life experiences other than therapy are viewed as significant and how does therapy compare with or how has it influenced these?

With regard to Therapy and the Therapy Relationship. What is the relative importance of personal and technical qualities of the therapy? Is perception of therapist empathy associated with outcome as positively as most outcome studies suggest? What relationship is there between liking the therapist and perception of outcome? How does similarity between the patient and the therapist affect outcome? What difference does therapist training make? Do patients tend to be satisfied with the sex of their therapist when they perceive that therapy was helpful but not otherwise? How important are transference interpretations and what types of transference interpretations are these? Are transference residues toward the followup interviewer evident and what do they tell us

about the therapy?

With regard to Design Considerations. How does the response rate in this study compare with that of other studies? What is the difference between respondents and nonrespondents? What experiences in therapy do patients remember and how much can they discuss about them? How much forgetting occurs?

METHOD

This study was an exploratory clinical inquiry. Its aim was to investigate patients' views of their therapy experiences in retrospect and to understand the relevance of this therapy to other events in their lives. Six men and six women were seen for indepth interviews for the purpose of learning about their therapy and about their lives since terminating therapy.

Subjects

Subjects were selected who were seen for an intake interview between 1966 and 1970, individuals who in most cases would have terminated therapy between 1967 and 1971, that is, between five and ten years prior to the time of the followup. Because it seemed probable that the longer the therapy the greater the likelihood that it was a meaningful experience which could be recalled, individuals were selected who attended more than 40 sessions of psychotherapy.

In order that the subjects in this study would be as representative as possible of the population that was seen by City University Clinical Psychology students between 1966 and 1970, individuals were chosen who were typical of the larger group with regard to age, marital status, race, occupational status and diagnosis. Thus, individuals who met the above criteria with regard to number of sessions attended and period of time during which they were seen who were white, who at the time of the initial intake interview were single, 25 years of age or less, and students, and who were viewed by their intake interviewer as falling within

the diagnostic category of "Transient Situational Disturbance," "Personality Disorder," or "Neurosis" were included.

Procedure

A list was compiled of all individuals who met the above criteria. An alternative list was compiled of all individuals who met these criteria except that they were seen in 1965 and 1971 rather than between 1966 and 1970 which meant that the followup would be carried out slightly more than 10 years or slightly less than five years from the time of therapy termination rather than between five and ten years. The current addresses of all of these individuals were obtained from the City College Alumni Association. The original and alternate lists were divided into two groups according to sex. Sixteen names, eight men and eight women, were selected from the original list. (Since the purpose of the study was to interview 12 individuals this allowed for a 75% response rate which, given the length of the followup, was a high estimate for rate of response.) Selection depended on the number of sessions attended, with those attending the greatest number chosen first.

If the current address was available, Letter #1 (see Appendix A) which introduced the research project, enlisted the individual's participation, and advised the person that he or she would be called by the researcher to discuss this study further, was sent. A telephone call from the researcher followed within the week. If only the original address was available (the individual's address at the time that he or she was seen for therapy), Letter #2 (see Appendix B), which was similar to Letter #1 except that contact with the Alumni Association was not mentioned, was sent. When it appeared, as the study progressed, that some individuals were concerned about the issue of authenticity or confidentiality,

a letter was also included from the Director of the Psychological Center which indicated that the researcher was a member of the staff of the Psychological Center and that it was anticipated that this research would help improve the service offered at the Center (see Appendix D).

When it was determined that an individual who was selected lived more than 60 miles outside of New York City, when a letter sent to an individual was returned, or when an individual declined to participate, another name was selected. When the entire group of names was exhausted, a name was selected from the alternate list. Selection from this list depended upon the number of sessions attended, that is, individuals attending the greatest number of sessions were contacted first, individuals attending the least number of sessions were contacted last.

When the researcher called an individual or was called by an individual, it was determined whether that person was interested in participating in the study. If he or she was not interested in participating, an effort was made to determine why. If he or she was interested in participating, an appointment was scheduled at the Graduate Center at the earliest convenience of that individual and the researcher. An offer was made to reimburse travel expenses if it appeared that this would provide an incentive to participation. If the Graduate Center was an inconvenient location, that is, if the individual lived outside of Manhattan and did not come into the city, if acceptable to that individual, the researcher offered to go to his or her home to conduct the interview.

When an appointment was kept, the individual was greeted by the researcher, was informed of the confidentiality of the study and was advised that if any question asked during the interview seemed too personal, he or she should so indicate and not feel obliged to respond to it. The

first part of the interview involved the individual's completing a three page "Formative Life Episodes Questionnaire" (see Appendix E), a slightly modified version of Barrett-Lennard's "Formative Life Episodes Questionnaire" (1974). The second part involved the interview itself (see Appendix F). It was estimated that the interview would take approximately one and one half to two hours. At the end of the interview the individual was asked if he or she would be able to speak with the researcher during a subsequent appointment or by telephone and a time was arranged for this. The purpose of this second contact was to follow up on any areas or questions which emerged from a review of the initial interview and to learn from the individual if there was anything that he or she wished to add to what was said in the original interview.

In order to clarify that the above procedure was generally a satisfactory one and that questions in the interview were ordered correctly and would provide the desired information, pilot interviews were carried out with two individuals who met the criteria of the study except that they were seen for therapy sessions in 1972.

FINDINGS AND DISCUSSION

The number of individuals who met the criteria of the follow-up study, that is, individuals who were single, Caucasian students, under twenty-five years of age at the time that they attended more than 40 sessions of psychotherapy between 1966 and 1970, who were diagnosed by their intake interviewer as having a "Transient Situational Disturbance," "Personality Disorder," or "Neurosis" was 32, 16 men and 16 women. These individuals comprised the original list. The number of individuals who met the above criteria except that they attended more than 40 sessions of psychotherapy during 1965 and 1971 was 10, seven men and three women. These individuals comprised the alternate list.

Current addresses were requested from the City College Alumni Association office for the 42 individuals on the original and alternate lists and were obtained for 37, 29 out of 32 from the original list and eight out of ten from the alternate list. These current addresses were not necessarily "current." In most instances they were the addresses listed for individuals at the time of their graduation and thus the same as the addresses listed in the files of the Psychological Center, and in several instances they were the current addresses of the individuals' parents rather than the individuals themselves.

The fact that 37 out of 42 had graduated is an interesting finding in itself, suggesting that a high percentage of these students resolved gross academic difficulties and problems in selecting a major, areas they often requested some assistance with in therapy. It is possible that people who stick with therapy, that is attend more than 40 sessions, are

more likely to stay in college or that those who stay in college are more likely to stick with therapy. It is also possible that individuals who maintain contact with the Alumni Association and who can thus be more readily contacted are those whose college experience was positive and thus whose therapy experience was positive. This had to be kept in mind in this study.

Letters were not sent to four individuals on the original list. It was determined that three were living several hundred miles from New York City and that one was currently in therapy at the Psychological Center. In order to interview 12 individuals, six men and six women, 30 letters were mailed, that is, 28 to individuals on the original list and one to a man and one to a woman on the alternate list; the man attended sessions in 1971, the woman attended sessions in 1965. In two instances the researcher learned from the individual's parents that the individual sought was living out of state. In 10 instances letters were returned, four addressed to men and six addressed to women, with notations "addressee unknown," "return to sender," and "moved, not forwardable." It should be noted that none of the three individuals on the original list who had not graduated from college, that is whose names were not listed in the file of the Alumni Association, could be reached. Letters sent to them were among the 10 returned to the researcher. It is possible that their therapy experience was not as positive as the therapy experience of those who completed college.

Thus there was a pool of 18 subjects who received letters. Telephone calls were made to ten, five men and five women, and were received from six, three men and three women (two individuals could not be contacted by phone and did not respond to followup letters). Seven men,

the first six of whom were selected, and six women agreed to participate in the interview. Of the remaining three, two individuals, one male and one female, were disturbed about the issue of confidentiality and declined to participate; another, a woman, stated that she did not have time even for a telephone interview. Thus, of the 18 who received letters, 13 out of 18 or 72% agreed to participate, seven out of eight or 87% of the men and six out of ten or 60% of the women. Thirteen out of sixteen or 81% of those spoken with personally on the telephone agreed to participate.

Consideration must be given to the possibility that the five individuals who did not participate had negative therapy experiences which they did not wish to look back on, but this may not necessarily be so. One of the two individuals who expressed concern about lack of confidentiality spoke with the Director of the Psychological Center and told him that while she was concerned about the issue of availability of records that her therapy experience had been positive, the most positive of several therapies she had been involved in. In terms of the criteria for selection for the study there did not appear to be any difference between individuals who participated and individuals who did not. Because many people who did agree to be interviewed were concerned about their record being reviewed by the researcher and agreed to participate only when they were assured that information about their therapy would remain confidential (the issue of confidentiality will be considered in the last section of this chapter), it is not possible to determine how individuals who were interviewed differed from those who were not with regard to underlying personality characteristics.

A 72% response rate may not be optimal but is higher than the

response rate obtained in most followup studies utilizing interviews and in some respects is greater than might have been expected. Predisposing against a high response rate are the length of time of the followup which was between five and ten years; the fact that individuals were seen for shortterm rather than longterm therapy which thus probably had less of an impact; the fact that they had not expected that there would be a followup, were not prepared for it and in some instances were distressed by it; the fact that there was considerable concern about confidentiality; the fact that the interviewer advised prospective participants that the interview would take approximately two hours; and the fact that the attitude of participants towards the therapy they were asked to discuss was not altogether positive.

On the other hand predisposing toward a positive response was the fact that telephone calls were made after letters were sent during which reservations about participating could be responded to. Also interviews were scheduled at a time and a place that was convenient to those individuals whose participation was requested. While an effort was made to schedule interviews at the Graduate Center this was not convenient for all individuals. Three were seen at their homes (they said that they rarely came into Manhattan), one was seen at a diner near her home (she said that she did not travel into Manhattan frequently and felt that there would not be enough privacy in her home), one was seen at her place of work, one was seen at the Psychological Center (she was attending courses in the area and felt that the Graduate Center would be inconvenient), six were seen at the Graduate Center in an office which the researcher was able to use, and one was inter-

viewed by telephone (he was attending graduate school in Illinois and requested to participate). For the most part it did not seem that the place where the interview was conducted influenced the individual's response to his or her therapy experience. One person who was seen in his home was generally satisfied with his therapy experience. Another who was seen in her home was generally dissatisfied. The one exception may have been the individual who was seen at the Psychological Center for the followup interview. Her therapy experience had been generally unfavorable and returning to the place where she had been so dissatisfied may have intensified her negative feelings more than if she had been seen at the Graduate Center.

The followup interviews ranged in length from one hour fifteen minutes to four hours fifteen minutes. Six interviews lasted between one and two hours, three between two and three hours, one between three and four hours and two between four and five hours. The time of the average interview was approximately two hours fifteen minutes. At the time of the followup interview individuals ranged in age from 26 through 31. The average age was 28.5, the median age 29. At the time that they were seen for therapy they ranged in age from 19 through 22. The average age was 19.4, the median age 19. All were white, ten Jewish and two Catholic. They attended therapy sessions between 1965 and 1971, one in 1965, two in 1966, four in 1967, one in 1968, two in 1969, one in 1970 and one in 1971. The length of time of the followup ranged from four and a half to ten and a half years. The average followup time was 7.8 years, the median 8.5 years. The number of sessions of psychotherapy attended ranged from 42 to 85. Three individuals were seen for between 40 and 49 sessions, five were seen for between 50 and 59 sessions,

two were seen for between 60 and 69 sessions, one was seen for between 70 and 79 sessions and one was seen for between 80 and 89 sessions. The average number was 57.8, the median number 56. Seven individuals were in treatment with male therapists, four with female therapists. One was in treatment with a male, then a female therapist. Eight individuals, three men and five women, entered further therapy (this will be discussed in the second section of this chapter). While all were single at the time of their therapy, at the time of the followup six were married, three men and three women, and one woman had married and divorced. Four, two men and two women, were parents.

Individuals interviewed expressed generally ambivalent attitudes about therapy. Some were more positive than negative, others more negative than positive. Before considering the various issues which the interviews raise a general summary of each of the individual's views of therapy will be presented. These are based on written notes taken during the interviews (tape recording would have been unacceptable to several of the subjects). In conformance with standards of confidentiality all names, significant dates and places have been changed.[1] Although it is not possible to clearly rank order respondents in terms of satisfaction or dissatisfaction with therapy the researcher has made a rough attempt to do so. The summaries are offered in order of the interviewees' subjective appraisals of their therapy, from most satisfied to least satisfied. It should be noted that impressions of therapy's helpfulness were

[1]To further protect confidentiality the protocols of the interviews and the Life Episode Questionnaires are not included with the dissertation. They are being kept at the Psychological Center where they can be made available through the Director of the Psychological Center for research purposes. All identifying data has been altered in these protocols as it has been in the summaries.

influenced by various factors and are not necessarily synonymous with therapy outcome (this will be discussed in the second section of this chapter).

A. SUMMARY OF INTERVIEWS

1. Richard Doran

Richard Doran is a 27 year old, single, white, Catholic male who attended 66 sessions of psychotherapy in 1970 when he was a Senior at City College living with his parents. The followup interview was conducted at the Graduate Center. It took approximately one hour forty five minutes to complete.

Richard is a tall, nice looking man who was dressed in a suit for a job interview scheduled for later in the day. He seemed slightly nervous but was generally relaxed and very sincere and frank as he responded to questions in the interview. He has held two jobs in advertising since graduation, the most recent one ending a year and a half ago. He spent one year in Southern California and for the past six months has been looking for a job in New York City. He lives with his parents with whom he has resided since he was in college.

Richard enjoyed his life at City, the classes, the courses, and the people, but was experiencing so much distress about his homosexuality that he wanted to discuss his feelings with someone. He had felt for a number of years that he was gay but was uncomfortable about admitting it and about meeting a man. "My desires were in conflict with my actions." He said that initially it was difficult for him to talk about his problems and feelings to a stranger (his therapist) but that he gradually became more and more comfortable and in time "got to the nitty gritty." He felt that his therapist's sincerity and understanding were important in permitting him to become more comfortable with his homosexuality, which was "the main thing" that therapy accomplished. Therapy helped him put these thoughts and feelings into per-

spective. "I had a good feeling after sessions, a feeling that I had gotten some heavy stuff off my head." He expressed the concern that he was seeing a graduate student but said that he did not have the impression that his therapist was inexperienced. It was "just that he was a graduate student." The one thing that he disliked was being pressed at the beginning to set a goal for his therapy. He felt that while he wanted to discuss his feelings about being gay and that this would be his goal, to become more comfortable with his homosexuality, he did not want to specify it, possibly to the exclusion of other issues or concerns.

Simultaneous with his beginning therapy Richard went to a gay bar where he met a man with whom he developed a relationship which extended over the next three years. This was a very important experience for him and he discussed it in detail in his therapy. As he looks back on this period, however, he is unsure how much of its development he should atrribute to therapy and how much he should attribute to the relationship itself. He recalls that toward the end of therapy this involvement was starting to become less and less satisfying. He felt a pressure to break off with his lover but an equally strong reticence to do so. Although he discussed this dilemma in his therapy, he believed that the ending of the relationship three years later came only after he had spent a year in Southern California and that it was this physical separation rather than therapy which was the major factor in its resolution.

Richard's one very strong feeling about his therapy experience is that he wishes he had begun sooner so that the pain and anguish he had been experiencing would not have built up over so many years. He would consider entering therapy again, "I don't think I'm so mentally

healthy that I wouldn't consider therapy in the future; it can only be helpful," particularly for help with the pressures, problems and stresses which he believes accompany a lifestyle in the gay community. But he does not feel a press to enter therapy now. He has one close female friend who is "very bright and very sensitive," whom he has known since highschool and with whom he can discuss his problems and feelings. While he does not confide intimate details which he would share only with a therapist, just talking with her is very helpful and important to him. He commented that even though he seeks intimate relationships with men, he feels more comfortable, is less embarrassed and has more fun with women.

2. Elliot Roth

Elliot Roth is a 30 year old, married, white, Jewish male. He attended 53 sessions of psychotherapy in 1966 with two male therapists when he was a Junior at City College living with his parents. The first interview scheduled at the Graduate Center was not kept. The second one was. It took approximately one hour forty minutes to complete.

Elliot is a moderately short, nice looking man with a beard. He was wearing jeans, a shirt and a sweater. A wide wedding band was striking. He seemed somewhat nervous, somewhat depressed and somewhat tense. He was tentative in his responses to certain questions, qualifying them or returning later to elaborate what he had said. Generally he was open and frank. He is currently working as a graphic artist, the field he has been involved in for two and a half years. He has been married for three and a half years and resides in Long Island in the second apartment he has lived in since his marriage.

When Elliot was attending City one of the most troubling ex-

periences he was having involved his relationship with women. He had not dated throughout his three years and pressure to resolve this difficulty led him to seek therapy. He is not sure whether therapy was responsible for the beginning resolution of this problem. At about the same time that he started therapy a friend fixed him up with a date, an event he believes may have occurred had he been in therapy or not but which was the beginning of his going out with women. He considers that "the main thing was going through the event" and feels that most progress occurred following graduation from City. He describes his involvement in a relationship which developed after he terminated therapy at City, a relationship through which he learned to be much less passive, as being very important. Still, he believes that therapy may have prepared the way for this and was generally helpful. His therapist was quiet, pleasant, supportive, reassuring, making his therapy a nonpainful experience, which at the time was what he needed. He recalls his therapist, who he viewed as somewhat like a big brother, responding to a remark he made in one of the first sessions of therapy "I must sound very incoherent" with the comment "No you sound very coherent." He also recalls feeling upset during a session in which he was discussing his attraction to a female classmate and his therapist turning off the tape-recorder so that he might feel more at ease talking about it. Neither incident may be exceptionally important but each seems to underscore his feeling that his therapist was supportive.

