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Clients' attributions about psychotherapy: What works?

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CLIENTS' ATTRIBUTIONS ABOUT PSYCHOTHERAPY:

WHAT WORKS?

by

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ABSTRACT

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Seventy-one clients having at least 12 weeks of psychotherapy assessed a list of 30 treatment characteristics and techniques for frequency and efficacy and made attributions about initial problems and outcome. The assessed techniques, which prior research found effective, were drawn from differing treatment orientations. As hypothesized, reported outcome and efficacy were associated with therapist flexibility, and frequency and variety of techniques used, while clients reported a similar body of techniques and therapist characteristics across different orientations. Contrary to expectations, few meaningful attribution differences were found between reported successes and failures and no relation was found between client problems and technique. Significant differences in reported outcome, helpfulness, number, and frequency of techniques were found among the three treatment types with the behavioral group highest, the psychodynamic lowest, and an eclectic group in-between. These differences do not reflect clear technique differences among orientations. The psychodynamic group is best characterized by the de-emphasis, but not absence, of a few "behavioral" techniques. It is suggested that psychotherapy is a highly individual practice where specific techniques matter less than context and that all techniques facilitate a similar process of change: The greater the flexibility of treatment, the more possibilities for change exist. Suggestions for further research are offered.

I should like to express my thanks to my dissertation committee for their help with this research, specifically to Professor Herbert Saltzstein for many valuable comments and suggestions, to Professor Louis J. Gerstman for statistical advice, for many valuable suggestions as well as much precious time freely given, and finally to my Chairman, Professor Alden Wessman for many years of consistent encouragement and for his belief in this project and in me.

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INTRODUCTION

Statement of the Problem

What Happens During Psychotherapy?

Because of the widely different goals, theories, and techniques employed by therapists of different schools, not to speak of its inherent conceptual difficulty, the process of psychotherapy has proven difficult to assess. Despite these difficulties, a fair amount of good research has been done in this area. While a consensus that psychotherapy does produce significant effects has developed, it still is by no means universal. The size of the effects found in research, while significant, has not been very large, and after more than forty years of research in this area, debate still rages over the source of psychotherapy's effectiveness. A low but still significant effect has been found for approaches that are widely different in both theory and technique. Moreover, in general, the size of the effect seems about the same regardless of the approach taken. This has occurred with some regularity throughout nearly 40 years of psychotherapy research despite the fact that such research is often undertaken with a wide divergence of aim and approach. One is led to wonder if there are not some common elements in all approaches that are responsible for the common baseline.

The question has already occurred to thoughtful psychologists. There is some evidence that there may be common elements among therapies, even when these elements do not fall into the a particular theoretical framework. For example, although psychodynamic therapists generally eschew controlling their clients' behavior, directly or indirectly (at least in theory), some observers of psychoanalysis (such as Wachtel (1977), Waskow (1962), and Truax (1966)) have noted that a form of reinforcement does take place in psychotherapy. Truax even found this to be true in client-centered therapy. And while few behavioral therapists would regard the establishment of empathy as part of their therapeutic model, yet, as Wachtel (1977) has pointed out, this often takes place during the evaluation phase of a behavioral session. (See also Beck, 1984.) Moreover, therapist and client may have different conceptions of what is actually taking place during their encounter and form very different impressions of it. The complex client/psychotherapist interaction may be legitimately conceived within many different theoretical frameworks and because of this, common elements may not be reported either because they are not noticed or because they carry different theoretical labels.

The Nature of the Proposed Research

Unlike much psychotherapy research, the present study is not evaluation research comparing the differences in effectiveness of different therapeutic conditions. This study examines common elements

among the major approaches to psychotherapy with the behavioral approach on one end of the spectrum and the psychodynamic approach on the other, by using a source of information that, surprisingly, has not, as far as I know, been tapped before: the reports of clients about their experiences in psychotherapy. Looking at client reports about the important elements in the psychotherapy process allows the process of such therapy to be examined from a new angle. Client reports are both interesting in their own right (as reflected in attribution theory) and can potentially strengthen the construct validity of previous psychotherapy research.

Three basic questions are examined: 1.) whether the type of reports that self-defined "successful" psychotherapy clients make about what was helpful in their therapy depends on their therapist's nominal orientation or upon the nature of the problem dealt with in therapy, 2.) whether these factors are in accord with the findings of previous psychotherapy research, and 3.) whether the nature of the attributions (internal or external) that self-defined "successful" clients make is essentially different from those of self-defined "failures".

Since this research is based on client attributions, the question of attribution bias as well as the function of attributions as indicators of psychological adjustment needs to be considered.

Attribution Theory

Attribution theory is an attempt to discover how people's attributions and patterns of attribution bias occur. The standard of such biases is usually the known effect of environmental determinants. Beginning with the seminal work of Fritz Heider, attribution theory conceives the man-in-the-street as "an intuitive psychologist who seeks to explain behavior and to draw inferences about actors and their environments.... The first task [of an observer] is causal judgment: the observer seeks to identify the cause, or set of causes, to which some particular effect (i.e., some action or outcome) may most reasonably be *attributed*. The second task is social inference: the observer of an episode forms inferences about the attributes of relevant entities, that is, either the dispositions of actors or the properties of situations to which those actors have responded" (Ross, 1977, p. 174).

One of the general findings of attribution theory is that observers typically attribute others people's actions to innate dispositions and underestimate the degree to which situational demands shape the actor's behavior. On the other hand, people *within* situations, such as an experimental situation, usually attribute their own actions to situational demands. This difference in attribution is known as Actor/Observer bias and is typical in psychology experiments where the subject's behavior has been manipulated. (Ross, 1977, p. 174).

However, the kind of attributions one makes (internal or external) also depends on other factors such as whether the situational outcome is positive or negative. It has been shown that people tend to make self-related attributions for positive outcomes. Such behavior, however, is not necessarily naive egocentrism. Almost any type of behavior can be reinforced within a favorable environment. Behavior that seems to produce desirable results tends to get reinforced. Since almost anything a person does in favorable circumstances is accompanied by favorable results, these positive results will be attributed to the behavior and not the environment and thus tend to be repeated. The longer the favorable conditions persist, the more a person will indulge in the behaviors associated with them. While the positive results are actually due to the environment and not the behavior, the continued association between the behavior and the result serves to reinforce the self-attribution of causality. Thus, it is possible that very different self-attributions will develop depending on whether the process and outcome have been favorable or unfavorable.

Another aspect of attribution theory is the kind of attributions made by people with specific types of psychological problems. For instance, a large number of studies have indicated that depressed people typically attribute negative events to stable, general qualities within themselves while causal attributions about positive events are ascribed to external factors such as luck. (See Sweeny, Anderson, & Bailey, 1986 for a recent review of some of this literature). Thus, in a prospective study of a successful psychotherapy process, one might expect a pre- and post-treatment change in attributions among depressives, with their attributions about the nature of their problems and responsibility for therapy outcome becoming increasingly internal. How this change would be reflected in the post-hoc attributions of improved depressives is less clear.

Since there is a large body of research literature on what kinds of attributions people make under different circumstances, only research that bears directly on the this study's hypotheses are considered here. However, there is no substantial body of research on the attributions made by people in psychotherapy. Attribution researchers, when they have looked at the therapeutic encounter at all, have usually focused on the attributions of a physician or a therapist about the client.

McGovern, Newman, and Kopta (1986), for example, found that clinicians with a psychodynamic orientation tended to attribute less responsibility to the client both for the cause of the problem and for the process of change than therapists with a cognitive-behavioral, family systems or eclectic orientation. Davis (1979) found that the "labeling" of psychological conditions as illnesses may have some effect on attributions of psychodynamically oriented therapists but that behavioral therapists did not show this effect. It is possible that the behaviorists did not show any labeling effect either because their orientation tends to preclude its acknowledgement or because none occurred. The study lacks generalizabilty but the author suggests that in more marginal cases this labeling effect may perhaps acquire some

significance.

While these studies raise interesting questions regarding possible differences among psychotherapists of differing orientations, they are not directly related to the concerns of the present research. Little has been done so far concerning the attributions of psychotherapy clients themselves and what factors they think are effective.

Work on the attributions of medical patients may provide an indication of the type of attributions psychotherapy clients are likely to make. Wagener and Taylor (1986) found that among patients who had undergone renal transplants, those with negative outcomes "recalled the circumstances of the initial decision in a manner that lessened personal responsibility" (p. 481). These results, while tentative, suggest that similar attribution biases may take place among psychotherapy clients. In other words, the more positive a client's outcome, the more responsibility he might assume for it. In the area of psychotherapy, Weary (1980) found that clients who were given experimentally manipulated 'positive affective outcomes' attributed these positive outcomes to themselves, reported more positive affect and greater 'egotism' than patients who were given negative manipulations. While these findings probably are not generalizable, they are suggestive because they are in line with the findings of typical Actor/Observer attribution bias in which self-attributions are more often made for positive, desired outcomes. They are also in line with the psychodynamic expectation that successful therapy will make a client more internal and more self-responsible in attributions relating both to the source of the problems and to their resolution. However, no published work seems to have dealt with the question of client attributions or with which factors clients think are working for them in the psychotherapeutic process.

The question of client attribution in psychotherapy is an interesting one. One useful way of conceiving the process of therapy may be in terms of the changes in a client's attributions, especially for disorders such as depression. Thus, successful therapy might not only cause a change in attributions, a change in attributions may be a valid indicator of progress in therapy. There are many related areas that might be fruitfully investigated and which offer interesting directions for the future. Based on some of the more general attribution research that has been done, one might expect that clients with problems such as depression would have initial attributions similar to those found in the learned helplessness research and that their attributions of failure or success might be more internal after successful therapy, giving them a greater sense of control over their lives. Attributions of the client about the therapist, about the process of therapy and about himself are likely to change markedly over the course of therapy. One possible approach is to look at this question, not only in terms of before and after but also in terms of whether definite stages can be determined which characterize these changes. This, of course requires a prospective design.

The specific issues examined in this study are the relation of clients' attributions about specific therapeutic interventions' helpfulness to their therapist's theoretical approach and whether self-defined "successful" clients differ from self-defined "failures" in the nature of these attributions. No claims are made here about the accuracy of client attributions, of course. But if clients give similar attributions about what was working for them in the therapeutic process, despite having undergone different types of therapy, this would be one more step toward developing a clearer understanding of the therapeutic process, especially if these attributions corroborate prior psychotherapy research findings.

It is often assumed that a certain amount of self-selection takes place among clients. Clients who seek a behavioral approach over a psychodynamic one might be expected to emphasize external approaches over internal, subjective ones in their attributions and the opposite tendency might be expected in the psychoanalytic group. (However, many other factors, such as availability, income, education and so forth may, and probably do, play a part in therapist selection and therefore the relationship between a client's personality characteristics and the type of therapist chosen may be far from direct.) Thus, despite possible differences in attribution styles between groups of clients in various treatment modalities, these differences are not expected to be significant. Instead, the nature of the problem, rather than the therapist's nominal orientation, is expected to be the most significant predictor of successful clients' attributions of efficacy.

The present research is frankly exploratory. However, the examination of a client's attributions provides one more way to assess the psychotherapeutic process and thus form a more valid theoretical construct. No one study can be definitive, especially in an area as complex as psychotherapy. Research has shown the number of potentially significant moderating variables to be very large, as the following brief review of some of this literature should demonstrate.

Some Issues In Psychotherapy Research

A. Efficacy

The first major psychotherapy research issue to arise was whether or not it was effective. Almost 40 years ago, Eysenck started a debate on this issue that continued for many years (1952; 1954; 1955; 1964; 1965; 1967). Eysenck's (1952) assessment was the first critical appraisal of psychotherapy based on empirical studies. After reviewing the literature, Eysenck argued that psychotherapy's positive effects are no better than what could be expected by chance alone and he concluded that psychotherapy did not produce any significant effects. He later published two additional literature reviews (1961; 1966) that reached the conclusion that the efficacy of psychotherapy still had not been demonstrated. His

argument was persuasive and is apparently still accepted in some quarters (see Rachman & Wilson, 1980; Rimland, 1979; Strahan, 1978).

However, a careful examination of the studies that Eysenck used by Meltzoff & Kornreich (1970) showed that Eysenck's data did not support his claims. Meltzoff & Kornreich pointed out that Eysenck relied on a large number of poor or inconclusive studies while ignoring a number of studies that could have lead to a contrary conclusion. Meltzoff & Kornreich's review concluded that psychotherapy had been shown to be effective. A large number of the studies that they included in their review indicated that some types of clients have received definite, positive effects from both long- and short-term therapies. On the other hand, there were also a number of good studies indicating either no, or negative results.

Summarizing the results of much of the then available literature Meltzoff & Kornreich found that psychotherapy was shown to have had significant positive benefits in roughly 80% of the cases and negative or null effects in only about 16%. "Far more often than not," they wrote, "psychotherapy of a wide variety of types and with a broad range of disorders has been demonstrated under controlled conditions to be accompanied by positive changes in adjustment that significantly exceed those that can be accounted for by the passage of time alone. As a group, [the therapists whose work was evaluated in this research] were not selected for their outstanding ability. Many were indeed quite inexperienced" (1970, p. 175).

A number of other reviews have followed Meltzoff & Kornreich and most of these have also come down in favor of psychotherapy's effectiveness (Bergin, 1971; Luborsky, Singer, & Luborsky, 1975; Bergin & Lambert, 1978).

However, one reviewer, Rachman (1971; 1973), a colleague of Eysenck, reached conclusions about psychotherapy's effects that were similar to Eysenck's. The one area of therapy that he found effective was behavioral therapy. Rachman & Wilson's (1980) review essentially confirmed Rachman's earlier findings: He found no data to suggest that psychotherapy was effective and only limited data to suggest that other forms of psychotherapy (with the exception of behavioral therapy) produced positive results. Unlike other reviewers Rachman & Wilson found a clear superiority for behavioral therapies and among these found cognitive behavioral therapy to be the most promising. They also criticized Smith & Glass' extensive 1977 review for omitting many sound studies of behavioral therapy.

It is possible that the differences found by different reviewers are attributable to personal biases in selection and evaluation of the available data. Most reviews have followed a standard box-score approach, totalling up the number of studies for or against. More recently, however, the technique of

meta-analysis has been applied to psychotherapy research reviews. The studies by Smith & Glass (1977) (375 studies) and Smith, Glass & Miller (1980) (475 studies) are among the largest reviews of psychotherapy research ever published and are also among the most positive in their appraisal of it. While their criteria for including studies were not made explicit, Smith, Glass and Miller (1980) found no significant differences between the results obtained in the published and unpublished studies that they used. Further, two partial reanalyses of selected studies from the Smith, Glass and Miller data (Prioleau, Murdoch & Brody, 1983; Landman & Dawes, 1982) upheld the general conclusions of the 1980 Smith *et alia* study.

In general, the available research confirms, but confirms no more than, the conclusion reached by The APA Commission on Psychotherapies (1982) that "psychotherapy appears efficacious more often than not, but the conditions under which it works are not well understood" (p. vii). However, the research focus now seems to have moved from the question 'Does psychotherapy produce any positive results?' to the more complex one of '*When* is psychotherapy effective, and *why*?'.

B. Factors Contributing to Psychotherapy's Effectiveness

The question of why psychotherapy is effective remains a puzzling one. No single approach, school or technique has been consistently found to be superior to any other, nor has any common factor among them been conclusively found to produce psychotherapy's effect.

Summarizing their review of research on the differential effectiveness of different types of treatments, Meltzoff & Kornreich (1970, p. 200-201) state that "there is hardly any evidence that one traditional school of psychotherapy yields a better outcome than another. In fact the question has hardly been put to a fair test." And although behavioral techniques have emerged as the treatment of choice for specific types of phobias, according to Meltzoff & Kornreich its comparative effectiveness for cases of generalized maladjustment had not been demonstrated.

More recently, some researchers have disputed this conclusion and made broader claims for behavioral therapy. Sloan & Staples (1984) stated that they found behavioral therapy *generally* useful and not just applicable to phobias or learning disorders. Furthermore, these researchers assert that symptom substitution, the replacement of one set of symptoms with another (presumably because the root cause of the problem has not been dealt with), was not found to occur when with the use of behavioral therapy.

However, these exceptions having been noted, most research has not found any effect for treatment technique and there does not appear to be any consensus on a differential effect for behavioral therapy.

It is also possible, as noted previously, that these more general uses of behavioral approaches, if valid, are the result of unintended by-products of therapy and not directly to the specifically behavioral elements. The specific factors that contribute to psychotherapy's effect remain to be demonstrated scientifically but there is no lack of hypotheses as to what is making the difference. Some of the main areas that have been looked at are discussed below.

C. Therapist Attributes: Common Factors

Some studies have found certain common factors among the majority of therapists. However, many such studies do not focus specifically on a comparison between psychodynamic therapists and behavioral but rather compare the different schools of psychodynamic therapies. Sundland & Barker (1962) found that the majority of therapists in their sample tended to set goals, plan the treatment and to reject the spontaneous approach. While the therapists tended to plan therapy, they did so within the constructs of their school of training. Ninety-five percent tried to figure out the nature of the therapeutic relationship, and 50% felt childhood was important.

Raskin (1965) found a high degree of consensus on the characteristics of the ideal therapist, even though the dimensions supplied cut across specific technique lines. These results are similar to Fiedler's (1950a). Strupp (1955) found that Rogerians differed from non-Rogerians in the types of responses given to clients across most categories. In another study, Strupp (1958b) found that Rogerians favored reflection of feelings while analytic therapist favored directed questions. However, the two groups did not differ in terms of clinical diagnosis. In terms of approaches, Rogerians were less concerned about poor motivation, excessive dependency, acting out, countertransference, and problems of technique. They were less apt to designate areas for focus or particularize attitudes and behaviors to be encouraged or discouraged. Analytic therapists favored inducing changes by means of interpretation, while Rogerians left things to the client in the hope of arriving at a corrective emotional experience. Wrenn (1960) found that counsellors of varying orientations gave responses to feeling aspects of clients' statements 83% of the time, regardless of their orientation.

D. The Effect of Therapist Experience

In general, results indicating the significance of therapist experience on outcome are lacking and this is most striking, since, in most areas, one assumes that practice improves performance. Significant differences have often been found between experienced therapists and inexperienced ones but the nature of such differences has varied from study to study and their significance on therapeutic outcomes, the ultimate criteria, has not been conclusively demonstrated.

McNair & Lorr (1964), for example, did not find experience related to technique pattern or factor scores. Sundland & Barker (1962) also found that, in general, attitudes and methods were not a function of experience. They did find that less experienced groups of therapists agreed more about the existence of innate, self-actualization in clients, reflecting a more optimistic view of clients than more experienced therapists.

Anthony's (1967) follow-up to the Sundland & Barker study found that experienced therapists of all orientations were more interpretive and more talkative (if initially low in this) and all became more concerned with conceptualizing how the client was relating to them. All increased goal setting, with Freudians changing from doing the least to the most. All groups became less sure of themselves in the therapy situation. Client understanding increased as a valued goal for all therapists as did the belief that therapy is a non-conceptual, non-verbal process rather than a verbal one. It is difficult to make broad generalizations from these findings, especially since, in some cases contrary results have been found on some of these changes. (See below.)

Sommer, Mazo, and Lehner (1955) found that more experienced therapists tended to offer more interpretive reactions to client statements but did not differ fundamentally in their assessments from graduate students in clinical psychology. Phillips & Agnew (1953) found that more experienced therapists used more reflective, understanding statements than untrained people. The technique of probing for more information was used by all. Rice (1965) found that more experienced therapists were characterized by more fresh, connotative language, more expressive voice quality and inner exploration while Grigg (1961) found that experience decreased verbal behavior in therapists and increased listening.

Fiedler (1951a) has suggested that the factors that differentiate experts from non-experts are the ability to communicate with and to understand clients, a sense of personal surety, and a greater emotional distance from clients. His design confounded success with experience, however, since "expert" was defined not by success but by experience.

Gamsky & Farwell (1966) reported that counselor experience decreased a therapist's avoidance of client hostility, which may also indicate greater emotional objectivity, and Fuller (1963) found that therapist experience increased client expression of feeling. However, Strupp (1955) found that differences between experienced and inexperienced therapists were due to chance and, contrary to Phillips & Agnew (1953), he found that Rogerians' reflective responses to clients declined with experience. Strupp concluded that reliance on only one technique is the result of inexperience. In a later study, the only difference that Strupp (1958a) found between experienced psychologists and psychiatrists and less experienced ones was the tendency of the experienced group to give clients a lower ego-strength rating,

to admit to having more negative attitudes toward clients and to have a more negative estimate of a client's social adjustment.

In findings that may be related to this, Storrow (1960) noted that student-therapists tended to see results in the same way as their clients while experienced therapists tended to agree more with external judges.

In general then, studies find that experience does change therapist conceptualization and practice and that experienced therapists have a less literal, more critical, and less optimistic view of clients. The therapist/client relationship is believed to more closely approximate an ideal with technique becoming more diversified, more versatile and adaptable while consensus about the goals of therapy increases as well as a willingness of therapists to confront clients on difficult issues. However, experience is often confounded with other things in these experiments and its definition is not consistent. Nor, more importantly, is experience consistently correlated with success.

E. Personal Characteristics of the Therapist

One widely held belief is that there is some personality factor or constellation of factors that contributes to a therapist's effectiveness. The issue of the therapeutic personality often surfaces in research. So far, however, research results supporting this thesis have not been consistent. Although studies often indicate that therapist's personality can be important, it is not yet clear what is important, to whom, why, and under what circumstances. None of these studies can fully answer these questions but they do seem to indicate that personality can be a factor. Holt & Luborsky (1958) combed the literature for lists of traits believed to affect success of therapy outcomes but their study yielded small and inconclusive results in this direction. Streitfield (1959) could not confirm the hypothesis that successful therapists are more accepting of themselves and others. Nor has any evidence been found to support the widely held belief that a therapist who has undergone psychotherapy is more effective than one who has not.

Levine, Marks & Hall (1957) compared the success of two therapists: One was relaxed, outgoing and enthusiastic, the other distant, critical and compulsive. Clients under the first therapist achieved significantly higher improvement scores. The limited generalizability of this study is evident, however. Bare (1967) found a correlation between social involvement and counselor helpfulness, empathy and mutual self-other knowledge of client and therapist. A factor to be considered in such studies is the fact that clients in two related studies (Simmons & Tyler, 1964; Tyler & Simmons, 1964) were shown to conceptualize therapists' traits very differently than did therapists and staff. Clients were much more personal in their concepts than staff, who saw themselves in terms of skills, duties, and professional identity with less emphasis on personal characteristics. This raises the question, is a therapist's or a

researcher's view of 'good therapist' characteristics more important in determining outcomes or is the clients'?

F. Psychologists Versus Psychiatrists

Strupp (1958), using a filmed client interview that could be stopped to elicit therapists' evaluations, found no significant differences in client evaluation as made by a group of psychologists and a group of psychiatrists matched on experience. Among the few differences that did appear: Psychologists expected more acting out from clients, and were stricter and discouraged free association. Psychiatrists asked more exploratory questions while the psychologists were more apt to allow the client's own frame of reference. There was a significant difference in the judgement of therapeutic goals for the film client, however; the psychologists tended to strive for insight, while the psychiatrists aimed for the relief of symptoms.

G. Individual Versus Group Therapy

No significance differences have been found in the effects of group versus individual psychotherapy (Frank et al., 1959; Thorley & Craske, 1950; Novick, 1965; Paul & Shannon, 1966), although there is some indication that individual therapy may be slightly faster in producing effects.

Thus, while there do not seem to be many really important differences among psychologists and psychiatrists, or between group and individual psychotherapy over the long run, there is some indication that certain attitudes of the therapist (positive, accepting, optimistic) can facilitate progress while negative, gloomy and pessimistic qualities can impede it. In general, however, the results of studies in this area are not clear cut. A further complication of the issue of therapist characteristics is the fact that the clients' view of such qualities may be quite different than the therapists'.

H. Client Characteristics

The more one delves into psychotherapy research findings, the more paradoxical the results seem to be. For instance, while it is generally believed that psychotherapy provides the most benefit to clients with less severe problems at the outset, findings that support this contention have been mixed. Some studies Barron (1953) Grummon & John (1954), Katz, Lorr & Rubinstein (1958), Schoenberg & Carr (1963), McNair, Lorr, Young, Roth & Boyd (1964), have supported this hypothesis, while others Raskin (1949), Page (1953), Klein (1960), Cappon (1964) have tended to find either no effect for client diagnosis or the opposite: Clients with the severest symptoms showed the most benefit. Much of this confusion may lie in the lack of specificity in defining initial conditions and outcomes; further research needs greater

specificity.

Client characteristics like education, sex, or marital status have provided no clear correlation to outcomes either, although Meltzoff & Kornreich (1970) found evidence that social class could interact with therapy in a variety of ways with clients in lower economic classes desiring more directive forms of therapy.

Searching for Synthesis

Possible Common Factors Affecting Research Outcomes

The large number of different theories and approaches in psychotherapy, and the fact that many of them seem to work, brings us back to one of the questions raised at the outset: Is there a core of skills and techniques that therapists adopt as a result of their own experience and regardless of the type of training they have received? Some suggestions that have made for a common underlying process follow.

One interesting idea regarding therapy's effect is that the therapist unconsciously reinforces some kinds of behavior. Waskow (1962) and Truax (1966) indicate that reinforcement does take place in therapy. The therapist's empathy was associated with client discrimination learning, directiveness was associated with client ambiguity and negatively with empathy. Similarity of client expression to the therapist's was also associated with therapist empathy. There is some evidence that reinforced behaviors increased over time.

Moos and Clemes (1967) maintain that therapists use a variety of styles depending on the client and that therapist behavior cannot be predicted from a general classification of counsellor style.

McNair & Lorr (1964) found three main factors in the techniques of psychiatrists, psychologists and social workers. These factors relate to a therapist's analytic approach, his interpersonal style and his degree of directiveness. The first factor, Factor A, reflected a psychoanalytic approach that included childhood experiences, dream analysis, resistance and transference, free association, emphasis on the unconscious. The next factor, Factor I, was a detached, objective, impersonal mode of relating. Those low on factor I endorsed close, personal, human interaction with the client. The third factor, Factor D, represented two poles: an active, directive approach, versus a free-form, non-directive approach. Psychiatrists were found to be concentrated in high factor A patterns, one-third endorsed psychoanalytically derived techniques, an impersonal relationship in which the therapist controlled the course of therapy. Social workers revealed two main preferences, both of which were nonanalytic and valued controlling the course of therapy. However, one-fourth of them favored a personal, directed therapy

and while another fourth favored impersonal, directed therapy.

Wallach & Strupp (1964) derived four factors from a 17-item scale of therapeutic practices. Therapists of different orientations were examined on the four factors:

I maintenance of personal distance,

II preference for intensive psychotherapy (i.e., a psychodynamic approach),

III preference for keeping verbal interventions to a minimum, and

IV view of therapy as a flexible, artistic and artful activity.