When Elliot discusses his therapy it is the second therapist he refers to. The first whom he saw briefly he believes was "totally ineffective." He was active to the point that he told him exactly what he should say on the phone when he talked to a prospective date, in-

cluding the words he should use to ask her out; "He really wanted me to act the way he thought I should act." His only objection to his second therapist was that he may have been too much the other way; "I have a feeling I might have felt I could push him around."

When he graduated from City he entered therapy at an institute for psychotherapy. He was in individual therapy for four years with two female therapists. Concurrently he participated in group therapy with a male therapist whom he thought was the most effective of all the therapists he had worked with. Individual therapy provided the support which he needed while group therapy offered confrontation and the opportunity to receive respect when he was active. He believes that his experience in group therapy may have produced the greatest amount of change and may have resulted in his meeting his wife which occurred six months after he terminated treatment.

Elliot is still disturbed about his lack of assertiveness and his feelings of passivity. "I feel like a little boy and accept it. This comes out as a problem in certain situations and in others not." If he were to enter therapy and if the problem were "deep," he might seek out a traditional type of therapy. If the problem were more superficial, however, he might seek out a behavioral approach where specific strategies could be suggested for dealing with specific difficulties, for example, techniques for standing up to his boss. He said he thought "the most important thing about therapy is to accept the way you are; maybe I'm into acceptance because therapy didn't result in that much change." Still, "I'm happier; whether it's the result of therapy, I don't know."

3. Irene Silverman

Irene Silverman is a 30 year old, single, white, Jewish female. She attended 75 sessions of psychotherapy in 1965 when she was a Senior at City College living with her parents. The followup interview was conducted at Fordham University, her place of employment. It took approximately one hour twenty minutes to complete.

Irene is a moderately tall, slim woman with short, dark, curly hair and strong features. She comes across initially as somewhat tough with an abrupt, businesslike and almost curt manner. When talking about herself, however, she seems different. She is open and frank, exhibiting a willingness and eagerness to talk about her life in a personal way. She conveys an impression of actively struggling with particular difficulties but of not having mastered them. She is currently a Fellow in the doctoral program in Bacteriology at Fordham University which she has been enrolled in for five years and which she hopes to complete within a year. She lives in an apartment in the Bronx, spending weekends with her boyfriend in Manhattan. Following her graduation from City she spent three years at the University of Nebraska obtaining a master's degree in Science.

Irene is not sure what her life was like at the time she came to City. She cannot remember the experience clearly. She thinks that things were pretty good but knows that college was difficult academically, mainly because of her poor memory. In fact difficulty remembering was one of the problems for which she sought therapy at City and on two subsequent occasions. While therapy was not helpful in terms of resolving this disturbance, she did find it a valuable experience. When she started therapy she felt that she was "not worthy" and believes that

therapy helped her to isolate instances when this feeling was prominent, particularly ones which occurred with her parents, to understand what was happening, to accept herself more, and to "get off my back." She was upset about difficulties she was having meeting men and believes that her therapist helped her by conveying the impression either directly or indirectly that she understood how stressful that could be, as though she had had the experience herself, and that Irene should not feel that the problem was entirely hers but that the men may have their own difficulties in relating which was reflected in their not calling.

She regretted that she was not given strong clues about her therapist's life but felt that in her next therapy, at the University of Nebraska, she "saw what could happen if someone got carried away." She recalled an occasion when her therapist shared an explicit sexual fantasy about her with her. This therapist was much more directive, which she felt was both helpful and not helpful. She does not recall her third therapy at all but knows it was in New York and thinks it was with a male.

She thinks that "therapy is basically someone to talk to; it's someone to talk your problems over with, who is objective; things shouldn't shock a therapist; talking in itself is the value." She believes that it is not valuable to pay for the experience, since doing so makes it difficult to openly discuss difficulties with finances, which if disclosed in full could lead to a higher fee. She would pay up to two dollars per session but no more. She also did not like the sessions ending. She thought it might be a good idea if the therapist would indicate when there was only five minutes left, just as a parent tells a child that in 30 minutes he has to go to bed.

Irene basically enjoyed therapy, feels that all subsequent therapies were influenced by her experience at City and would resume therapy immediately, "tomorrow," if it were convenient and free. She would like some help with her problem with self esteem and depressions, which she is "close to all the time" and which she believes mask frustrated anger. She has few friends to talk things over with but has a close relationship with her boyfriend of nine years. She keeps this relationship private, from everyone in her program, as well as from her father, who would be so upset about his not being Jewish that he cannot be told about the relationship at all.

4. Rebecca Feiner

Rebecca Feiner is a 27 year old single, white, Jewish female. She attended 59 sessions of psychotherapy in 1968 when she was a Junior at City College living with her parents. The followup interview was conducted at her home. It took approximately four hours to complete, three hours at her home and one hour on the phone.

Rebecca is an attractive, slim woman with curly blond hair. She is extremely articulate, has an excellent detailed memory of events which have occurred in the past and relates personal experiences in a compelling storytelling manner. She appears to have thought a great deal about her therapy at City and about her subsequent therapy. She is currently employed at a publishing company where she is a programmer. Prior to this she worked for three years in a management job with the city. Prior to that she attended the Master's Program in Psychology at Queens College during which she applied without success to Clinical Psychology programs. One year after her graduation from City she moved in with her boyfriend with whom she resided until two years ago when she

moved to her present apartment.

City College introduced Rebecca to a world that was different from what she had known before. She felt as if she was very much on her own and was eager to meet different kinds of people and to join as many groups and activities as possible. Because she was involved in everything so intensely she believed that there was a sense of strain and depression and that she may have started therapy for help with these feelings. She had a mixed reaction to her therapy, believing that she was solving some problems more effectively but also occasionally wondering what she was doing there. She had a mixed reaction to her therapist also, feeling that he was "so damn nervous...so unsure of himself" and resenting his always "trying to do the stereotypical thing" but also believing that she got something from him, mainly from "his counter-transference." She recalled two occasions when his concern for her showed "in spite of himself," once when she reported stealing an article from a department store when he said "Do you realize you could get caught?" and another more important event when, as she relayed an experience of pain associated with drug abuse, he seemed to be crying. She believed that at these times there was a "sharing" and a feeling "of being cared about."

Rebecca thinks that as a result of this therapy she worked through some problems with dependency to the extent that she could enter a subsequent therapy and make a commitment to it. She believes that this occurred because she was able to allow herself to experience dependency in her therapy while at the same time come to feel that she could handle crisis situations on her own. She considers it a plus that the therapy at City was time limited and that the fee was low.

Had it been otherwise she would have been too threatened by the commitment involved to have undertaken it.

She feels that the therapy which she entered after terminating at City, which extended over four and a half years, was a very rich experience for her. In contrast to what she perceived as defensiveness on the part of her first therapist, she found her second to be more professional, conveying a sense of being masterful but ready to admit that he did not know everything. He was "someone experienced, who no longer had something to prove...he seemed to have faith in himself." She believes that this therapy was helpful in allowing her to understand what was happening in her relationship with her boyfriend, which ended during therapy, and to understand what was happening in her relationship with her therapist. In this way it was better than her first therapy. "I don't think Joe (her first therapist) was able to evaluate what was going on between him and me. I don't think he could deal with his own reactions. When he could, that was good; when he couldn't he couldn't help me."

Summarizing the differences in the therapies she said, "Joe was a very careful person who seemed to have little confidence in his own judgment" while Jarrell, her second therapist, "was a very careful person who seemed to have a lot of confidence in his own judgment." Summarizing the outcome of the therapies she said, "Without the first one I couldn't have trusted men enough to get into that relationship (with her boyfriend). Without the second I couldn't have broken off that relationship." She believes that her decision to abandon her pursuit of psychology as a career was based in part on her rejection from Clinical Psychology programs and in part on her gradual recognition that she had made the choice originally for the wrong reason: "I had picked a field where I thought I

had to mother; my sense of importance rested on my sense that people needed me." During her second therapy when this became clear to her she chose another area of work. "I was using psychology to build an identity that I didn't have. When I realized it, I didn't need the field."

5. Mark Geller

Mark Geller is a 30 year old married, white, Jewish male. He attended 85 sessions of psychotherapy in 1966 with two different male therapists when he was a Junior at City College living with his parents. The followup interview was conducted at his home. It took approximately one hour fifty-five minutes to complete.

Mark is a moderately tall, thin, good looking man with medium long dark hair. He was dressed in jeans and a King Kong t-shirt. He appears to be casual, easygoing and unpretentious. During the interview he was able to limit the attention he paid to his one and a half year old son but when attentive, played with him in a relaxed and affectionate manner. Mark has taught high school for seven years, first math and more recently photography and art. He has been married for ten years, has one child and his wife is pregnant with a second. He has lived in his current residence for less than a year, in the area for five years and in the Bronx his entire life.

When Mark started therapy he did so because he was "not happy" in general and was concerned about his relationship with women in particular, difficulties which he did not elaborate but which were sexual in nature and which were problematic to him in all relationships except that with his girlfriend whom he married during therapy. He describes himself as a somewhat undisciplined person and says that therapy offered

a discipline which was helpful, referring to it as "formalized introspection." He illustrated this with the analogy of the advantage of going to Jack Lalane's, which you have to pay for, and therefore will go to regularly, as opposed to having weights in your home which you might not use. He believes that in therapy he started thinking about himself and developing a self awareness, a process which continued after therapy terminated. Even so, he is not sure that the questions he raised in therapy he might not have raised anyway.

Mark feels that the main advantage of therapy was that it offered him a place to go to talk about himself and to explore certain resistances to thinking about areas that would have been difficult otherwise. He refers primarily to his second therapist. His first "reminded me of someone younger...like he didn't know what he was doing...he was going through the motions: rigid, uncomfortable, not warm." He recalls more specific incidents from the second therapy. He remembers offering "gee the train was late" as a reason for being late and the effect that the silence that followed had; "I would see what really needed to be talked about." The disadvantage of therapy was that it was "like talking to a mirror," that the therapist offered little support, reassurance or guidance and made few interpretations. He thought, "This is 40 sessions and he hasn't said anything" and wondered whether this was the way that therapy was or whether this was the way <u>his</u> therapist was. However, he did recall one specific suggestion that his therapist made which was helpful and which involved a strategy that he could use when he had a particular fear. Mark said that sometimes when he was driving he would have the feeling that he might crash into a pole and that his therapist told him to follow through with the fantasy and imagine

that this had happened. Doing so took the fear away, gave him a feeling of mastery and is a strategy that he has employed since terminating therapy when he has been similarly afraid.

Therapy had the effect of improving his self image in every area except the one that he wanted help with, his difficulties with women, which is one of the reasons for his reservations about its helpfulness. He believes that one possible explanation for the lack of change in this area may have been that it was a situation that was out of his complete control, involving a person other than just himself. Through a brief extra-marital affair he has recently resolved this to his satisfaction.

He would enter therapy now for the purpose of talking about "pressures that can be overwhelming" but believes it is too expensive for him to consider seriously and the press to seek help is not what it was when he was at City. Also he has a close relationship with his wife with whom he can discuss almost everything.

6. Mary Spinelli

Mary Spinelli is a 29 year old, married, white, Italian female. She attended 44 sessions of psychotherapy in 1966 when she was a student at Kingsborough Community College living with her parents. After failing to keep an appointment scheduled at the Graduate Center she said that she was not planning a trip into Manhattan in the near future and asked that the interviewer meet her at a diner near her home. The followup interview took approximately three hours to complete.

Mary is short and pretty with long blond hair and dark eyes. She seems to be an outgoing and engaging person with an easy-going manner. She appears somewhat younger than her age evidencing a child-

like quality at times. She has taught elementary school for five years, a job she began soon after her marriage. She has a three year old daughter. Currently she is living with her husband and daughter at her parents' home in the Bronx, a residence which she says is temporary until she and her husband move to either the Village (her choice) or Queens (his choice). She has lived in eight different places since graduation.

While she was attending Kingsborough Community College a close friend told her about therapy. Mary thought this might help her deal with her reaction to a traumatic event which occurred when she was 13, an incident which she would not describe to the interviewer except to indicate that it involved her relationship with her parents. She said that she benefited from therapy by learning that it was all right to have strong feelings about this event, to be mad, to be scared and to cry. While laughing, she remarked "and I've been angry ever since."

Mary felt that this distressing incident interrupted the close relationship which she had enjoyed with her parents and believed that she was looking for such a relationship or commitment in therapy. She said that she looked at her therapist in a totally personal way and that anything that altered this image of a personal relationship, such as paying for therapy, having sessions end, and not being able to call her therapist at any time of the day or night, "negatively reinforced" her feeling of commitment. She would have liked a "live-in-psychologist." She recalls wishing for a stronger reaction from her therapist at the time of therapy termination, including an offer to let her be special and continue treatment without paying or at least a display of some emotion such as "crying and stomping her feet." Still, she be-

lieves that the "abandonment" may have helped in itself. "I had to let go of this person...I associated this with some kind of abandonment as a child."

She feels that therapy was of some value, particularly in helping her increase her understanding of what had happened in the past and in allowing her to ventilate feelings and frustrations. She might seek out a therapist in the future for help with a specific difficulty that could be solved if she had particular information. However, she would not enter a traditional therapy because she believes that it fosters dependency and that it is not helpful to dwell on difficulties in the past; "You should face them and then move on...relying only on yourself" or on friends. She has one friend in particular whom she is very close to, a woman who was in therapy at the same time as Mary and with the same therapist. She believes that her feelings about herself have been positively influenced by involvement in relationships outside of therapy. Before she was married she went out with several different men each of which was "enamoured" with her and made her feel attractive in some way; "They did a lot to reassure my ego...all positive experiences help." She did not marry any of these men but selected a man toward whom she felt less "in love" but with whom she believed she would develop stronger and stronger loving feelings. She says that this has happened.

The pain that resulted from the experience that occurred when she was 13 still surfaces at times, such as when she was recently watching "Sybil" on television. At those times it can be emotionally wrenching, but it does not last.

7. Linda Kellar

Linda Kellar is a 27 year old, divorced, white Jewish female.

She attended 50 sessions of psychotherapy in 1967 when she was a Junior at City College living with her parents. The followup interview was conducted at the Graduate Center. It took approximately one hour twenty-five minutes to complete.

Linda is a pretty, slightly overweight woman with red hair who was wearing slacks and a sweater. She responded quickly with short unelaborated statements to most questions. At times she seemed pensive. At other times she appeared to be assessing the interview and evaluating the interviewer as a fellow professional. She has been working at a rehabilitation center for mentally disturbed patients for the past four and a half years, which was her field placement when she was obtaining her Master's degree in Social Work from Columbia University. She was married in 1971 and separated from her husband a year later. She has lived in two apartments in Manhattan since her graduation from college.

Linda recalls her life at City as being pretty good although thinks "some of the pain fades." She sought therapy because she was involved in a relationship that was "fucked up" since her boyfriend was making himself feel good by making her feel bad. During therapy she broke off with this boyfriend but believes it was not because she was ready but because she wanted to be a good patient by saying, "Look, I'm in therapy, see what I can do." During therapy she also separated from her parents, in the sense of leaving home, but felt that she was ready for this. "That was a major change" and she attributes its occurrence to therapy.

Overall, however, she had reservations about therapy. "It was not what I would have chosen." She thought that her therapist was too

rigid in adhering to a Tavistock model, making process comments at times when he might have been more active or supportive, and that it was particularly difficult for her to tolerate his "passive authoritarian stance" because she was "into battling authority." She was somewhat disturbed that the same room was not used, "We were hither and thither," which contributed to a sense of impermanence. She felt intimidated by the tape recorder; "I'm used to them now but then it was a big mother of a thing...I would look at the green light to see if I was alive." She felt very little sense of trust. Even so, she does not think that her therapy was a negative experience, believing that her feelings have been confused to some extent by her husband's therapy at City which followed hers. He saw "an extremely insecure guy who used the Tavistock model to hide behind."

Three years later she began therapy with a Social Worker, a therapy which lasted for two and a half years. She found this a better experience and remembers it more clearly. Her second therapist was much more active; there were times when he would bring up issues; there were moments of lightness when she would use her sense of humor -- "we would play a little;" and there were occasions when he would offer support by touching her or holding her hand. She thought that there was more fluidity in his style than there was in the first therapy. She experienced a sense of trust, a stronger transference and the feeling of working, of taking the experience more seriously. She thinks that this occurred because her therapist was more professionally competent but also because she was "in a different place." As an adult who was working, paying rent and paying for therapy, she was making a greater commitment than she had in her first therapy. "I think the first time was a little like

playing; when I missed a session I thought 'what the hell, it's a dollar, so what's the difference.' Paying meant that I was making a comitment to therapy." In terms of content the second therapy involved a consideration of patterns, the first a discussion of specific issues.

Since terminating therapy she has taken advantage of brief forms of counselling experiences which she believes help resolve immediate kinds of difficulties by letting you "clear the shit out and go on." If she felt that she needed more formal therapy, she would contact her former therapist. If she had it to do over again, she would have seen a woman. She feels that "by and large" her relationships with men have been different than her first one, although they are not resolved; recently she was "attacked" by her boyfriend. Her general feeling about therapy is that it helps influence "when" rather than "what" changes occur.

8. Jim Myers

Jim Myers is a 27 year old, single, white, Jewish male. He attended 54 sessions of psychotherapy in 1966 when he was a Junior at Queens College living with his parents and grandmother. The followup interview was conducted in two segments at the Graduate Center. It took approximately four and one fourth hours to complete.

Jim is a short, balding, neatly dressed, nice looking man who appears somewhat older than his age. He seemed moderately tense and controlled during the interview, discussing his therapy and other life experiences in an articulate but somewhat intellectualized manner. It was apparent that he has thought a great deal about his life. He seemed slightly depressed. At present he is unemployed, having recently left a job where he worked for one and a half years, gradually being promoted to

a level of considerable responsibility. He resigned when he was not granted a salary raise. He is looking for a similar job. He lives at home, his residence since graduation.

College was a difficult time for Jim. While he had achieved academic superiority in high school, he was not able to succeed in college, graduating with only a C+ average. His relationship with his mother, which had always been difficult, was taxed to the limit when she decided to return to college at the same time as he did. She graduated with him but with "honors." When Jim came to the Psychological Center he was seeking help for symptoms of depression which he felt were related to his relationship with his mother, to his coursework which was overwhelming and which he did not like, and to sleep deprivation. Throughout this therapy and for several months following it he took elavil, stelazine, and etrafon which were prescribed by a physician.

Jim believes that therapy offered a place where he could feel at ease and could unwind and discuss certain things which he could not talk about with anyone else without a fear of being judged. However, it was not the positive experience that it might have been. He had expected that he would be provided with direction and advice, he felt that he needed this and was disappointed after several months when his therapist, despite knowing him well, did not offer such guidance to him. The two specific incidents which he recalls from his therapy are those in which his therapist "went out on a limb." Once when Jim asked whether his family was normal, his therapist replied, "hell, no." Another time when he was discussing difficulties in his relationship with his mother, his therapist suggested that he stand up for himself. He had mixed feelings about this latter advice, which resulted in his releasing a tremendous amount of

anger toward his mother, a catharsis which he believed was good for him but which may not have been good for her. He seemed to imply that her death within a few months of graduation may have been in part a reflection of the stress she experienced as an outgrowth of his rage.

He does not believe that pushing a person who cannot tolerate such active confrontation is advisable. He had seen a psychiatrist for a consultation before coming to the Psychological Center and was antagonized by his "get up and go" attitude. The relationship which reminded him the most of therapy was one where he was able to offer suggestions to a female coworker who was experiencing personal difficulties. In that situation he was giving to her what he believed his therapist had not given to him. In general he considers that more important than therapy in allowing for the development of self esteem is the gradual mastery of small tasks so that bigger ones can be attempted. He attributes his success in this area to changing his career from teaching to an area of work which he chose following his mother's death; teaching had been her idea. He is currently working on a complex task related to his job, a task which he believes he never would have had the discipline to succeed in at college. Periodic depressions still occur and are alleviated by drinking. "Things may come tumbling down sometime" but right now seem relatively stable.

9. Donald Schiller

Donald Schiller is a 26 year old, single, white, Jewish male. He attended 58 sessions of psychotherapy in 1969 when he was Junior at City College living with his parents. The followup interview was conducted at the Graduate Center. It took approximately two hours and five minutes to complete.

Donald is a slightly short, nice looking young man with curly reddish hair and a beard. He is personable and pleasant mannered, conveying his thoughts clearly and easily, although he seemed more comfortable volunteering information of a professional than a personal nature. As a result, it was somewhat difficult to obtain an impression of what he is like and of what his relationships are like. He seemed slightly depressed. He is now working at a Mental Health Center in Connecticut, having obtained a Master's degree in Social Work from the University of Virginia within the past year. He plans to move with his male roommate to an apartment in Connecticut in the near future.

When he came to the Psychological Center, Donald was feeling nervous and lost, concerned that he did not have enough friends and worried about what he wanted to major in. At a time when he needed someone to talk to, he was pleased that his therapist was "there." He never missed a session, was never late and when more time was needed, possibly an extra session, he was available. He was nonjudgmental and nice and as such was a "model" for a therapist. In every other way, however, he was an "antimodel" for what Donald believes is the effective attitude and orientation that a therapist should take. He maintains that a therapist should be active, confrontative and provide the individual with specific tools or problem solving techniques that he can use to resolve difficulties he is experiencing. He believes his therapist helped him get to the source of some of his difficulties, that he cried, got angry and "got the shit out" but does not feel he was helped in terms of moving beyond the pain. There was nothing to hold on to and no direction. Referring to his therapist, he remarked, " I think one of his supervisors must have told him, 'When in doubt, say nothing.'"

Donald believes that more helpful and beneficial to him than his therapy at City was his experience in Houseplan and Ricorso. Both of these organizations sponsored workshops or encounter situations designed to help individuals identify interpersonal difficulties and to relate to others in the groups in a more honest and open way. He believes that because these activities involved more active confrontation than did individual therapy, involvement in them was more helpful to him.

Upon graduating from college he applied to Clinical Psychology programs, was not accepted and took a job working as a caseworker with brain damaged and mentally retarded children in a Day Camp in Vermont. During this time he became involved and lived with a woman, a relationship through which he "learned a lot" and "grew up a lot." It was "damn equal, very giving, nonsexist." After two years he applied to Social Work programs and was accepted at the University of Virginia. During this two year program he had his best experience with therapy in a group that was led by a Social Worker, a group which was contract oriented, where expectations were clearly stated and where the anxiety level was sometimes high but so too was the level of support. The therapist offered education about the process and shared personal experiences where relevant. "You couldn't pull the shit you could at City." He felt that it helped him to relate more easily to other people and to stay in school, which he had been considering leaving.

He believes that he has drawn from this second "model" in his own practice as a therapist. "As a clinician I believe that you have to break through defenses." If an individual is depressed, you must look at what underlies the depression. If an individual is angry, you must look

at what he is angry at. Letting out feelings is important. If banging on a pillow helps, he has a pillow in his office for that purpose. If it would help an individual to rehearse emotions he needs to express toward another person, he encourages this in therapy. Time limited rather than time extended therapy is preferable.

While City has a warm spot, "memories of gold," his therapy there does not.

10. Gloria Rieser

Gloria Rieser is a 28 year old, married, white, Jewish female. She attended 46 sessions of psychotherapy in 1966 when she was a Sophomore at City College living with her parents. The followup interview was conducted at the Psychological Center and completed on the telephone. It took approximately one hour five minutes.

Gloria is an attractive thin brunette who appeared relaxed and relatively at ease during the interview. She made eye contact with the interviewer, spoke quickly and articulately and conveyed the general impression of being comfortable with herself. She has been teaching high school English for the past three years and is currently completing her master's thesis at Brooklyn College. She has been married for three years. Since her graduation from college she has lived in two different apartments.

At the time that she came to the Psychological Center Gloria was having a mixed reaction to being in college. She enjoyed her studies in English and her participation in politics and the antiwar movement; yet she felt that she was floundering and having trouble meeting friends. She is not sure that she would have sought therapy on her own but did so as the result of her boyfriend's strong encouragement: "You're crazy,

you should go into therapy." Believing that one of her main problems was her relationship with him since he was constantly putting her down and she was taking it, she thought that through therapy she might better learn how to deal with this situation.

She feels that her therapy was limited in its helpfulness, in part because she was hostile and belligerent and not ready for it and in part because her therapist did not know how to deal with her. She viewed him as earnest and sincere but also as inexperienced and incompetent. At a time when she could have used support he was confrontative. "I found therapy painful. It made me feel more inadequate. It was another person making me feel inadequate about myself." However, she recalled one helpful intervention which he made. After she described a discussion which she had with her boyfriend about Jane Austen, her therapist said that she did not have to defend her views to him, that it was all right to like the author and that she did not have to justify her likes and dislikes. She feels that therapy marked the beginning of her standing up to her boyfriend, although the relationship did not end immediately and she did enter others which were similar.

Two further therapy experiences followed, neither of which she viewed as particularly helpful. The first therapist was supportive where she felt she could have used confrontation. When this therapist left for an extended trip, she began treatment with a therapist whom she believed was the most incompetent of the three because he was cruel, made harsh interpretations that caused her "to cry three times a week," and left her feeling bitter about the experience. She terminated therapy after six months.

She believes that her generally negative viewpoint about the

effectiveness of therapy results from having had therapy experiences with people in training. For the past five and a half years she has been involved in Women's consciousness raising groups, the first for one and a half years and the second for the past four years. She considers this experience to have been much more beneficial than any of her therapies. She believes that while therapy tends to label a person as crazy in some way, the Women's Movement considers society rather than the individual to be the cause of the problem although "of course you have a role in it." Her general belief is that most people seek therapy for problems like "growing pains" which can be handled in other ways but that for people who have more severe difficulties therapy can be helpful. In selecting a therapist "chemistry is important" and "it is not necessarily true that people making assignments know more about what's good for you than you do." An individual should choose a therapist after shopping around "for someone who is good and who you should expect to have to pay." Training facilities should be steered clear of.

11. Sally Ehrlich

Sally Ehrlich is a 31 year old, married, white, Jewish female. She attended 62 sessions of psychotherapy in 1965 when she was a City College Senior living with her parents. The followup interview was conducted at her home. It took approximately two hours fifteen minutes to complete.

Sally is a tall large woman with pretty facial features and short brown hair. She is soft spoken. For the most part she is open and direct but at times pulls back, leaving the interviewer with a slight feeling of unease as to what to expect. Most striking was the amount of at-

tention which she paid to her daughter, two year old Karen. When her child demanded it and even when she did not demand it, she was given a different toy to play with or the interview was interrupted so that a story could be read to her. Mothering is a full time job for Sally who interacts in an indulgent but warm and affectionate way with her daughter. For the five years prior to the birth of her child she taught elementary school. Three years before that she married and moved into her present residence.

In college Sally immersed herself in the academic and extracurricular activities that City offered. She started therapy because of her feeling that a relationship she was involved in was basically destructive. She believes that the most important feature of therapy was that she had her "own place to go to which was only mine," where she could talk about this relationship and understand to some extent why she put up with it. However, she did not feel that her therapy was helpful. While she admits that she may not have been ready and that she may not have been sufficiently mature to benefit from it, she does not feel that her therapist was particularly good. She was soft, gentle, tentative in her comments and responses to questions and in general "did not come across as a professional." Therapy was amorphous, and her therapist did not help her see what was happening or provide the guidance or advice which she was looking for. "She should have been more direct" and more forceful. College was somewhat overwhelming, lacking in structure, and Sally was looking for this structure in her therapy.

The relationship with her boyfriend ended several years later, "a little bit at a time . . . through the school of hard knocks;" when he took trips she experienced gradual disappointments and as she dated

other men she developed an increased awareness of what other relationships could be like. She feels that while therapy may have been a catalyst, the relationship would have dissolved anyway. She does not believe that therapy made any difference. "A salient feature is that I would have gotten to the point I got to regardless, although at the time I felt I really needed something."

Two years ago she entered therapy for the second time for the purpose of obtaining help for tremendous difficulties she was having in her marriage. She thinks that with the birth of her child she was shocked into the realization that she could not be as free and independent as she had been, that she was responsible for someone else's life and that this resulted in such stress in her marriage that she and her husband separated. This therapy was much more important to her, in part because her marriage was "on the line" and in part because her therapist was more able to be helpful. She viewed this second therapist as more personally confident and professionally experienced, better able to respond to questions which she put to her, and more active in ways that were more helpful, particularly in terms of encouraging her, even pushing her, to express certain feelings like anger. This therapy lasted a year and "was definitely helpful." Sally said that she was able to better understand the differences between her and her husband and to respect them. They got back together and are experiencing no major difficulties at present. "Comparing the therapy I had recently with the one at City" she noted, "I had difficulty expressing negative things, anger. I had the problem more so at City. I could have been helped with that, with being able to yell when something bothered me."

12. Jerry Borg

Jerry Borg is a 31 year old, married, white, Jewish male who attended 42 sessions of psychotherapy with two different therapists in 1967 when he was a Junior at City College living with his parents. The interview was conducted by telephone since Jerry is living in Chicago. It took approximately two hours to complete.

Jerry seems to be a personable man with a ready sense of humor and a full laugh. He appears to be sensitive and reflective and conveys the impression of having struggled actively with certain difficulties and of coming out of the struggle well. He is living in Chicago, his residence for the past seven years. He is married and has a son. He has just started a doctoral program in Psychology which he views as "the culmination of a long growing process." He said that he welcomed the interview as an opportunity to "look back on some of my experiences . . . somehow your questions come at an important time."

When he started college Jerry intended to major in an area of Science. However, he found the math requirements very difficult and began to fail classes in Calculus. He felt depressed and helpless. He tried to obtain specific help in study skills in a course which was advertised in the student newspaper but when he attended the class was disappointed and discouraged to find that the instructor used it as an opportunity to encourage people to explore their feelings about not doing well rather than offering specific help. When he started therapy at City two years later, he still wanted some help. While he did not expect to receive study skills, he did feel that his academic difficulties were real and he wanted to discuss them. But he found that "sometimes I would bring up school and it would be shuffled under the table and my parents

brought up." He did not find the "analytic approach" which his therapists assumed, sitting back and saying little, to be valuable. He does not recall his first therapist making more than one comment per session. While he recalls his second therapist as being more active and remembers two comments which he made, one questioning his tendency to go out with castrating women and a second addressing itself to his separation of intellect and feelings, he did not find these helpful. In fact he thought that the first remark was accurate but premature and as a result made him feel worse. At a time when he needed structure, some feedback as to how he was coming across and some help in focussing on what he should look at inside himself, he received none.

He believes that both of his therapists were inexperienced but felt more personally uncomfortable and dissatisfied with the second, whom he veiwed as pompous and who seemed to be "looking down his nose at me." He did recall one positive experience with his first therapist which occurred when she cried a little in the final session after he said, "Thank you very much for caring." However, with the exception of offering an opportunity to talk with someone, he found his therapy experience without value, an anti-model for what he believes therapy should be and something he would "never" recommend to a student "assuming they would have the same experience I had." Much more important to him at the time that he was at City were his involvements in various organizations such as the fraternity he belonged to, Freshman Orientation which he helped run, and an organization which he and several others founded which sponsored workshops at various universities. He had much more to say about these activities than about his therapy at the Psychological Center.

He believes that his decision to leave New York for Chicago at

the suggestion of a friend was an important one for him which allowed a "creative chaotic process" to occur. In order to work through difficulties he began experiencing in his relationship with the woman whom he later married, he became involved in several therapies. The first three were with individuals whom he left within short periods of time, in two instances because they began sharing intimate personal experiences which he considered to be anti-therapeutic. The fourth was with a woman who he believed was the most helpful and with whom he remained in treatment for three years. "She did some incredible therapy with me. She would concentrate her attention on me. I felt like she was completely with me. Just out of that process a lot emerges." She was firm but flexible. She was eclectic in her orientation using gestalt and transactional analysis techniques where helpful. He viewed it as a personal relationship but one in which there was no question who was the therapist and who was the patient.

A Few More Issues Raised

It was intended that the interviews conducted would raise questions and generate ideas for further research. Several questions are suggested by the summaries, a few of which are: how does perception of therapy relate to outcome of therapy? how good a judge is the patient of his or her own therapy? what is the relationship between diagnosis or character style and perception of outcome? and how does a person's current orientation about problem solving strategies affect perception of past experiences in therapy?

These questions as well as those raised in the first chapter will be considered in the next two sections.

B. DISCUSSION OF INTERVIEWS

Attitude toward Therapy

As evidenced in the above summaries, the 12 individuals interviewed in this study were generally ambivalent about their therapy experiences. They believed that certain features of their therapy had been helpful but that others had been not helpful. Overall their reaction might be described as modestly positive. Even so, a modest positive response stands in some contrast to the attitudes or findings which most followup studies have reported. Generally results have been more favorable.

Overall findings of other studies

Stone et al. (1961) found that 97% of the patients in treatment who were tested on the Ineffectiveness Scales improved their score (p. 415). Cowen and Combs (1950) found that 90% thought they had been helped, with 60% believing gains had been relatively complete (p. 257). Stewart (1972) found that 88% had either "recovered" or "improved" (p. 428). Bartlett (1950) found that 82% were much improved or somewhat improved (p. 393). Avnet (1965) found that 81% of the patients sustained recovery or improvement (p. 7). Feifel and Eells (1963) found that 78% of the patients reported one or more changes for the better (p. 315). Schjelderup (1955) found that 78% were very satisfied or satisfied with their therapy (p. 120). Klein (1960) found that 76.6% thought they had received "good improvement" or "very good improvement" (p. 164). Board (1959) found that 67% were successfully treated (p. 188). Malan (1976) found that 61% had improved with regard to the specific symptom for which they sought treatment. Strupp et al. (1969) found that 59% of

the patients in their study felt that they had benefited "a great deal from their therapy" (p. 63). Whittington (1960) found that 56% of those individuals who had come to the Student Health Service had benefited from therapy (p. 333). Luff and Garrod (1935) found that 55% were "much improved" or "improved" (p. 59). Meyer and Zegans (1975) found that 52% thought that therapy was "definitely helpful" (p. 13). And Pichel (1974) found that 40% felt that their contact with their therapist was positive and helpful (p. 143). The median figure for overall satisfaction for these studies is 77%. Such a figure of course provides only a rough estimate since the studies vary in quality and use different outcome criteria but it may be worth noting that that rough estimate suggests more satisfaction with therapy than was found in this study -- unless the category "helped slightly" or "helped somewhat" as opposed to "helped a great deal" is applied, in which case most respondents would qualify.