Therapists of different orientations were found to be significantly different on all 4 factors. The most variation was found on factor IV. While the differences were statistically significant, it is unclear how they would translate into specific practices or modes of interpersonal relationship. It is possible that such therapists would be inclined to be more eclectic, individualized, and personal in their approaches but this was not specifically studied.

Noblin, Timmons, and Reynard (1963) have suggested that anything that the therapist gives the client that will allow change to take place is therapeutic. Any *believable* cognitive framework that will support a behavioral or attitudinal change will do. This is essentially the conclusion reached by George Kelly (1955; 1958) as well as by Meltzoff & Kornreich. In summarizing studies dealing with the kinds of interpretations therapists offer to clients Meltzoff & Kornreich note that "there is more of what clients see as movement, less resistance, and greater client preference for intermediate-level interpretations that go beyond mere reflection of feelings yet are plausible to the client (whether or not they are true). When too "deep," abstruse, or beyond the client's present ability to understand, accept, and be influenced by it, the interpretation may serve as an aversive stimulus that arouses anxiety and resistance to a degree that interferes with the therapeutic process" (1970, p. 427). Noblin, Timmons and Reynard have also suggested that more specific interpretations help reduce client anxiety but that the depth of interpretation has a curvilinear relationship to acceptance.

Brayfield (1968) has suggested five major methods for the shaping of human behavior:

1. Reinforcement of responses,
2. Modeling,
3. Conveying the belief that change is possible,
4. Dealing with beliefs, discussing dynamic concepts, and
5. Problem solving/decision making with the client's involvement.

Reisman (1971) defines psychotherapeutic communication as having three common elements, namely:

I. "a wish to be of help to the client";

II. "a respect for the client"; and

III. "a communication of understanding of what the client has said or done or of what the client might do to improve his condition or behavior". (1971, p. 66)

Reisman specifically excludes modeling as a psychotherapeutic approach. However, it might be argued by defenders of approaches like Bandura's self efficacy training (Bandura, Adams, & Beyer, 1977), that their approach meets these specific criteria. For instance, a client who came to such a therapist for the treatment of a snake phobia must first communicate, directly or indirectly, the nature of the problem he would like to address. The therapist communicates his understanding of the clients needs and wishes by designing an approach for its treatment and by modeling appropriate coping and behavioral skills. His overall attitude as well as his implementation of a program of treatment indicate a wish to be of help. The client is given the opportunity to model the behavior until he can feel confident in his own response.

Garfield (1984) suggests that the most appropriate treatment for a client may be a tailored-made program for a specific individual rather than a general illness model. This approach may be more truly psychological than the disease medical model. Among the variables Garfield suggests may be common to all psychological treatments are:

1. suggestion,
2. support,
3. explanation,
4. emotional release,
5. practice,
6. Exposure to negative stimuli,
7. encouragement and reinforcement, and
8. the relationship in therapy. (1984, p. 302).

Garfield views these as the general, common important aspects of all psychotherapy. Similarly, as Frank (1974a) has suggested, psychological disorders show common features, demoralization, lack of hope, low self-esteem. In addition to these kinds of general factors, there are probably also specific factors relating to specific problems. Exposure is a possible specific factor for overcoming fear. As has been done in intelligence theory, Garfield has proposed a general factor as well as specific ones operating co-extensively in the therapeutic process.

Frank (1974b) has suggested that all psychotherapy modalities, despite apparent wide differences, derive their effectiveness from nonspecific elements that include:

1. EXPECTATION OF BENEFIT: There is some evidence that this requires some congruence between expectations and what actually occurs in therapy. The client must have some idea of what to expect. An explanation of how therapy works (not necessarily true but plausible) may be needed too.
2. NEW OPPORTUNITIES FOR LEARNING BOTH EXPERIENTIALLY AND COGNITIVELY: In other words, specific suggested ways of change, modeling therapist behavior and values, positive responses from therapist that counteracts early, negative reactions from family.
3. SUCCESS EXPERIENCES: These include new insights, behavioral changes, or acknowledgement of responsibility.
4. DECREASE IN ONE'S SENSE OF ALIENATION THROUGH THE THERAPEUTIC RELATIONSHIP
5. EMOTIONAL AROUSAL

According to Frank the essence of therapy is to reduce demoralization. The initial impact of psychotherapy is to reduce distress and symptoms. With more prolonged therapy, the client can become more socially effective. However, specific techniques might produce benefits over and above the reduction of demoralization (as in the areas of phobias, sexual disorders and compulsions).

The implication of Frank's thesis is that any person is a suitable candidate for psychotherapy if their problems are due to demoralization, especially if the problems are due to the 'functionally autonomous residue' of a past life crisis or emotional disorder. These clients are also the most likely to undergo a spontaneous remission of symptoms. Psychotherapy is thus an accelerator of recovery. Frank also hypothesizes that if demoralizing life circumstances are enduring, or if personality limitation prevent personal effectiveness, or if the demoralization is secondary to a biological illness, then therapy should be useless. Frank suggests that some therapists do well with a wide range of demoralized clients because of their personalities and suggests that an element of telepathy may be involved. Conversely, very poor therapists radiate gloom, sabotage movement, and substitute intellectualization for positive action. Thus, in Frank's view, psychotherapy does not treat primary problems or illnesses but secondary complications.

Beck (1984) has suggested that, for depressives at least, the common component for all therapies is their induction of 'cognitive restructuring,' using the term cognitive to cover conscious, rational processes as well as more primitive ones. Thus, he notes that "Although behavior therapy explicitly short-cuts the high-level cognition insofar as it focuses exclusively on direct exposure to threatening situations, it actually provides the client with a powerful framework to correct, cognitively, his unrealistic fears" (p. 129). Beck emphasizes a certain similarity of concepts between the cognitive approach (with its primitive levels) and the conditioned reflex of the behavioral. "The key to therapy consists in correcting

the negative [psychological] balance through insight; through establishing positive reinforcements; through changing the negative cognitive set; or through the increasing availability of catecholamines and/or serotonin." "A common denominator of the various systems is the ascription of cognitive mechanisms to the process of therapeutic change. Research has indicated that improvement in the clinical condition is associated with changes in cognitive structuring of experience irrespective of the type of therapy. It is suggested that changes in the cognitive processes play an essential role with each type of treatment" (p. 133).

Summary

There is no lack of theories about what core processes may be taking place in psychotherapy. Is any sort of synthesis possible? Given the broad differences in details among theories, only the broadest elements from each theory can be considered. And yet all of these theories from Freud to behavior modification claim to be instrumental in producing positive changes in a client's behavior. What do they have in common?

All start with the proposition that the client who seeks help has a problem. The formulation of the nature of the problem is where huge differences among theories start to emerge. For radical behaviorists the problem is purely one of behavior, change the behavior and you solve the problem and that is the end of the matter. Cognitive and psychodynamic schools view the behavior as the result of intra-psychic states or as an interaction between acts and cognition. Is there one correct view? As in most such dilemmas the answer is most likely neither black nor white but gray. Purely behavioral change can be explained perfectly well in terms of cognitive change (Beck, 1984) and the order of precedence does not appear to be invariant. Cognitive changes produce behavioral change and behavioral change can produce or accompany cognitive change. If they exist at all, problems that are purely behavioral or purely intrapsychic are probably quite rare and of little practical moment. If both behavioral and intrapsychic approaches can produce the same result, does it matter to the client which is used?

To some degree the choice of therapeutic approaches is a question of personal values and of efficacy. While some degree of consensus has been shown about the nature of various types of psychological problems, there is less agreement about what kinds of solutions are most desirable. This question rests on personal choice and values. Whether certain values are more adaptive than others is still a matter for investigation. The question then becomes one of efficacy. Some problems, such as phobias, seem best treated by behavioral approaches. But while this may be the case in terms of specific phobias or behaviors, but what of more general or vague fears? Is a purely behavioral approach possible? What of the client that needs reassurance before even beginning a behavioral treatment? Aren't such non-

behavioral factors such as the personal characteristics of the therapist, the client/therapist match, getting in touch with feelings -- in short, intrapsychic exploration -- helpful and necessary with such a client?

In addition, the question of efficacy must be viewed, in turn, in a defined temporal context. What kind of efficacy? One may speak of efficacy in terms of the appropriate treatment for a specific problem or in larger time frames. The psychodynamic therapist might argue that in larger terms a psychodynamic solution is more efficacious even though it takes longer because of its (presumed) more pervasive effects on a person's life.

Thus, it would appear that the nature of the client's problem and not the theories of any one school probably dictate the solution to a client's individual problem and thus a successful, experienced therapist's approach. This inference seems to be supported by Moos and Clemes (1967) and others who found that therapists used a variety of styles depending on the client. Thus, the nature of the problem and not the school of the therapist should be the chief predictor of what techniques were used among successful clients.

Given the theories of etiology and therapy that have developed around the various behavioral and psychodynamic theories, it might be expected that the principal predictor of the techniques used by a therapist would be the therapist's technical and theoretical orientation. However, since the technique that could be most effective changes from client to client and depends upon the point reached in the therapeutic process, more successful therapists should be the most flexible, the least doctrinaire and have the greatest variety of techniques at their disposal. Thus, a similar body of successful techniques would be employed in practice by effective therapists regardless of their nominal orientation. Effective therapy would thus be a synthetic blend of techniques that were selected for an individual case and psychotherapy an individualized endeavor as Garfield (1984) has suggested, and not a standardized approach. Furthermore, as discussed above, if clients who consider their psychotherapy successful attribute efficacy to the same body of therapeutic techniques that previous research has shown effective, these attributions, while inconclusive in themselves, can help strengthen construct validity for these elements in the psychotherapy process. Further, if the therapeutic elements named as effective by such clients depend not as much on the therapeutic school of the therapist as the nature of the problem(s) dealt with in therapy, this gives more weight to Wachtel's (1977) suggestion that, despite their differences, approaches as different as the behavioral and psychodynamic actually have a common core of elements.

In addition to shedding some light on the most important elements of the therapeutic process, looking at "successful" client attributions versus "failures" may provide a useful way of conceptualizing the changes that take place during the course of therapy. It is known that depressives often make blame

themselves for failure and minimize their self-attributions for success; these attribution styles change after treatment becoming more internal for success. However, it is not known whether successful psychotherapy clients with different types of initial problems also make more internal attributions (and thus assume more personal responsibility for their outcome) than failures, although this hypothesis is in line with both attribution and psychoanalytic theory. (See the discussion of this above.) Thus, for some types of problems at least, a change in a person's attributions may be a useful index of overall psychological change. While the present study is an exploratory, hypothesis-generating one, attribution differences between self-reported successes and failures may point to a useful future direction for research effort.

QUESTIONS AND HYPOTHESES

Research Questions

As stated earlier, the primary questions of the present research are: 1.) do clients who have undergone different types of psychotherapy report the same common core of techniques used regardless of treatment; 2.) are the elements selected by these clients in accord with prior research findings on effective elements in psychotherapy, and 3.) are the attributions (self- or other-related) made by reported successes different from those of self-defined failures.

While clients of behavioral therapy were expected to give slightly greater weight to external, behavioral factors, and clients of more traditional psychodynamic approaches were expected to give greater weight to psychodynamic processes and self-understanding, these differences were not expected to be significant. The main issues dealt with during therapy and not the therapist's orientation were expected to be the main predictors of efficacy attributions.

Although client reports about psychotherapy may be subject to attribution bias, one cannot therefore assume they have no validity. If reports about efficacy accord with existing literature, this finding strengthens the construct validity of such elements' importance in the psychotherapy process. If, in addition, such techniques are not usually associated with a particular clinical orientation, then, at the very least, one may question to what degree the major theoretical formulations of either the behavioral or psychodynamic schools are adequate descriptions of the therapeutic process.

Based on the preceding discussion of the psychotherapy literature, it was expected that the nature of the client's problem, not the therapist's orientation, would be the main predictor of which techniques a successful therapist uses and that their clients' reports will reflect this in terms of both frequency and helpfulness.

Hypotheses

In addition to an examination of the questions discussed above, specific hypotheses were made concerning the differences between "successful" clients' reports and those of "failures". It was expected that the use of a greater number and variety of techniques by the therapist would be associated with success. Specifically, it was hypothesized that:

1a. Self-defined successful clients would describe their therapists' attitude and approach as significantly more flexible than would self-defined failures, and

1b. Reported successes would describe their therapists as using a greater number and a wider variety of techniques including behavioral, cognitive and psychodynamic elements than unsuccessful clients.

A significant relationship between reported success and client attributions was also expected, specifically:

2a. Self-defined "successful" clients would make more self-related attributions about the nature of their problems than would unsuccessful clients;

2b. Reported successes would take more responsibility for outcome than reported failures;

2c. Clients who take no responsibility for therapy outcome would not report their therapy a success, and

2d. Clients who report their therapy as less successful would also tend to attribute the reasons for entering therapy more to other-related than to self-related factors.

METHODS

Participants

Recruitment

Participants were recruited mainly through private or university-affiliated clinics and through private practitioners in the New York metropolitan area. An effort was made to enlist the cooperation of therapists of different orientations. Participating clinics and therapists fell into three broad self-classifications: 1. Cognitive/Behavioral, 2. Psychodynamic, and 3. Eclectic. "Behavioral" participants were drawn from two clinics; one was affiliated with a university doctoral program, the other was private but provided in-house training and supervision for some of its therapists. "Psychodynamic" participants were clients from two training institutions; one a university clinic and the other a private institute that accepted only advanced-degree recipients for training. Some of the therapists from these two groups, therefore, were still receiving clinical supervision. However, some clients also saw the more experienced therapists on the staff. Therapist experience is, therefore, variable. Information matching therapists/experience with clients/outcome was not available. The "eclectic" group were clients of private therapists; these were established professionals with, presumably, more experience than the many of the psychodynamic or behavioral therapists. This group of therapists consisted of both psychologists and clinical social workers. Six cases from pilot-study data that met selection criteria were also included in this group. These data did not differ significantly from that of the main study. However, no information on these therapists' training and background is available.