Before discussing the attitude of individuals interviewed in this study, a comment might be made about some of those studies in which positive response to therapy is lower than in others. Unfortunately Luff and Garrod and Pichel did not elaborate why people in their studies felt as they did. Whittington remarked only that of the 44% who reported that the Student Health Center was of no benefit "one can only speculate about the significance of this" (p. 333); but he did not do so maintaining rather that his results "may be somewhat more favorable than in other mental health centers" (p. 236). Meyer and Zegans noted that the individuals who believed that their therapy was unsuccessful did not attend as many therapy sessions as did those who were satisfied with therapy and did not feel that they received comfort, warmth or support in working things

out for themselves. Those who were ambivalent believed that whatever change occurred was not attributable to therapy. They perceived of therapy as some kind of game or ritual, a relationship lacking in an opportunity for collaborative exchange and an experience which did not meet their expectations. Board found that most people in his study had been successfully treated but enumerated certain qualities of those who, according to patients and therapists, were "failures." Half were in therapy for less than six months, all believed they had been discharged from therapy too soon, none felt they had "changed" in any meaningful way; and a few said they did not know what therapy was all about.

It was anticipated that utilizing an interview as opposed to a questionnaire as a way of understanding attitudes toward therapy might result in less than clearcut positive impressions of the therapy experience. While negative or ambivalent responses may be reported in questionnaires, they can not be pursued (by an interviewer) and thus may remain unclarified or unelaborated. It is also possible that the generally ambivalent attitude of individuals in this study occurred because they were asked for "the bad as well as the good." If those studies are eliminated from consideration which involve objective measures of "outcome" as opposed to attitude toward therapy (Malan, McNair et al., Masterson, Stone et al., and White et al.) or which are poorly designed, that is, conducted by the original analyst (Assum, Deutsch, and Sager et al.) or including two subjects or less (Assum, Deutsch, and Pfeffer) only four remain, those carried out by Cowen and Combs, Klein, Meyer and Zegans, and Rogers and Dymond. And none of these involved a long followup; that is, their followups were several years shorter than in this study, which is what distinguishes this study and which may explain its ambivalent

findings to some extent.

It is possible that after time, after some distance from termination of treatment and the reaction that accompanies this, a reaction which may last several years, that individuals retain some sense of what is positive as well as being able to more clearly elucidate what is negative. Perhaps this occurs because they are able to put their therapy experiences into the context of other life experiences, particularly other therapy experiences, with which they can compare it. This tendency to enumerate negative as well as positive qualities of therapy over time is most clearly discussed by Feifel and Eells (1963) who administered openended questionnaires to the same individuals at termination and again four years later. They found at the time of the followup that "the patients vent displeasure and specify discontentment more openly and clearly than heretofore, 95% doing so compared to 43% previously" (p. 316). There was a noticeable fall-off in the "everything was helpful" category from 37% to 20% (p. 315) with examination of the nonhelpful areas showing that faultfinding centered mainly on the therapist's professional skills. There was an increase in people "speaking up" and offering suggestions about their therapy with only 13% of the patients failing to do so at the time of followup compared with 35% originally" (p. 316). "The past statistical difference in the area of 'nothing was nonhelpful' has disappeared in the wake of the patients' sharpened self expression" (p. 317).

Positive and negative attitudes expressed

In this study too there is a "sharpened self expression" by individuals concerning the negative as well as the positive aspects of

their therapy. Why they "speak up" will be considered in subsequent sections of this chapter. What they speak up about will be considered next.

Asked what they liked least about their therapy or their therapists individuals responded: "to me it was a negative model" (Jerry Borg); "probably nothing in regard to the type of person he was" (Richard Doran); my therapist wasn't strong enough . . . she didn't strike the right thing" (Sally Ehrlich); "he was so damn nervous . . . really I have seen very few people who seem so nervous, he was so unsure of himself" (Rebecca Feiner); "my therapist seemed secretive . . . I never heard an interpretation" (Mark Geller); "I think the fact that he followed the Tavistock model" (Linda Kellar); "I wanted more of a free exchange" (Jim Myers); "I have an image of his incompetence, inexperience" (Gloria Rieser); "there's hardly anything negative. I'm not sure that this has any bearing but he wouldn't take any action and get me out of the draft. He said he wasn't allowed to" (Elliot Roth); "no direction" (Donald Schiller); "the fact that it was so short" (Irene Silverman); and "when the time was up" (Mary Spinelli).

It is apparent that a few of the above "dislikes" were really positive responses to therapy: the fact that there was nothing that stood out that was negative and the fact that sessions had to end. In most instances however criticisms were volunteered about therapy before specific questions were asked. This was true for other areas also. In fact the tendency of individuals to offer comments in a spontaneous and unsolicited manner, often including personal anecdotes, was one of the main advantages of using an interview. But including a few focussed questions such as those which asked individuals to single out aspects of therapy or qualities of the therapist that they liked or disliked the most

was also valuable. If the above four individuals who were generally pleased with their therapy are not considered, of the remaining eight who were ambivalent, more negative than positive comments were offered.

An ambivalent or somewhat negative attitude toward therapy is reflected in the response which individuals offered to the question "would you recommend the Psychological Center to a student at City interested in therapy?" Two, Richard Doran and Elliot Roth, offered a clearcut "yes"; one, Jerry Borg, said "never, assuming they would have the experience I had"; and nine qualified their response with comments such as "I'd have to see the person; if they were really into themselves (understood themselves), it wouldn't do that much good" (Mark Geller); "I would tell him to go and also tell him what to look for; he has a right to say 'that's good, that's not good'" (Donald Schiller); "he should try to find out if he will get advice, see who the therapist is . . . it all depends on the therapist" (Jim Myers); "yeah, but I'd (say) to be careful . . . if the person is not overly directive and tells you to do what is not really you" (Irene Silverman); "maybe if problems are severe, therapy is a good idea but not the Psychological Center; (the person) would need someone more experienced" (Gloria Rieser); "it would depend on what the problem was and how disturbed they were; if they were really disturbed the Psychological Center would not be the place" (Linda Kellar); and "I think it would depend on how disturbed they were; I don't think (my therapist) should have worked with anyone who was too disturbed; more disturbed patients can evoke more anxiety; they (patients) should be more together."

To the question, "would your life be any different if you had not been in therapy?" four answered "no" while the others, with the exception

of one, Richard Doran, were equivocal. In response to the question, "if you could have changed anything, what would it have been?" only one, Richard Doran, said "I can't think of anything." Everyone else offered suggestions, some of which included: "I think I would have wanted a therapist who was more involved" (Linda Kellar); "more support, guidance, interpretation. I was really interested in my mind and could have used this" (Mark Geller); "more problem solving" (Donald Schiller); I would have requested a male therapist . . . also more direction to therapy" (Sally Ehrlich); "a stronger sense of direction . . . not merely advice, some suggestion as to what can be done" (Jim Myers); "(I) would have liked a combination of group therapy and individual therapy . . . having a good therapist is the main thing" (Elliot Roth); and "a different therapist . . . at that point either I shouldn't have been in therapy or I should have been in it with someone more skilled . . . I would have suffered less if the person knew how to handle the situation" (Gloria Rieser).

Qualities of the therapy or therapist that individuals seem to appreciate least have to do with the perception of a lack of activity, structure or direction on the part of the therapist or the sense that their therapist was not as experienced or skilled as they would have liked. More will be said about each of these in subsequent sections.

It might be noted, however, that no one felt that his or her therapy was detrimental, although Jerry Borg believed that it was of no value and Gloria Rieser said that "it made me feel more inadequate; it was torturous; it was another person making me feel inadequate about myself." It is possible that had Gloria been asked about therapy at the time of termination that she might have said it was detrimental but that with the passage of time it did not seem as painful: not helpful but not

detrimental.

Asked what they liked most about their therapy or their therapist individuals responded: "good in the sense that I had someone to talk to" (Jerry Borg); "he was cute; he seemed to take an interest; he seemed very sincere" (Richard Doran); "I saw it as my own private personal place to go to which was only mine" (Sally Ehrlich); "he tried hard; for a three credit course I never would have put all that into it; he really worked very hard to understand me" (Rebecca Feiner); "his warmth, the way he spoke" (Mark Geller); "I could talk about my ideas and concerns and get out some of the guilt" (Linda Kellar); "she seemed warm, understanding" (Jim Myers); "the times when he gave me support" (Gloria Rieser); "reassurance, support" (Elliot Roth); "he was a nice guy; he was a regular guy" (Donald Schiller); "the fact that I could understand my actions better and it helped me accept myself more than I had originally" (Irene Silverman); and "letting out the anger, frustrations and confusion . . . the bottled up things I couldn't lay on my friends" (Mary Spinelli).

Qualities of the therapy or therapist that individuals appreciate the most have to do with the opportunity to ventilate feelings, sometimes intense feelings, in an atmosphere of warmth, support and understanding. Cowen and Combs (1950) state, "perhaps the single most universal feeling expressed by these individuals (in his study) has been that growth from the point of view of the client has been made possible through the friendliness, warmth and understanding of the counsellor . . . the contribution of the counsellor's warmth cannot be overestimated" (p. 247).

One of the interesting, although not surprising findings of this study, was that the ambivalence which people seemed to feel about their

therapy was expressed toward the interviewer. Some of the ambivalence could have reflected generally negative feelings about being included in a research project but it seems to be more than that. Almost everyone displayed some behavior that suggested a particular reluctance about participating. Two failed to keep their appointments without advising the interviewer in advance (subsequent appointments were scheduled); two took a very long time to return the questionnaire, doing so after two reminders; one suggested a time that she could be called for a followup interview and when the researcher called, found that the line was busy because the phone had been taken off the hook. One changed appointments twice. On the other hand, some expressed a willingness to be helpful, particularly students, who seemed to want to assist a fellow student by volunteering two hours of their time even though they were very busy. Klein (1960) found that individuals who felt gratified or enthusiastic about being contacted rated their improvement as higher, while individuals who felt dissatisfied and reticent about being interviewed reported some but less improvement than the group that was eager to come to the interview (p. 163). In this study ambivalence about being contacted or interviewed was reflected in an overall ambivalent reaction to therapy.

Before taking at face value what individuals report as their response to therapy, particularly their negative response, some of the possible factors which influenced this might be considered.

Factors influencing attitudes

People generally believe that if therapy worked, if the problem for which they sought treatment was resolved, then therapy was good but that if it did not "work," then it was not good. This is understandable.

But perhaps if individuals believed that they benefited from treatment somewhat but not as much as they would have liked, they might react more negatively than if treatment had met their expectations. Since expectations can influence attitudes about therapy, this may have occurred in some instances. Borin (1974), for example, found that favorable expectations about therapy were related to favorable outcome. More will be discussed about the expectation which several individuals expressed that their therapist would provide direction and advice in the section on "Technical Aspects of the Therapy." An underlying, often unexpressed expectation was probably for some kind of magical cure. Sally Ehrlich stated "I imagine they (expectations) were that I would talk about what was troubling me about the relationship and I would miraculously be persuaded how to deal with the person." Mary Spinelli was hoping for "Enlightenment about what would be the proper attitude to take." Disappointment that cure or enlightenment was not obtained could have influenced attitudes about therapy. On the other hand, as was noted earlier, with the passage of considerable time following therapy several individuals seemed to realize how long it takes to resolve certain difficulties and may have felt that therapy provided the first step in a long process. This will be discussed further in the section "Significance of Other Life Experiences."

It is possible that an individual's feelings about his or her therapist could color feelings about the helpfulness of therapy or vice versa. This may have occurred in a positive direction in the therapy of Richard Doran who liked his therapist and who thought that his therapy was helpful. But in more instances than not there appeared to be an ability to discriminate between the two. In fact, the capacity of indi-

viduals to discriminate about various aspects of their therapy was one of the important findings of this study. Elliot Roth thought his therapist was very nice and very pleasant but questioned at times how good a therapist he was. Gloria Rieser found her therapist to be formal and stiff but believed that as a result of her therapy she was able to begin to stand up for herself in relationships with men. Linda Kellar found her therapist to be passive authoritarian but felt that as a result of her therapy she was able to leave home, an important achievement. And Rebecca Feiner considered her therapist to be insecure and "so damn nervous" but believed that her therapy was very successful and that without question it made a difference in her life.

It is possible that individuals expressed an ambivalent attitude about therapy at City because they found it difficult and painful as opposed to pleasant or supportive. This may have been true in the therapy of Gloria Rieser who felt that it was painful and that it made her feel more inadequate. But in general this was probably not true. In several instances individuals reported entering subsequent therapy which was also difficult and painful but which they indicated had been better. The issue of further therapy will be considered in detail when level of experience and its perceived impact on therapy is discussed.

It is possible that feelings about termination influence individuals' retrospective views of therapy. The fact that patients who were interviewed had strong feelings about stopping, in some instances before they might have wanted to, is reflected in the fact that they were unable to remember the circumstances of their termination very clearly. Jim Myers said that he was not sure how therapy ended but believed it stopped when he told his therapist that he did not want to continue after she re-

fused to give him advice about a sexual problem. Later in the interview he remembered that therapy ended because she had to leave for an internship.

The most common reaction expressed with regard to ending therapy was sadness but it is possible that there was also anger and that this emotion negatively influenced individuals' subsequent perceptions of their experience. Cowen and Combs (1950) reported that patients in their followup study expressed feelings of "implicit rejection" which seemed to color their reaction to therapy. This appears to have been somewhat true in several therapies and definitely true in at least two, those of Mary Spinelli and Irene Silverman. Mary commented, "I remember I felt hurt when the breakoff came. She didn't seem upset about it. If she only would have cried and stomped her feet." And Irene, who commented that she wished her therapy hadn't stopped, went to her therapist's home after terminating therapy and felt rebuffed when her therapist would not be her friend. Even so, this did not negatively color her impression of her therapy; she thought her experience had been a very good one. It might be noted that everyone's reaction was not as strong. Mark Geller seemed to be expressing the sentiment of a few individuals when he remarked, "If all things (had stayed) the same I would have continued for a while but it wouldn't have taken much for me to stop."

It is possible that feelings about therapy may be reflective of feelings about City College, that is, if individuals found their life and experiences at City to be positive they may have felt this way about therapy too, especially since its setting was in a building where courses were offered. This does not seem to have been the case, however. More often than not individuals interviewed indicated a sense of satisfaction

and excitement about being in college but considerably less enthusiasm about their therapy. This further illustrates their ability to discriminate.

It is possible that some individuals express a negative attitude toward their therapy experience because with the passage of considerable time since being in treatment they have come to adopt a different orientation. Gloria Rieser, for example, believes that the Women's Movement benefited her much more than did any of her three therapy experiences. Certain other individuals who entered further therapy seem to have adopted an orientation similar to that of their second therapist, although it is possible that they sought out a therapist with a different orientation as a result of a negative experience with therapy at City. This may have been at least partially true for Jerry Borg who was the most dissatisfied with his experience at City. In two instances individuals who were seen by students at City applied to doctoral programs in Clinical Psychology and were turned down. It may be that this embittered them about their experience at City and led them to adopt an orientation different from the one they had experienced in their therapy. This does not appear to have happened with Rebecca Feiner; she was rejected from Clinical Psychology Programs but entered a long-term analytic therapy, similar in orientation to that at City. It appears that it may have occurred with Donald Schiller; he has become adamant in espousing a style of therapy very different from that offered at City.

It is possible that negative feelings about therapy may be related to an experience other than an individual's personal experience in therapy. Linda Kellar indicated after discussing her mixed reaction to therapy that "I think the negative feelings come from my experience of

my husband's therapy. He graduated after I did. He had a therapist who was a very insecure guy, who used the Tavistock model to hide behind. I may have transferred some of these feelings to my therapy."

Perceived Helpfulness of Therapy

"Outcome" of therapy includes various components, such as attitude toward therapy, an individual's subjective perception of the change that occurred, and an objective measure of what therapy accomplished. The focus of this study has been primarily on attitude, although it has also included individuals' comments about their perception of change(s) that occurred. Since no pre or post tests were administered and in most cases records were not read so that a comparison of the therapist's clinical impression with the researcher's clinical impression is not possible, there can be no objective assessment of outcome. Before considering the second component, subjective reporting of change that occurred, consideration should first be given to the reasons that people sought treatment.

Presenting problems and initial diagnosis

Most individuals entered therapy because they were having interpersonal difficulties, ranging from either a general feeling of loneliness and of having no friends to a specific dissatisfaction with a relationship in which that person was involved. It is of some interest that while all spoke about problems in interpersonal relationships men discussed sexual difficulties more often and more openly than did women. It may be that sexual problems are more disturbing to men who may feel that in experiencing impotence in particular that their "identity" as men is more called into question than is true of women experiencing sexual problems. It might be noted that a review of a few of the intake reports

confirms that individuals accurately remembered their reason for seeking treatment.