Participation was voluntary and was limited to adults who had completed at least 12 weeks of voluntary psychotherapy (regardless of type). A small number of respondents were dropped from the analysis because of incomplete data or because, in one case, the length of treatment was insufficient. Participants were contacted directly by their former clinic or therapist or were mailed questionnaire packets supplied by the investigator. These packets also included a cover letter from the clinic explaining the study and a letter from the investigator which explained the purpose of the study, requested participation, and offered an honorarium of $10.00 for participation.

In order to protect participants' anonymity, no participants' names were requested by the investigator. Furthermore, to insure that participants would feel comfortable answering questions about their therapists frankly, participants were assured that their therapists would not see their answers: Questionnaires were either mailed directly to the investigator or were, in one case, turned over to the investigator in sealed envelopes by the clinic.

TABLE 1

Scale Questions Grouped by Theoretical Category

Checklist Question #	General Therapist Techniques
1.	My therapist would ask questions to get at important information
17.	My therapist set specific goals for therapy
3.	My therapist would confront me on issues when s/he felt it was necessary
4.	My therapist was adaptable in technique, attitude, and focus according to the needs of the situation
20.	My therapist forced me to focus on what I was doing in the here and now
12.	My therapist gave me feedback and comment when appropriate

Checklist Question #	Behavioral Techniques
15.	My therapist worked with me to change specific things I was doing to create specific problem(s)
22.	My therapist showed me specific problem-solving techniques
23.	My therapist helped me learn new ways of responding to situations that were difficult for me
6.	My therapist worked with me on changing bad habits
11.	My therapist showed me concrete ways to change my behavior
19.	My therapist helped me change the way I thought about things
25.	My therapist corrected me when I made mistakes
14.	My therapist used external things to reinforce new patterns of behavior for me

Checklist Question #	Psychodynamic Techniques
7.	My therapist did not give me insights but helped me discover these for myself
9.	My therapist let me know whether s/he understood what I was saying or feeling
16.	My therapist helped me to feel and express my emotions
10.	My therapist focused on the way I related to him/her during therapy
8.	My therapist gave me a different way of seeing my actions, thoughts or feelings
29.	My therapist disclosed personal information about him/herself
13.	My therapist used his/her approval to motivate me

Checklist Question #	Personal Characteristics of the Therapist
2.	My therapist and I had good rapport
21.	My therapist communicated that change was possible for me
24.	My therapist showed that s/he was sympathetic
5.	My therapist got involved with my problems in a way that was meaningful to me
18.	My therapist showed that s/he was warm and caring
26.	My therapist gave me acceptance and approval
27.	My therapist was generally calm even in a crisis
28.	My therapist communicated enthusiasm about working with me

The Research Instrument

Participants were asked to complete a three-part questionnaire that included questions on participant demographics; the therapist and therapy (gender of therapist, duration and type of therapy and reasons for starting therapy); the severity of the initial problem, and the issues dealt with in therapy. Participants were also asked to assess their outcome success/failure and to partition responsibility for this outcome as well for their initial problems between self (internal states and external behaviors) and others (circumstances, other people).

The core of the research instrument is The Psychotherapy Checklist (Part III of the Questionnaire in the Appendix). The Checklist consists of 30 items describing different types of therapeutic techniques and therapist characteristics. The items selected were either characteristic of a specific psychotherapy approach or represent techniques and/or therapist characteristics which research indicates have a significant effect on therapy outcome. An attempt was made to describe these techniques and characteristics in non-theoretical language.

Hypotheses would be tested based on responses to the questionnaire. Grouping participants according to reported outcomes (Part One, Question 1 of the questionnaire) groups were expected to differ according to outcome on: 1.) reported flexibility of the therapist (Part III, Question 4 of the Psychotherapy Checklist, and 2.) the therapist's reported use of techniques in terms of variety and frequency. Variety would be assessed by summing the number of techniques reported on the Checklist regardless of frequency (Checklist items with a score of 2 or more) and overall frequency would be assessed by the total mean of all Checklist frequency items. Reports of success were expected to increase with reports of greater therapist flexibility and variety on these measures. The issues dealt with during therapy were expected to predict the types of techniques used with successful clients (general issues were expected to elicit a more psychodynamic approach while more specific issues a behavioral one); a wider range of techniques of all types was expected for successful clients than for failures.

Finally, it was expected that reported successes would make greater self-attributions for therapy outcome (Part one, Question 2) than would reported failures. The same would also apply to their attributions about the initial cause of their problems (Part one, Question 3); successful clients would take more responsibility for these initial problems while failures would attribute their problems more to external factors.

RESULTS

A initial pilot study was run to assess the questionnaire. Based on these pilot-study data some questions were reworded for greater specificity. Some participants had answered the questions with several therapists in mind rather than their most recent one. One question about financial reasons for terminating therapy was added (Part I Question 7.C) as well as a few write-in questions that do not relate to any of the study's principal questions or hypotheses and which are not included in any of the results presented here.

Listed in Table 1 are the principal scale questions grouped according to the main therapeutic orientations they are intended to represent. An initial attempt was made to validate these items by having therapists sort them into appropriate categories before the study began. None of these therapists worked at participating clinics. This effort was abandoned when it was observed that clinicians from different orientations seem to have unique, orientation-specific views about what features are characteristic of their own approach vis-a-vis others. This, in fact, opens up a very interesting line of research. Items, therefore, are offered at face validity in the belief that there is no general clinical consensus on this matter.

Reliability estimates were computed for each category of reported technique frequency and these are listed in Table 2, Type and Variety of Techniques Used Grouped by Orientation. Given the small number of items involved, reliabilities are quite respectable, ranging from a low of .74 for psychodynamic techniques to a high of .86 for behavioral techniques. Question 30 of the Checklist *My therapist prescribed psychotherapeutic drugs and medications when I really needed them* was dropped before further analyses were done since it was significantly lower than any other item in terms of both frequency and helpfulness and seemed to apply to very few respondents. Presumably, most participants' therapists were not in a position to prescribe drugs. The reliability for all frequency items (1-29) of the scale was .93 which is quite high and indicates that the scale is essentially assessing one factor. Therefore, no factor analysis was undertaken.

Participant Characteristics

Seventy-one participant responses were used in the study. No data on response rates are available since it is not known how many clients were actually contacted. Some clinics contacted their clients directly and in other cases it is not known how many clients actually received the questionnaires since many had moved since leaving therapy. Fifty-nine of the participants are female, twelve are male. These proportions reflect that fact that more women tend to use therapy as a means of assessing their problems. The number of female therapists (48) was also much higher than that of males (23). No

significant success/failure differences were found by dividing the population according to sex.

Age is evenly distributed through the sample ranging from 21 to 63 with the mean age of 37 close to the median of 35. Half of the population is married or has a significant live-in relationship. The population is above-average in education; only one participant has less than a high-school education. The mean, the median, and the mode are all centered near the college-degree level while 14% have some graduate-level schooling. Time in therapy for the entire sample ranged from 3 months to 10 years, with a mean of 21 months (raised by two outliers of 8 and 10 years) and a median of 12. Eight participants also attended group therapy concurrently with individual psychotherapy. Time spent in group therapy was much shorter, an average of 2 months, with 15 months as the highest value. Time in therapy varied considerably *within* all groups. The Behavioral group ranged from 3 to 48 months, with a mean of 14 months and a standard deviation of 12.88. The psychodynamic group also ranged from 3 to 48 months with a mean of 20 months and a standard deviation of 14.68. The eclectic group ranged from 3 to 120 months, the mean was 23 months and the standard deviation was 25.10. This group contained the two outliers of 8 and 10 years.

Subject Differences

It is often assumed that some self-selection takes place in therapy so that clients with certain characteristics are pre-disposed to choose one type of therapy over another. To check this possibility, participants were tested for group differences according to various demographic criteria. The success/failure groups did not differ on most demographic variables such as age, education, sex, having a significant live-in relationship or whether financial considerations played a part on choosing a therapist or the type of therapy received. A rough, ad-hoc measure used in lieu of a longer test and intended to assess introversion/extroversion (Part II, question 8) also failed to discriminate the groups. Neither did the groups vary on monetary reasons for choosing a therapist or type of therapy. However, a significant difference did emerge between successes and failures on whether financial considerations were a factor in *ending* therapy. Failures reported ending therapy for financial reasons significantly more often than successes, $t(60) = 2.30$, $p = .03$. In general though, demographic variables are not significantly different among clinic sources or theoretical orientations using analysis of variance.

Assessing Outcome Differences

One of the main questions to be looked at in this study was whether clients in different types of therapy would report the occurrence of same core of elements and whether the use of a greater number and variety of techniques would be associated with reported success. To examine this question, the population was divided into successes and failures based on respondent reports of therapy outcome on

TABLE 2
Type and Variety of Techniques Used
Grouped by Orientation

Clinic Orientation	N	Type of Technique	Mean	SD
Behavioral	16 (22%)	General Tech.	6.38	0.62
		Behavl. Tech.	5.98	0.67
		Psych Dyn. Tech.	5.39	1.04
		Thpst. Char.	6.59	0.78
		Total # Tech. Used	27.38	1.63
Eclectic	34 (48%)	General Tech.	4.53	1.24
		Behavl. Tech.	3.84	1.18
		Psych Dyn. Tech.	4.80	1.04
		Thpst. Char.	5.38	1.04
		Total # Tech. Used	25.56	4.27
Psychodynamic	21 (30%)	General Tech.	3.65	1.22
		Behavl. Tech.	2.76	0.88
		Psych.Dyn. Tech.	4.57	0.76
		Thpst. Char.	5.28	0.84
		Total # Tech. Used	23.67	3.18

Reliabilities for Technique Types (Reported Frequencies)

Type of Technique	Scale Mean	SD	Standardized Reliability Estimates (Cronbach's Alpha)
General Techniques	30.56	7.45	.83
Behavioral Techniques	32.61	11.29	.86
Psychodynamic Techniques	31.98	7.47	.74
Therapist Characteristics	45.00	8.46	.82

Question 1 of the Questionnaire (see Appendix). Answers of "0" *I was not in therapy long enough to have an opinion* were excluded from the data from the outset; there was only one such case. The remaining six responses to Question 1 formed a scale for therapy outcome ranging from total success to total failure. The scale was evenly divided; the first three answers defined the success group and the last three defined failures. Using this method of division, 62 of the 71 participants fell into the success group and nine were failures. The distribution for the entire population on reported outcome is found in Table 3 (Type and Variety of Techniques Used Grouped by Outcome). Despite these disproportionate numbers, significant differences emerged. All results reported are two-tailed significance unless otherwise noted.

For these analyses, two scales OFTEN and HELPFUL, reflecting the total frequency and perceived helpfulness of all Checklist items, were derived from the frequency and helpfulness items of questions 1 through 29 of the Checklist. A few, scattered missing values were replaced with modal values. Analyzing these scales for reliability, Alpha's of .93 and .95 were obtained for the OFTEN and HELPFUL Scales respectively, indicating a very high reliability for both. Dividing the groups into successes and failures, group means for the success group were significantly higher on both the OFTEN and HELPFUL scales using a t-test, $t(69) = 4.12$, $p < .001$ and $t(69) = 5.41$, $p < .001$ respectively. Group means and standard deviations on these variables are listed in Table 4. A more powerful way of examining this question, however, is the one-way analysis of variance. An ANOVA using outcome level as the classification variable revealed significant differences on both OFTEN $F(5,65) = 12.75$, $p < .0001$ and HELPFUL, $F(5,65) = 22.19$, $p < .0001$. A test of linearity was also significant $p < .0001$ for both variables. However, these means also deviated significantly from linearity $p = .03$ for OFTEN and $p < .001$ for HELPFUL. These deviations from linearity appear to be caused by the fact that the means for both OFTEN and HELPFUL are slightly higher for "Total Failure" outcome than for "Mostly Failed" outcome and also higher for "Limited Success" outcome than for "Partial Success" outcome (see Table 4). The fact that only 6 points are used to define linearity makes any deviation more pronounced. In general, however, reported success appears to be significantly associated with reported frequency of technique use of all kinds.

Hypothesis 1: Therapist Flexibility and Variety of Technique

The first hypothesis states that self-defined successful clients are expected to describe their therapists attitude and approach as more flexible than self-defined failures. This was confirmed. Flexibility was assessed with a one-way analysis of variance on the frequency and helpfulness answers of Checklist question 4, *My therapist was adaptable in technique, attitude, and focus according to the needs of the situation*, by reported outcome. This result was significant, $F(6,64) = 5.57$, $p < .001$ for frequency and for helpfulness $F(5,65) = 8.15$, $p < .0001$. Linearity was significant at $< .001$ and deviation from linearity was not significant. Given the high reliabilities for the OFTEN and HELPFUL scales, it is difficult to make a strong case for a single Checklist item being significant in isolation. However, only about half of the individual items were significantly related to success/failure (see Table 12) and the results for this question do confirm the stated hypothesis.

TABLE 3
Type and Variety of Techniques Used
Grouped by Outcome

Outcome	N	Class of Technique	Mean	SD
Total Failure	3 (4%)	General Tech.	2.61	0.92
		Behavl. Tech.	1.46	0.51
		Psych.Dyn. Tech.	3.11	0.82
		Thpst. Char.	3.96	1.37
		Total # Tech. Used	18.33	7.23
Mostly Failed	2 (3%)	General Tech.	2.50	***
		Behavl. Tech.	1.75	0.88
		Psych.Dyn. Tech.	2.92	0.35
		Thpst. Char.	3.25	0.35
		Total # Tech. Used	19.00	4.24
Limited Success	4 (6%)	General Tech.	4.17	1.05
		Behavl. Tech.	3.31	0.87
		Psych.Dyn. Tech.	4.83	0.83
		Thpst. Char.	5.88	0.29
		Total # Tech. Used	26.75	1.26
Partial Success	17 (24%)	General Tech.	4.04	1.10
		Behavl. Tech.	3.29	1.04
		Psych.Dyn. Tech.	4.43	0.68
		Thpst. Char.	5.14	0.70
		Total # Tech. Used	24.94	4.01
Success	36 (51%)	General Tech.	5.11	1.49
		Behavl. Tech.	4.43	1.36
		Psych.Dyn. Tech.	5.15	0.85
		Thpst. Char.	5.86	0.94
		Total # Tech. Used	26.08	2.80
Total Success	9 (13%)	General Tech.	5.61	1.01
		Behavl. Tech.	5.28	1.47
		Psych.Dyn. Tech.	5.56	0.87
		Thpst. Char.	6.57	0.39
		Total # Tech. Used	26.78	2.05

TABLE 4
Group Means on OFTEN and HELPFUL

By Success/Failure

Group	Variable	Mean	SD
Success	OFTEN	4.97	.93
N=62	HELPFUL	5.88	.08
87.2%			
Failure	OFTEN	3.57	.37
N=9	HELPFUL	4.50	.35
12.8%			

By Outcome Level

Outcome	Variable	Mean	SD
Total Failure	OFTEN	2.81	.85
N=3	HELPFUL	4.12	.19
(4%)			
Mostly Failed	OFTEN	2.69	.34
N=2	HELPFUL	3.17	.44
(3%)			
Limited Success	OFTEN	4.59	.58
N=4	HELPFUL	5.45	.60
(6%)			
Partial Success	OFTEN	4.24	.61
N=17	HELPFUL	5.27	.70
(24%)			
Success	OFTEN	5.12	.88
N=36	HELPFUL	6.10	.51
(51%)			
Total Success	OFTEN	5.78	.67
N=9	HELPFUL	6.35	.29
(13%)			

TABLE 5
Reported Outcome
Grouped by Orientation

General Techniques

Reported Outcome	Mean	Std Dev	N	Pct
Total Failure	3.72	.26	3	(4%)
Mostly Failed	3.08	.83	2	(3%)
Limited Success	5.46	.58	4	(6%)
Partial Success	5.13	.91	17	(24%)
Success	6.07	.73	36	(51%)
Total Success	6.59	.37	9	(13%)

Behavioral Techniques

Reported Outcome	Mean	Std Dev	N	Pct
Total Failure	3.75	.66	3	(4%)
Mostly Failed	2.63	.53	2	(3%)
Limited Success	4.38	1.02	4	(6%)
Partial Success	4.77	.96	17	(24%)
Success	5.65	.75	36	(51%)
Total Success	5.78	.72	9	(13%)

Psychodynamic Techniques

Reported Outcome	Mean	Std Dev	N	Pct
Total Failure	4.00	.44	3	(4%)
Mostly Failed	3.58	.83	2	(3%)
Limited Success	5.54	.48	4	(6%)
Partial Success	5.39	.80	17	(24%)
Success	6.13	.56	36	(51%)
Total Success	6.06	.60	9	(13%)

Therapist Characteristics

Reported Outcome	Mean	Std Dev	N	Pct
Total Failure	4.58	.07	3	(4%)
Mostly Failed	3.48	.80	2	(3%)
Limited Success	6.31	.60	4	(6%)
Partial Success	5.67	.78	17	(24%)
Success	6.37	.59	36	(51%)
Total Success	6.83	.18	9	(13%)

Hypothesis one also states that "successes" will report a wider variety of techniques used including behavioral, cognitive and psychodynamic elements than "failures". In other words, reported success will be associated with an eclectic approach that uses all types of techniques, emphasizing both internal states as well as external behaviors, rather than just a single approach. The results in **Table 3**, showing the number of orientation-specific techniques grouped by outcome, confirm this. Means for techniques of all types are higher for successful outcomes and lower for failure outcomes. It should be noted too that the two lowest outcome levels do not reflect an even distribution of technique types. Behavioral techniques are more than one standard deviation unit lower than other types of techniques. One-way analyses of variance comparing the four technique types with outcome were also significant, $F(5,65) = 16.12$, $p < .0001$, for General Techniques, $F(5,65) = 10.87$, $p < .0001$, for Behavioral Techniques, $F(5,65) = 13.71$, $p < .0001$, for Psychodynamic Techniques, and $F(5,65) = 17.18$, $p < .0001$ for Therapist Characteristics. Linearity estimates for all variables is significant, deviation from linearity is significant for all but behavioral techniques. **Table 5** lists outcome means grouped according to these different orientations.

An analysis of variance comparing the variety of techniques used by a therapist (the total number of different techniques used regardless of reported frequency) with outcome level was also significant, $F(5,65) = 5.10$, $p = .0005$. The relationship of outcome and technique variety is significantly linear $p < .0001$, with no significant deviation from linearity, indicating that the more techniques a therapist uses, the more success is reported by clients. A t-test comparing success/failure groups on the variety of techniques reported used was significant, $t(69) = 2.89$, $p < .005$.

Hypothesis 2a: Attributions for Initial Problem

The hypothesis 2a predicts that reported successes will make more self-related attributions about the nature of their problems than reported failures. Listed in **Table 6** are means and standard deviations for problem attributions grouped according to outcome. Three respondents, all failures, who elected to make their outcome attributions for failure rather than success were dropped from the outcome attribution analyses. Problem attributions (Part I, Questions 3.1 through 3.4 from the Questionnaire) did not prove significantly related to outcome using analysis of variance.

Hypothesis 2b: Attributions for Outcome

Hypothesis 2b predicted that self-reported successes would take more responsibility for their outcome than self-reported failures. The results of this hypothesis test are weak and inconclusive. A one-way analysis of variance on outcome with outcome attribution (Part I, Question 2) revealed a significant relationship between outcome

level and attributions for outcome based on life circumstances (Part I, Question 2.3), $\underline{F}(5,61) = 4.32$, $\underline{p} = .002$, and attributions for outcome due other people (Part I, Question 2.4), $\underline{F}(5,61) = 2.42$, $\underline{p} < .05$. However, these patterns are not consistent, are not significantly linear, and/or deviate significantly from linearity. Other success attributions, most importantly self-attributions, were not significantly related to outcome. Means and standard deviations for outcome attributions are listed in Table 7 grouped by outcome.

Hypothesis 2c: Failure and Responsibility for Outcome

The hypothesis 2c states that clients taking no responsibility for their outcomes will not report outcome success. This hypothesis could not be tested. There was only one case where a client took no responsibility for outcome at all and in this case it was one of three respondents who elected to make these attributions for failure.

Hypothesis 2d: Self/Other Initiative to Start Therapy

Hypothesis 2d states that failures will attribute the reasons for entering therapy more to other-related than to self-related factors than will successes. An analysis of variance on self/other reasons for entering therapy (Part I, Question 6) with outcome failed to confirm this. A t-test comparing successes with failures found no significant differences.

Other Attribution Findings

One other finding on attributions should be mentioned. The reported compliance (Part I, Question 8) of participants with therapists' suggestions is significantly related to the reported outcome. A one-way analysis of variance of reported outcome with reported compliance is significant, $\underline{F}(16,49) = 2.38$, $\underline{p} < .05$. Linearity is also significant at $< .03$ and deviation from linearity is not significant, indicating that as compliance increases so does the report of outcome success. A t-test comparing successes and failures on reported compliance was also significant $t(64) = 3.40$, $p < .001$.

Differences Among Clinical Orientations

Some unexpected and interesting differences emerged when groups were broken down according to theoretical orientation. Clinics were divided into three main categories: behavioral, eclectic and psychodynamic. These categories basically accord with the self-described orientations of participating clinics and therapists. Table 2 lists the means and standard deviations for the variety of techniques used by therapists according to clinical orientation.

The variety of different techniques used by a therapist varied significantly not only with outcome, as reported above, but also with clinical orientation using a one-way analysis of variance, $F(2,64) = 12.20$, $p < .0001$. Putting Behavioral orientaton at one end of a three-point scale and the Psychodynamic orientation at the other, and considering the Eclectic group as a mixture of the two reveals a significantly linear relationship, $p < .0001$, with no significant deviation from linearity. These three clinical groups also differed on three significant variables: the reported outcome, frequency and helpfulness of all techniques used. A one-way analysis of variance on the three categories of clinic orientation revealed significant differences on outcome, $F(2,68) = 5.62$ $p < .006$, the OFTEN scale, $F(2,68) = 29.87$, $p < .001$, and the HELPFUL scale, $F(2,68) = 12.09$, $p < .001$. Linearity was significant for all three variables as was deviation from linearity for OFTEN and HELPFUL, indicating an imperfect linear relationship. However, because only three categories of orientation are used to define classes, deviations from linearity become more pronounced. It is interesting that OFTEN and HELPFUL were not significant with the actual clinic rather than clinical orientation as the classification variable, only outcome was significantly related to the specific clinical source, $F(8,62) = 2.28$, $p < .03$. **Table 8** lists OFTEN, HELPFUL, and outcome means grouped by clinical orientation for all participants and for successes only.

Since this result was unexpected and failures may have very different types of attributions than successes, these results were analyzed again with failures eliminated. Descriptive statistics are presented in **Table 8**. A one-way analysis of variance on clinic orientation with outcome, OFTEN and HELPFUL using only successes in the analysis is again significant with even higher F values, $F(2,59) = 10.62$, $p < .0001$ for Outcome, $F(2,59) = 36.51$, $p < .0001$ for OFTEN and $F(2,59) = 15.09$, $p < .001$ for HELPFUL. Linearity is significant and deviation from linearity is not significant for all variables. The behavioral group scores remained the same since that group contains no failures. It should be noted that only 3 of the 9 failures are in the psychodynamic group, the rest come from the eclectic group. While most scores increased slightly and standard deviations decreased slightly with failures removed, the relative ratings for the three orientations remains the same. The behavioral group is highest on all three variables, the eclectic group next, and the psychodynamic group last. Comparing the groups on how different techniques, classed and averaged according to **Table 1**, occurred with different clinical orientations revealed significant differences on all classes of items, General Techniques, $F(2,68) = 26.18$, $p < .001$, Behavioral Techniques, $F(2,68) = 49.16$, $p < .001$, Psychodynamic Techniques, $F(2,68) = 3.39$, $p < .04$, and Therapist Characteristics, $F(2,68) = 11.31$, $p < .001$. Putting the Behavioral at one end of a three-point scale and the Psychodynamic group at the other, and considering the Eclectic group as a mixture of the two reveals a consistent, though not perfect, linear relationship on all of these variables with orientation.

TABLE 6
Attributions for Initial Problem
Grouped by Reported Outcome

Outcome	N	Problem Attribution	Mean%	SD
Total Failure	1	Circumstances	25.00	****
	(1%)	Self Behavior	25.00	****
		Others	25.00	****
		Self Cognitions	25.00	****
Mostly Failed	1	Circumstances	00.00	****
	(1%)	Self Behavior	00.00	****
		Others	50.00	****
		Self Cognitions	50.00	****
Limited Success	4	Circumstances	27.50	22.17
	(6%)	Self Behavior	26.25	20.57
		Others	22.50	05.00
		Self Cognitions	23.00	12.50
Partial Success	17	Circumstances	20.13	18.75
	(25%)	Self Behavior	25.44	14.90
		Others	18.69	21.94
		Self Cognitions	39.73	22.95
Success	36	Circumstances	26.11	21.85
	(53%)	Self Behavior	19.17	15.52
		Others	15.97	16.01
		Self Cognitions	38.75	26.68
Total Success	9	Circumstances	36.48	32.42
	(13%)	Self Behavior	25.37	18.01
		Others	19.44	34.86
		Self Cognitions	18.70	21.47

TABLE 7
Attributions for Outcome
Grouped by Reported Outcome

Outcome Outcome	N	Attribution	Mean%	SD
Total Failure	1 (1%)	Therapist	50.00	****
		Self	25.00	****
		Circumstances	00.00	****
		Others	25.00	****
Mostly Failed	1 (1%)	Therapist	30.00	****
		Self	20.00	****
		Circumstances	50.00	****
		Others	00.00	****
Limited Success	4 (6%)	Therapist	43.24	14.91
		Self	45.77	07.76
		Circumstances	06.09	04.55
		Others	04.90	05.69
Partial Success	17 (25%)	Therapist	36.00	15.25
		Self	43.65	16.71
		Circumstances	08.88	09.19
		Others	11.47	09.81
Success	35 (53%)	Therapist	42.48	11.63
		Self	41.96	12.14
		Circumstances	08.27	10.39
		Others	07.29	08.43
Total Success	9 (13%)	Therapist	46.67	10.90
		Self	46.67	09.01
		Circumstances	03.89	08.58
		Others	02.78	05.65

In other words, the more behavioral the orientation, the more techniques of all kinds are used; the more psychodynamic the orientation, the fewer techniques of all kinds are used. These differences do not appear to reflect basic differences in techniques associated with a specific orientation but, rather, a tendency for reported frequencies for all types of techniques to vary by orientation group. Thus, while clients from psychodynamic therapists reported more techniques classified as psychodynamic than behavioral, the behavioral group had higher reports of both behavioral and psychodynamic techniques than did the former group. As expected, client reports do reflect their therapists' orientations to some degree. The psychodynamic group's means for are lower behavioral items than for other types of techniques, and the behavioral group's means are higher for behavioral than for psychodynamic ones. It was not expected that the behavioral groups' reported means for psychodynamic items would be higher than the psychodynamic group's for the same items. This seems to indicate a more frequent use of techniques of all types for the behavioral group and a de-emphasis, but not exclusion, of certain behavioral techniques by the psychodynamic group. (See **Table 2** for a list of means and standard deviations for these techniques grouped according to clinical orientation.)