In terms of the particular difficulties with interpersonal relationships which were cited, Richard Doran, Elliot Roth and Irene Silverman indicated that they wanted to meet someone with whom they could develop a relationship and sought help to discuss their fears and wishes about becoming involved. Sally Ehrlich, Linda Kellar and Gloria Rieser were interested in discussing relationships in which they were currently involved, relationships which they considered to be detrimental in some way. Mark Geller wanted to understand the sexual difficulties he was experiencing in specific situations. Mary Spinelli and Jim Myers were having difficulty in their relationships with their parents, and Jerry Borg and Rebecca Feiner were having general difficulties with academic pressures and interpersonal stresses related to overinvolvement in a variety of activities.

Individuals were diagnosed by their intake interviewers in 10 instances as having a personality disorder and in two instances as having a neurosis, the most common diagnosis being Personality Disorder, Passive Aggressive -- Passive Type. No personality disorders were considered to be severe. The two individuals with diagnoses of neurosis appeared to be doing better at the time of the followup; but this sample is too small to allow any conclusions to be drawn. While an individual's character style did not seem to influence outcome, it may have had an effect on perception of the therapy experience. For example, Richard Doran and Irene Silverman appeared to be generally uncritical while Rebecca Feiner and Jim Myers appeared to be very critical. The positive attitude toward therapy of Richard and Irene may have reflected some lack of critical judg-

ment. But the converse did not appear to be true. Rebecca and Jim were not especially negative. Their tendency to be critical enabled them to better discriminate among different aspects of their therapy, the good as well as the bad.

Help received

What were the changes that occurred with regard to the problems for which treatment was sought? It was noted in the introductory chapter that the areas most frequently cited as those in which change occurred through therapy are an increase in self esteem, improved interpersonal relationships, an increased sense of mastery, and greater insight. It is possible that it is because individuals sought help with difficulties with close relationships that this was the area of greatest change. Richard Doran and Elliot Roth entered their first relationships. Jim Myers and Mary Spinelli changed the quality of their relationships with their parents. Gloria Rieser believed that she started acting differently with the men she was involved with. Linda Kellar broke off with her boyfriend although she was not satisfied with the change she experienced, believing that she ended the relationship before she was ready, doing so mainly because she was saying, "look, I'm in in therapy, see what I can do."

The above would be examples of "behavior changes." There were other individuals who credited their therapy not with a change in behavior but with the development of insight. Donald Schiller believed that he received no help in terms of problem solving strategies but thought that he developed some insight and experienced some catharsis. Sally Ehrlich felt that she was able "to understand maybe a little bit why I put up with things" although the relationship in which she was involved persisted for

several years following therapy. Mark Geller believed that "therapy didn't resolve the difficulty with the band but it got me to think. It started me being more introspective." Irene Silverman felt that "therapy forced an awareness in present day situations of what I feel worthless about." Rebecca Feiner considered that there were changes in both insight (her understanding of her fears about entering a relationship) and behavior (her ability to enter a personal and a therapy relationship after terminating at City). Feifel and Eells (1963) found that after the passage of time changes in behavior assumed more importance than did changes in insight. It is difficult to evaluate whether this is true in this study. There appeared to be changes in behavior in some instances and changes in insight in others, but what is clear is that almost all changes involved the area of interpersonal relationships.

Some individuals considered that the changes which they experienced were not that great and believed that more was not accomplished in their therapies in part because their therapist was not skilled and in part because they were not "ready" to be helped. Comments included: "I don't know how much was my problem and how much was his" (Jerry Borg); "Maybe I wasn't ready" (Sally Ehrlich); "I was battling with authority at that time" (Linda Kellar); and "I was very critical at the time. I was hostile. I don't think I would be so much that way now. I don't know how much of a chance I gave him" (Gloria Rieser). It is interesting that people interviewed seemed able to evaluate what was negative as well as positive about their therapy experience and to blame themselves as well as their therapists for its deficiencies. It might be asked whether this tendency to cast mutual blame would be as true of therapists who in assessing outcome often attribute lack of success to the patient's "re-

sistance" or problems.

Barrett-Lennard (1975) notes, "The periodic, visible shifts or movements in self-identity . . . qualities and choice of relationships and other life-patterns can arise from intensely involving experiences that the person is probably 'ready' for" (p. 22). Richard Doran and Elliot Roth who became involved in relationships during their therapy believed that they may have been "ready" for such involvement. In fact in both instances personal relationships occurred at the same time as their therapy. For both the positive experience of therapy paralleled the positive experience of the relationship in which they became involved. It is difficult to say which affected or influenced the other, whether the positive therapy experience was reflected in the positive personal relationship or the positive personal relationship was reflected in the positive therapy relationship. But there was a readiness to enter a relationship that would be productive. This stands in contrast to the lack of readiness of both Sally Ehrlich and Gloria Rieser to break off relationships which were nonproductive. Their feelings of annoyance and anger about these relationships may have been reflected in their experience of therapy or of their therapist.

Overall, with the exception of Jerry Borg, therapy seemed to provide everyone with at least modest help in beginning to resolve major difficulties and a few with significant help. While changes might have occurred in behavior or insight without therapy, in some instances therapy appeared to make a difference that could be pointed to. For example, Jim Myers and Mary Spinelli benefited in a way that might not have occurred had they not entered therapy. The realization, insight or change which occurred as a result of therapy (for Jim that he could stand up to

his mother and for Mary that she could be angry about what happened when she was thirteen) was not being offered in any other way, that is, by any other therapy or personal experience.

In general, it would seem that the changes that occurred as a result of therapy were somewhat more positive than the individuals' attitude toward therapy. This may be because, as was noted earlier, attitude is influenced by various factors (including the expectation that therapy will be different, an individual's personal reaction to his or her therapist, feelings about termination, and the adoption of a different orientation since being in treatment).

Significance of Other Life Experiences

One of the reasons it is difficult to determine how effective therapy was in terms of the changes that occurred (and this must be true in other studies where outcome is measured objectively) is that in several instances individuals were involved in experiences outside of therapy which were influencing the difficulties for which they sought help and which in some cases they believed were more important in helping them resolve these. Schjelderup (1955) uses the phrase "doubtful" to describe change that occurs for the better or greatly for the better but which is related to change in external life situations.

Group experiences

Several individuals, Jerry Borg, Rebecca Feiner, Linda Kellar, Elliot Roth and Donald Schiller, were involved in group activities at City such as Houseplan (similar to a fraternity), Freshman Orientation (designed to assist freshmen in their adjustment to college), and Ricorso (an organization which sponsors various groups and offers seminars on

psychological topics, predominantly with a Gestalt orientation); or they were enrolled in group courses (based on Tavistock principles) and were active in the group experiences which accompanied them. Jerry Borg and Rebecca Feiner participated in as many of the above as possible; Rebecca noted that there was a period during her college days when she was involved in six hours of "therapy" activities per week, one two of which were therapy at the Psychological Center. This illustrates the difficulty of assessing "change" as a function of therapy. The willingness or eagerness of individuals to enter group courses or experiences also suggests a readiness to work on interpersonal difficulties which they felt they were experiencing.

Two individuals, Jerry Borg and Donald Schiller, believed that their involvement in the various groups was much more beneficial to them than was their therapy. Donald developed an interest in Psychology which he chose to major in but attributed this decision to his experience in Ricorso and Houseplan rather than to his "individual therapy." The Ricorso program was "a plus," a bigger plus than was therapy and Houseplan was "a double plus." He felt that the people in these groups "treated me like a human being. They were more active, confrontative and one of the people who ran the group was very good." Jerry felt that he was able to experience a sense of potency and accomplishment as well as to receive support and encouragement from other people through his involvement in Freshman Orientation and an organization which he and several others founded. In these activities he and the other participants were active and involved, in contrast to his therapy where his perception was that neither he nor his therapist was "involved." Both Jerry Borg and Donald Schiller seemed eager, at times almost desperate, for

feedback which groups offered but which individual therapy did not.

On the other hand Linda Kellar found her therapy more helpful than her group experience but remarked that she had stronger feelings toward the person who taught the group course. Rebecca Feiner and Elliot Roth believed that the combination of individual therapy and the group experience was a valuable one. Rebecca suggested that her experience in individual therapy gave her the opportunity to ventilate about what disturbed her in her group experience and to understand why she was concerned. Elliot believed that he learned to be active and confrontative in his group experience while deriving support and reassurance from his individual therapist. "Instinctively" he believes that group therapy may be the more valuable of the two but thinks that a combination may be ideal.

Significant events

The above could be viewed as therapeutic or semi-therapeutic activities. In terms of other life experiences or relationships, how important or significant does therapy appear to be? Asked to list between five and 10 happenings or experiences within the past 15 years that had been especially eventful, only five people, Sally Ehrlich, Jim Myers, Elliot Roth, Irene Silverman and Mary Spinelli, cited therapy at City as one of these and only three, Jim Myers, Irene Silverman and Mary Spinelli, indicated that therapy had been helpful in a particular way (see Page 2 of Appendix E). Irene specified that it had "had an enhancing effect on (her) basic sense of worth as a person." Jim specified that it had "helped (him) become more self-reliant" and Mary specified that it had "confronted (her) with some fundamental pattern or quality in (herself),

such that (she) became more self-knowing in some important way." It was noted earlier in this chapter that therapy seemed to result in some but limited change in the area of enhanced self esteem, development of insight, improved interpersonal relationships and an increased sense of mastery. How did individuals in this study understand changes that occurred in these areas; that is, if therapy did not make a difference, what did?

Events which had an effect on enhancing and deepening people's interpersonal lives were noted as: becoming involved in one's first close relationship (Jerry Borg, Rebecca Feiner, Jim Myers, Elliot Roth, Irene Silverman, and Mary Spinelli), moving in with that person (Irene Silverman), getting married (Mark Geller and Gloria Rieser) or separating from a partner (Sally Ehrlich, Rebecca Feiner, and Linda Kellar). Others included leaving home (Jerry Borg), travelling (Jerry Borg). attending college (Richard Doran and Gloria Rieser), taking college seriously (Jerry Borg), becoming serious about graduate studies (Mark Geller and Donald Schiller), beginning a particular job (Richard Doran, Mark Geller, and Donald Schiller), the birth of a daughter (Sally Ehrlich), mother's returning to school (Jim Myers), mother's death (Jim Myers), participating in a women's group (Gloria Rieser) and therapy experiences subsequent to therapy at City (Jerry Borg and Sally Ehrlich). Beginning involvement in a relationship, increasing involvement in a relationship or separation from a partner appear to stand out.

Events which had an effect on increasing an individual's sense of self worth were becoming involve in one's first close relationship (Jerry Borg, Richard Doran, Rebecca Feiner, Elliot Roth and Irene Silverman), having an affair (Mark Geller and Linda Kellar), marriage (Mark

Geller and Gloria Rieser), the birth of a child (Sally Ehrlich and Mary Spinelli), separating from a lover (Rebecca Feiner), becoming serious about school (Jerry Borg and Mark Geller), leaving home (Jerry Borg, Linda Kellar, Elliot Roth and Donald Schiller), taking a trip (Donald Schiller), the first job (Gloria Rieser), a successful job or career choice (Jerry Borg and Jim Myers), a decision to change jobs (Rebecca Feiner), becoming serious about school (Jerry Borg and Mark Geller), involvement in Eastern philosophy (Jim Myers), joining a Women's Group (Sally Ehrlich and Gloria Riesner), therapy experiences subsequent to therapy at City (Jerry Borg and Sally Ehrlich), and leaving therapy (Donald Schiller). Some type of involvement in a close relationship or decision about school or a job appear to stand out.

Events which had an effect on increased self reliance or mastery were noted as separation from a lover (Sally Ehrlich, Rebecca Feiner, and Linda Keller), separation from parents in the form of leaving home (Elliot Roth), attending college (Rebecca Feiner) or leaving New York for a job (Donald Schiller) or a vacation (Richard Doran and Gloria Rieser), beginning a job (Mark Geller and Gloria Rieser), making a decision about a particular career choice (Rebecca Feiner and Mark Geller) or achieving success in a job or career (Mark Geller and Jim Myers), having an affair (Mark Geller), the birth of a daughter (Sally Ehrlich and Mary Spinelli), acceptance into Graduate School (Donald Schiller), entering a relationship and becoming involved with that person (Irene Silverman), an important fight with a spouse (Elliot Roth), involvement with Eastern Philosophy (Jim Myers), therapy at City (Jim Myers), therapy subsequent to therapy at City (Jerry Borg and Sally Ehrlich) and participation in a Women's group (Gloria Rieser). Some form of separation or sense

of achievement through school or work appear to stand out.

While therapy at City is not mentioned and while most of the events cited appear to have occurred after termination, it appears that therapy may have had an influence, particularly in those areas in which difficulties with close interpersonal relationships were discussed. In fact individuals did view therapy as having been of some value in helping with their beginning involvement in and subsequent problems which developed as the result of close relationships. Separating from individuals with whom they were involved does not seem as attributable to therapy, except in certain specific situations such as Linda Kellar's leaving home. Separation came later and may be related to other factors. Sally Ehrlich believed that as the result of experiencing gradual frustrations and disappointments as well as allowing herself more positive experiences with other men she was able to finally end the destructive relationship in which she was involved. Gloria Rieser believed that separation from men who were not good for her came as a result of her adopting a different view or understanding of her "problem." Others, Rebecca Feiner, Linda Kellar and Elliot Roth, commented that therapy experiences which followed their therapy at City allowed them to see patterns which resulted in relationships ending sooner than they might have otherwise.

Mark Geller observed that he did not list therapy as an event of importance because it seemed more like a process than an event, "like the development of political awareness," which could not be cited as an event. Still, certain "processes" such as subsequent therapy (Sally Ehrlich and Rebecca Feiner) or participation in Women's Groups (Sally Ehrlich and Gloria Rieser) or participation in sensitivity training (Jerry Borg) and the Ricorso program at City (Donald Schiller) were listed and seemed more

important. In general individuals indicated that another therapy experience, particularly subsequent therapy, was more meaningful than their experience at City. This will be discussed in a later section of this chapter.

Helping relationships other than therapy

Gurin et al. (1960) have reported that individuals often find people other than therapists, such as physicians or clergymen, to be more helpful to them in dealing with problems. This was generally not the finding of this study although it may be that if individuals are invested in seeing therapists that these are the individuals they will seek out if they wish help, and not physicians or clergymen. An exception to this was Irene Silverman who sought out a rabbi at the University of Nebraska because she was concerned about the fact that her boyfriend was not Jewish. While she did not receive outright support for her involvement in the relationship, she did believe that his attitude was mildly positive when he said that her boyfriend seemed to be a very good person and "that he was Jewish in his qualities and sensibilities."

In terms of personal relationships that were important almost all individuals indicated that the close relationship in which they were currently involved was very important to them and offered an opportunity for sharing. Two examples were cited in which personal relationships were viewed as being as important or possibly more important than therapy in helping resolve certain difficulties. Mark Geller believed that the most important relationship for him was the one with his wife. "We can talk. All these things we speak about. She would let me try anything. She hated the band and it was a factor in my stopping. She gave me support as far

as the band was concerned. I don't know if I could have faced (these) alone. The fact that she was there was major." Elliot Roth stated that "the first girl I went out with may have been as important or more important than therapy. I was dependent and passive. She pushed me. She was more aggressive. The relationship ended but I recognized that being passive was not the way to be. I gradually changed. She said toward the end that I was different, more aggressive." In both of these instances individuals were more able to resolve or begin to resolve an area of difficulty because either someone was available to talk to and provide them with support or to push them in a way that was helpful.

Most individuals had friends who were helpful to them although everyone saw friends as being different from therapists in terms of the help which they could provide. Most people expressed the sentiment that it was possible to be more open with a therapist because he or she was not a part of the individual's personal life. The advantage of the therapist was that he or she assumed an objective and nonjudgmental position and a detachment which allowed "you to get into your life and untangle (it)." The therapist is a stranger but at the same time "someone you can talk more freely with." The disadvantage was that he or she often did not provide the desired feedback or information which a friend would offer, nor was the therapist available for discussing a problem at the time of a crisis or when the need was great. Sally Ehrlich said she believed that in most instances an objective point of view was not crucial but that when a crisis arose and such an objective point of view was needed that a therapist could be more helpful than a friend. Most individuals seemed to feel that there was at least one individual with whom they could speak relatively openly and that that was important for them.

Even with the intervention of therapeutic and personal relationships the problems for which individuals sought treatment have not necessarily disappeared. They have improved but in many instances they remain. Irene Silverman still has deep questions about her self worth. Richard Doran has become involved in several homosexual relationships but still does not seem comfortable with his homosexuality. Linda Kellar continues to have some difficulty with men abusing her; last year she was attacked by her boyfriend. And Elliot Roth says his life is good but he is not sure how happy he is and is still bothered by his problem with assertiveness. On the positive side all of these individuals seem aware of areas which disturb them and convey a sense of struggling with them.

Therapy and the Therapy Relationship

If therapy made a difference in some way, what was it about the therapy that was perceived as helpful in producing change and if it did not, what was it about the therapy that was perceived as being limiting? The point of view of this researcher is that it is a therapy which is comprised of both personal and technical qualities, with the personal qualities being primary. Those cited in the Introductory Chapter, that is, empathy, liking, similarity and therapist sex, will be considered first. The technical qualities, including a discussion of the transference, will be considered next. The conceptualizations of Horwitz will be considered last.