Discriminating Among Orientations

With the significant and unexpected differences found between groups on the basis of clinical orientation, I wondered if this type of classification might be one way to distinguish the frequency items on the Psychotherapy Checklist. When scales have reliabilities as high as the Checklist items a factor analysis will not yield meaningful results. A statistical technique called discriminative analysis was chosen instead. This technique attempts to find ways to discriminate groups of data using either pre-defined categories or those derived for a "best fit" solution from the data. In this case, the latter approach was used, without any predefining specifications. Two separate analyses were run first using the three categories of clinical orientation and then using only the behavioral and psychodynamic orientations, which were expected to differ the most. It was expected that the eclectic group would have characteristics of both groups and so might make classification prediction more problematic.

Three-group Discriminative Analysis

Using the three clinical orientations as the main group divisions, only four variables were needed to predict group membership: item 2, *My therapist and I had good rapport*, item 10, *My therapist focused on the way I related to him/her during therapy*, item 22, *My therapist showed me specific problem-solving techniques*, and item 25, *My therapist corrected me when I made mistakes*. These four frequency variables were able to predict group membership with an accuracy of 70%. **Tables 9, 10 and 11** list the principal discriminative analysis results in-

TABLE 8
Means for OFTEN, HELPFUL and Outcome
Grouped by Clinical Orientation

For All Participants

Clinic Orientation	N	Variable	Mean	SD
Behavioral	16	Helpful	6.49	0.33
	(22%)	Often	6.05	0.50
		Outcome[1]	2.38	0.50
Eclectic	34	Often	4.64	0.95
	(48%)	Helpful	5.57	0.90
		Outcome	1.18	1.57
Psychodynamic	21	Often	4.09	0.62
	(30%)	Helpful	5.34	0.67
		Outcome	1.00	1.38

For Success Outcomes

Clinic Orientation	N	Variable	Mean	SD
Behavioral	16	Helpful	6.49	0.33
	(26%)	Often	6.05	0.50
		Outcome[1]	2.38	0.50
Eclectic	28	Often	4.83	0.78
	(45%)	Helpful	5.79	0.67
		Outcome	1.82	0.61
Psychodynamic	18	Often	4.23	0.46
	(29%)	Helpful	5.48	0.47
		Outcome	1.50	0.51

[1] The higher the mean the more successful the reported outcome.

TABLE 9
Three-Group Discriminative Analysis
Behavioral/Psychodynamic/Eclectic Groups

Step	Action Entered/removed	Vars in	Wilks' Lambda	Sig.	Minimum D Squared	Sig.	Between Groups
1	Q.22	1	.47	<.0001	1.12	.0003	2 3
2	Q.11	2	.42	<.0001	1.25	.0008	2 3
3	Q.1	3	.38	<.0001	1.38	.0014	2 3
4	Q.10	4	.35	<.0001	1.45	.0029	2 3
5	Q.2	5	.30	<.0001	1.50	.0057	2 3
6	Q.10	4	.32	<.0001	1.43	.0032	2 3
7	Q.1	3	.35	<.0001	1.27	.0024	2 3
8	Q.11	2	.37	<.0001	1.14	.0014	2 3
9	Q.25	3	.33	<.0001	1.25	.0026	2 3
10	Q.10	4	.30	<.0001	1.32	.0050	2 3

Classification Function Coefficients
(Fisher's Linear Discriminant Functions)

Checklist Variable	Behavioral Orientation	Psychodynamic Orientation	Eclectic Orientation
Q.2 (Rapport)	9.09	7.37	7.22
Q.10 (Relation in Therapy)	0.39	0.69	
Q.22 (Specific Problem Solving)	1.90	0.19	0.83
Q.25 (Corrected Mistakes)	1.38	0.28	0.54
(CONSTANT)	-43.41	-24.00	-24.50

Canonical Discriminant Functions

FCN	Eigenvalue	% of Variance	Cum pct	Canoncl corr	After FCN	Wilks' Lambda	Chi^2	df	Sig
				:	0	0.30	79.85	8	<.001
1*	2.05	95.88	95.88	0.82 :	1	0.92	5.62	3	<.13
2*	0.09	4.12	100.00	0.29 :					

*Marks the 2 canonical discriminant functions remaining in the analysis.

Standardized Canonical Discriminant Function Coefficients

	FUNC 1	FUNC 2
Q.2	0.44	0.83
Q.10	-0.41	-0.16
Q.22	0.70	-0.56
Q.25	0.49	0.05

cluding the variables entered at each step of the analysis, Wilk's Lambda, distance between groups, Fischer's linear discriminant functions, canonical discriminant functions, and classification results. **Tables 9** and **10** reflect the analysis for the three orientation groups while **Table 11** contains the results for the behavioral/psychodynamic dichotomy.

Two-group Discriminative Analysis

In a two-group comparison (psychodynamic versus behavioral groups), only three variables were necessary to predict membership with an accuracy of 100%.: item 2, *My therapist and I had good rapport*, item 11, *My therapist showed me concrete ways to change my behavior*, and item 22, *My therapist showed me specific problem-solving techniques*.

It is interesting to note that of the 5 variables used in the two analyses for predicting group membership, only two are significantly related to outcome using analysis of variance and they appear in both analyses. They are item 2, $\underline{F}(5,65) = 7.183$, $\underline{p} < .001$ and item 22, $\underline{F}(5,65) = 5.12$, $p = .001$. There is also a trend for significance for item 25, $\underline{F}(5,65) = 2.10$, $p < .08$. Bear in mind that looking for significances among individual items is tentative at best, especially given the high reliability of the OFTEN scale.

TABLE 10
Three-Group Discriminative Analysis
Behavioral/Psychodynamic/Eclectic Groups

Classification Results

Actual Group	No. of Cases	Predicted Group Membership: Behavioral	Psychodynamic	Eclectic
Behavioral	16	15 93.8%	0 0.0%	1 6.3%
Psychodynamic	21	0 0.0%	14 66.7%	7 33.3%
Eclectic	10	21 8.8%	34 29.4%	30 61.3%

Percent of "Grouped" Cases Correctly Classified: 70.42%

TABLE 11
Two-Group Discriminative Analysis
Behavioral/Psychodynamic Groups

Step	Action Entered/removed	Vars in	Wilks' Lambda	Sig.	Minimum D Squared	Sig.	Between Groups
1	Q.22		.19	<.0001	16.40	<.0001	1 2
2	Q.2	2	.13	<.0001	26.54	<.0001	1 2
3	Q.11	3	.11	<.0001	31.80	<.0001	1 2

Classification Function Coefficients
(Fisher's Linear Discriminant Functions)

Checklist Variable	Behavioral Orientation	Psychodynamic Orientation
Q.2 (Rapport)	18.49	13.66
Q.11 (Concrete Change)	3.74	1.61
Q.22 (Specific Problem Solving)	6.74	3.07
(CONSTANT)	-98.85	-43.54

Canonical Discriminant Functions

FCN	Eigenvalue	% of Variance	Cum pct	Canonical corr	After FCN	Wilks' Lambda	Chi²	df	Sig
1*	8.25	100.00	100.00	0.94	0	0.11	74.53	3	<.0001

*Marks the 1 canonical discriminant function remaining in the analysis.

Standardized Canonical Discriminant Function Coefficients

	FUNC 1
Q.2	0.58
Q.11	0.42
Q.22	0.76

Classification Results

Actual Group	No. of Cases	Predicted Group Membership: Behavioral	Psychodynamic
Behavioral	16	16 100.0%	0 0.0%
Psychodynamic	21	0 0.0%	21 100.0%

Percent of "Grouped" Cases Correctly Classified: 100.00%

Looking at the group means for these items divided according to clinical orientation reveals a difference of more than one standard deviation unit for the behavioral group on item 2, rapport. The behavioral group's mean on this item is 6.94, SD 0.25; the psychodynamic group's mean is 5.57, SD .87, and the eclectic group's mean is 5.50, SD 1.02. One would expect this to be most important in a psychodynamic situation and least important in a behavioral setting, the exact opposite of what was reported. More dramatic than this are the differences on item 22, *My therapist showed me specific problem-solving techniques*. Here the mean for the behavioral group is 6.63, SD .72, while the psychodynamic group is a low 1.9, SD 1.41. The eclectic group is slightly higher at 3.62, SD 1.99.

Item 22 refers to the specificity of problem-solving techniques. Assuming the accuracy of client's reports, which this pattern of differences among orientations tends to substantiate, it is possible that specific problem-focused techniques are a good *general* tool that the psychodynamic therapists under utilized and that this fact may also account for the lower outcomes found in the psychodynamic group.

Many other explanations are also possible, of course, and while these findings are interesting, it is unwise to attach too much importance to them. Without any strong defining categories for group membership discriminative analysis items are subject to the variabilities of a particular sample. Such category items should not be considered in any way defining of group membership generally, merely predictive under certain circumstances. As can be seen from the two analyses conducted, specific variables are chosen for their ability to predict group membership, and for no other reason. Depending on the circumstances one variable or another may assume prominence in making membership predictions.

Nevertheless, it is interesting to note that some of the items used to predict group membership are based on orientation-specific techniques and there is such a dramatic difference between the behavioral and psychodynamic groups on the use of specific problem-solving techniques. Thus, while the body of techniques used across different orientations may be relatively similar, different orientations may produce different emphases or have one or two characteristic approaches. However, the fact that therapist characteristics also were important predictors of group membership should make one doubly cautious about leaping to conclusions.

Summary of Results

Significant relationships were found according to stated hypotheses between reported outcome success and the variety and frequency of techniques used by the therapist and with the therapist's reported flexibility. Significant differences were also found among different clinical orientations on outcome as well as the frequency and helpfulness of techniques used by the therapists. There is a general difference in the frequency of techniques by therapeutic orientation and these differences do not reflect theoretical

differences but affected all types of techniques reported. The behavioral group tended to have the highest number of frequencies of all types and the psychodynamic group, the lowest. Tables 2 and 3 list these "orientation-specific" techniques grouped according to orientation and outcome. The psychodynamic group is characterized by the lack of a few problem-focused techniques and this lack may account for the generally lower reported levels of success for that group.

Almost all techniques used in the Psychotherapy Checklist were reported as helpful by clients from all clinical groups, confirming prior research findings of efficacy for these techniques and strengthening the validity of client reports as a significant source of information about the psychotherapy process. However, contrary to expectations no clear relationship was found between the nature of the issues dealt with in therapy and the types of techniques used.

Finally, the pattern of success/failure attributions is unclear and most of these hypotheses were not confirmed; these results are quite inconclusive and require more careful study.

DISCUSSION

Orientation Versus Technique

As expected, specific techniques were not, on the whole, associated with specific psychotherapy orientations. The very high reliabilities of the OFTEN and HELPFUL scales indicate that, from the participants' perspective, there is not much to distinguish these techniques from one another in terms of their frequency or their helpfulness. There are no significant differences among clinical sources on the number of techniques used, their frequency or their helpfulness. Nor is the seriousness of the initial problem (Part I, Question 4) significant in any analysis. There were significant differences on outcome, variety of techniques used and the OFTEN and HELPFUL scales when clinical sources were grouped according to their self-defined orientation: behavioral, psychodynamic, and eclectic. These differences are more reflective of overall differences in the number of techniques reported in each group and are not generally based on the specific techniques associated with a specific orientation. The psychodynamic group seems characterized by the partial exclusion or de-emphasis of a few behavioral techniques (or perhaps by specificity of problem-solving approaches) rather than a pattern that might be expected by theoretical differences.

The main findings also indicate that for the most part, the use of a larger number and frequency of techniques is associated with reported success. Table 3 lists the mean number of techniques reported grouped according to outcome. Except for one outcome level, limited success, which is higher than its next higher success level, partial success, the mean frequency of items used increases directly with the level of success. Signifcant success/failure differences were also found on variety of techniques reported.

It should be noted also that there is a significant, positive, linear relationship in Table 3 between reported success and the mean of behavioral techniques used. It is possible to infer from this that success is associated with technique specificity. One of the main expectations of this study was a relationship between techniques used by a successful therapist and the issues dealt with in therapy. This, rather than clinical orientation, was expected to be the main predictor of the type of techniques a successful therapist uses. No clear-cut results were found to confirm this. The relationship of behavioral techniques, or technique specificity, and reported success hints at the possibility of this relationship. For future research it may be more productive to frame this question in terms of how specifically a therapist's techniques and approaches relate to a client's specific problems rather than in terms of orientation-specific techniques.