Personal aspects of the therapy

Empathy

Most of the studies that attempt to relate empathy to outcome

indicate a positive correlation between perceived empathy and evaluation of helpfulness of therapy. Board (1959), Cowen and Combs (1950), Feifel and Eells (1963), Mendelson and Geller (1965), Meyer and Zegans (1975), Sloane et al. (1975) and Strupp et al. (1969) found that the presence of therapist warmth or empathy were considered by patients to be instrumental in allowing them to experience more positive feelings about themselves. An interesting finding of this study is that while most individuals believed that their therapist was empathic, that is, that he or she was generally sensitive, understanding and respectful (of them), most did not believe that they were helped or benefited a great deal and that positive gains were modest. Examples of several comments made about therapist empathy were: "It was a good feeling. He was understanding. I never felt in any way that he was condescending or condemning of what I did or said" (Richard Doran); "Yeah, basically she was (sensitive and understanding) but she kept her objectivity" (Irene Silverman); and "He cared about what was going on" (Donald Schiller). One individual, Gloria Rieser, allowed that her therapist may have been empathic but that because of her hostile attitude she "did not think so at the time . . . to a certain extent he was (empathic) but I didn't allow him to be too much." A comment made by Donald Schiller represented the sentiment of several others: "Yes (he was sensitive) but he didn't know what to do with it." This will be considered in the section on "Therapist's Level of Skill." The fact that individuals believed that their therapist was empathic but that they were not helped very much further illustrates their capacity to differentiate aspects of their therapy experience.

Patient liking therapist

For the most part people reported that they liked their therapists. This tendency was accompanied by a tendency to dislike certain qualities and further points to their capacity to discriminate aspects of their therapy. Mullen and Abeles (1971) also found that empathy and liking do not predict successful outcome.

Similarity between patient and therapist

In most instances individuals interviewed did not believe that they were similar to their therapists. They felt that they were similar "only in that we lived near each other " (Linda Kellar); "only in our mutual interest in psychology" (Mary Spinelli); but different "personalitywise" (Richard Doran); "no, he was more like my father" (Rebecca Feiner). Perceived similarity did not appear to have a significant effect on therapy or on therapy outcome. Perceived dissimilarity appeared to be of more importance. Sally Ehrlich considered that she and her therapist were "physically very dissimilar. She seemed very self confident, self centered" in the way that Sally would like to have become; but "I didn't get that way," a factor which may have contributed to her dissatisfaction with therapy. She seemed to like her therapist as a person but not her therapist as a therapist, illustrating a capacity to discriminate. Gloria Rieser regretted that she and her therapist were not similar, "you know I think that's important." She appreciated the peer identification or modelling in her subsequent involvement in consciousness raising groups. Elliot Roth felt that he and his therapist were dissimilar but that his therapist seemed to provide a good model: "He was assured and calm. I was nervous and insecure." It would seem that per-

ceived similarity is not detrimental and that it can be an asset. Perceived differences where the therapist possesses qualities valued by the patient can also be of value.

Therapist sex

Four individuals were seen by female therapists, seven by male therapists and one by a woman, then a man. Asked during the interview if they would have preferred a therapist of the opposite sex five said yes, four who had been treatment with a male and one who had been in treatment with a female. As had been anticipated in the Introductory Chapter, individuals who were satisfied with their therapy experience were satisfied with the sex of their therapist and those who were dissatisfied with their therapy were dissatisfied with the sex of their therapist. For example, Gloria Rieser and Linda Kellar who saw male therapists and who became involved in women's groups following therapy believed that they received support and reality testing from women in these groups and would have preferred seeing a woman for therapy. Sally Ehrlich who was one of the most dissatisfied with her therapist because she did not consider her strong enough would have preferred seeing a man. It seems that individuals who felt that their therapy was lacking in some way considered that the deficiency might have been compensated for in the imagined qualities of a therapist of the opposite sex.

Technical aspects of the therapy

The technical qualities of the therapy include interventions which the therapist makes, particularly those which promoted the development of the transference, although others will be mentioned as well.

Transference

The nature of the transference as described by patients was difficult to ascertain. Perhaps recollection of specific aspects was limited because the therapy was short and because a considerable amount of time had passed since termination. Most individuals did not recall having many intense feelings toward their therapist and for the most part remembered only the experience and expression of strong feelings toward one or both parents or the individual with whom they were involved. With one exception they did not remember any transference interpretations.

However, it is apparent from what has been discussed that there were transference feelings toward the therapist which were at times strong. Some of these could be understood in terms of the attitude expressed toward the interviewer. Pfeffer (1959), who maintains that transference residues can be examined toward the followup analyst, has commented, "One of the striking phenomena observed in this patient is that a single followup interview with a new analyst resulted in the equating of the followup study with the analysis itself along with its transference manifestations. This has occurred without exception and with varying degrees of vividness and clarity" (p. 429).

There appear to be several illustrations of transference residues in this study. Irene Silverman, who conveyed the impression that she had not wanted to let go of her therapist, when asked by the interviewer if she was experiencing feelings toward her which were at all similar to feelings she had toward her therapist said, "I don't know. I'd rather it was therapy because this way I know it's the end unless you call me about any question. Feel free to call if I can expand on anything I've said." When the interviewer called to ask some further

questions, she said to call back if she need to: "you may find there are some more questions and may want to call me again." Mary Spinelli, who said that her therapy helped her believe that experiencing anger toward her parents was an appropriate response to have and that "I've been angry ever since," appeared to manifest this anger in several passive aggressive behaviors such as failing to keep the first appointment without calling, not being available for a phone call to schedule the second appointment and forgetting her money as she met the interviewer in a coffee shop where the interview was to be conducted. In describing a dream which her therapist "left me hanging about" and which she "(hates) her for," Mary conveyed the vague expectation that the interviewer would make the final correct interpretation. It is apparent that both Irene and Mary had developed an important relationship with their therapists including strong transference feelings. It is possible that it is because these were not worked through that they manifested themselves so strongly toward the followup interviewer. What is unresolved is still unresolved.

It was clear that other individuals felt different during the followup interview than they had at the time of their therapy, although seeing a Clinical Psychology student from City College and discussing the therapy which they had there did make the experience seem reminiscent of therapy. For example, when Elliot Roth, who had entered several years of therapy subsequent to City, was asked whether he felt toward the interviewer the way he felt toward his therapist said "No. I feel I've taken an active role in this therapy. That's an interesting slip. I'm very easily into the role of patient. But I feel that I've taken an active role. I was more passive at City, more passive in terms of this

kind of situation." He did seem more assertive in the interview than he described himself as being during therapy. Of the three he was the one who had entered subsequent therapy, which may account in part for the difference.

Some researchers including Klein (1960) and Pfeffer (1959) have maintained that more than one interview is necessary in order for the negative transference or negative attitude to become apparent. In this study where one long interview was conducted negative attitudes were evident immediately. Perhaps more positive feelings would have been expressed in subsequent interviews, although most researchers have found positive feelings to be expressed first, negative ones later. Sargent (1960) maintains that too many interviews should not be conducted because too much probing can hurt. The impression of this interviewer was that there was no "hurting" but in some instances there was an arousal of hope and some vague if not always spoken expectations for help.

Advice, guidance and reassurance

Most individuals recalled the therapy situation as one in which they did the talking, even when there was nothing to say, or so they thought. They felt that by and large they were working in their therapy and were responsible for the progress that was made. Interventions from the therapist consisted of questions which would help guide thinking. In some instances this was enough (Richard Doran and Elliot Roth) but in most others it was not. "I remember thinking I suffered a lot and got a lot out but nothing to hold onto. There was no problem solving" (Donald Schiller). "Just talking was inadequate. A stronger sense of direction, not merely advice would have been helpful" (Jim Myers). "I thought

'this is more than 40 sessions and (for his therapist) never to have said anything'" (Mark Geller). And "My therapist never said because of this and this, you feel self destructive. She could have helped put things together more. I would have liked more information about myself, possibly toned down, if necessary" (Mary Spinelli). These complaints appear to center around a wish for something to ground emotions onto or a wish for more advice, guidance, direction or structure.

Because several individuals had expected that therapy would center around offering advice or guidance, their disappointment about lacks in these areas may be the result of unmet expectations. For example, Mark Geller said he had no idea what to expect when he went into therapy but thought he would be given advice and was unsure whether his experience of therapy which did not include advice-giving was the way that therapy was or the way that <u>his</u> therapy was. Donald Schiller similarly commented that at the time he was at City he felt that "this is the way it is" and was not as disappointed then as he was later when he discovered how different therapy could be. Sally Ehrlich and Jim Myers were also looking for advice and direction. They both expressed the sentiment that because college was so lacking in structure, particularly as it compared with their highschool experience, that they were looking for this in their therapy. It was difficult for them to discover that they would not find it there either. Therapy mirrored their experience in college rather than shed light on it. Jim Myers said, "I was expecting to get advice. I was disappointed when I didn't get it. When I asked for advice she would say, 'What do you think? Let's talk about it.' It was not what I wanted or needed." He had expected that his therapist would ask what his goals were, provide a structure and suggest a course of action.

Jerry Borg had expected to get help in terms of his schoolwork, particularly some understanding of why he was failing his courses and was discouraged that he did not get this. The reaction expressed by these individuals may have been the reaction of others who felt that they were lost or floundering and found therapy another place to be lost.

Several individuals indicated that they would have liked more support in the form of reassurance from their therapists. Mark Geller observed that if his therapist had said "that's only natural, I can understand that" that therapy would have been a better experience. Linda Kellar commented that her therapist "wasn't at all supportive. At times I was looking for it." Gloria Rieser felt similarly.

The question might be asked whether patients are the best judge of what is best for them in terms of their treatment. Problems with judgment may be one of their difficulties, so how can they judge good or bad therapy? Do they know when advice or guidance or reassurance is indicated, if at all? It is possible that they do not and it is very likely that at different times the particular technique or strategy employed by their therapist was in their best interest and they did not realize it.

On the other hand if a particular technique is employed consistently and is not perceived by the patient as being responsive to where he or she is "at" at the time then it could be viewed as insensitive and not helpful and might undermine confidence in the therapist's professional ability. If a great incompatibility exists between therapist style and patient response to therapist style, perhaps there should be a change in therapist. At the very least the patient's expressed or unexpressed concern should be recognized and responded to with either an interpretation or an explanation in the form of education about the process or both.

Since lack of direction and structure was such an issue for individuals in this study it was undoubtedly an issue for those who terminated from therapy prematurely. This population was considerable. More will be discussed about this in the section on "Therapist's Level of Skill."

Interventions recalled

In terms of the specific interventions which therapists made it is interesting that those that are recalled, interventions which must have been meaningful because they have "stuck" over at least five years and in some instances as long as 11 years, are those in which the therapist offered a specific suggestion or advice. It might be noted that individuals who experienced therapy as a significant event were able to recall at least two specific incidents from their therapy while others such as Sally Ehrlich and Linda Kellar who found that it was not helpful were not able to recall any specific event but only impressions.

Mark Geller and Jim Myers may have remembered the particular remarks which they related to the interviewer because they exemplified what they were eager to hear more of in their therapy. Mark recalls his therapist suggesting a strategy he could use when he felt as though he might crash into a pole on the highway, a strategy which he still uses. Jim recalls his therapist stepping out of her usual posture of neutrality when she responded to his question "Is my family normal?" with the remark "God, no!" and when she suggested that he stand up to his mother. The recollections of these two seem to point to the importance of ascertaining an individual's expectations of what therapy will be like and of keeping in mind that those interventions which conform to expectations may be more recalled and more useful, both during and following therapy.

Irene Silverman recalls the advice of her therapist that she "get off your back" meaning that she should not be so hard on herself. She also recalls a poignant interpreation: "the reason you feel so terrible about Concentration Camps, why you cry, is because as far as you're concerned, your parents have died already," an interpretation which she says did not mean a great deal at the time but which has become meaningful to her since.

It is interesting that other interventions or experiences which are recalled as being significant are ones in which the therapist demonstrated a particular sensitivity, such as when Elliot Roth's therapist turned off the taperecorder when he was feeling embarrassed, or a stronger or more "real" reaction than usually occurred. Rebecca Feiner recalls her therapist crying at one point as she told him about a terrible few days that she had been through while coming down from drugs. Jerry Borg recalls his therapist crying at the end of their therapy when he said "thank you very much for caring." Mary Spinelli noted, "My therapist was concerned. She seemed on the verge of tears sometimes." Jim Myers said that his "strongest impression" of his therapist was of her outside therapy, when he met her at a concert. "I think I sat with her and talked with her."

What is interesting about the experiences recalled is that each in its own way is an example of the therapist behaving out of character, of acting in a different way than was generally expected by the patient. Deutsch (1959) found that a former patient she interviewed recalled instances when she acted out in treatment more clearly than she did some aspects of her therapy. In a sense what individuals recall about their therapists or their therapy is like acting out, that is, instances when

their therapists "acted out" of the context of therapy, giving them gifts which they could take with them and use, whether this gift was a suggestion or an emotion. The therapists may have been showing a kind of caring which may have been lacking in their homes or families (or in other moments of their therapy).

The therapy process as conceptualized by Horwitz

The above may be examples of instances when therapists provided a "corrective emotional experience," but this is unclear. In fact corrective emotional experience, identification and transference cure as conceptualized by Horwitz are somewhat difficult to ascertain, probably because of the length of the followup and because of the shortterm nature of the therapy. Such conceptualizations are better suited to an evaluation of an analysis or an evaluation of recently terminated therapy, such as in the Menninger study where the number of sessions attended was between 289 and 835, a great deal more than 55 and the followup study was conducted between five and 10 years as compared with two years following the termination of therapy.

In order to try to understand whether a corrective emotional experience had occurred a question was included which concerned the similarity between the therapist's response and those of other individuals, but it failed to yield significant information. Much more significant were the patient's spontaneous recollections of their therapists' comments and behaviors. In terms of identification the question which concerned the possible adoption of certain attitudes or values of their therapist also met with little significant information. While certain individuals may have had impressions of the similarity and differences

between themselves and their therapists there was no perception of any increase in similarity and no adoption of values, even given some knowledge or speculation about what these might be. That there may have been some modelling is possibly evidenced in the fact that two individuals applied to Clinical Psychology programs at the time of their graduation and in the fact that three others are either studying or working in an area of psychology. However, it may also be that individuals interested in the field sought therapy so that it could not be said that their experience in therapy influenced these future interests.

The viewpoint of this researcher, as expressed in the Introductory Chapter, was that a therapy in which the patient was positively affected by personal and technical qualities of the therapy and the therapist was optimal. An important focus of the interview conducted was to ascertain the relative importance ot the patient of the personal and technical qualities of the therapist. Horwitz (1974) has observed that in a shortterm therapy the real as opposed to the transference relationship is of prime importance. Patients in this study would appear to agree. This may be because their therapy was short and because they were young and were possibly looking for someone like a counsellor. With the exception of the interpretation which Irene Silverman recalled, what people remember, appreciate and have taken with them are "relational" aspects of their therapy, the times when their therapist was giving in some way. It seems that the personal or human qualities of the therapy were considerably more important to them although they wanted to experience these personal qualities from someone who they believed was skilled or professionally assured. It was this sense of being with a professional which was lacking in many instances and which will be considered next.

Therapist's Level of Skill

Several researchers conducting outcome studies have indicated that there is a positive correlation between therapist training or experience and therapy outcome. Barrett-Lennard (1962) found that patients treated by more expert therapists gave higher scores to their therapists on empathic understanding. Cartwright and Vogel (1960) found that patients of more experienced therapists showed more improvement in their self picture as measures by the TAT. Katz et al. (1958) found that positive outcome as measured by the Behavior Disturbance Scale and the Taylor Manifest Anxiety Scale was related to years of therapist experience. Myers and Auld (1955) found that patients seen by less experienced therapists tended to leave therapy unplanned or to quit. And Sullivan et al. (1958) found that patients who remained in treatment and who evidenced greater improvement were treated by more experienced therapists.

It seems that some of the negative comments which patients in this study made about their therapists may be related to the fact that they were being seen by "beginners." In fact it is possible that their therapists' status as learners was the salient feature or variable which accounted for patients' reservations about their therapy. It must be taken into consideration that the perception that their therapists were inexperienced may have been colored by the fact that individuals knew that they were being seen by students, that their therapists were young, that the setting lacked the quality of a professional's office and that they were paying very little for their therapy. Questions were included in the interview so that the relative meaning of each of these factors could be assessed and so that it would be understood how much feelings

about these aspects of their therapy influenced their attitude that their therapists were beginners.

Factors influencing the perception of therapist inexperience

In most instances individuals did not equate low fee with low quality. One exception was Linda Kellar who thought that paying a dollar contributed to her opinion that therapy was not a significant experience, in contrast to her feeling that her subsequent therapy, where the fee was high and where she believed she was making a greater commitment, was a significant experience. Another was Gloria Rieser who, when asked how she knew her therapist was inexperienced, said "Who else would work for 50¢?" In these instances paying a small amount probably did negatively color their impression of the value of their therapy and their therapist. On the other hand several individuals indicated that had the cost been greater they would not have taken advantage of therapy, and they appreciated that they could. Rebecca Feiner said that she would not have entered therapy if it had cost more because at that point paying meant that it was a commitment or a dependency which she was not willing to allow herself; but working through these feelings in therapy enabled her to make a commitment, to pay her next therapist a much greater fee and to remain in treatment for four and a half years.

Very few individuals remarked that there was anything about the setting of their therapy that was disturbing to them. Exceptions were Linda Kellar who observed that the same room was not always used, "we were hither and thither," and that this contributed to a sense of impermanence, Gloria Rieser who noted that "there wasn't a feeling of privacy," and Donald Schiller who recalled an instance when someone came into

the room and interrupted the session. These attitudes about the setting may have contributed to their sense that their therapist was not a "professional."

Most individuals were not concerned about the age of their therapist, that is, they did not believe that the fact that their therapist was young was detrimental. Three individuals, Richard Doran, Elliot Roth and Irene Silverman, all commented that their therapists were young but considered that they seemed mature and older. Richard viewed his therapist's young age positively, "I don't know . . . I think I felt more comfortable speaking to someone approximately my age. The fact that I could relate better to him than to an older person." Elliot said his therapist was "a little older but I thought of him as older." Irene noted, "She was young but mature." On the other hand age did contribute to a sense of inexperience for a few individuals. Donald Schiller commented, "The good part was that I was comfortable. The bad part was that sometimes I didn't take him that seriously." And Rebecca Feiner observed, "He was in his early thirties. This contributed to his seeming inexperienced. He looked young. He was young. He had the mannerisms of a very young man. He would look as though he was ready to jump." Only one of these two, however, Donald Schiller, had negative feelings about therapy.

Some of the above comments suggest that individuals may be aware that they are seeing a beginner because of the fee or the setting or their therapist's age. But there are not as many such observations or remarks as might be expected so that it seems that the view which individuals express about seeing inexperienced or beginning practitioners is a reflection of something other than the above. Perceived qualities

of the therapist are of greater significance.

Observations about therapist inexperience

The following are some of the comments which individuals made about their therapist's level of experience. Sally Ehrlich remarked, "I got the feeling that the therapist at City was a student. I knew that but I had the feeling that she was not so secure. She didn't come across as a professional. Part of the problem at City is that people may be attempting to take on more than they can handle. They aren't as experienced as they should be." Jim Myers commented that his therapist "(was) not as confident as she might become. (There was) a lack of a sense of her guiding the sessions." Linda Kellar believed that her therapist seemed inexperienced because of "the way he handled himself, his rigidity in terms of the Tavistock model."

Several individuals felt that they took advantage of their therapist's lack of experience. Gloria Rieser said, "He had a lot of good qualities. He was earnest and sincere but he didn't handle me well. I sensed his uncertainty. I used it. He was uncomfortable. I have an impression of his incompetence, inexperience. I remember a lot of times I could startle him. I manipulated his reaction." Elliot Roth observed, "I have the feeling I might have felt I could push him around. If I was in therapy now I would want someone who I couldn't push around. He may have been letting me get away with too much." Mary Spinelli commented, "I guess with someone you feel isn't that experienced you try to put something over on her. There were some things I lied to her about, some things I didn't tell her about." And Donald Schiller noted, "I feel I was trying to prove I was very smart. I was playing 'gee you're

smart.' He should have confronted me. I felt that at times I had him around my finger. I guess I see him as a young clinician. In retrospect I think I was one of the first people he ever saw."

In most of the followup studies described in the Introductory Chapter individuals were treated by experienced professionals although in five they were treated by professionals and students or just students. What were their findings concerning the effectiveness of student therapists? In three of the studies, Imber et al. (1968), Meyer and Zegans (1975) and Whittington (1960), professionals as well as students carried out therapy and in all there was some report of failures as well as successes, but no explanations were given regarding whether individuals in less successful therapy were in treatment with students or not.

Strupp et al. (1969) in examining which patients were "failures" according to their self reports found that one of the variables which seemed to differentiate the successfully treated patients from the less successfully treated patients was that a disproportionate number of the latter group were seen by Clinical Psychology students: 13% of the entire population was seen by students, 30% of the failures were seen by students (p. 107). They hypothesized that the reason why student therapists might not have been as effective was because they were close in age to their patients and were involved in many of the same life issues. One patient said, "It was hard for me to think of him as an expert. He seemed scarcely older than I was" (p. 107). This may be true but does not seem a sufficient reason for the therapy to be less effective. Often therapists of any age face similar problems as their patients but this does not in itself interfere with therapy outcome. Cowen and Combs (1950) reported that in treating students the experienced counsellor

was more effective than the inexperienced counsellor. They found that patient attitude as well as therapist skill influenced the perception of inexperience, a finding which may have relevance to this study as well.

> Much of this difference may be explained in terms of real differences in skill . . . However, the comments of these follow-up clients would seem to indicate a second possible factor which may be contributing to this difference in effectiveness is the attitude or feeling of the client as he enters the counselling situation. Such an attitude may be entirely apart from the skill of the beginning counsellor and in some cases might be strong enough to impede seriously therapeutic progress (p. 250).

This study is different from the above five in that it involves an interview with a longterm followup of individuals seen by students: Imber et al. utilized a specific index of change; Strupp et al. and Whittington utilized a questionnaire; and Cowen and Combs and Meyer and Zegans utilized an interview with shortterm followup. It is possible that individuals in this study demonstrated a greater awareness that they were being seen by students because with the passage of considerable time they had become involved in different types of relationships, including therapy relationships, and they could compare these with their therapy at City. Thus, they had more to say.

Further therapy and the issue of therapist inexperience

Several individuals interviewed believed that a comparison between their therapy at City and their subsequent therapy underscored their feeling that their therapist at City was relatively inexperienced. It would have to be considered that individuals who entered subsequent therapy and who in most instances remained in treatment longer valued it more and that this resulted in their devaluing their experience at City

and in highlighting their therapist's inexperience. This may have occurred or it may be that entering therapy with someone who seems more experienced makes it possible to delineate those qualities which contribute to the first therapist seeming inexperienced. It might be noted that it was not only individuals who entered further therapy who felt that their therapist was lacking in experience. Of the four individuals who did not enter subsequent therapy, three, Richard Doran, Mark Geller and Jim Myers, made observations which suggested a sensitivity to the issue of inexperience.

The number of individuals who sought further therapy, eight out of 12, is higher than is reported in most studies, even considering the length of the followup. Since it is a small sample it is not possible to generalize from this finding but entering subsequent treatment might suggest that certain difficulties had not been resolved and that there was some pressure to do further work or that there was a positive attitude about therapy which was reflected in a desire for further therapy. There appears to be some justification for both points of view. Gloria Rieser and Donald Schiller entered subsequent therapy dissatisfied with what they had gotten from their therapy at City and wanting further help. Four individuals entered subsequent therapy but much later and with different problems than those for which they sought help at City. Two, Linda Kellar and Irene Silverman, had felt that therapy at City was generally helpful while two others, Jerry Borg and Sally Ehrlich, had not. In general it does not seem possible to differentiate individuals who entered further therapy from those who did not. While Paul (1967) found that people did not report that they had entered further therapy, it appears that for the most part individuals in this study were trying to

relate their subsequent therapy experiences accurately and truthfully.

How did the subsequent therapy of these eight individuals compare with their therapy at City and what information does it provide about aspects that were and were not helpful about their original therapy? Gloria Rieser believed that none of her therapists were helpful because she felt that they did not know how to approach her, offering support when she could have used confrontation and confrontation when she could have used support. Jerry Borg believed that his therapy at City was not helpful but that neither was it detrimental. He entered several subsequent therapies, leaving the first three because of what he perceived as the therapist's inappropriately sharing personal experiences. The fourth therapist he remained with for several years. It would seem that for him subsequent therapy was both better and worse than therapy at City. This was true also for Irene Silverman whose therapy at the University of Nebraska was helpful but somewhat unnerving at times. She had felt that more direction from her therapist at City would have been beneficial but believed that her second therapist was too active, especially when he shared an explicit sexual fantasy about her with her.

Linda Kellar considered that her second therapy was better because she was at a different place and because her therapist was better: "The transference was stronger. There was more fluidity." Sally Ehrlich also was at a different place when she entered further therapy: "My marriage was on the line so it was different." She had felt that her therapist at City was not strong so she challenged her second therapist: "I tested her. I spent a couple of sessions talking about her credentials and how therapy should help. The original therapist seemed uncom-

fortable with questions that I asked. I recall asking the therapist at City some questions and just didn't feel that convinced of her responses. (There was) a tentativeness." Rebecca Feiner walked into the office of her second therapist and "felt immediately I could trust him. Of course it didn't happen without difficulty but it did happen. He was someone experienced, who no longer had something to prove. He seemed to have faith in himself. No matter what I did it would not throw him. I think with the first one it was a little like castles fighting each other."

It is possible that these individuals' subsequent therapy was better because the therapists were able to ascertain what had been lacking in the original therapy and to provide it, to offer what might be in a sense a "corrective emotional experience." In fact, the interviewer found herself aware of an inclination to do this during the followup interview. Overall, it appears that most individuals had been sensitive to the issue of inexperience in their first therapy and that this perception was clarified in their experience of subsequent therapy.

Qualities of inexperienced therapists and some implications

If it is difficult for individuals to specify what made their therapists seem to be inexperienced, this is understandable. Rice (1965) concluded that therapy outcome was related to therapist experience and that therapist experience was related to therapist style. She found that even when experienced and inexperienced therapists would say the same thing that their voice quality and use of language in saying what they said was different. More experienced therapists tended to use forthright and connotative language. Inexperienced therapists tended to offer very few responses in a fresh connotative language and to evidence

a disturbed voice quality (p. 158). Individuals interviewed in this study may have experienced this in their therapy but may not have been able to specify it as it is a somewhat subtle quality, difficult to elaborate, particularly with so much distance from the original therapy experience.

Some studies have suggested that inexperienced therapists tend to be more active and less withdrawn or neutral than experienced therapists. Rice et al. (1972) conducted a study involving 25 experienced therapists (mean number of years doing therapy: 13.96) and 25 inexperienced therapists (mean number of years doing therapy: 3.52) in which these therapists were asked to rate themselves in terms of certain qualities. It was found that experienced therapists evaluated themselves as higher in terms of "Blank Screen," that is, "passive, unchanging, unprovocative, anonymous and cautious" while less experienced therapists evaluated themselves as higher in terms of "Maternal," that is, "talkative, explanatory, supportive, guiding and interpretative." Grigg (1961) also found that inexperienced counselors were perceived by their clients as being more active, making more interpretations, tending to clue the client as to the topics to be discussed, and setting the tone of the session (p. 222).

The findings of the above studies concerning therapist style are consistent with the observations made by several individuals in this study and inconsistent with the observations made by several others. Some felt that their therapist veered in the direction of "Blank Screen." Linda Kellar noted, "(My therapist) just wasn't at all supportive. At times I was looking for it." Contributing to this impression of inexperience was "his rigidity in terms of the Tavistock model." Gloria

Rieser remarked, "I think I could have used support. I don't know how supportive he was." And Mark Geller said, "(My therapist) could have said 'that's only natural . . . I understand that.' Reassurances or explanations would have been better." Some felt that their therapist veered in the direction of "Maternal." Sally Ehrlich commented, "She didn't force me to confront things. I needed someone to force me to look at things." Donald Schiller noted, "It's nice to have a shoulder to cry on but you can get that from a friend."

As this researcher evaluates comments made by individuals interviewed it seems that what they point to as a lack in their therapy was a kind of fluidity or flexibility. It would seem that the ideal therapy would involve both "Blank Screen" and "Maternal" qualities (as described above) and that it is a sensitivity about which to use when that a therapist tends to learn or to develop. What individuals in this study seem to be saying is that their therapist could be one way or the other but not adaptable to what was necessarily called for at the time. They could not attend well to their patients' emotional status. Fiedler (1950) observes, "We find the experts are generally more capable of maintaining an emotional distance which is neither too far on the withdrawing side nor too close to the patient" (p. 443).

Peplau (1952), in describing a theory of anxiety patterned after the conceptualizations of Sullivan, delineates levels of anxiety optimal for learning. Severe or panic level anxiety makes it difficult to attend. No anxiety makes an interest in attending irrelevant. Mild or moderate anxiety which allows for awareness and focussed attention and which helps foster skill in seeing relationships is optimal. It appears from what individuals in this study report that the anxiety level

was often at either the nonexistent or the moderate to severe level, that is, that there was either too much support or too much withdrawal, probably because therapists were not able to monitor the level of anxiety. Too much support makes for too little anxiety and too much deprivation makes for too much anxiety, and learning or change is difficult in either situation.

Why is it difficult for beginning therapists to modulate this level of anxiety? One reason may be that they themselves are possibly anxious because seeing patients is a new experience. If they are anxious it is difficult for them to monitor anxiety in their patients. Their rigidity in terms of being "Blank Screen" or "Maternal" may be a function of their own anxiety. Also, if they are anxious it may be difficult for them to recognize their own feelings other than anxiety. Both Jerry Borg and Rebecca Feiner did not believe their therapists were "plugged into" whatever these feelings were. Rebecca commented, "I don't think Joe was able to evaluate what was going on between him and me. I don't think he could deal with his own reactions. When he could, it was very good. When he couldn't, he couldn't help me." Cartwright and Lerner (1963) seem to be making this point when they note that it may be barriers in the therapist which distort perceptions and which threaten the therapy situation and that this is more true with inexperienced than experienced therapists (p. 144).

An implication of this would appear to be that therapists should be aware that their patients are more cognizant of their "beginningness" than they realize. Perhaps they should introduce this into the therapy as a concern of their patients if and when it seems relevant to do so. One reason that this may not be done very much is that beginning thera-

pists may be trying to "play down" both to themselves and to their patients that they are beginners and may be trying to persuade themselves that this is not a concern of their patients, particularly if their patients continue to keep appointments. There may be a tendency to believe that if the patient remains in treatment that he or she is satisfied with treatment. This apparently is not necessarily true.

It seems that anxiety on the part of the beginning therapist -- anxiety which almost has to be present -- should be addressed in teaching or in supervision. If this anxiety can be acknowledged and expressed by the beginning practitioner outside of the therapy situation, then it may not be present to the extent that it often is in the sessions with the result that the therapist's capacity to estimate and monitor the anxiety level of the patient is increased. It would seem that while a certain orientation is necesary in conceptualizing psychodynamics, no one approach should be advocated to the complete exclusion of others. Patients probably should not be obliged to conform to a particular response pattern; the response pattern should be tailored to "conform" to the individual. A "how to" course that does not take "with whom" into consideration may not provide the best model for learning how to do therapy.

Most researchers have concluded that there is a correlation between length of therapy and satisfaction with therapy or therapy outcome. Luborsky et al. (1971) in a review of variables associated with positive therapy outcome found that in 20 of the 22 studies which he examined a significant positive relationship was reported between number of sessions attended and therapy outcome. Researchers who have conducted followup studies and who have considered therapy duration as a variable (Avnet,

Bartlett, Cappon, McNair, Strupp and Whittington) have also found this to be true. These findings would suggest that if individuals in this study who remained in treatment were disturbed by certain aspects of their therapy that it can be assumed that many of those who terminated therapy prematurely were at least as concerned.

The interview material suggests that careful attention must be given to the attitude of individuals toward therapy. We can learn from them what was good and what was bad. They may be speaking for others as well.

C. RECOMMENDATIONS FOR FURTHER RESEARCH

Areas discussed in the previous section which seem salient in terms of their potential for further research are 1) various means of assessing therapy outcome, 2) the importance to patients of specific therapist interventions, and 3) the therapist's level of skill. Within these broad categories eight areas which suggest possibilities for research studies will be described.

Various Means of Assessing Therapy Outcome

One: The relationship between an individual's attitude toward therapy, his or her subjective perception of change that occurred as a result of therapy, and an objective measure of what therapy accomplished, is not necessarily a parallel one.

The followup studies reviewed in the Introductory Chapter have for the most part concentrated on only one of these means of assessing outcome. Certain researchers such as Luborsky (1971) stress the value of the individual's reporting about his or her therapy and several others have observed that there is a correlation between the patient's report of the helpfulness of therapy at the time of followup or a measure of therapy outcome at followup and the therapist's impression of or prognosis for the patient at termination: Avnet (1965), Board (1965), Feifel and Eells (1963), Klein (1960), Pichel (1974), Rogers and Dymond (1954), Rosenberg et al. (1968), and Strupp et al. (1969). However, these do not involve a comparison of an objective assessment of what therapy accomplished with the patient's subjective evaluation of the helpfulness of therapy. In only one, the study carried out by Fiske and Goodman (1965), was an attempt made to correlate the patient's report at followup with a measure of outcome at followup. They found

that in general the patients' report of gain on the questionnaire sent to them had variance in common with two out of three measures of gain: the Q sort and a subtest of the MMPI.

It would be interesting to carry out a study in which an attempt was made to compare an individual's attitude toward therapy, his or her subjective appraisal of the helpfulness of therapy and a more objective assessment of change that occurred as a result of therapy. The first two might be accomplished as they were in this study. The third might be accomplished by establishing an outcome criterion. It was pointed out in the first chapter that many of the specific measures utilized in other followup studies seem weak and insensitive to complex change but perhaps an interview might be carried out in which the clinical impression of the followup interviewer could be compared with the impression of the patient's therapist at the time of termination and an overall assessment of improvement compared with the individual's attitude toward treatment and perception of helpfulness of therapy. Subjectivity may be a problem but if there was some validation of the therapist's and the followup interviewer's clinical impressions this could be a meaningful approach to take with regard to these three components of therapy outcome. Unfortunately, since this researcher did not have access to the therapy material (because of the patients' concern about confidentiality), it was not possible to make such a comparison in this study.