Table 12
Means and Correlations of Frequency and Helpfulness Items From the Psychotherapy Checklist

Scale Item	Frequency Mean	Helpfulness Mean	Correlation
Q.1	5.34	6.23[1]	.70
Q.2	5.85	6.28	.57
Q.3	5.16	5.89	.63
Q.4	5.47[1]	5.80	.76
Q.5	5.28[1]	5.94[1]	.74
Q.6	4.41[1]	5.44	.70
Q.7	4.78[1]	5.68[1]	.65
Q.8	5.45[1]	6.13[1]	.67
Q.9	5.96	6.18	.59
Q.10	4.34	5.41	.72
Q.11	3.89[1]	5.30[1]	.69
Q.12	5.61	6.17	.73
Q.13	3.32	5.16	.51
Q.14	2.32[1]	4.93	.76
Q.15	4.16[1]	5.44[1]	.78
Q.16	5.34[1]	5.96[1]	.83
Q.17	3.66[1]	5.27[1]	.75
Q.18	5.89[1]	6.21[1]	.84
Q.19	4.93	5.76	.66
Q.20	4.83	5.69[1]	.76
Q.21	5.28	6.06	.72
Q.22	3.79[1]	5.06[1]	.80
Q.23	4.99[1]	5.73[1]	.84
Q.24	5.87	6.06[1]	.68
Q.25	3.51	4.90[1]	.60
Q.26	5.42	6.03	.67
Q.27	5.82	6.10	.75
Q.28	5.59	6.10	.79
Q.29	2.76	5.07	.46

Correlations represent the Pearson correlation coefficient and are all significant. Table data represents both success and failure responses.

[1] These items were significant on a t-test comparing success failure differences at $\leq .05$.

It is not surprising that, besides being greater in number, the techniques used are also reported as being more helpful by the success group. Based on participant responses, it seems fair to conclude that all of the techniques included in the Checklist are considered helpful by the majority of participants. As can be seen in Table 12, almost all of the Checklist items were considered at least "Somewhat Helpful" (a mean of 5 or above) by successes and failures alike. Only Question 14 *My therapist used external things to reinforce new patterns of behavior for me or to discourage old ones* and Question 25 *My therapist corrected me when I made mistakes* fell slightly below this with means of 4.93 and 4.90 respectively. Question 25 also had one of the lower correlations of frequency and helpfulness at .60.

The correlations of the frequency items with their corresponding helpfulness items are also listed in Table 12. In general, the frequency of an item had a high correlation with helpfulness, but this was not the universal case. Since participants were asked to rate the helpfulness of an item based on the frequency with which it occurred, there may have been cases where participants considered a low occurrence of an item to be helpful, although given the generally strong correlations, this did not seem to have happened very often.

This pattern of response may be partially responsible for the lower correlations found on items 14 and 25. For instance, some participants may have found it helpful to have their therapists correct them when they made mistakes (Question 25), while others may have found it helpful that their therapists let them learn from their mistakes. A few participants also had trouble with the wording of Question 14. While it was deliberately worded very broadly to tap a broad behavioral approach to change, one person found it too vague, writing something like "Be more specific" next to this question. This was the only item that elicited this kind of write-in comment on the questionnaire. Thus, while the relationship between frequency and helpfulness is generally straightforward, it is not necessarily so for all items. The generally high correlation of frequency and helpfulness is probably the strongest explanation for outcome differences found among different clinical orientations. Some orientations may be using a wider variety of techniques more frequently and therefore producing better reported results. It is also possible that the specificity of techniques used by a therapist contributes to reported success. The psychodynamic group was lowest on both measures and seems defined more by what it excludes than includes. Given the generally equal findings for different orientations' efficacy in much prior research, this conclusion must be quite tentative. However, this pattern of basic differences is constant even with failures eliminated from analysis.

These results tend to support the conclusion that successful therapists have more flexibility and a greater number and variety of techniques at their command. This was one of the rationales for predicting a wider variety of techniques associated with success. This cannot be the whole story, however, since some of the successes and failures in the sample come from the same therapists. Another explanation for some of the success/failure differences, and it is one that supplements rather than supplants the first explanation, is that successes remember more techniques because these techniques are associated with positive change and therefore have greater personal meaning. As in any study involving post-hoc reports, a variety of factors can affect the results and findings must therefore be interpreted cautiously. This is particularly so in light of the relatively small sample size of 71.

Given the similar body of techniques reported in use among therapists one must wonder if thinking of therapy in terms of specific types of techniques is getting at the core of the psychotherapy process. Psychotherapy may be, as Garfield (1984) suggests, more of an idiosyncratic endeavor in which the use of specific techniques is only one of many possible means to an end. It is also possible that, as Kelly (1955; 1958) and Noblin, Timmons and Reynard (1963) suggest, anything the therapist does that supports change within a believable framework will have some effect and that the context of trust in which client and therapist operate is more important than specific techniques. The importance of client/therapist framework is indicated by the discriminative analysis results. Rapport and problem-focused, behavioral modification techniques were the main discriminators of the behavioral and psychodynamic groups with the eclectic group falling in-between. This also follows the pattern of reported success.

Whatever the interpretation given these findings, many different kinds of approaches may be able to accomplish the same end and what matters most is how techniques are used in specific contexts for very specific ends—not the specific techniques themselves. If we look at the behavioral techniques in Table 3 in terms of their context-specificity (as discussed above), rather than orientation-specificity, this conclusion is reinforced. Looking at the techniques and therapist characteristics alone, apart from their situational and human specificity, may tell us little except that their correct use produces positive results and that a similar body of basic techniques is employed by most therapists regardless of theoretical labels. Presumably the techniques used by a therapist are the product of training, personality, and finally of experience, and research cited earlier has shown that as the therapist becomes more experienced, more techniques are incorporated into his repertory. One would expect an approach toward synthesis among therapists of different orientations with time and this seems to be what has taken place historically.

In general, the process of therapy appears to an individual, holistic process in which no one part is of

prime importance. All techniques are used as tools by an experienced therapist to get a well rounded appraisal of a client's unique situation; they cannot be meaningfully isolated from that context. It is likely that an experienced therapist will use a variety of techniques with all clients, especially with cases that prove difficult. Therefore, in some cases, an experienced therapist might use an even wider variety of approaches and techniques with less successful clients. In any scenario, therapist variety and flexibility are of prime importance in promoting a successful outcome.

The Relation of Therapy Issues to Therapy Techniques

One surprising result is the lack of any clear pattern of relationship between nature of the problems dealt with in therapy and the specific techniques used. Although DSM-III diagnoses were requested from all clinical sources and all agreed to supply it, not enough clinics supplied this information to do a meaningful analysis. This left only client reports as the basis of issues dealt with in therapy. As originally conceived, therapy issues (Part I, Questions 5.A to 5.K) were divided into specific and general categories. It was expected that therapists would deal with more specific types of problems using behavioral techniques while more generalized conditions would call for a psychodynamic approach. When these items were correlated with the Checklist items specific correlations were few and no meaningful pattern was evident. When inter-correlated these items fell into a pattern: affect items correlated with other affect items, whether specific or general in nature, while social/behavioral items also tended to inter-correlate. Item J, *To get help in making choices or decisions* correlated with both affect and behavioral items. While significant, these correlations were not very high and given the large number of blanks and zero's did not involve many cases. Even using this affect/behavioral division, no clear pattern of relationship of these items with the Checklist items emerged. A factor analysis of the Question 5 items also failed to find any meaningful patterns. No definite pattern that could distinguish groups according to these items was found, nor did any meaningful pattern of these factors correlated with the Checklist emerge.

This finding may be due to the fact that most psychotherapy techniques are less issue-oriented than supposed and primarily provide a framework to encourage change. Within this framework, approaches that are more problem-specific may contribute significantly more to positive change. If widely applicable, this finding certainly would speak against both the specificity of conditioning model which lead to behavioral therapy and the generality of the psychodynamic one, at least for most client issues. Thus, as noted earlier, it may be more useful to frame this issue in terms of whether a therapist's approaches are problem-focused, not whether they are nominally behavioral or psychodynamic.

However, it is also possible that the fault lies not with a lack of specific problem/technique relationships but with the way this question was assessed or with the characteristics of this particular sample. Another possible confound is the fact that the set of questions that ranked therapy issues (Part I, Questions 5.A to 5.K) elicited the greatest variability in responses of any part of the survey. In fact, a few participants did not seem to understand the ranking procedure clearly and answered with ranks of multiple "1's" and "2's" which indicated that for them many issues were of primary importance during therapy. There were also other variations in response styles. Some participants ranked only one or two items while other dutifully and carefully ranked them all; some had few or no changes in the items' importance before entering therapy and during it, while others changed these radically. A item ranked as '1' *before* entering therapy in some cases was not even considered an important issue *during* therapy.

It is difficult to make any generalizations from this. Apparently some clients enter therapy knowing exactly what their issues are, while finding out what their real problems are is part of the process for others. The tendency of some therapists to steer therapy toward the kinds of issues they prefer to deal with cannot be dismissed either. The best way to satisfactorily explore this issue is through a series of in-depth interviews at various stages of the therapeutic process that ask psychotherapy clients what issues are important to them and how and whether these issues are related to specific therapist techniques.

Outcome and Attribution

The findings on success/failure attributions were either not confirmed or were difficult to interpret. No relation was found between self-related attributions for outcome or initial problem and reported success. The only outcome attributions that are significant are those relating to the effect of other people and life circumstances on outcome. These relationships are not significantly linear and are at times not in the predicted direction. However, the attribution for outcome success to other people is low for all cases except one case of total failure outcome and the life circumstances attributions do not vary much by reported outcome either except for one case (a "mostly failed" outcome). The small N associated with failure attributions makes any inferences in favor or against the hypotheses difficult.

Furthermore, in assessing outcome attributions the number of failures, already low, was reduced still further because of the need to drop attributions for outcome failure from the analysis. Outcome is significantly related only to outcome attributions relating to "life circumstances" and "other people" but to no other attributions. A look at the means for these items on Table 7 shows no definite pattern. The "life circumstances" attribution is about the same in for all levels of success, is zero for "total failure" and is 50.00 for "mostly failed" (both based on one case). Except for the "mostly failed" outcome level on

Table 7 all other 'circumstances' ratings are also low in comparison with self/therapist outcome attributions. This higher level of 50.00 is also based on only one case. Also, the "others" outcome attribution is highest at the "partial success" level, 11.47 and lowest, not with success but with failure, "limited success", at 4.90 and "mostly failed" at zero. At all outcome levels, except for "total failure" at 25.00, the 'others' attribution is comparatively low, and again it must be emphasized that the two lowest outcome levels contain only one case each. Looking at the means for "self attribution" one may notice a difference between the two lowest outcome levels and the four highest, indicating a possible relationship between outcome success and increasing self-attribution but it is certainly not a smooth, step-wise trend upward. Under the circumstances it is difficult to make any inferences from these results.

Orientation Differences

The differences found on outcome with clinical orientation are interesting but should be interpreted cautiously. Although some findings have indicated a slight edge for behavioral approaches in a few areas, these conclusions are neither definitively established nor universally accepted. Nevertheless the results suggest that even though all therapists seem to use the same basic techniques, the inclusion or exclusion of just a key few may characterize a given approach. The psychodynamic orientation in particular seems best characterized by the exclusion or de-emphasis of a few "behavioral" techniques rather than an across-the-board difference according to theory. The finding of a few differences is far from the theoretical stance that maintains that the basic process of change that takes place in different kinds of therapy is radically different; all techniques may be just facilitators and the same basic process of change may take place for a given client whatever brand of therapy he chooses to buy.

A consistent and important inference from these findings is that the more ways a therapist can facilitate change, the better, and therefore, the therapist with the greatest flexibility and variety of techniques has the better chance of success. The same reasoning applies to clinical theories and orientations; the less limited they are by the strictures of received canons, the more likely they are to succeed. The issue of problem-focused techniques is also an important one and should be explored further. Problem-focused specificity may not be limited to behavioral modification techniques; for clients with some types of problems, psychodynamic techniques may seem problem-specific.

Other Findings

The finding that failures tended to terminate therapy for financial reasons is not surprising although

there may be a number of reasons for it. Most likely the costs of therapy weigh more heavily with clients who did not feel they are making much headway and they are therefore more likely to terminate therapy for what they consider financial reasons, although one may assume that if substantive progress were being made, money would be less of a factor.

Conclusions and Recommendations

To summarize, no differences that corresponded to theoretical expectations were found among the clinical groups in terms of the type or number of techniques used. While there were significant differences among orientations, this finding is suggestive of many possible explanations, all enticing but none conclusive. An important issue raised by these findings is the relation of problem-focused techniques to reported outcome success. While the findings are open to more than one interpretation, the relation of behavioral (problem-specific) techniques to outcome success is significant. However, given the wide array of research that has found little difference in efficacy among different orientations, contrary findings must be explored carefully.

Given the presumed individual nature of therapy, the best way of doing further research would appear to be individual as well. A few in-depth, single-subject designs, or a series of in-depth interviews, would seem to be the best approach. Perhaps the attribution aspect of this problem would benefit from this approach as well; many individual factors probably contribute to a person's attributional style in specific situations. People with a certain attributional style, such as self-attribution, may make better (or worse) candidates for therapy generally. It is also possible that people's attributional styles may make them more compatible with specific therapeutic orientations. In any case, a longitudinal study with a prospective, individually oriented design seems the best way to go in exploring these issues further in a meaningful way.

At the very least, the present study points up the importance of using client attributions as a valuable source of information about the therapy process. The most robust finding of this research is that the wider range of techniques a therapist uses, and the greater his flexibility in approaching each case uniquely, the better. The fact that a basically similar body of techniques is reported by clients of therapists who varied in orientation, training, and experience suggests that current theoretical formulations are not accurate or adequate descriptions of what actually takes place during therapy, and suggests that, in fact, therapy contains both general and specific factors that are used in a process of individual exploration by both client and therapist alike. The context in which specific techniques are used may be more important than the specific techniques themselves.

APPENDIX

Research Questionnaire

1. Cover Letter
2. Cover Page
3. Questions re: Problem/Outcome Attributions
   Seriousness of Problem
   Reasons For Seeking Psychotherapy
   Financial Considerations for ending therapy
   Issue dealt with in Therapy
   Therapist
4. Questions re: Demographics
5. Questions re: Psychotherapy Experience: Therapist Characteristics and Techniques

Facimile of general letter sent to prospective participants. Letters sent to different clinics varied slightly according to the needs of specific therapists and institutions but did not differ in essential content.

[Graduate School of the City University of New York Letterhead]

Dear Psychotherapy Client:

There are a lot of competing theories about what works in psychotherapy and why. The point of view of clients is one aspect of the therapy process that is just beginning to get the attention it deserves. This is long overdue when you consider that the client is the one having the most important experience.

The information gathered in this study has the potential to improve the understanding of psychotherapy and to influence how therapists are trained. The ultimate aim, of course, is to improve the experience of the many people who, like you, have felt the need for this kind of help at some point.

People who have not had a positive experience with their psychotherapy may be the least likely to participate in a study like this one. However, in order to obtain a balanced view of therapy, it is just as important to know the reasons for dissatisfaction as for satisfaction. The aim of this project is to find out what psychotherapy *clients* feel was important (or not!). We therefore want to emphasize that we are interested in hearing from you *regardless of whether or not you considered your psychotherapy a success*. A $10.00 honorarium will be given to those study participants who request it.

Psychotherapy is a complex process that involves many different elements. We have tried to keep the enclosed questionnaire as brief as possible and still be complete. We estimate that the questionnaire should take approximately half-an-hour to complete. But since people vary widely on how quickly they answer questionnaires such as this one, your own time may be slightly longer or shorter than this.

Since the number of people who are eligible to participate in this study is limited, your participation is really needed. Your opinion will definitely count!

This study is being conducted in cooperation with the department of Psychology of the City University of New York.

Thanks in advance for your help.

Sincerely,

Reduced Facimile of Research Questionnaire:

One of the main purposes of this survey is to determine what *clients* think went on in psychotherapy and what worked for them. The survey is divided into three parts.

PART ONE consists of 14 questions such as *why* you started your most recent psychotherapy, how long it lasted, what kind of therapy you were in, and your therapist's orientation.

PART TWO consists of 8 demographic questions (age, sex, marital status, etc.).

PART THREE is a 30-item checklist about what happened in therapy and how helpful you felt it was.

The total time to answer all questions should be approximately 30 minutes. However, people vary over how much time they take to answer these questions and your own time may be longer or shorter than this.

Please mail your completed questionnaire in the enclosed envelope. If you wish to be eligible for the honoraria be sure to read the sheet called "Payment of Honoraria" carefully and fill out the reverse side of this page. Thank you for your help.

PART ONE - REASONS FOR SEEKING PSYCHOTHERAPY No._____

Below are some questions about your most recent experience in psychotherapy. For each question, please **CIRCLE** the number next to the answer that best fits your feelings.

1. Overall, how well did your most recent psychotherapy work for you?

   0. I was not in therapy long enough to have an opinion
   1. I accomplished enough of what I wanted to accomplish to consider it a *total success.*
   2. I accomplished enough of what I wanted to accomplish to consider it a *success.*
   3. I accomplished enough of what I wanted to accomplish to consider it a *partial success.*
   4. I accomplished only a small part of what I wanted to accomplish so I consider it a *limited success.*
   5. I did not accomplish enough of what I wanted to accomplish so I consider it *mostly a failure.*
   6. I did not accomplish any of what I wanted to accomplish so I consider it a *total failure.*

2. How would you assign responsibility for whatever *success* you had? You can give any category below a rating of 0 to 100% as long as the sum of all the percentages equals exactly 100%. If you had no significant success (numbers 5 and 6 above) how would you assign responsibility for the failure to each of the following?

   0.) **IF** you circled numbers 5 or 6 above and wish to indicate responsibility for **FAILURE** on the items below check here: _____

   1.) My therapist _____%
   2.) Myself _____%
   3.) My Life Circumstances _____%
   4.) Other people _____%

   TOTAL = 100 %

3. How would you assign responsibility for the cause of your *problems* now that therapy is over? Please make sure that the total equals 100 %.

   1.) life circumstances _____%
   2.) things I was doing to create the problems _____%
   3.) other people _____%
   4.) my own thoughts or feelings about myself _____%

   TOTAL = 100 %

4. How serious were your problem(s)? **(CIRCLE the number that fits best:)**

   1. CRITICAL. The problem(s) caused a significant disruption in my sense of wellbeing, my personal relationships, and/or my work

   2. SERIOUS. The problem(s) caused some disruption in my sense of wellbeing, my personal relationships, and/or my work or seemed likely to do so over time

   3. NOT SERIOUS. The problem(s) did not cause any acute or serious disruption in my life or my sense of wellbeing

5. What kind of problems did you *first* seek help for?

Please rate each of the following items, according to their importance to you **BEFORE** you started **your most recent** therapy. For example, put a 1 under "Initial" after the most important item, a 2 on the line after the second most important item (if there was one) and so on. **Blanks will be considered not important to your therapy.**

	Initial	During
A. General feeling of dissatisfaction with myself or my life	_____	_____
B. Need to change **specific** behavior(s), compulsions, and/or habit(s)	_____	_____
C. Need to change **general** behavior(s), compulsions, and/or habit(s)	_____	_____
D. Need to change the way I related to others generally	_____	_____
E. Need to change the way I related to specific individual(s)	_____	_____
F. Need to deal with my feelings and needs	_____	_____
G. Need to overcome **specific** fears or phobias	_____	_____
H. Need to overcome **general** fears	_____	_____
I. Sense of loss	_____	_____
J. To get help in making choices or decisions	_____	_____
K. Other **(Specify)** _____	_____	_____

Often therapy changes its focus as it proceeds. Please rate these items a second time according to their importance **DURING** therapy. **(If there was no change just recopy the number from the first column to the second.) Blanks in either column will be considered NOT important to your therapy.** You may explain your answers more fully below if you wish.

_____

_____

6. Whose idea was it to start therapy? **(CIRCLE** the number that fits best:)

   1. My own.
   2. Someone else's. Relationship to you:_____

6a. Why did your therapy end?

_____

_____

7. Did economic considerations play a significant role in

a) ___ your choice of therapist, or b) ___ the type of therapy you received or c) ___ the decision to terminate therapy? (**CHECK** all that apply.)

8. Out of a possible 100%, how much of the time did you follow your most recent therapist's suggestions?
_____% of the time.

9. How did you choose your psychotherapist?

_____

_____

10. Was there a point in your most recent psychotherapy that you think of as the turning point? Would you please describe it below?

_____

_____

_____

11. How long and how often were you in your most recent psychotherapy? **(FILL IN WHICHEVER APPLY TO YOU.)**

11.a INDIVIDUAL THERAPY ____ months
and/or
11.b GROUP THERAPY ____ months.

11.c If you had both, were they ____ SEPARATE or ____ CONCURRENT? **(CHECK ONE.)**

11.d How long ago was your last psychotherapy session? _____months (One week = .25 months)

11.e How often were you in INDIVIDUAL therapy per week?_____/week;

11.f How often were you in GROUP therapy? _____/week.

12. Why do you consider your most recent therapy a success (or failure)?

_____

_____

_____

_____

BELOW ARE A FEW QUESTIONS ABOUT YOUR THERAPIST

13. My most recent therapist's gender is **(CIRCLE ONE):** 0 ____ Female 1 ____ Male

14. Overall I would say that my most recent therapist's approach to therapy was *primarily....*
(PLEASE **CIRCLE** THE **ONE** LETTER BELOW THAT FITS BEST:)

a. **BEHAVIORAL:** My therapist dealt with specific issues, and/or situations and offered direct instructions or training on how to deal with my problems and/or practice in developing new ways of behaving.

b. **PSYCHODYNAMIC:** My therapist and I concentrated on issues that went beyond specific situations and affected broad areas of my life. Our sessions emphasized the importance of insight and self-understanding. (If you choose this description would you say your therapist was primarily: **(CIRCLE ONE.)**

1. Freudian 2. Jungian
3. Interpersonal 4. Other: _____
5. Not Sure

c. **HUMANISTIC/EXPERIENTIAL:** My therapist mainly emphasized the importance of spontaneity and getting in touch with and expressing my feelings.

d. **PHYSIOLOGICAL:** The major part of treatment was based on physical treatment of my problems, including medications and drug therapy.

e. **ECLECTIC:** My therapist employed a number of different approaches. Please describe:

_____

_____

_____

f. **OTHER** orientation **(Please explain.):**_____

_____

_____

PART II -- PERSONAL DATA

1. Sex (CIRCLE ONE) 0 Female 1 Male 1a. Age: _____

   Occupation _____

2. Current Marital Status? CIRCLE appropriate number:

   Married 1
   Divorced 2
   Separated 3
   Widowed 4
   Live-in Lover 5
   Single 6

3. Do you have any children? (CIRCLE ONE) 1 No 2 Yes

4. CIRCLE the number that best corresponds to the highest grade of formal schooling you have completed:

   Grade School: 1 2 3 4 5 6 7 8 High School: 9 10 11 12
   College: 13 14 15 16 Graduate: 17 18 19 20+

5. CIRCLE one or more numbers that best describe your ethnicity.

   Asian 1
   White 2
   Black 3
   Native American Indian or Eskimo 4
   Hispanic 5
   Other (specify) 7

   Country of Origin _____

6. According to your own definition of the terms religious or spiritual, how would you say these terms apply to you? (CIRCLE ONE)

   Very well 1
   Moderately well 2
   A little 3
   Not at all 4

7. Up until the time you were 18, had your parents ever been divorced OR separated for more than six months? (CIRCLE ONE)

   (No) 1
   (Yes Divorced) 2
   (Yes Separated) 3
   (Yes Both) 4

7a. If yes, how old were you when they were divorced? _____; separated? _____
(Answer both if both apply.)

8. How much do each of following descriptions fit you? Fill in the blanks with a percentage so that the total equals 100%. For example, if both apply equally put 50% in each blank.

   _____% I prefer small gatherings and generally rely more on my "inner life" than on my environment for stimulation

   _____% I like large parties and feel good when there is a lot happening around me

PART III -- PSYCHOTHERAPY EXPERIENCE CHECKLIST

For each statement, first decide *how often* the statement was true of your own your most recent psychotherapy experiences, then and put the appropriate number **in the first blank space** after the statement, using the scale below:

0 Not Applicable
1 Never
2 Almost never (once or twice)
3 Seldom
4. Frequently (at about half the sessions)
5. Most of the Time
6. Almost always (at almost every session)
7. Always (occurred on a continual basis)

In the **second space** indicate how *helpful* **overall** you think this frequency, as you experienced it, was in the process of your therapy using the scale below:

0 Not Applicable
1 Very Harmful
2 Harmful
3 Somewhat Harmful
4. Neutral or Mixed Effect
5. Somewhat Helpful
6. Helpful
7. Very Helpful

Note: Some people may find it easier to answer "how often" for all questions first and then go back and answer "how helpful".

	How Often?	How Helpful?
1. My therapist would ask questions to get at important information	1. _____	2. _____
2. My therapist and I had good rapport	1. _____	2. _____
3. My therapist would confront me on issues when s/he felt it was necessary	1. _____	2. _____
4. My therapist was adaptable in technique, attitude, and focus according to the needs of the situation	1. _____	2. _____
5. My therapist got involved with my problems in a way that was meaningful to me	1. _____	2. _____
6. My therapist worked with me on changing bad habits	1. _____	2. _____
7. My therapist did not give me insights but helped me discover these for myself	1. _____	2. _____
8. My therapist gave me a different way of seeing my actions, thoughts or feelings	1. _____	2. _____
9. My therapist let me know whether s/he understood what I was saying or feeling	1. _____	2. _____
10. My therapist focused on the way I related to him/her during therapy	1. _____	2. _____
11. My therapist showed me concrete ways to change my behavior	1. _____	2. _____
12. My therapist gave me feedback and comment when appropriate	1. _____	2. _____

	How Often?	How Helpful?
13. My therapist used his/her approval to motivate me	1. _____	2. _____
14. My therapist used external things to reinforce new patterns of behavior for me or to discourage old ones	1. _____	2. _____
15. My therapist worked with me to change specific things I was doing to create specific problem(s)	1. _____	2. _____
16. My therapist helped me to feel and express my emotions	1. _____	2. _____
17. My therapist set specific goals for therapy	1. _____	2. _____
18. My therapist showed that s/he was warm and caring	1. _____	2. _____
19. My therapist helped me change the way I thought about things	1. _____	2. _____
20. My therapist forced me to focus on what I was doing in the here and now	1. _____	2. _____
21. My therapist communicated that change was possible for me	1. _____	2. _____
22. My therapist showed me specific problem-solving techniques	1. _____	2. _____
23. My therapist helped me learn new ways of responding to situations that were difficult for me	1. _____	2. _____
24. My therapist showed that s/he was sympathetic	1. _____	2. _____
25. My therapist corrected me when I made mistakes	1. _____	2. _____
26. My therapist gave me acceptance and approval	1. _____	2. _____
27. My therapist was generally calm even in a crisis	1. _____	2. _____
28. My therapist communicated enthusiasm about working with me	1. _____	2. _____
29. My therapist disclosed personal information about him/herself	1. _____	2. _____
30. My therapist prescribed psychotherapeutic drugs and medications when I really needed them	1. _____	2. _____

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