Two: An individual's attitude toward therapy becomes more negative as distance from the termination of therapy increases, particularly if the therapy was not an entirely satisfactory experience.

Only Feifel and Eells (1963) have spelled out in a specific manner areas that change in importance as distance from therapy increases,

although their study involved administering a questionnaire as opposed to an interview to individuals at the time of termination and at one follow-up point four years later. It would interesting to interview individuals at several points following the termination of therapy to understand how their attitude changes over time and to try to learn what contributes to this change in attitude. As Bergin and Suinn (1975) note, "It is time to extend research for longer followup periods instead of limiting reports to single posttesting" (p. 543). Another means of ascertaining whether people view therapy more negatively as distance from termination increases might be to interview a number of individuals who were involved in a similar type of therapy, selecting several who were seen at different followup times and comparing attitudes toward treatment as a function of distance from termination.

The question might be raised concerning which of the three components of outcome is more important. It seems that all must be considered in something as subjective and personal as a therapy experience. The attitude which an individual has can influence subsequent experiences, not the least of which are therapy experiences. It is interesting that only three individuals in this study, Rebecca Feiner, Linda Kellar and Elliot Roth, entered a subsequent therapy that was similar in orientation to their therapy at City. And only two of these, that is, two out of twelve, indicated that they would seek out a similar therapy orientation if they wanted help with current difficulties. While all felt that they could use assistance with emotional problems, they have found strategies other than therapy or a therapy strategy that is more active or behavioral to be preferable.

Interventions on the Part of the Therapist

Three: Interventions on the part of the therapist or therapy experiences which are recalled by individuals are those which coincide or clash with expectations of what therapy will be like.

It seemed that in many instances interventions were recalled which either meshed with the individual's prior expectations of what therapy would be like or which were sharply at odds with these expectations. A potential difficulty in a study such as this one is that the memory of a particular therapist's verbalizations or behavior may influence what the individual believes were his or her expectations of the therapy process. It would be interesting to ask individuals what their expectations are at the time that they enter treatment (and to consider in particular whether their expectation is that therapy will be psychoanalytic or more directive) and then to compare their recollections at the time of followup with their initial expressed expectations to ascertain whether they coincide or clash as dramatically as this study suggests. For example, do individuals with expectations of a psychoanalytic approach recall interpretations while those with expectations of a directive approach recall advice? Since much of what individuals in this study recalled from their therapy had been useful to them and since their recollections tended to mesh with their expectations of therapy, the importance of the therapist's carefully understanding what an individual's expectations are can not be overstated.

Four: Interventions on the part of the therapist which are recalled are those which are gratifying in some way.

In this study it seemed that what was most gratifying was recalled; but it is unclear whether individuals recalled what they did be-

cause the therapist's response was important in conveying a human quality (which may have been different from the response they had experienced from their parents, that is, some type of corrective emotional experience) or whether they remembered what they did because the intervention which was made was unusual for their therapist to make, that is, that it stood out because it was discrepant from the therapist's usual method of responding. This was certainly true in several instances. Since many of the therapists in this study evidenced a style of being relatively inactive in the therapy process this issue might be explored in a study in which the style of the therapist was more active and gratifying. It might then be determined whether individuals in treatment with more "active" therapists recall what is gratifying or whether they recall what is unusual, that is, whether when seeing therapists who are gratifying they recall instances of withholding. If they remember instances of gratification with both types of therapists this would suggest that such interventions are important to them, have meaning to them and should be acknowledged as such by their therapists.

Five: There is a relationship between the type of interpretation which the therapist makes and outcome at followup.

Malan (1976) has suggested that interpretations which focus on the parent - therapist transference are more likely to be associated with positive outcome than are interpretations which focus on the expression of hostility about termination. In this present study it was difficult to draw any conclusions about the relationship between the type of interpretation made and attitude toward therapy because with one exception interpretations were not recalled. This does not mean that they were not offered. Perhaps a study could be conducted in which the

general type of interpretation which the therapist offered was categorized and an attempt made to correlate the three components of therapy outcome at followup -- the individual's attitude toward therapy, his or her subjective evaluation of the effectiveness of therapy, and an objective measure of therapy "outcome" with the type of interpretation offered.

Therapist's Level of Experience

Six: Patients are more sensitive to their therapist's level of experience than has been generally acknowledged.

Most beginning therapists do not seem as aware as it appears they should be that their "beginningness" is apparent to their patients. While learning how to do therapy is a gradual process, it might be interesting to try to better understand when a therapist conveys a general impression of being "experienced" as opposed to "inexperienced." Since patients have something to say about this, perhaps therapists could enlist a researcher to interview former patients to determine whether there is a particular period when patients feel that these therapists seem "experienced" and can describe what this means, that is, can delineate those qualities which are associated with being "experienced," or describe what the therapist does to seem "experienced." It might then be better understood which personal or training experiences make a difference. Implications for teaching might also emerge.

Seven: The anxiety level of inexperienced therapists is greater than that of experienced therapists.

If experienced and inexperienced therapists can be differentiated in terms of responsiveness to their patients' and to their own emotional states (the former has been demonstrated in several studies) it may be because the beginning therapist is anxious about doing something new --

therapy. It might be possible to determine whether this is true by giving experienced and inexperienced therapists a measure of anxiety before a scheduled therapy session.

Eight: Individuals who terminate from therapy prematurely do so because they perceive their therapist as being insensitive to their emotional state (which is possibly related to their level of experience) and because they find therapy incompatible with their expectations of what therapy will be like.

Individuals who terminate from therapy prematurely might be interviewed and these areas as well as others assessed carefully in order to understand what they perceive to be deficiencies in their therapy.

Concluding Remarks

Almost all individuals interviewed were concerned about the issue of confidentiality and about the availability of their records to the researcher. It might be noted that for the most part the negative reaction expressed was greater as distance from the therapy increased. It was as though the longer ago that therapy occurred the more it seemed like something was being "dug up" from the past and the more concern was verbalized about records being kept.

This researcher considers the expressed concern about confidentiality to be legitimate and believes that it is important to maintain confidentiality and to assure individuals that this is being done. One of the aspects of their therapy experience which individuals valued highly was that it was a privileged, private communication between themselves and their therapists. The sentiment of several was that just because their therapy took place in a clinic it seemed unfair that their records should be subject to examination in a way that would not be true

had they been able to afford a higher fee and seen a private therapist. It is interesting and striking that this issue of confidentiality and concern about access to records was not discussed in any of the follow-up studies which were reviewed. It seems unlikely that the issue was not raised.

And yet there is a need to evaluate services which are provided. If there is no review or followup, how do we know that what we do as therapists is good or not good? One individual who declined to participate suggested that a preferable way of doing followup research might be either to have the Director of the Psychological Center ask people if they would be interested in participating in a followup study or asking people at the time that they enter therapy to sign a release which would make their record available for research purposes.

Bednar and Shapiro (1970) found in a study of 16,000 psychologists and psychiatrists who were asked to participate in a large scale investigation of psychotherapy that less than one percent were interested. Perhaps this is because they are not persuaded of the meaningfulness of psychotherapy research. Luborsky (1969) comments, "At present, whatever findings have been consistently established and cross-validated have not been enough to force, entice or persuade clinicians into modifying their entrenched patterns of behavior" (p. 140). This researcher would like to believe that one or more aspects of this followup study might persuade clinicians that such a study of psychotherapy has something to teach us. Meyer and Zegans (1975) observe,

> If more is to be learned about the beguiling art of psychotherapy then therapists must attend to what patients tell them about their treatment experiences. Adolescents will be seeking more psychotherapeutic help in the future; they can be articulate about their needs and experiences -- therapists should listen to them (p. 22).

Letter #1

THE CITY COLLEGE

OF

THE CITY UNIVERSITY OF NEW YORK

NEW YORK, N.Y. 10031

THE PSYCHOLOGICAL CENTER
DEPARTMENT OF PSYCHOLOGY

(212) 690-6602, 3, 4

January , 1977

Dear Miss/ Mr./ Mrs.,

I am a Ph.D. student in Clinical Psychology at City University. I am working on my doctoral dissertation which is concerned with how people feel about their past experiences in therapy.

My dissertation is not one involving large number of subjects or complicated statistics. Rather it is concerned with personal interview contact of a relatively small number of people. I'm interested in learning about their therapy experiences, positive as well as negative, so that I can better understand aspects of therapy from a practical point of view.

To this end I have gathered names of several former City College students who attended therapy sessions between 1965 and 1970, obtaining their current addresses from the City College Alumni Association. is the address listed for you. I am hoping that this reaches you and that you can help me by participating in the interview part of my dissertation.

This letter represents an initial contact which I plan to follow up with a phone call to discuss my research further and to enlist your help. If is not a number where you can be reached, I would appreciate it if you could call me at home at 212 787-4685 or return the enclosed postcard with your phone number and times you can be reached so that I might call you.

Thank you very much.

Sincerely,

Jo-Ann Townsend

Letter #2

THE CITY COLLEGE
OF
THE CITY UNIVERSITY OF NEW YORK
NEW YORK, N.Y. 10031

THE PSYCHOLOGICAL CENTER
DEPARTMENT OF PSYCHOLOGY

(212) 690-6602, 3, 4

(same as Letter #1 except for Paragraph #3)

To this end I have gathered names of former City College students who attended therapy sessions between 1965 and 1970.
is the address which we have for you. I am hoping that this reaches you and that you can participate in the interview part of my dissertation.

Letter #3

THE CITY COLLEGE

OF

THE CITY UNIVERSITY OF NEW YORK

NEW YORK, N.Y. 10031

THE PSYCHOLOGICAL CENTER
DEPARTMENT OF PSYCHOLOGY

(212) 690-6602, 3, 4

(same as Letter #1 except for Paragraph #4)

I would like to discuss this research with you further and would contact you by phone but we do not have a telephone listing for you. I would appreciate it if you could call me at home, at 212 787-4685, or return the enclosed postcard with a phone number and times you can be reached so that I might call you.

THE CITY COLLEGE
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NEW YORK, N.Y. 10031

THE PSYCHOLOGICAL CENTER
DEPARTMENT OF PSYCHOLOGY

(212) 690-6602, 3, 4

January 17, 1977

Miss Jo-Ann Townsend is a Psychological Center staff member who is conducting a follow-up inquiry as part of a doctoral research study regarding the long range effects of therapy.

The follow-up interviews will provide us with information which should help improve the service that we provide at the Center.

Harold W Lensky

Harold Wilensky, Ph.D.
Professor and Director
The Psychological Center

APPENDIX E

FORMATIVE LIFE EPISODES QUESTIONNAIRE

1. As you think back over the period since about 1960, what particular happenings or episodes in the course of your life have been exceptionally eventful and significant to you? Please list between five and ten episodes. Do not give details. Simply indicate the kind of event it was and when it happened. If psychotherapy was one of these, please include it. If it was not, do not feel obliged to include it.

2. Please review the items you have recorded and clearly number each one, preferably in the order you have listed them, without repeating any numbers. Now please consider the following questions and indicate by the numbers you have just assigned, which formative event or episode is (are) the best fit in answer to each question.

Which do you feel had the greatest effect on the quality of your interpersonal life, in the direction of enriching, enhancing and deepening your personal relationships?

_____ in the short run

_____ in the long run

Which (if you feel any applies) has had a diminishing or negative effect on the quality of your interpersonal life?

_____ in the short run

_____ in the long run

Which (if any) has helped you significantly to become more self reliant (has led you to feel a sense of mastery in situations)?

_____

Which has (have) had an enhancing effect on your basic sense of worth as a person?

_____

Which (if any) have had a marked negative effect on your feeling of your own worth?

_____

Through which episode have you been most strongly (even if painfully) confronted with some fundamental pattern or quality in yourself, such that you became more self-knowing in some important way?

_____

3. As you review again your answer to question 1, do you see any order in the events you describe? Can you see connections between them? Do some events seem to have influenced others?

   For example, if event #1 was college, event #2 was marriage, and event #3 was graduate school, if college influenced your decision to enter graduate school, you might indicate

   #1 ⟶ #3

   If marriage as well as college influenced your decision to enter graduate school, you might indicate

   #1 ↘
#2 ↗ #3

   If three or more events are connected, if for example, event #4 influenced event #6 which influenced event #7, you might indicate

   #4 ⟶ #6 ⟶ #7

APPENDIX F

LIFE EXPERIENCES FOLLOWING THERAPY

1. tell me something about your life now
   - what doing -- work, school, other
   - where living
   - with whom involved closely

2. what has happened since terminating therapy?
   - what doing -- work, school, other
   - where living (number of different residences)
   - with whom involved closely

3. do you think any of the above are related to or reflect your therapy experience? if so, how? if not, why not?

4. what was your life like at the time that you came to City?

5. can you remember what problem(s) brought you to therapy?
   was there any change in this (these) problem(s) during therapy?
   what is its (their) status now?
   if there has been a change, how do you understand that?
   if there has not been a change or if it is (they are) worse, how do you understand that?
   would you say that you do or do not experience a sense of mastery or control with regard to these problems?

6. was there any change in your feelings about yourself during therapy?
   following therapy?

7. was there any change in your understanding of yourself during therapy?
   following therapy?

8. were you ever in therapy before you came to City?
   - reasons for starting
   - issues dealt with
   - general orientation of therapist
   - frequency and approximate number of sessions
   - reasons for terminating
   - was experience similar to or different from one at City?
   - did experience in therapy influence decision to enter therapy at City? how?

9. have you been in therapy since City?
   are you in therapy now?
   - reasons for starting
   - issues dealt with
   - general orientation of therapist
   - frequency and approximate number of sessions
   - if terminated reasons for terminating

how is (was) experience similar to or different from one at City?
was decision to enter therapy at all influenced by experience at City? how?

10. if no to above question, have you thought of entering therapy for help with any particular problem?
    if you did not, why not?
    what was type of problem for which you considered therapy?

11. if you were to enter therapy now what would be the main area(s) you would want to work on?

12. have you ever seen anyone other than a therapist for help? a clergyman, a physician?
    was the help you received similar to or different from that received at City?

13. can you think of anyone who reminds you of your therapist?
    anyone you knew before you started therapy?
    anyone you have met since terminating therapy?

14. is there any relationship you have had which is like the relationship you had with your therapist?

15. what is the difference between a therapist and a friend?

16. can you think of any personal relationship in which you have been involved that has affected you positively in terms of personal growth?
    what about the relationship caused this to happen?
    how was this relationship similar to or different from therapy?

17. can you think of a personal relationship that has been detrimental?

18. what do you think your life would have been like today if you hadn't been in therapy?

THERAPY AND THE THERAPY RELATIONSHIP

19. when you think back to your therapy at City, what stands out most clearly about your therapy experience?

20. what stands out most clearly about your therapist?

21. what did you like most about your therapist or your therapy?

22. what did you like least about your therapist or your therapy?

23. was there anything that was detrimental, that you think made you feel worse in any way?

24. did you feel that your therapist was sensitive to your feelings?

25. did you feel that your therapist understood you?

26. did you feel that your therapist respected you?

27. did you feel that your therapist was empathic?

28. did you like or dislike your therapist?
how did this affect your therapy experience?

29. did you feel that you and your therapist were similar or dissimilar?
how did this affect your therapy experience?

30. did you have any sense of what your therapist's attitudes or values were?
did you feel that you became more like your therapist in any way, possibly in terms of the development of certain attitudes or values?

31. do you recall the expectations you had of what therapy would be like before you came to therapy at City?
what did you think a therapist would be like?
how did your experience with your therapist match with these expectations?

32. do you remember your therapist indicating what therapy would be like?

33. do you recall your therapist's response to particular problems you were having?
was it similar to or different from the responses of other people?

34. what do you recall about the kinds of comments or interventions which your therapist made?
    point out inconsistencies
    interpret what he/ she thought you were feeling
    make other kinds of interpretations
    offer advice

35. do you remember your therapist being supportive or reassuring?

do you remember him/ her making interpretations that this was what you wanted?

36. do you remember having feelings toward your therapist that you had toward any other person or persons in your life, toward either of your parents?
    was this feeling intense, moderately intense, mild?
    do you think that experiencing these feelings was helpful in any way? if so, how?

37. do you recall any times when you felt angry?
    if so, do you think this was helpful?

38. did you have any sense of how experienced (or skilled) your therapist was?
    do you have any thought about how this level of experience or skill affected your therapy?

39. did you have any sense of how old your therapist was?
    do you think his/ her age had any effect on your therapy?

40. did you have any particular reaction to the setting in which your therapy was conducted?

41. what difference did it make to you that your therapist was a male/ female?
    would you have preferred a therapist of the opposite sex?

42. did you feel that you were working in your therapy?

43. did you feel as though it was primarily you, you and your therapist, or your therapist who was responsible for your progress in therapy?

44. do you recall the circumstances that led you to terminate therapy? be as specific as you can

45. have you found yourself thinking at all about your therapist?
    if so, what have your thoughts been?
    when (in what situations) have these thoughts occurred?

46. if you could have changed anything at all about your therapy, what would it have been?

47. if a student at City was interested in entering therapy at City, would your feeling be, based on your experience, that it would be beneficial?

48. during this interview have you felt at all the way you felt with your therapist?

49. how have you felt about this interview in general?

50. is there anything else you would like me to know?
    is there any question you would like me to have asked?

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